STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagle Pointe Skilled Nursing & Rehab	87 Staley Road Orwell, OH 44076

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, review of a grievance form, and facility policy review, the facility failed to ensure that care was provided in a manner that maintained the resident's dignity and honored the resident's right to be informed of and refuse treatment. This failure affected one resident (Resident #20) of three residents reviewed for resident rights. The facility census was 53.Findings include:Record review revealed Resident #20 was admitted on [DATE] with diagnoses including panlobular emphysema, acute and chronic respiratory failure, and severe morbid obesity.Review of a grievance form dated 11/10/25 revealed Resident #20 reported that Certified Nursing Assistant (CNA) #625 used vinegar on him during his shower. The facility investigated the incident and educated CNA #625 on customer service and patient care. The grievance documentation indicated vinegar was not to be used with Resident #20 in the future, and CNA #625 was removed from his care assignment.Review of nurse's notes dated 11/01/25 through 12/01/25 revealed no documentation that Resident #20 was educated on the use of vinegar during bathing or personal hygiene.Review of the physician orders dated 11/01/25 through 04/07/26 revealed no orders for the use or application of vinegar as a treatment.Further review of nurse's notes dated 11/01/25 through 04/07/26 revealed no documentation that vinegar had been used during Resident #20's showers, and no documentation that the resident reported on 11/09/25 he was upset that vinegar had been used without his prior knowledge or consent.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #20 was cognitively intact and required moderate assistance with bathing and personal hygiene.An interview with Resident #20 on 04/07/26 at 8:20 A.M. revealed that during a shower on 11/09/25, CNA #625 told him she needed to pour vinegar on him and then applied it to his leg. He stated he told her no, but she proceeded anyway. He further reported that CNA #625 stated she had been instructed to do so by Social Service Designee (SSD) #654.An interview with CNA #625 on 04/07/26 at 9:05 A.M. revealed that some residents previously requested vinegar during baths to help with odor and yeast issues. She stated she added vinegar to a washcloth with soap and water while assisting Resident #20. According to CNA #625, the resident asked what she was using and why, but did not tell her no. She stated that after the shower, Resident #20 began yelling no means no, at which time she apologized.An interview with SSD #654 on 04/07/26 at 9:22 A.M. revealed Resident #20 reported to her that he told CNA #625 he did not want vinegar used, and that CNA #625 told him SSD #654 instructed her to do so. SSD #654 stated she never told staff to use vinegar on any resident. She reported that vinegar was removed from the unit, discontinued from use, and an investigation was completed.Review of the facility's policy titled Resident Rights, revised 02/2021, revealed residents have the right to be informed of and participate in their care planning and treatment.This deficiency represents noncompliance investigated under Complaint Number 2655050.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/08/2026
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on record review, interview, observation, self-reported incident (SRI) review and facility policy review, the facility failed to ensure residents were free from misappropriation. This affected five Residents (#20, #35, #46, #54, and #55) out of six residents reviewed for misappropriation. The facility census was 53.Findings include:1. Review of the closed medical record for Resident #54 revealed an admission date of 02/19/24. She passed away at the facility on 08/28/25. Her diagnoses included rheumatoid arthritis, chronic pain, and chronic obstructive pulmonary disease (COPD). Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #54 had intact cognition and was on a scheduled pain medication regimen that included opioids (medications prescribed to treat severe or persistent pain, but they can also be addictive). Review of July 2025 physician orders revealed Resident #54 had an order dated 09/09/24 for Oxycodone hydrochloride (HCL) 5 milligram (mg) tablet (opioid pain medication) give one tablet by mouth two times a day for pain. 2. Review of the medical record for Resident #20 revealed an admission date of 07/15/23 with diagnoses including COPD, diabetes, and morbid obesity. Review of the July 2025 physician orders revealed Resident #20 had an order dated 03/05/25 for Oxycodone HCL 5 mg tablet take one tablet by mouth every eight hours as needed for pain. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #20 had intact cognition and received scheduled and as needed pain medications including opioid usage. Interview and observation on 04/07/26 at 8:20 A.M. with Resident #20 revealed he was not aware of any misappropriation, including medications. He revealed he received his medications as ordered and felt his pain was well managed. He displayed no signs of pain on observation. 3. Review of the medical record for Resident #35 revealed an admission date of 11/06/23 with diagnoses including schizophrenia, phantom limb pain (real pain felt in a limb or body part that had been amputated), and muscle wasting. Review of the July 2025 physician orders revealed Resident #35 had an order dated 05/28/24 for Gabapentin (anti-convulsant medication also used for nerve pain) 600 mg by mouth three times a day for pain. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #35 had intact cognition and received pain medications. Interview and observation on 04/08/26 at 11:10 A.M. revealed Resident #35 was not aware of any misappropriation, including medications. He revealed he received his medications as ordered and felt his pain was well managed. He displayed no signs of pain on observation. 4. Review of the medical record for Resident #46 revealed an admission date of 05/13/20 with diagnoses including arthritis of the right hip, muscle wasting, and COPD. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #46 had intact cognition. Review of the July 2025 physician orders revealed Resident #46 had an order dated 05/28/24 for Gabapentin 100 mg give one capsule by mouth three times a day for pain. Interview and observation on 04/07/26 at 8:03 A.M. with Resident #46 revealed he was not aware of any misappropriation, including medications. He revealed he received his medications as ordered and felt his pain was well managed. 5. Review of the closed medical record for Resident #55 revealed an admission date of 06/24/25. She was discharged on 07/31/25. Her diagnoses included osteomyelitis, rheumatoid arthritis, and muscle wasting. Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #55 was cognitively intact and received an opioid. Review of the July 2025 physician orders revealed Resident #55 had an order dated 06/24/25 for Oxycodone HCL 10 mg give one tablet by mouth every four hours as needed for pain. 6. Review of controlled substance (medications with a risk of misuse and dependence that were regulated) delivery sheet dated 06/23/25 revealed the facility received 28 tablets of Oxycodone HCL 5 mg for Resident #54. The facility Individual Patient Controlled Substance Administration Record for this medication was missing. Review of controlled substance pharmacy delivery sheet dated 07/21/25 revealed the (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility received 28 tablets of Oxycodone 5 mg for Resident #20. The facility Individual Patient Controlled Substance Administration Record for this medication was missing. Review of staffing schedule for 07/22/25 to 07/23/25 revealed from 7:00 P.M. to 7:30 A.M. Agency Registered Nurse (RN) #661 was assigned to the south side and Agency Licensed Practical Nurse (LPN) #662 was assigned to the north side. There were no other nurses scheduled. Review of Individual Patient Controlled Substance Administration Record for Former Resident #54 revealed on 07/22/25 at 11:10 P.M. Agency RN #661 had wasted one Oxycodone HCL 5 mg tablet (#28) on the count sheet and the initials next to Agency RN #661 were unrecognizable. The facility stated the initials were not from any staff working on 07/22/25 that had witnessed Agency RN #661 waste this medication. Review of Individual Patient Controlled Substance Administration Record for Former Resident #55 revealed on 07/23/25 at 3:15 A.M. Oxycodone HCL 5 mg tablet number 23, and number 24 were signed out and initialed by Agency RN #661 as wasted. The initials next to Agency RN #661 were unrecognizable and the facility stated they were not from any staff working on 07/23/25 that had witnessed her wasting these medications. Review of SRI tracking number 263138 with date of discovery date of 07/23/25 revealed the facility filed an alleged allegation of misappropriation involving Residents #20, #35, #46, and #54. The SRI revealed on 07/23/25 Agency RN #661 was finishing her assigned shift (7:00 P.M. to 7:00 A.M.) and conducted controlled substance shift-to-shift counts with LPN #639 and LPN #660. Agency RN #661 reported that the nurse from the other side (Agency LPN #662) had come down and helped her organize the controlled substances because she had dropped the cards and that they were out of order. They completed the controlled substance count, and Agency RN #661 left the facility. Within ten to 20 minutes, LPN #639 started to question items in the cart and requested LPN #660 to recount with her. During the recount it was discovered that a full card (28 tablets) of Oxycodone HCL 5 mg was missing as well as another card (four tablets) of Oxycodone HCL 5 mg. The SRI revealed the corresponding controlled substance sheets were missing from the above medications. Also, the nurses noticed some of the controlled substances signed off as wasted during the night had initials as cosigning the observation of the medication as being wasted not matching any of the staff that were in the building the night of 07/22/25 to 07/23/25. The facility attempted to reach Agency RN #661, but there was no answer. All narcotics in the facility were audited, and no other discrepancies were noted, but three cards of Gabapentin (non-controlled medication) were noted to be missing. Police were notified and report #2025-0353 was filed. Agency LPN #662 (the only other nurse on night shift from 07/22/25 to 07/23/25) was contacted and she denied ever going to the south side assisting Agency RN #661 to reorganize the controlled substances and/or witness any controlled substances being wasted. The Medical Director/Primary Care Physician (PCP) #663, pharmacy, residents, family and Board of Nursing were notified of the incident. The medications were replaced by the facility at the cost of the facility. Review of the Controlled Medication Shift Change Log for South B/C cart revealed on 07/22/25 at 7:00 P.M. there were 25 cards and 25 sheets, and the shift-to-shift count was completed by LPN #639 and Agency RN #661. The log revealed before the next shift-to-shift count ,four cards and sheets were removed including Resident #54's Oxycodone, Resident #35's Oxycodone/Acetaminophen (APAP) (controlled substance pain medication), Resident #55's Clonazepam (controlled substance benzodiazepine used to treat seizures or panic disorder) and a (unrecognizable name) for a Tramadol (controlled substance pain medication) card and sheet. The facility revealed no residents on 07/22/25 and/ or 07/23/25 had an order for Tramadol on the south B/C cart during this time frame. The log revealed on 07/23/25 at 7:00 A.M. there were 21 cards and 21 sheets when Agency RN #661 and LPN #639 counted. Review of the incident reports dated 07/23/25 at 7:30 A.M. and completed by LPN/Minimum Data Set (MDS) #634 revealed Resident #54 was missing four tablets of oxycodone HCL 5 mg as well as the count sheet, Resident #20 was missing 28 tablets of oxycodone HCL 5 mg as well as the count sheet that went along with the medication, Resident #35 was missing two cards of Gabapentin 300 mg, and Resident #46 was missing one card of Gabapentin 300 mg. Review of the undated and unauthored Explanation of Events (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed Resident #54 received 28 tablets of Oxycodone HCL 5 mg on 06/23/25, and the card and sheet was completed on 07/10/25 at 7:25 P.M. Resident #54 received a new card on 07/04/25 and that sheet started on 07/11/25 at 8:00 A.M. The summary revealed Resident #54's card and sheet were missing. Resident #54 also had a new Oxycodone HCL card that the facility received on 07/22/25 and one tablet was wasted with initials next to but was not the other nurse's initials in the building. Resident #20 received a card of Oxycodone HCL 5mg (28 tablets) with a count sheet on 07/21/25 and when counting on 07/23/25 the card and sheet were missing. Review of the witness statement dated 07/23/25 at 7:50 A.M. and completed by LPN #639 revealed she came on duty on 07/23/25 at 7:00 A.M., and Agency RN #661 asked her to clock her out before report. Agency RN #661 proceeded to give report and complete controlled substance count, but before counting, Agency RN #661 stated she dropped all the cards, and the other nurse from the north side came over and helped her organize the cards. The statement revealed they counted and the controlled substance count was correct. LPN #639 started putting the controlled substances back in alphabetical order with LPN #660 beside her and noticed that Resident #20 had gotten a new Oxycodone HCL card on Monday night, 07/21/25 with 28 tablets. The card and the count sheet were not in the cart, and the book and the card were not signed off as taken out of the cart. LPN #639 then had LPN #660 check, and they also could not find Resident #54's controlled substance sheet as it was taken out of the cart. Review of the witness statement dated 07/23/25 at 8:00 A.M. and completed by LPN #644 revealed she arrived on the shift on 07/23/25 at 7:02 A.M. and Agency RN #661 was trying to have staff sign her out on the agency app. LPN #644 completed controlled substance count on the south A/ B cart and the count was correct. Then Agency RN #661 counted with LPN #639 on the south B/C cart, and Agency RN #661 stated she had dropped the cards, and the nurse from the north side last night had helped her put them back in order. The statement revealed she proceeded to complete the shift-to-shift count, and all the pages and count were correct, and Agency RN #661 left. LPN #639 then stated something was not right and recounted at which time she noted a card of Oxycodone HCL that she had signed in from pharmacy a few days ago was not in the drawer. The statement revealed both, LPN #644 and LPN #639 recounted the pages, cards and looked to see when cards were signed in and out of the cart. They discovered on 07/21/25 the card of Oxycodone HCL was signed into the cart on 07/21/25; however, the card and controlled count sheet was missing, and another controlled substance was signed out that was not taken out and was fully accounted for, present in the cart and the sheet was in book. The statement revealed management was immediately notified. Review of the witness statement dated 07/23/25 at 4:32 P.M. and completed by the Administrator revealed on 07/23/25 at 7:38 A.M. he was notified of suspected drug diversion involving Agency RN #661. Resident #20 was missing a card (28 tablets) of Oxycodone HCL, and Resident #54 was missing four tablets of Oxycodone HCL 5 mg. The statements also revealed he was notified of other discrepancies with medications that had been wasted. Review of the witness statement dated 07/23/25 at 5:00 P.M. and completed by LPN/MDS #634 revealed LPN #639 had contacted her on 07/23/25 at 8:00 A.M. regarding the shift-to-shift controlled log revealed Agency RN #661 had signed out that four medications were completed throughout the night but that there were only two papers located for the completed medications. Review of the witness statement dated 07/24/25 at 3:00 A.M. and completed by Former RN #664 revealed he was performing medication pass and noticed missing medications: Resident's #46's one card of Gabapentin 300 mg and Resident #35's two cards of Gabapentin. The statement revealed the facility had received Resident #35's Gabapentin on 07/16/25 and Resident #46's Gabapentin on 07/20/25. Review of the witness statement dated 07/24/25 at 2:56 P.M. and completed by Agency LPN #662 revealed she worked the north side on 07/22/25 at 7:00 P.M. to 07/23/26 at 7:00 A.M. and never stepped foot on the south side. She revealed during the shift she had seen Agency RN #661 one time when she came to the north side asking if she had seen any of her aides. The statement revealed she never wasted any controlled substances with Agency RN #661. Interview on 04/07/26 at 10:22 A.M. with LPN #660 revealed she and LPN #639 came on duty on (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/23/25 at approximately 7:00 A.M. to relieve Agency RN #661 including obtain report and complete shift-to-shift count on the south A/B cart. She revealed the south A/B cart was correct, and then Agency RN #661 counted the south B/C cart with LPN #639. She revealed prior to giving report and counting, Agency RN #661 wanted to leave as she was trying to get LPN #639 to sign her out on the agency app. After LPN #639 counted, she realized a whole Oxycodone card for Resident #20 was missing from the cart. She felt it was odd as she had remembered she had just recently signed in Resident #20's card, and it was no longer in the cart. They also found other sheets with Oxycodone marked as wasted, but the person that cosigned witnessing was not a nurse that they recognized initials for. They immediately notified management of the misappropriation of medications. Interview on 04/07/26 at 12:42 P.M. with MDS/LPN #634 and the Director of Nursing (DON) revealed the DON was on vacation at the time of the incident on 07/23/25. MDS/LPN #634 verified she was involved in investigating the incident and verified medications were misappropriated including Resident #54 was missing four tablets of Oxycodone 5 mg as well as the count sheet, Resident #20 was missing 28 tablets of Oxycodone 5 mg as well as the count sheet that went along with the medication, Resident #35 was missing two cards of Gabapentin 300 mg, and Resident #46 was missing one card of Gabapentin 300 mg. They also verified Former Resident #54's Individual Patient Controlled Substance Administration Record on 07/22/25 at 11:10 P.M. revealed Agency RN #661 had wasted one Oxycodone 5 mg tablet (#28) on the count sheet, and the initials next to Agency RN #661 were unrecognizable. They revealed the initials were not from any staff working on 07/22/25 that had witnessed her wasting this medication. They also verified Individual Patient Controlled Substance Administration Record for Former Resident #55 revealed on 07/23/25 at 3:15 A.M. Oxycodone HCL 5 mg tablets number 23 and number 24 were signed out and initialed by Agency RN #661 as wasted. The initials next to Agency RN #661 were unrecognizable, and the facility stated they were not from any staff working on 07/23/25 that had witnessed her wasting these medications. They felt the medications were misappropriated by Agency RN #661 but that they unsubstantiated the SRI as from their understanding the case was still being investigated and prosecuted. Interview on 04/07/26 at 3:06 P.M. with LPN #639 revealed she came on duty on 07/23/25 at approximately 7:00 A.M. and before counting and getting report found it odd that Agency RN #661 was trying to get her to clock her out on the agency app. She obtained report and completed the shift-to-shift count for the B/C cart with Agency RN #661. Prior to counting, Agency RN #661 stated she had dropped all the controlled substance cards and that they may be out of order as she had the nurse from the other side come over and assist in putting the cards back in order. She revealed the number of cards and the amount of medication in the cards were correct. After Agency RN #661 left, she realized Resident #20 did not have his Oxycodone HCL card in the cart which she found was odd as she had just recently added it to the cart on 07/21/25 when it was delivered. She requested LPN #660 assist in recounting and at that time they discovered that Agency RN #661 had documented that she removed (an unrecognizable name) for a Tramadol card and sheet. There were no residents with an order for Tramadol. She also noted that medications were signed out as wasted with initials cosigning that they were witnessed, but they were not recognized as initials of staff that worked at the facility. She immediately contacted management, and an immediate investigation was conducted including notifying the police. Review of the policy labeled, Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigation, last revised September 2022, revealed all reports of resident abuse including theft and misappropriation were to be reported to local, state and federal agencies as required. There was nothing in the policy in regard to residents were to remain free from misappropriation. The deficient practice was corrected on 07/25/25 when the facility implemented the following corrective actions:- On 07/23/25, the Administrator filed an SRI to the state agency involving misappropriation of medications for (Residents #20, #35, #46, and #54) that involved Agency RN #661 and completed an investigation including witness statements that were conducted by Former Regional Director #667, Administrator, LPN/MDS #634 and Former RN/Assistant Director of Nursing (ADON) #666.- On (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/23/25, Former Regional Director #667, Administrator, and LPN/MDS #634 attempted to contact Agency RN #661 to obtain statement but were unable to reach her. The agency and police attempted but were also unable to reach her.- On 07/23/25, the police department was notified by the Administrator, and a police report #2025-0353 was filed. They were unable to obtain the report at this time due to the incident being prosecuted. - On 07/23/25, the agency was contacted by the Administrator to report the incident of misappropriation involving Agency RN #661 and to have her account deactivated to not return to the facility.- On 07/23/25, Agency LPN #662 was notified by Former Regional Director #667 and denied assisting Agency RN #661 reorganize the controlled substances and/or witnessing wasting any controlled substances.- On 07/23/25, all the narcotics in the facility were audited by Former RN/ ADON #666 to ensure that there were no other missing narcotics. At this time, it was determined that three Gabapentin cards were found to be missing. - On 07/23/25 and 07/24/25, all residents were interviewed by Former RN/ADON #666 that were capable of being interviewed and those not able to be interviewed were assessed for their pain management. No issues were noted. An audit of resident records revealed no residents missed any medications. This audit was completed by Former Regional Director #667 and Former RN/ADON #666.- On 07/23/25, incident reports and head-to-toe assessments were completed by LPN/MDS #634 on affected residents (Residents #20, #35, #46, and #54), and they were all at baseline. Additional head-to-toe assessments were completed by LPN/MDS #634 on residents unable to be interviewed. No concerns were identified. - On 07/23/25, Medical Director/Primary Care Physician (PCP) #663 was notified of the incident by Former RN/ADON #666.- On 07/23/25, vital signs and pain evaluations were completed for affected residents (Residents #20, #35, #46, and #54). This was overseen by Former RN/ADON #666.- On 07/24/25, all nurses were in-serviced on controlled substance counts by the Administrator and Former RN/ADON #666.- On 07/24/25, controlled substance sign off audits were initiated: five residents three times a week for three weeks and then five residents weekly and then randomly. These were completed by Former RN/ADON #666.- - On 07/24/25, The Ohio Board of Nursing was contacted by Former Regional Director #667 regarding the incident.- On 07/24/25, the facility pharmacy was contacted by Former RN/ADON #666 regarding the incident and reported the incident to the Board of Pharmacology. The facility replaced all medications at the facility cost. - On 07/24/25 a Quality Assurance and Performance Improvement (QAPI) meeting was held 07/24/25 at 2:00 P.M. and the Medical Director/PCP #663, Administrator, Former Director of Clinical Services #667, Medical Records #602, Former RN/ADON #666, MDS/LPN #634, Rehabilitation Director #657, Activities Director #601, Scheduler #603 attended. - On 07/25/25, psychosocial follow up was completed per the Administrator for the affected residents (Resident #20, #35, #46, and #54), and no adverse effects were identified.This deficiency was an incidental finding identified during the complaint investigation.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of a grievance form and facility policy review, the facility failed to ensure treatments were provided in accordance with professional standards and failed to obtain a physician's order prior to administering a topical treatment. This resulted in vinegar being applied to Resident #20 without a physician's order and against the resident's expressed refusal. This deficient practice affected one (Resident #20) of three residents reviewed for physician-ordered treatments. The facility census was 53.Findings include:Review of medical record for Resident #20 revealed he admitted on [DATE] with diagnoses including panlobular emphysema, chronic obstructive pulmonary disease (COPD), obstructive sleep apnea (OSA), insomnia, congestive heart failure (CHF), gastroesophageal reflux disease (GERD), deep vein thrombosis (DVT), Lupus anticoagulant syndrome, anemia, muscle wasting and atrophy, difficulty walking, pain, major depressive disorder, anxiety, iron deficiency, bilateral primary osteoarthritis (OA) hips, acute and chronic respiratory failure, and morbid severe obesity.Review of the grievance form dated 11/10/25 showed Resident #20 reported Certified Nursing Assistant (CNA) #625 used vinegar on him during a shower despite him refusing. The facility educated CNA #625 and removed vinegar from future use with Resident #20. Review of physician orders dated 11/01/25-04/01/26 revealed no physician order for the application or use of vinegar for Resident #20. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #20 was cognitively intact and required moderate assistance with bathing and personal hygiene.Interview with Nurse Practitioner (NP) #665 on 04/07/26 at 8:00 A.M. revealed he had not ordered vinegar for resident baths and stated he would not order acetic acid for bathing. Interview with Resident #20 on 04/07/26 at 8:20 A.M. revealed on 11/09/25 he was getting a shower with assistance from CNA #625, and she told him she had to pour vinegar on him. Resident #20 stated he said no, but she applied it anyway. Interview with Primary Care Physician (PCP)/Medical Director #663 on 04/07/26 at 8:55 A.M. revealed she had discussed vinegar conceptually with staff but had never written an order for vinegar use for any resident. Interview with CNA #625 on 04/07/26 at 9:05 A.M. confirmed she used vinegar on Resident #20 on 11/09/25 and stated vinegar baths were used for some residents to minimize yeast and odors. Interview on 04/07/26 at 9:22 A.M. with Social Services Designee (SSD) #654 revealed Resident #20 came to her about the vinegar used in his bath. She revealed Resident #20 stated he told CNA #625 he did not want to use it, and that she said SSD #654 told her to. SSD #654 denied telling CNA #625 to use vinegar, and stated vinegar was removed from the floor after the incident. Interview on 04/07/26 at 2:15 P.M. with CNA #625 revealed vinegar baths were still being done for residents who requested them. She revealed the vinegar was now kept in the Director of Nursing (DON's) office and the CNA must request it.Review of the facility policy titled Medication and Treatment Orders, dated 2001 and revised July 2016, revealed medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state.Review of the facility policy titled Wound Care, revised 10/2010, revealed to verify that there was a physician's order for any procedure involving skin and wound management.This deficiency represents non-compliance investigated under Complaint Number 2655050.