STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366312	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gardens of St. Francis	930 South Wynn Road Oregon, OH 43616

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, and policy review the facility failed to ensure adequate monitoring for psychotropic medication effectiveness, side effects and adverse effects. This affected four (#16, #6, #38, and #68) of five residents reviewed for unnecessary medications. The facility identified 39 residents receiving psychotropic medications. The facility census was 57.Findings include: 1. Resident #16 admitted to the facility on [DATE] with the diagnoses including major depression and anxiety disorder. According to the most current Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #16 with moderately impaired cognition, no resistive behaviors, required supervision or touching assistance with eating, and dependent for completion of activities of daily living. On 11/18/25 a nursing plan of care was revised to address Resident #16's mood disorder related to her diagnoses of cyclothymic disorder, insomnia, anxiety, and depression. Currently being seen by psychiatric services. Has had crying episodes and refusals of care and will refuse to eat when she is upset about something. Is not always easy to redirect. Refused medications if she is already in bed at times. Interventions included; Provide adequate rest periods throughout the day. Administer medications as ordered. Monitor/document for side effects and effectiveness. Monitor/document/report to Nurse/Physician (MD) signs/symptoms (s/sx) of depression, including: hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, tearfulness. Monitor/record/report to MD as needed (prn) risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. Pharmacy review monthly. Review of physician orders noted the following; 03/04/26 lamotrigine 100 milligrams (mg) give one table by mouth once daily for depression/anxiety. Give 100 mg by mouth in the evening for depression/anxiety. 03/21/26 sertraline 100 mg by mouth daily with 25 mg total dose 125 mg for anxiety/depression. 01/15/26 duloxetine 60 mg give two capsules by mouth one time daily for depression to equal 120 mg. There were no orders for monitoring for medication effectiveness, adverse effects and side effects. Review of the nurses' notes, medication administration records (MARs), and treatment administration records (TARs) from 01/01/26 through 03/25/26 revealed no documentation the resident was monitored for medication effectiveness, adverse effects, and side effects of the psychotropic medications. Interview of 03/25/26 at 10:02 A.M., the Director of Nursing (DON) verified there was no documentation Resident #16 was monitored for adverse effects and side effects of the psychotropic medications. 2. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE]. (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Diagnoses included unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, bipolar disorder, major depressive disorder, anxiety disorder. Review of the quarterly MDS assessment for Resident #6, dated 02/04/26, revealed a Brief Interview for Mental Status (BIMS) score of three indicating severe cognitive deficits. Further review of the MDS revealed Resident #6 exhibited wandering behaviors one to three days a week. Review of the admission care plan for Resident #6, dated 07/31/25, revealed interventions for nursing staff to administer antidepressant and psychotropic medications as ordered by the physician. Additionally, care plan for Resident #6 contained interventions to monitor, document and report adverse reactions of psychotropic medications. Review of orders for Resident #6 revealed an order entered on 07/31/25 for Lexapro oral tablet 5 mg by mouth one time a day for anxiety. Additionally, an order was entered on 01/20/26 for Risperdal oral tablet 0.5 mg, give one tablet by mouth one time a day for bipolar. No order was entered to monitor the side effects of psychotropic medications. Interview on 03/25/26 at 10:02 A.M. with the DON revealed verification of monitoring for psychotropic side effects was not being done for Resident #6. 3. Record review revealed Resident #38 was admitted on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominate side, major depressive disorder, chronic embolism and thrombosis of deep veins of lower extremity, and contracture of joint. Review of the quarterly MDS dated [DATE] revealed Resident #38 was cognitively intact and received psychotropic medications. Review of Resident #38's medication orders revealed an order dated 04/02/25 for Sertraline HCL Oral Tablet 25mg one tablet three times a day for depression or anxiety and an order dated 02/18/26 for buspirone HCL Oral Tablet 2.5mg by mouth three times a day for anxiety. Review of the nurses' notes, MARs, and TARs from 02/22/26 through 03/25/26 revealed no documentation the resident was monitored for medication effectiveness, adverse effects, and side effects of the psychotropic medications. Interview on 10/25/26 at 10:02 A.M. with the Director of Nursing (DON) confirmed that psychotropic medication side effect monitoring was not in place for Resident #38. 4. Review of Resident #68's medical record revealed an admission date of 11/19/25 and a discharge date of 06/02/25. Diagnoses included type II diabetes, protein calorie malnutrition, muscle wasting, cognitive communication deficit, symbolic disfunctions, reduced mobility, anxiety disorder, fracture of upper end of left humerus subsequent encounter, major depressive disorder, Alzheimer's disease, and peripheral vascular disease. Review of Resident #68's MDS dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of nine indicating Resident #68 was moderately cognitively impaired. Resident #68 required maximal assistance with toilet use, bathing, and parts of dressing. Resident #68 was independent with bed mobility and transfer with supervision. Resident #68 displayed no behaviors at the time of the review. Resident #68 was on hospice at the time of the review. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #68's care plan revised 06/03/25 revealed supports and interventions for psychotropic medications use including antidepressant medications, antianxiety medications. Resident #68 was at risk for adverse reactions. Interventions included administer medications as ordered and monitor, document, and report as needed adverse reactions. Review of Resident #68's physician orders revealed Resident #68 was ordered Mirtazapine (antidepressant) 15 milligrams (mg), lorazepam (antianxiety) 0.5 mg, Ativan (antianxiety) 1 mg, and Seroquel (antipsychotic) 25 mg. Review of Resident #68's 05/29/25 geriatric mental health stabilization documentation from his acute stay from 05/13/25 to 05/29/25 revealed Resident #68 was monitored for psychotropic medication side effects during his stay at the acute care geriatric psychiatric facility. Resident #68 was monitored for potential side effects for antidepressant medication use, antipsychotic medication use, and antianxiety medication use every shift. Review of Resident #68's medical record from 11/19/25 to 05/14/25 and 05/29/25 to 06/02/25 found no evidence Resident #68 was monitored by the facility for psychotropic medication side effects. Interview on 03/25/26 at 10:02 A.M. with the Director of Nursing (DON) verified monitoring for side effects of psychotropic medications had not been completed. Review of the facility policy titled, Use of Psychotropic Medications, revised 08/29/25 revealed the residents response to the medications including progress toward goals and presence or absence of averse consequences should be documented in the resident's medical record. Review of the facility policy titled, Medication Administration, revised 05/03/22 revealed the facility would report and document any adverse side effects or refusals of medications.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews, staff interviews, and review of facility policies, the facility failed to ensure pneumococcal and influenza vaccinations were up to date. This affected five (Residents #13, #17, #33, #36, and #56) of five residents reviewed for immunizations. The facility census was 57.Findings include:1.Review of the medical record for Resident #13 revealed he was admitted on [DATE] with diagnoses including cardiomegaly, hypertension, type two diabetes mellitus, stage 3B chronic kidney disease, chronic obstructive pulmonary disease, and obstructive sleep apnea.Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] for Resident #13 revealed he was cognitively impaired and did not display any behaviors nor refusals of care at the time of this assessment. He required moderate assistance with ambulation and activities of daily living. Resident #13 had chronic lung disease and experienced shortness of breath when lying down. This assessment indicated his pneumococcal vaccine was up to date.Review of the care plan for Resident #13 revealed focus areas dated 11/11/25 for risk of altered respiratory status related to respiratory disorders and risk for infection related to communal living and medically complex diagnoses.2. Review of the medical record for Resident #17 revealed she was admitted on [DATE] with diagnoses including hemiplegia and hemiparesis following a stroke, muscle weakness, dementia, stage three chronic kidney disease, anxiety, depression, and a personal history of brain cancer.Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] for Resident #17 revealed she utilized a walker independently up to 50 feet and required set-up to moderate assistance with activities of daily living. This assessment indicated she experienced shortness of breath when lying down, had received her influenza vaccine outside the facility, and her pneumococcal vaccine was up to date. Resident #17 had not experienced any falls since her prior MDS assessment dated [DATE].Review of the most recent care plan for Resident #17 revealed interventions related to being at risk for falls, infections due to communal living, verbally abusive behaviors, altered respiratory status and difficulty breathing.3. Review of the medical record for Resident #33 revealed she was admitted on [DATE] with diagnoses including dementia, dysphagia, hypertension, hyperlipidemia, muscle wasting, protein-calorie malnutrition, pain to lower extremities, and reduced mobility.Review of the quarterly Minimum Data Set 3.0 dated 01/04/26 for Resident #33 revealed she was cognitively impaired, did not exhibit behaviors, and did not refuse care. She utilized a wheelchair and was dependent for transfers and mobility. Resident #33 required maximal to dependent level of care with activities of daily living. This assessment indicated she was at risk for developing pressure injuries and her pneumococcal vaccine was up to date.Review of the care plan for Resident #33 revealed a goal dated 09/25/25 to maintain intact skin through the next review. Related interventions did not include the ordered heel protector boots to bilateral feet every shift. Additionally, there was a focus area dated 12/27/25 for risk for infection related to communal living and a focus area dated 01/08/26 for the potential for altered respiratory status related to respiratory disorder.4. Review of the medical record for Resident #36 revealed she was admitted on [DATE] with diagnoses including acute respiratory failure with hypoxia, heart failure, pleural effusion, obstructive sleep apnea, shortness of breath, and type two diabetes mellitus.Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] for Resident #36 revealed she experienced moderate cognitive impairment, displayed verbal behavioral symptoms toward others, and did not refuse care. She utilized a wheelchair, was dependent for transfers and mobility, and required maximal assistance with activities of daily living. Resident #36 experienced shortness of breath while lying down. This assessment indicated her pneumococcal vaccine was not up to date because it had not been offered.Review of the care plan for Resident #36 revealed a focus area dated 12/18/25 indicating she was at an increased risk for infections due to communal living and chronic obstructive pulmonary disease. Additionally, the care plan included a focus area dated 12/27/25 related to Resident #36 being at risk for altered respiratory status.5. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record for Resident #56 revealed she was admitted on [DATE] with diagnoses including retroperitoneal hematoma, chronic kidney disease, non-pressure chronic ulcer of right lower leg, atrial fibrillation, dilated cardiomyopathy, atrioventricular block, heart failure, iron deficiency anemia, intestinal malabsorption, and type two diabetes mellitus.Review of the admission assessment dated [DATE] for Resident #56 revealed she was alert and oriented to person, place, and time, pleasant and cooperative. Review of the pressure ulcer risk tool revealed she was at risk for skin breakdown.Review of the care plan for Resident #56 revealed a focus area dated 03/24/26 indicating she was at risk for infection due to communal living.Review of the influenza immunization record for Resident #56 revealed the absence of evidence regarding this resident having received this vaccine, nor was the vaccine offered when she was admitted to the facility on [DATE].Review of pneumococcal immunization records for Residents #13, #17, #33, #36, and #56 revealed their pneumococcal immunizations were not up to date.Interview on 03/25/26 at 8:15 A.M. with the Director of Nursing confirmed pneumococcal immunizations for Residents #13, #17, #33, #36 were not up to date. Continued interview confirmed there was no documentation regarding Resident #56 having received this vaccine, nor was the vaccine offered when she was admitted to the facility.Review of a facility policy dated 03/01/23 and titled Influenza Vaccination revealed the facility would offer residents immunization against influenza disease annually between October 1st and March 31st. Additionally, the policy stated residents' medical records would include documentation if the vaccine was received, not received due to medical contraindications, or declined.Review of a facility policy dated 03/02/23 and titled Pneumococcal Vaccine (Series) revealed the facility would offer residents immunization against pneumococcal disease in accordance with CDC guidelines. Additionally, the policy stated residents' medical records would include documentation if the vaccine was received, not received due to medical contraindications, or declined.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews and record review, the facility failed to respect a resident's preference to sleep in. This affected one (#16) of one resident reviewed for sleep preferences. The facility census was 57. Resident #16 admitted to the facility on [DATE] with the diagnosis including, chronic obstructive pulmonary disease, myasthenia gravis, epilepsy, dysphagia, major depression, pseudosarcomatous fibromatosis, hypertension, anxiety disorder, coronary artery disease, insomnia, congestive heart failure, and neurofibromatosis.According to the most current Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #16 with moderately impaired cognition, no resistive behaviors, required supervision or touching assistance with eating, dependent for completion of activities of daily living, and utilized a wheelchair for mobility propelled by staff. On 11/17/25 a nursing plan of care was revised to address Resident #16 activity of daily living (ADL) self care performance deficit d/t weakness, lower extremities, balance problems, muscle atrophy, cognitive deficit and immobility. Interventions included; two person assist with transfers using Hoyer lift. ADLs are moderate to maximum assist. ADLs may vary from day to day. Anticipate my needs. Assist with meals as needed. Coordinate care with hospice. Encourage resident to use bell to call for assistance. Head of the bed elevated to comfort to prevent shortness of breath if lying flat. Wheelchair for mobility. Interview on 03/23/26 at 11:25 A.M. with Resident #16 revealed staff wake them early in the morning, provide morning activities of daily living and place them in their wheelchair. This occurs in the morning at approximately 5:00 A.M. Resident #16 states they prefer to sleep in. On 03/24/26 at 5:40 A.M. interview with Certified Nurse Aide (CNA) #387 revealed Resident #16 was woken up at 5:15 A.M. dressed, groomed, and left in bed. CNA #387 stated Resident #16 is resistant at times. On 03/24/26 at 2:00 P.M. interview with CNA #377 noted a hand written instruction with the heading 6:00 P.M. to 6:00 A.M. Get ups. Each unit/hall is to have three (3) patients up prior to 6:00 A.M. to 6:00 P.M. arriving. Thank you for your cooperation. A second handwritten list with the heading A hall get ups. Five residents were listed including Resident #16. Instruction noted Resident #16 to be washed and dressed in bed, then get into wheelchair at 5:00, if she refuses try again or get nurse. Whirlpool Tuesday, Thursday, Saturday. On 03/24/26 at 2:35 P.M. interview with the Assistant Director of Nursing (ADON) and Director of Nursing (DON) during a review of the list revealed they were unaware of the get-up list. On 03/24/26 at 2:42 P.M. telephone interview with Resident #16's Responsible Party (RP) was unaware resident was to be risen from bed during the 6:00 P.M. to 6:00 A.M. shift. Resident #16 RP stated if resident was sleeping, leave resident sleeping.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview and policy review, the facility failed to have a required Preadmission Screening and Resident Review (PASARR) in place prior to admission. This affected one resident, #6, out of four residents reviewed for PASARR. The facility census was 57. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE]. Diagnoses included unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, bipolar disorder, major depressive disorder and anxiety disorder.Review of the quarterly Minimum Data Set (MDS) assessment for Resident #6, dated 02/04/26, revealed a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive deficits. Further review of the MDS revealed Resident #6 exhibited wandering behaviors one to three days a week. Review of the admission care plan for Resident #6, dated 07/31/25, revealed interventions included, staff are to distract resident from wandering by offering pleasant diversion. Further review of the care plan revealed staff were to administer antidepressant and psychotropic medications as ordered by physician.Review of the medical record for Resident #6 revealed no PASARR was completed and resident had mental illness diagnoses of bipolar disorder, major depressive disorder, and anxiety disorder. Interview on 03/25/26 at 11:03 A.M. with Director of Marketing (DOM) revealed PASARR was completed on 03/24/26. DOM stated a search was done through the Healthcare Electronic Notification System ([NAME]) and was unable to find that a PASARR was completed prior to 03/24/26. DOM verified that Resident #6 did not have a PASARR complete prior to admission to the facility. Review of the policy titled Resident Assessment- Coordination of PASARR Program dated 03/01/23, revealed all applicants to the facility will be screened for serious mental disorders or intellectual disabilities and related conditions. Further review of the policy revealed the initial pre-screening would be completed prior to admission to the facility.

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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 observation, medical record review, staff interview, and policy review, the facility failed to apply anti-emboli stockings (TED hose) as ordered by the physician. This affected one resident (#6) out of one reviewed for application of TED hose. The facility census was 57.Review of the medical record revealed Resident #6 was admitted to the facility on [DATE]. Diagnoses included unspecified dementia without behavioral disturbance, muscle wasting and atrophy, generalized osteoarthritis, rheumatic tricuspid insufficiency and cardiomegaly. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #6, dated 02/04/26, revealed a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive deficits. Further review of the MDS revealed functional abilities for Resident #6 included substantial/max assist for toileting hygiene, shower/bathing, upper/lower body dressing and personal hygiene.Review of the admission care plan for Resident #6, dated 07/31/25, revealed the resident was at risk for edema of the lower extremities with interventions of applying support stockings and elevation of legs. Additional care plan in place for self- care deficit. Review of the orders entered on 08/01/25 at 7:00 A.M. for Resident #6 revealed an order for the application of TED hose to bilateral lower extremities every day for edema. Additional order entered on 07/31/25 to remove TED hose at bedtime for edema. Review of the Treatment Administration Record for Resident #6 revealed TED hose have been applied to the resident every morning and removed every evening. Further review of the TAR revealed Resident #6 had TED hose applied the mornings of 03/24/26 and 03/25/26. Observation on 03/24/26 at 7:30 A.M. revealed Resident #6 was sitting in the recliner in the common area with eyes closed. No TED hose was seen on lower extremities. Observation on 03/24/26 at 10:16 A.M. revealed Resident #6 was sitting in the recliner in the common area. No TED hose was seen on lower extremities. Observation on 03/24/26 at 1:00 P.M. revealed Resident #6 was sitting in the recliner in the common area with eyes closed. No TED hose was seen on lower extremities. Observation on 03/25/26 at 9:41 A.M. revealed Resident #6 sitting in the recliner in the common area with eyes closed. No TED hose was seen on lower extremities.Interview on 03/25/26 at 9:41 A.M. with the Assistant Director of Nursing (ADON) verified that Resident #6 did not have TED hose on lower extremities as ordered by the physician. Interview on 03/25/26 at 9:50 A.M. with Registered Nurse (RN) #407 revealed Certified Nursing Assistants (CNAs) are to place TED hose on the residents in the morning and CNAs are to remove TED hose at bedtime. RN #407 continued to state it is the nurses' responsibility to document in the TAR if the TED hose had been applied and removed. RN #407 was asked if TED hose were placed on Resident #6 on the morning of 03/25/26, RN #407 stated he has not yet verified the placement of the TED hose. Review of the TAR with RN #407 verified his initials were entered on 03/25/26 as verification that TED hose was in place. Review of policy titled, Applying Ant-Emboli Stockings (TED Hose), last revised 10/2010 revealed the purpose of anti-emboli stockings are to improve venous return to the heart, to improve arterial circulation to the feet, to minimize edema to the legs and feet, and to prevent complications associated with deep vein thrombosis and pulmonary embolism. Further review of the policy revealed anti-emboli stockings should be applied in the morning, prior to the resident getting out of bed. Additionally, a supervisor is to be notified if the resident refuses to wear the anti-emboli stockings.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews, observations, resident interview, staff interview, and review of facility policy, the facility failed to ensure pressure ulcer prevention measures were utilized. This affected three Residents #3, #33, and #56) of five residents reviewed for pressure ulcers. The facility census was 57.Findings include:1. Resident #3 admitted to the facility on [DATE] with the diagnosis including, congestive heart failure, hypertension, chronic kidney disease stage 3, major depression, atrial fibrillation, left hip bursitis, polyneuropathy, osteoporosis, and anemia. According to the most current minimum data set assessment dated [DATE] Resident #3 was assessed with intact cognition, lower extremity impairment on one side, required substantial to maximal assistance with activities of daily living, independently mobile using an electric wheelchair, frequently incontinent of urine, continent of bowel, received a therapeutic mechanically altered diet, at risk for pressure ulcer development with open lesions and skin tears. Review nursing plan of care dated 08/07/25 addressing Resident #3 potential for impairment to skin integrity of the related to incontinence, decreased mobility and fragile skin. Interventions included; Air mattress to bed to help with skin integrity (added 03/18/26). Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Encourage good nutrition and hydration in order to promote healthier skin. Follow facility protocols for treatment of injury. Identify/document potential causative factors and eliminate/resolve where possible. Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. On 10/15/25 Resident #3 was assessed at moderate risk of developing a pressure sore with a numeric score of 14. On 02/19/26 physician orders initiated wound care to right buttock- cleanse with wound wash, apply hydrocolloid paste (triad paste) twice daily and as needed, every shift for blister to right buttock and as needed for right buttock wound/blister. Review of Resident #3 weight noted on 03/23/26 a weight of 209.5 pounds. Physician order on 03/17/26 air mattress to bed every shift for pressure reduction. No addition instruction or settings were ordered. Observation on 03/24/26 at 8:49 A.M. noted Resident #3 assisted to the bathroom. Certified Nurse Aide (CNA) #377 exposed Resident #3 buttock after removing an adult incontinence brief. Observation noted a open area of skin breakdown to the right buttock with a scant amount of blood tinge drainage. Triad past residue was in place. Review of the medical record between 03/24/26 at 8:49 A.M. and 03/25/26 at 6:45 A.M. revealed no evidence indicating the open wound was assessed or reported for treatment modification. On 03/25/26 at 6:47 A.M. interview with wound physician during assessment of Resident #3 noted a stage 2 (II) pressure ulcer to the right buttock. Description noted measurements of 1.0 centimeters (cm) long by (x) 0.3 cm wide x 0.1 cm deep with light light Serosanguinous drainage. Further observation noted wound physician to decrease the weight setting of the air mattress from 250 pounds to 180 pounds. Review of air advance mattress and bariatric owners manual dated 2017. Common method of sizing an air mattress is to check to see if suitable pressure is selected by sliding one hand between the air mattress and the air/foam base under the residents buttocks. Users should be able to feel the space between their hand and the residents buttocks with the acceptable range being from 25 to 50 millimeters or 1 inch to 1.5 inches. Review of Air Mattress compressor control unit undated. Installation instructions determine the patients weight and set control knob to that weight setting on the control unit. On 03/25/26 at 6:59 A.M. interview with Licensed Practical Nurse (LPN) #428 during a review of Resident #3 medical record verified the air mattress physician order did not include mattress settings or function. LPN #428 went on to state maintenance staff place the air mattresses to the beds and nurses observe them in place. LPN #428 was unaware if mattress settings were required or how to ensure mattresses were monitored for proper function. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366312	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gardens of St. Francis	930 South Wynn Road Oregon, OH 43616

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #33 revealed she was admitted on [DATE] with diagnoses including dementia, dysphagia, hypertension, hyperlipidemia, muscle wasting, protein-calorie malnutrition, pain to lower extremities, and reduced mobility. Review of the quarterly Minimum Data Set 3.0 dated 01/04/26 for Resident #33 revealed she was cognitively impaired, did not exhibit behaviors, and did not refuse care. She utilized a wheelchair and was dependent for transfers and mobility. Resident #33 required maximal to dependent level of care with activities of daily living. This assessment indicated she was at risk for developing pressure injuries. Review of physician orders for Resident #33 revealed an order dated 02/05/26 for heel protectors to bilateral feet every shift. Review of the care plan for Resident #33 revealed a goal dated 09/25/25 to maintain intact skin through the next review. Related interventions did not include the ordered heel protector boots to bilateral feet every shift. Observation on 03/23/26 at 10:55 A.M. of Resident #33 in her room sitting in her wheelchair revealed her feet were resting on foot pedals, she had white socks on but did not have heel protectors on. Observation on 03/23/26 at 4:43 P.M. of Resident #33 in her room revealed she was in bed with white socks on her feet but did not have heel protectors on. Interview on 03/23/26 at 4:45 P.M. with Registered Nurse (RN) #407 confirmed Resident #33 did not have heel protectors on and should have. 3. Review of the medical record for Resident #56 revealed she was admitted on [DATE] with diagnoses including retroperitoneal hematoma, chronic kidney disease, non-pressure chronic ulcer of right lower leg, atrial fibrillation, dilated cardiomyopathy, atrioventricular block, heart failure, iron deficiency anemia, intestinal malabsorption, and type two diabetes mellitus. Review of the admission assessment dated [DATE] for Resident #56 revealed she was alert and oriented to person, place, and time, pleasant and cooperative. Review of the pressure ulcer risk tool revealed she was at risk for skin breakdown. Review of physician orders for Resident #56 revealed an order dated 03/17/26 for heel protectors to bilateral feet when in bed or in a recliner. Review of the care plan for Resident #56 revealed a goal dated 03/18/26 to maintain intact skin through the next review. Related interventions included heel protector boots to bilateral feet as tolerated. Observation on 03/23/26 at 4:40 P.M. of Resident #56 in her room resting in bed revealed she had elastic compression bandages applied to both lower extremities but did not have heel protectors on. Interview on 03/23/26 at 4:40 P.M. with Resident #56 revealed staff did not always ensure her heel protectors were on, and she denied refusing to wear them or asking for them to be removed. Interview on 03/23/26 at 4:45 P.M. with Registered Nurse (RN) #407 confirmed Resident #56 did not (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have heel protectors on and should have. Review of a facility policy dated 10/24/22 and titled, Pressure Injury Prevention and Management revealed the facility would implement resident-specific interventions to prevent pressure injuries.