STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366328	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Divine Rehabilitation and Nursing at Toledo	1011 North Byrne Road Toledo, OH 43607

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, resident interview, and review of the facility policy the facility failed to ensure call lights were within residents' reach. This affected two (#3 and #11) of three residents reviewed for call lights. Additionally, the facility failed to ensure a sufficient supply of clean linens were available for resident use. This affected Resident #41 with the potential to affect all residents, except for 14 (#6, #23, #28, #35, #36, #38, #44, #45, #50, #51, #52, #60, #71, and #76) residents identified as residing on the secured memory care unit. The facility census was 79. Findings include: 1. Review of the medical record for Resident #3 revealed an admission date of 11/13/19 with diagnoses of cerebral vascular accident (CVA - stroke), glaucoma, peripheral vascular disease (PVD), and heart disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was cognitively intact and was dependent for toileting and personal hygiene. Review of the care plan focus area, revised 10/28/20, revealed Resident #3 was at risk for fall related injury and falls related to weakness, impaired mobility incontinence, history of falls, CVA, seizure disorder, osteoarthritis, and impaired vision. Further review revealed a care plan focus area, revised 06/14/22, indicating Resident #3 had an Activities of Daily Living (ADL) self-care deficit and required assistance with ADLs and mobility related to weakness, impaired mobility, incontinence, history of falls, CVA, seizure disorder, osteoarthritis and contractures. Interventions for both focus areas included to have the call light within reach. Observation on 05/05/25 at 8:42 A.M. of Resident #3 revealed she was laying in bed and her call light was laying on the floor, underneath her bed. Concurrent interview with Resident #3 revealed she was not able to reach her call light. Interview on 05/05/25 at 8:45 A.M. with Certified Nursing Assistant (CNA) #363 verified Resident #3's call light was laying on the floor, underneath the bed, and not within her reach. 2. Review of the medical record for Resident #11 revealed an admission date of 12/02/19 with a diagnosis of legal blindness. Review of the quarterly MDS assessment, dated 01/13/25, revealed Resident #11 was cognitively intact. (continued on next page)

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan focus area, revised 12/11/19, revealed Resident #11 was at risk for fall related injury and falls related to weakness, impaired mobility and contractures. Interventions included to have call light within reach. Observation on 05/05/25 at 8:41 A.M. of Resident #11 revealed she was laying in bed and the call light was draped across the chair that was sitting next to her bed. Concurrent interview with Resident #11 revealed she did not know where her call light was. Resident #11, who was legally blind, felt around her bed and stated she did not have her call light. Resident #11 was advised her call light was draped on the chair next to her bed and the resident verified she was not able to reach the call light. Interview on 05/05/25 at 8:45 A.M. with CNA #363 verified Resident #11's call light was draped over the chair and not within her reach. Observation on 05/06/25 at 8:39 A.M. of Resident #11 revealed her call light was pinned to the top of her bed, above her head, and not in the resident's reach. Concurrent interview with Resident #11 revealed she did not know where her call light was and began to feel around for her call light. Resident #11 was advised her call light was pinned above her head and she verified she could not reach it. Coinciding interview with CNA #328 verified Resident #11's call light was not within the resident's reach. Review of the facility policy titled, Call Light Accessibility and Timely Response, undated, revealed the facility would assure all residents were equipped with a call light at each resident's bedside to allow for residents to call for assistance. 3. Interview on 05/21/25 at 10:00 A.M. with CNA #365 revealed there was a lack of clean towels and washcloths available for resident care. Observation on 05/21/25 at 10:00 A.M. of the 100 hall shower room/linen supply revealed there was one hand towel available, and no regular towels or washcloths. Observation on 05/21/25 at 10:05 A.M. of the 200 hall shower room/linen supply revealed there was one bath towel, two hand towels, and no washcloths available. Interview on 05/21/25 at 10:35 A.M. with Resident #41 revealed her morning care had been delayed. Resident #41 stated staff told her the delay was due to there being no clean towels available. Interview on 05/21/25 at 12:03 P.M. with Unit Manager (UM) #525 revealed she was unaware there was a sufficient supply of clean linen available, resulting in resident care being delayed. Interview on 05/21/25 at 1:45 P.M. with Laundry Attendant (LA) #322 revealed there were laundry staff in the facility from 9:00 A.M. to 11:00 P.M. daily. LA #322 stated it was the responsibility of the CNAs to bring soiled linen to the laundry room. Once the linens were processed, LAs filled the shower rooms with clean towels and linens. LA #322 was unaware there was insufficient clean linen available for residents. This deficiency represents non-compliance investigated under Complaint Numbers OH00165786 and OH00163870.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on closed medical record review, staff interview, and review of facility policy the facility failed to notify the provider of a missed dose of total parenteral nutrition (TPN - intravenous delivery of nutrition) to a resident that required nutritional needs to be met by methods other than oral intake. This affected one (#101) of one resident reviewed for notification of change. The facility census was 79. Findings include: Review of the closed medical record for Resident #101 revealed an admission date of 04/17/25 and a discharge date of 05/04/25. Diagnoses included intestinal blockage, intestinal fistula (abnormal opening between the intestines and either the stomach or other parts of the body), colon cancer, hypertension (high blood pressure), and chronic kidney disease. Review of the admission Minimum Data Set (MDS) assessment revealed it was not yet submitted. Review of the admission Assessment, dated 04/17/25, revealed Resident #101 was alert and oriented to person, place, time, and situation. Further review revealed the resident was admitted for TPN therapy from an intestinal blockage. Review of the physician orders, dated 04/17/25, revealed Resident #101 had a NPO (nothing by mouth) diet. Further review revealed an order for TPN Electrolytes Solution, use 1480 milliliter (ml) intravenously one time a day for TPN 14 hours, the first hour to infuse at 55 ml/hour (hr), 12 hours to infuse at 110 ml/hr, and the last hour to infuse at 55 ml/hr. Review of the Medication Administration Record (MAR) for April 2025 revealed on 04/18/25, the TPN Electrolytes Solution administration for Resident #101 was documented as an eight, indicating to see nursing progress notes. Review of a nursing progress note dated 04/18/25 revealed the TPN was not administered due to medication on order; per pharmacy, Registered Nurse (RN) needed for administration, on-call aware. Further review of the nursing progress notes revealed no documentation that Resident #101's physician was notified of the missed dose of TPN on 04/18/25. Interview on 05/07/25 at 2:30 P.M. with Licensed Practical Nurse (LPN) #302 revealed she was on-call for after hours concerns on 04/18/25. LPN #302 stated she received a call from LPN #320 requesting to clarify the TPN orders for Resident #101. LPN #302 stated she directed LPN #320 to consult with the RNs that were in the building because the RNs were responsible for administering the TPN and were to clarify TPN orders with the on-call physician or the pharmacy if they had questions. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/08/25 at 12:57 P.M. with the Director of Nursing (DON) verified Resident #101 was not administered the ordered TPN dose on 04/18/25. The DON stated on 04/18/25, the senior RN (RN #391) was responsible for the TPN and requested LPN #320 verify the TPN orders. LPN #320 called the on-call manager, LPN #302, to clarify the orders and LPN #320 was directed to consult with the RN on duty to clarify orders with the on-call physician or the pharmacy. The DON further stated there were two RNs (#346 and #391) in the building that night and the RNs were responsible to administer the TPN per the physicians orders. A follow-up interview on 05/08/25 at 2:33 P.M. with the DON verified Resident #101's physician was not notified of the missed dose of the TPN on 04/18/25. Review of the facility policy titled, Notification of Changes, undated, revealed the purpose of the policy was to ensure the facility promptly informed the resident, consulted the resident's physician, and notified when there was a change requiring notification. This was an incidental finding discovered during the complaint investigation.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, staff interview, resident interview and review of the facility policy, the facility failed to ensure residents had working lights in their rooms. This affected two residents (#3 and #11) of three residents reviewed for functional lights. The facility census was 79. Findings include: 1. Review of the medical record for Resident #3 revealed an admission date of 11/13/19 with diagnoses of cerebral vascular accident (CVA-stroke), glaucoma, peripheral vascular disease (PVD), and heart disease. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/21/25, revealed Resident #3 was cognitively intact and staff dependent for toileting and personal hygiene. Review of the care plan, initiated 10/28/20, revealed Resident #3 had impaired vision function related to glaucoma. Interventions included to place items in field of vision, orient to surroundings, place personal items in a consistent location to ensure they are easy to find, and provide the resident with large print books or books on tape. Review of an optometry note, dated 05/29/24, revealed Resident #3 required glasses for full time use for distance and reading. Observation on 05/05/25 at 8:42 A.M. revealed Resident #3 was laying in bed, her television was, but the resident did not have a light on. Further observation revealed Resident #3's overbed light did not work. Concurrent interview with Resident #3 revealed her light had not worked for about three weeks. The resident stated she was moved out of the room due to her bed not working, but she was moved back and the light still did not work. 2. Review of the medical record for Resident #11 revealed an admission date of 12/02/19 with a diagnosis of legal blindness. Review of the quarterly MDS assessment, dated 01/13/25, revealed Resident #11 was cognitively intact. Review of the care plan, revised 11/10/22, revealed Resident #11 had impaired visual function related to age related visual decline, legally blind. Interventions included notify resident where you are placing her items, be consistent and monitor, report, and document any acute eye problems as needed. Observation on 05/05/25 at 8:41 A.M. revealed Resident #11 was laying in bed with no lights on. Further observation revealed the resident's overbed light did not work. Concurrent interview with Resident #11 revealed the lights in the room had not worked for three weeks, and further stated the only light that worked was in the bathroom. (continued on next page)

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/05/25 at 8:45 A.M. with Certified Nursing Assistant (CNA) #363 verified the overbed lights in the room were not working. CNA #363 stated she was unsure how long it had been since the lights stopped working in Resident #3 and Resident #11's room. Interview on 05/06/25 at 2:55 P.M. with Director of Maintenance (DOM) #369 verified he was aware Resident #3 and Resident #11 did not have working lights in their room. DOM #369 stated the electrician that had come out to the facility identified an issue with broken electrical wires underground and the plan was to rewire the resident's room. DOM #369 further stated he reached out for quotes for work and he was waiting for the third work quote to come in to get the work completed to fix the problem. A follow-up interview on 05/06/25 at 3:58 P.M. with DOM #369 verified the overbed lights had not worked in Resident #3 and Resident #11's room since 04/14/25, and further confirmed the resident's did not have working lights in their room. After the surveyor inquired about lamps being placed in the residents' room, DOM #369 stated I don't know why I didn't think about purchasing lights before you mentioned it, that's on me, that's my fault. Review of the facility policy titled, Safe and Homelike Environment, dated 2024, revealed in accordance with residents rights, the facility would provide a safe, clean, comfortable and homelike environment. This included ensuring that the resident can receive care and services safely. Further review revealed the facility would provide and maintain adequate and comfortable lighting levels in all areas, with adequate lighting defined as the level of illumination suitable to tasks the resident chose to perform or the facility staff must perform. The maintenance director would perform periodic rounds to ensure functioning lights. This deficiency represents non-compliance investigated under Complaint Number OH00165258.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of the medical record for Resident #100 revealed an admission date of [DATE] and a discharge date of [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), dementia, prostate cancer, and hypertension with congestive heart failure. Review of the annual MDS assessment, dated [DATE], revealed Resident #100 had mild cognitive impairment. Further review of the MDS assessments revealed on [DATE], an assessment was completed for Resident #100's death in the facility. Review of a physician order dated [DATE] revealed Resident #100 had an order for Full Code status. Review of the care plan initiated [DATE] revealed Resident #100 had a Full Code status. Interventions included to call 911 for transport to a local hospital, initiate Cardiopulmonary Resuscitation (CPR) in the absence of a pulse, notify family and physician of changes in condition. Interview on [DATE] at 12:23 P.M. with LPN #300 verified she did not initiate CPR on Resident #100 when he was found to be not breathing and did not have a pulse. Interview on [DATE] at 8:00 A.M. with the Administrator verified CPR was not initiated for Resident #100 when he was found not breathing and without a pulse. Review of the EIDC for the past three months revealed no evidence the facility submitted an SRI to the SSA related to staff failing to initiate CPR for Resident #100, who was a Full Code status. Review of the facility policy titled, Abuse, Neglect, and Exploitation, dated 2024, revealed neglect was defined as failure of the facility, its employees, or service providers to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility would report all alleged violations to the Administrator, state agency, adult protective services, and to all other required agencies immediately, but not later than two hours after the allegation was made, if the event that cause the allegation involve abuse or result in serious bodily harm or not later than 24 hours if the events that caused the allegation did not involved abuse and did not result in bodily injury. This deficiency represents non-compliance investigated under Complaint Number OH00165258 and Complaint Number OH00164697. Based on medical record review, staff interview, review of the Enhanced Information Dissemination and Collection (EIDC - system for reporting information) and review of the facility policy, the facility failed to report incidents of resident elopement to the State Survey Agency (SSA). This affected one (#53) of two residents reviewed for elopement. Additionally, the facility failed to report an incident of resident death related to staff failure to implement life-saving measures for a resident with a Full Code status. This affected one (#100) of three residents reviewed for code status implementation. The facility census was 79. Findings include: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of the medical record revealed Resident #53 was admitted on [DATE]. Diagnoses included angina pectoris, depression, schizoaffective disorder, anxiety disorder, unspecified osteoarthritis, iron deficiency anemia secondary to blood loss, and unspecified hearing loss. Review of the Minimum Data Set (MDS) assessment, dated [DATE], revealed the resident was cognitively intact. Review of a nursing progress note, dated [DATE], revealed Resident #53 exited the building around 5:30 P. M. and went to the carryout store. Resident #53 sat on the floor and refused to get up, stated she was being kidnapped. Extensive effort was required as the resident refused to get up until store clerk told her she had to leave. Emergency services (911) were called to help. Resident #53 was delusional and stated she wanted to take a cab to [NAME] Road. Resident #53 was encouraged to talk to her doctor that helped her with her voices and behaviors. Resident #53 finally got into the car with staff and returned to the facility. Emergency services were canceled due to prolonged wait. Facility management was aware, the physician was notified, and attempted to call family three times with no answer. Psychiatric Nurse Practitioner (PNP) to visit with the resident this week. Review of the facility video surveillance, dated [DATE], revealed at 6:55 P.M. Resident #53 was seated in her wheelchair in the front lobby. At 6:56 P.M. an unknown visitor entered the code from outside of the facility and entered. Upon the visitor passing, Resident #53 abruptly stood up and walked out the front doors, without staff present with her. Review of the EIDC system from [DATE] through [DATE] revealed no evidence the facility submitted a self-reported incident (SRI) to the SSA related to Resident #53's elopement on [DATE]. Interview on [DATE] at 11:48 A.M. with the Administrator revealed she was not notified Resident #53 had eloped on [DATE] and verified an SRI was not completed to report Resident #53's elopement to the SSA.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview and review of the facility policy, the facility failed to investigate an incident of resident elopement. This affected one (#53) of three residents reviewed for elopement. The facility census was 79. Findings include: Review of the medical record revealed Resident #53 was admitted on [DATE]. Diagnoses included angina pectoris, depression, schizoaffective disorder, anxiety disorder, unspecified osteoarthritis, iron deficiency anemia secondary to blood loss, and unspecified hearing loss. Review of the Minimum Data Set (MDS) assessment, dated 04/09/25, revealed the resident was cognitively intact. Review of the care plan, dated 02/05/25, revealed Resident #53 was an elopement risk/wanderer. Interventions included to assess for fall risk, check device (WanderGuard) for function and location every shift, distract resident from wandering by offering pleasant diversions (structured activities, food, conversation, television, and books), monitor for fatigue and weight loss, provide structured activities (toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes), and wander alert (WanderGuard). Review of the elopement risk assessment, dated 03/25/25, revealed Resident #53 was at risk of elopement. Review of a nursing progress note, dated 04/21/25, revealed Resident #53 exited the building around 5:30 P. M. and went to the carryout store. Resident #53 sat on the floor, refused to get up, and stated she was being kidnapped. Extensive effort was required as the resident refused to get up until the store clerk told her she had to leave. Emergency services (911) was called to help. Resident #53 was delusional and stated she wanted to take a cab to [NAME] Road. Resident #53 was encouraged to talk to her doctor that helped with her voices and behaviors. Resident #53 finally got into the car with staff and came back to the facility. Emergency services were canceled due to prolonged wait. Facility management was aware, the physician was notified, and attempted to call family three times with no answer. Psychiatric Nurse Practitioner (PNP) to visit with resident this week. Review of video surveillance, dated 04/21/25, revealed at 6:55 P.M. Resident #53 was seated in her wheelchair in the front lobby. At 6:56 P.M., an unknown visitor entered the code from outside of the facility and entered. Upon the visitor passing, Resident #53 abruptly stood up and walked out the front doors, without staff. Resident #53 returned to the facility at 7:59 P.M. with staff. Interview on 05/05/25 at 11:17 A.M. with the Director of Nursing (DON) revealed Resident #53 heard voices that told her to leave the facility; however, it was not safe for her to leave without supervision. The DON stated Resident #53 recently made it to the carryout and her understanding was that a staff member was right behind her. The DON stated she may have a typed investigation of the incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow up interview on 05/06/25 at 8:09 A.M. with the DON revealed she was not aware until 05/05/25 that Resident #53 had eloped from the facility without staff knowledge on 04/21/25. The DON verified an investigation was not initiated until 05/05/025. Review of the facility policy titled, Abuse, Neglect, and Exploitation, dated 2024, revealed the facility would complete an immediate investigation when there was suspicion or reports of abuse, neglect, or exploitation. This deficiency represents non-compliance investigated under Complaint Number OH00165258 and OH00164697.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, staff interview, and review of the facility policy, the facility failed to ensure dependent residents received showers as scheduled and further failed to ensure dependent residents received assistance with all activities of daily living (ADLs) timely. This affected three (#39, #45, and #53) of five residents reviewed for ADLs. The facility census was 79. Findings include: 1. Review of the medical record revealed Resident #39 was admitted on [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD) with acute exacerbation, chronic respiratory failure, chronic diastolic heart failure, essential hypertension, pure hypercholesterolemia, and paroxysmal atrial fibrillation. Review of the Minimum Data Set (MDS) assessment, dated 04/04/25, revealed Resident #39 was cognitively intact and staff dependent for toileting, showering, lower body dressing, footwear, and personal hygiene. Review of the care plan, revised 02/17/25, revealed Resident #39 was totally dependent on one to two staff to provide showers two times a week and as necessary. Review of shower/bathing documentation for the past 30 days (04/07/25 through 05/07/25) revealed Resident #39 was scheduled for showers on second shift on Tuesday and Fridays. Within the last 30 days Resident #39 received one shower, two bed baths, and had refused twice. Resident #39 had a documented shower on 04/22/25 and the next bathing event (including refusals) was a bed bath on 05/02/25 (9 days). Further review revealed no evidence of any additional showers or refusals of care. Interview on 05/06/25 at 3:41 P.M. with Certified Nursing Assistant (CNA) #338 revealed on Easter Sunday (04/21/25) she worked half a shift from 2:30 P.M. to 6:30 P.M. At approximately 8:00 P.M. she received a call from Unit Manager (UM) #302 asking her to speak with CNA #319, who was refusing to care for Resident #39. CNA #338 reluctantly spoke with CNA #319 regarding providing nighttime care for Resident #39, including assisting the resident to bed. CNA #319 stated CNA #338 was upset and complaining about always being stuck providing care for Resident #39. CNA #338 told CNA #319 to not provide care to Resident #39 due to her attitude and told her she would come back into work to do it. CNA #338 verified she returned to the facility to ensure Resident #39 received appropriate care. Interview on 05/06/25 at 4:02 P.M. with UM #302 verified CNAs have refused to provide care for Resident #39 because the CNAs were frustrated with the resident and would refuse to provide care. UM #302 stated the resident was particular and could be mean. UM #302 stated the nurse would notify her that no one was available to provide care for Resident #39, adding it happened so frequently that the CNAs refused to provide care for Resident #39 that she could not track it. UM #302 verified that on 04/21/25, she called CNA #338 to talk her co-worker, CNA #319, into providing nighttime care for Resident #39, which resulted in CNA #338 coming back to the facility after her shift and providing the resident with care. UM #302 stated she notified the Director of Nursing (DON) regarding the situation. UM #302 verified second shift staff often left Resident #39 up for third shift to provide her care. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Divine Rehabilitation and Nursing at Toledo	1011 North Byrne Road Toledo, OH 43607

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/06/25 at 1:25 P.M. with Licensed Practical Nurse (LPN) #399 revealed Resident #39 was particular and difficult to provide care for. LPN #399 stated, over time, CNAs have refused to provide care for the resident because they do not like how she talks to them. Interview on 05/07/25 at 12:57 P.M. with the Director of Nursing (DON) verified Resident #39 was not offered or provided showers. Interview on 05/07/25 at 1:40 P.M. with Resident #39 revealed on 04/21/25, none of the staff would put her to bed, stating they did not know who her aide was. Resident #39 confirmed CNA #338 came in to assist her with her nighttime care and assisted her to bed. Resident #39 stated she often had to wait an hour to go to bed because the staff would tell her they did not know who her aide was. 2. Review of the medical record revealed Resident #45 was admitted on [DATE]. Diagnoses included unspecified dementia, hypothyroidism, hyperlipidemia, essential hypertension, and generalized anxiety disorder. Review of the MDS assessment, dated 03/01/25, revealed the resident was severely cognitively impaired and staff dependent for showers/bathing. Review of the care plan, revised 09/10/24, revealed Resident #45 was (staff) dependent for bathing/showering two times a week and as needed. Review of shower documentation for the past 30 days (04/07/25 through 05/07/25) revealed Resident #45 received a bed bath or shower on 04/09/25, 04/12/25, 04/16/25, 04/19/25, 04/30/25, 05/03/25, and 05/07/25. Resident #45 did not receive a shower/bath from 04/19/25 until 04/30/25 (11 days). Further review revealed no evidence of additional showers or refusals of care. Interview on 05/07/25 at 12:57 P.M. with the DON verified Resident #45 was not offered or provided showers. 3. Review of the medical record revealed Resident #53 was admitted on [DATE]. Diagnoses included angina pectoris, depression, schizoaffective disorder, anxiety disorder, unspecified osteoarthritis, iron deficiency anemia secondary to blood loss, and unspecified hearing loss. Review of the MDS assessment, dated 04/09/25, revealed Resident #53 was cognitively intact and required partial/moderate staff assistance for showering/bathing. Review of the care plan, dated 10/09/24, revealed Resident #53 was able to complete the bathing/showering task with (staff) assistance. Review of shower/bath documentation for the past 30 days (04/07/25 through 05/07/25) revealed Resident #53 refused a shower on 04/16/25 and 05/08/25 and received showers on 04/19/25 and 05/03/25. Further review revealed no evidence of additional showers or refusals of care. Interview on 05/07/25 at 12:57 P.M. with the DON verified Resident #52 was not offered or provided showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Activities of Daily Living, dated 2024, revealed the care and services would be provided for ADLs, including bathing, dressing, grooming, oral care, transfers and ambulation, toileting, eating, and communication systems. This deficiency represents non-compliance investigated under Complaint Numbers OH00165571, OH00164178, and OH00163870.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, family interview, staff interview, review of staff statements and review of the facility policy, the facility failed to initiate Cardiopulmonary Resuscitation (CPR) or call 911 for Emergency Medical Services (EMS) assistance for Resident #100, who was found unresponsive, absent of breaths, without a pulse/heartbeat and was identified to have advance directives reflecting the resident was a Full Code (full life-saving measures to be taken in the event of cardiac/respiratory arrest) status. This resulted in Immediate Jeopardy and serious life-threatening harm/death on [DATE] when Licensed Practical Nurse (LPN) #300 responded to Resident #100's room and assessed the resident to be unresponsive and absent of vital signs. LPN #300 called for former LPN #501 to verify Resident #100 was absent of all vital signs and neither nurse initiated CPR nor called 911 for EMS assistance. Resident #100 subsequently passed away in the facility, without life-saving measures being implemented, without 911 being called, and LPN #300 and LPN #501 called the resident's time of death without the direction of a physician or other qualified health professional (for example, a Nurse Practitioner [NP]). This affected one (#100) of three residents reviewed for death in the facility. The facility census was 79. On [DATE] at 12:07 P.M., the Administrator, Director of Nursing (DON), and Regional Executive Director (RED) #502 were notified Immediate Jeopardy began on [DATE] at 1:11 A.M. when LPN #300 was informed by Certified Nursing Assistant (CNA) #339 that Resident #100, who had an advanced directive for a Full Code status, appeared to not be breathing. LPN #300 responded to Resident #100's room and assessed the resident and called for another nurse, LPN #501. LPN #300 and LPN #501 found the resident was not breathing and was absent of vital signs, including a pulse/heartbeat and blood pressure. Without initiating CPR, calling 911, or seeking direction from a physician, LPN #300 and LPN #501 called Resident #100's time of death at 1:11 A.M., stating the family at bedside refused life-saving measures. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: • On [DATE] at 1:11 A.M., LPN #300 and LPN #501 assessed Resident #100 and found he was absent of vital signs. LPN #300 and LPN #501 called the resident's time of death in the facility at 1:11 A.M. • On [DATE] at 2:02 A.M., LPN #300 notified the DON, who was the on-call nurse, of Resident #100's passing. • On [DATE] at 2:02 A.M., LPN #300 notified the on-call physician of Resident #100's passing in the facility. • (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 5:12 A.M., the Administrator educated all licensed nurses on the facility CPR protocol; to initiate any time a resident was a Full Code status. • On [DATE] at 7:49 A.M., the Administrator educated all licensed nurses on Ohio Law and Administrative Code regarding who can pronounce a time of death. • On [DATE] at 6:11 A.M., the DON provided individual educational consultation to LPN #300 and LPN #501 that the pronouncement of death by two LPNs on a Full Code resident was out of their scope of practice and the implementation of the facility CPR protocol and policy for all residents with a Full Code status. Additionally, LPN #300 and LPN #501 were educated that family refusal of CPR for a resident with a Full Code status still required the initiation of CPR. • On [DATE] at 9:00 A.M., the DON audited all residents to ensure accurate code status. Any identified concerns were addressed immediately. • On [DATE] at 9:00 A.M., LPN #503 audited all resident care plans to ensure code statuses were accurate. Any identified concerns were immediately addressed. • On [DATE] at 9:30 A.M., Human Resources Director (HRD) #314 audited all licensed nurses to ensure CPR certifications were up to date, with no concerns identified. • On [DATE], an Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting was held to discuss CPR and code status for all residents. The facility policies and procedures related to the initiation of CPR and code status were reviewed, with no needed changes identified. The meeting also addressed the root cause of LPN #300 and LPN #501 not initiating CPR. In attendance at the meeting were the Administrator, DON, Unit Manager (UM) #302, UM #304, Wound Nurse (WN) #396, Business Office Manager (BOM) #336, Social Service Director (SSD) #373, HRD #314, LPN #503, and Activities Director (AD) #504. • By [DATE] at 5:30 A.M., the DON completed a code blue (indicating a medical emergency, typically cardiac or respiratory arrest) drill on all three shifts to ensure appropriate staff responses, with no concerns identified. • (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:00 P.M., a QAPI meeting was held, and CPR was discussed as an area of performance improvement. Those in attendance were the Administrator, DON, Dietary Manager (DM) #505, HRD #314, BOM #336, Staffing Coordinator (SC) #328, WN #396, Director of Maintenance (DOM) #369, Therapy Director (TD) #506, and Medical Director (MD) #520. • On [DATE] at 9:38 A.M., the Administrator reported LPN #300 and LPN #501 to the Ohio Board of Nursing for not initiating CPR per physician ordered code status and for working outside of their scope of practice for calling Resident #100's time of death without physician direction. • On [DATE], the Administrator completed a post emergency code blue audit for [DATE] and [DATE] to ensure appropriate staff response. No additional emergency codes occurred in [DATE] or [DATE]. The Administrator will continue to audit all code blue situations for the next six months to ensure on-going compliance. Any areas of concern will be addressed with QAPI to ensure appropriate follow-up. • Review of two (#11 and #27) additional residents, reviewed for appropriate implementation of code status, revealed no additional concerns. • Interviews from [DATE] through [DATE] with Registered Nurse (RN) #304, LPN #300, LPN #302, LPN #406 and LPN #503 verified education was provided on initiating CPR on all residents with a Full Code status and qualified personnel to pronounce a resident's time of death. Additionally, each staff member confirmed mock emergency code drills were completed. Although the Immediate Jeopardy was removed on [DATE], the facility remains out of compliance at Severity Level 2 (the potential for more than minimal harm that is not Immediate Jeopardy) as the facility is in the process of implementing their corrective actions and monitoring for effectiveness and on-going compliance. Findings include: Review of the closed medical record for Resident #100 revealed an admission date of [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), dementia, prostate cancer, hypertension (high blood pressure), congestive heart failure, and orthostatic hypotension. Resident #100 passed away in the facility on [DATE]. Review of the Power of Attorney (POA) documents, dated [DATE], revealed Resident #100's daughter was his POA. Review of the annual Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #100 was moderately cognitively impaired. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a plan of care, initiated on [DATE], revealed Resident #100 had Full Code advanced directives. Interventions included call 911 for transportation to the local hospital, initiating CPR in the absence of a pulse, notify family and physician of changes in condition, and provide privacy during code situation. Review of a physician order dated [DATE] revealed Resident #100 had an order for Full Code status. Review of a nursing progress note dated [DATE] at 2:02 A.M. and written by LPN #300, revealed she was notified by CNA #339 that Resident #100 was not breathing. LPN #300 assessed the resident and called for another nurse to verify. Family was present at bedside and refused Full Code procedures. Resident #100 was pronounced (deceased) at 1:11 A.M. The on-call nurse and physician were notified. Review of LPN #300's written statement, dated [DATE], revealed she was called to Resident #100's room by CNA #339 to check on the resident as he appeared to not be breathing. LPN #300 called another nurse to verify Resident #100's death. Family was in the room and did not want CPR to start, so CPR was not initiated. Resident #100's daughter was called to get the body moved. LPN #300 notified the on-call nurse by way of text and phoned the on-call physician at 1:24 A.M. Review of LPN #501's written statement, dated [DATE], revealed she was called to Resident #100's room to verify signs of life. No heartbeat or pulse were noted. Per family, CPR was not started. Review of the DON's statement, dated [DATE], revealed she inquired with Resident #100's daughter if she was present the previous night due to the nurse notification indicating the granddaughter was present. According to the statement, Resident #100's daughter indicated she was present, as well as her niece (Resident #100's granddaughter), the night of the resident's passing. The statement further stated Resident #100's daughter was at the facility and made arrangements for her father to be transferred to the funeral home of his choice. A telephone interview on [DATE] at 11:22 A.M. with Resident #100's daughter verified she was the resident's POA. Further interview with Resident #100's daughter revealed she was contacted by the facility on [DATE] to discuss possible hospice care for the resident. Resident #100's daughter stated she went to the facility but the staff member who called her was already gone for the day. Resident #100's daughter stated she did not discuss hospice care or a change in code status with anyone at the facility. Additionally, Resident #100's daughter verified she was not present at the time the resident was found unresponsive and without vital signs and did not give direction to facility staff to withhold CPR. Resident #100's daughter stated her niece, the resident's granddaughter, was at bedside at the time of the resident's death. Resident #100's daughter denied her niece would have directed facility staff to withhold CPR. A telephone interview on [DATE] at 1:19 P.M. with Resident #100's granddaughter verified she was at bedside with the resident when he passed away. She denied any other family being present at the facility. Resident #100's granddaughter stated she traveled from another state to visit Resident #100 and arrived at the facility on [DATE] at approximately 12:00 A.M. Resident #100's granddaughter stated she read to the resident from the bible and then laid her head down to try to get a small nap before she had to get back on the road. She reported the nurses came in and told her he was gone (deceased). Resident #100's granddaughter confirmed nursing did not attempt to perform CPR and she did not direct any staff to not perform CPR. Resident #100's granddaughter confirmed the resident's daughter was not present at the time of his death and she did not arrive until after he had passed away. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview on [DATE] at 12:23 P.M. with LPN #300 revealed she began her shift on [DATE] with duties to collect a urine sample and to get laboratory (lab) draws done for Resident #100. LPN #300 stated she obtained the urine sample and called the lab to let them know it was ready to pick up and to get the blood draws completed. LPN #300 further stated that at an unknown time, a family member arrived and prayed over Resident #100. LPN #300 stated she was alerted by CNA #339 that Resident #100 did not appear to be breathing, so she went and got another nurse and they both verified Resident #100 was not breathing and did not have a heartbeat. LPN #300 stated she informed the family member she needed to perform CPR, and the family member directed her not to. LPN #300 further stated the family member at bedside called the POA (Resident #100's daughter), who stated, that's ok (to not perform CPR). LPN #300 stated she then called Resident #100's daughter and notified her of his passing. LPN #300 confirmed Resident #100's daughter was not at bedside when he passed away and did not arrive at the facility until after she notified her of his passing. LPN #300 stated Resident #100's daughter came to the facility to make arrangements because the resident's funeral home of choice was out of state. LPN #300 stated this incident taught her that when a resident was a Full Code status, even if family says not to do CPR, she must initiate CPR to comply with the advanced directive. An interview on [DATE] at 8:00 A.M. with the Administrator revealed she learned of the code situation while reading the 24-hour report in the early morning hours on [DATE]. After reading the information, the Administrator stated she immediately sent out education to all licensed nurses regarding Full Code status and the requirement to initiate CPR. The Administrator verified the education on performing CPR and code status was sent on [DATE] at 5:12 A.M. and an additional education was sent to all licensed nurses related to the personnel qualified to pronounce a time of death on [DATE] at 7:49 A.M. The Administrator verified LPN #300 and LPN #501 did not initiate CPR and called the resident's time of death, which was outside of the scope of practice for an LPN. A follow-up telephone interview on [DATE] at 8:35 A.M. with Resident #100's daughter revealed the only phone call she received on the night her father passed away was from the nurse who called to inform her he had passed away. Resident #100's daughter denied being on the phone with the resident's granddaughter and authorizing the withholding of CPR. Resident #100's daughter stated she went to the facility after she received the call to see him and make the funeral arrangements. Resident #100's daughter stated she never changed the resident's code status because she wanted the extra time with him. Review of the facility policy titled, Cardiopulmonary Resuscitation, undated, revealed it was the policy of the facility to adhere to residents' rights to formulate advanced directives. In accordance with these rights, this facility would implement guidelines regarding CPR. If a resident experienced cardiac arrest, facility staff would provide basic life support, including CPR, prior to the arrival of emergency medical services in accordance with the residents advanced directives. This deficiency represents non-compliance investigated under Complaint Number OH00165258.

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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 0684 Level of Harm - 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 medical record review, staff interview, review of radiology results, radiology vendor interview, review of electronic mail (e-mail) correspondence, review of hospital records and review of the facility policy, the facility failed to ensure X-ray results were received timely to prevent a delay in treatment. This resulted in Actual Harm to Resident #49 on 05/05/25 at approximately 9:58 A.M. when the radiology vendor faxed stat (immediate) X-ray results to the facility, showing the resident had a right hip fracture, the facility did not receive the results, and then failed to follow up with the radiology vendor to verify the outcome until 05/06/25. Consequently, Resident #49 experienced a pain level of 10 on a scale of zero to 10 (with 10 being the worst pain) and was not transferred to the hospital for evaluation and treatment for approximately 24 hours after the X-ray results were initially faxed to the facility. Resident #49 was subsequently admitted to the hospital, where he received surgical repair for the fractured right hip. This affected one (#49) of three residents reviewed for falls. Additionally, the facility failed to ensure weekly wound monitoring and assessments were completed for one resident (#19), that placed the resident at risk for the potential for more than minimal harm that was not actual harm. This affected one (#19) of three residents reviewed for wound care. The facility identified 10 residents (#1, #19, #20, #29, #44, #51, #65, #67, #71, and #72) who required wound care at the facility. The facility census was 79. Findings include: 1) Review of the medical record revealed Resident #49 was admitted to the facility on [DATE]. Diagnoses included acute on chronic systolic (congestive) heart failure, malignant neoplasm of the prostate, cocaine use, major depressive disorder, and nonrheumatic aortic stenosis. Review of the Minimum Data Set (MDS) assessment, dated 02/08/25, revealed Resident #49 was moderately cognitively impaired and required supervision assistance with toileting, shower/baths, upper and lower body dressing, applying footwear, and personal hygiene. Review of a nursing progress note, dated 05/04/25 at 9:56 P.M., revealed Resident #49 was found lying on his right side on the floor of his bedroom. The resident was assessed, including range of motion (ROM), vital signs and pain, and assisted into bed. Resident #49 denied hitting his head, was provided the call light and necessities in reach. The physician and the on-call manager, Registered Nurse (RN) #304, were notified. Resident #49 complained of pain to the right knee and an order was given for a stat X-ray of the right knee. Review of a nursing progress note dated 05/05/25 revealed Resident #49 complained of right hip pain when he moved. Resident #49 rated the pain as a 10 on a zero to 10 pain scale. The physician was notified, and a new order was received for an X-ray of the right hip. The X-ray was completed. Review of the radiology report results on 05/05/25 at 9:55 A.M., revealed Resident #49 was diagnosed with an acute non-displaced right femoral neck (hip) fracture. Review of a nursing progress note, dated 05/06/25 at 9:15 A.M., revealed X-ray results were received, the physician was notified, and an order was received to transport Resident #49 to the emergency room (ER) for evaluation. Transportation was arranged at 8:50 A.M. and Resident #49 was transported at 9:15 A.M. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of an Interdisciplinary Team (IDT) progress note, dated 05/07/25 at 2:40 P.M., revealed the IDT met to discuss the resident ' s fall on 05/04/25. Resident #49 was observed on the floor in his room, lying on the right side. Resident #49 complained of right knee pain to the nurse at the time of the fall. An X-ray of the right knee was ordered and the following morning the resident complained of hip pain and stated the knee pain had resolved. A hip X-ray was ordered, and the results revealed the resident had a non-displaced fracture of the right femur neck. Resident #49 was transported to the ER for evaluation and was admitted to the hospital. Review of the hospital records, dated 05/06/25 at 9:47 A.M., revealed Resident #49 presented to the ER with an X-ray obtained on 05/05/25 that was positive for a femoral fracture. Further review of an orthopedic surgery note, dated 05/08/25, revealed Resident #49 ' s femoral fracture was surgically repaired on 05/06/25 with the insertion of an intramedullary (a metal rod inserted into the hollow center of a long bone to stabilize and support fractures to promote healing) rod. Review of e-mail correspondence from the Administrator, received on 05/08/25 at 12:28 P.M., verified a stat X-ray of Resident #49 ' s right hip was ordered on 05/05/25 at 9:09 A.M. The X-ray technician arrived on 05/05/25 at 9:33 A.M., the X-ray was completed on 05/05/25 at 9:34 A.M., the X-ray was verified on 05/05/25 at 9:36 A.M., and the final report was completed on 05/05/25 at 9:55 A.M. An interview on 05/07/25 at 11:25 A.M. with the Director of Nursing (DON) verified Resident #49 had a stat X-ray of the right hip on the morning of 05/05/25 and the results were not received by the facility until the morning of 05/06/25. A follow-up interview on 05/07/25 at 2:27 P.M. with the DON revealed on 05/06/25, she reviewed the facility ' s 24-hour report and saw that the X-ray results for the right hip X-ray completed on 05/05/25 had not been received. The DON stated she accessed the radiology vendor ' s system and reviewed the results, which showed Resident #49 had a right hip fracture. The DON stated the results should have been faxed to the nurses ' station and to the primary fax in the copy room. The DON verified the nurse on shift would have been expected to follow-up with the radiology vendor if the results had not been received within four to six hours after the X-ray was taken. The DON confirmed there was no evidence the facility followed up on the results of Resident #49 ' s X-ray until 05/06/25, approximately 24 hours after the X-ray was completed. An interview on 05/12/25 at 9:10 A.M. with Registered Nurse (RN) #317 revealed she cared for Resident #49 during the day shift on 05/05/25. RN #317 stated she was informed during report that the resident had complained of knee pain; however, upon assessing the resident, he reported the knee pain had resolved but he had significant pain in the right hip. Around the same time, the X-ray technician was there to complete the order for the right knee X-ray. RN #317 stated she contacted the physician to change the order to an X-ray of the right hip, which was completed at that time. RN #317 confirmed she did not receive the results of the X-ray during her shift and reported to the oncoming shift nurse that the results were pending. RN #317 stated she knew it was a hip fracture and had been curious about the results all day. RN #317 stated she checked the radiology tab in the facility ' s medical record system throughout the day and did not see a report. RN #317 stated she did not know where else to look for the X-ray results. Interview on 05/12/25 at 9:29 A.M. with Customer Support (CS) #524 with the radiology vendor verified Resident #49 ' s hip X-ray was completed on 05/05/25 at 9:35 A.M. and the results were faxed to the facility on [DATE] at 9:58 A.M. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Divine Rehabilitation and Nursing at Toledo	1011 North Byrne Road Toledo, OH 43607

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F 0684 Level of Harm - Actual harm Residents Affected - Few	2) Review of the medical record for Resident #19 revealed an admission date of 03/25/21 with diagnoses of diabetes mellitus and peripheral vascular disease (PVD). Review of the annual Minimum Data Set (MDS) assessment, dated 04/06/25, revealed Resident #19 was cognitively impaired and had one venous ulcer (these types of ulcers are considered chronic and they tend to heal and re-open frequently, the result of PVD). Review of the physician orders for May 2025 revealed Resident #19 had an order to cleanse the right ankle wound with normal saline, pat dry and apply collagen alginate, cover with an abdominal (ABD) pad, and apply an Unna boot (boot for reduction of venous fluid to help with vascular circulation) from the toes to two fingers below the knee. Change the dressing three times per week on Monday, Wednesday, and Friday and as needed. Review of the wound assessment dated [DATE] revealed the area on Resident #19's right ankle was previously healed and re-opened on this date. The assessment indicated the area measured 4 centimeters (cm) by (x) 3.6 cm x 0.1 cm and was a venous ulcer. Further review of the medical record from 04/09/25 through 05/13/25 revealed no evidence weekly wound assessments or monitoring was completed for Resident #19 ' s venous ulcer. Interview on 05/13/25 at 10:24 A.M. with Licensed Practical Nurse (LPN) #396 revealed she had all of the wound measurements for Resident #19 ' s venous ulcer and would obtain them, adding she had not uploaded all of the information into the electronic medical record (EMR) yet. Further interview with LPN #396 revealed the facility policy was to complete weekly monitoring and measurements of wounds. LPN #396 further stated that Resident #19 was followed by an outside wound care provider, and on the weeks he had an appointment there (generally every two weeks), she utilized the measurements from the appointment and entered them into the resident's EMR for continued monitoring of the wound. A follow-up interview on 05/13/25 at 11:03 A.M. with LPN #396 verified there was no evidence that wound monitoring and/or assessments had been completed for Resident #19 ' s venous ulcer since 04/09/25, including any assessments from the outside wound care provider. LPN #396 stated she had been on vacation for approximately one month and she was unable to locate any documentation related to the resident's wound assessments. Review of the facility policy titled, Documentation of Wound Treatments, undated, revealed the facility completed accurate documentation of wound assessments and treatments, including response to treatment, change in condition, and changes in treatment. Wound assessments were documented upon admission, weekly, and as needed if the resident or wound condition deteriorated. The following elements were documented as part of a complete wound assessment: type of wound, stage of the wound, measurements to include height, width, depth, undermining and tunneling, and wound characteristics. Additionally, documentation should include weekly progress towards healing and effectiveness of the current intervention. This deficiency represents non-compliance investigated under Complaint Number OH00165492 and Complaint Number OH00165258.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, Carryout Attendant (CA) interview, review of facility video surveillance, and review of the facility policy, the facility failed to provide adequate supervision to ensure Resident #53, who had a diagnosis of schizoaffective disorder (a severe mental illness characterized by symptoms of schizophrenia, such as hallucinations and delusions, and a mood disorder), was assessed to be at risk for elopement, had a history of numerous elopement attempts, had a WanderGuard (wearable bracelet that triggers alarms at the doors to alert when a resident attempts to exit) applied to her wheelchair, and who was on 15-minute staff supervision checks, did not elope from the facility without staff knowledge. This resulted in Immediate Jeopardy and the potential for serious harm, injury and/or death when a visitor used a code to enter the locked front door of the facility, and Resident #53 was able to exit through the front door before the door was securely closed. The facility staff were unaware Resident #53 was missing until Certified Nursing Assistant (CNA) #301, who was on a lunch break, happened to enter a local carryout and found the resident sitting on the floor, approximately 35 minutes after the resident had eloped. This affected one (#53) of two (#53 and #08) residents reviewed for elopement. The facility identified two residents (#53 and #08) to be at risk for elopement. Additionally, the facility failed to complete admission and quarterly smoking assessments for two residents (#48 and #58), that placed the residents at risk for the potential for more than minimal harm that was not Immediate Jeopardy, to ensure they were safe to smoke unsupervised or if safe smoking measures were needed, in accordance with facility policy. This affected two (#48 and #58) of three residents reviewed for smoking. The facility identified 16 (#08, #12, #14, #22, #24, #26, #33, #34, #48, #58, #65, #66, #67, #68, #72, and #77) residents who smoked cigarettes. The facility census was 79. On 05/06/25 at 12:05 P.M., the Administrator, the Director of Nursing (DON), and Regional Executive Director (RED) #502 were notified Immediate Jeopardy began on 04/21/25 at 6:56 P.M. when a visitor entered the code to the locked front door, entered the facility, and Resident #53 was able to exit out of the front door without staff knowledge. Resident #53 ambulated through the open door, leaving her wheelchair with the attached WangerGuard inside the lobby area. Resident #53 walked approximately 0.2 miles from the facility to a carryout. The route traveled included a sidewalk with broken concrete and rocks along a five-lane road with posted speed limits of 45 miles per hour (MPH). Staff were unaware the resident had eloped from the facility until approximately 7:31 P.M., when CNA #301 incidentally discovered the resident sitting on the floor of the carryout. At the time, Resident #53 was actively hallucinating and stating the facility kidnapped her. CNA #301 notified the DON, who sent UM #302 and LPN #300 to assist with returning the resident to the facility at 7:59 P.M. The Immediate Jeopardy was removed on 05/06/25, when the facility implemented the following corrective actions: • On 04/21/25, UM #302 and LPN #300 assisted with returning Resident #53 to the facility. • (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/22/25, LPN #305 ensured CNAs completed every 15-minute supervision checks for Resident #53 to ensure safety. • On 04/28/25, Registered Nurse (RN) #317 completed a skin observation for Resident #53, with no concerns identified. • By 05/05/25, the Administrator or designee educated all facility staff members on elopement prevention and missing resident policy. • On 05/05/25, an Ad Hoc Quality Assessment and Performance Improvement (QAPI) meeting was held to review the incident and identify corrective action. In attendance were the Administrator, the DON, Director of Maintenance (DOM) #369, Medical Records (MR) #333, Human Resource Director (HRD) #314, Social Services Designee (SSD) #373, LPN #503, UM #304, Director of Therapy (DOT) #522, and Wound Care Nurse (WCN) #396. • On 05/05/25, the DON reassessed Resident #53 for elopement risk to ensure accuracy. Additionally, Resident #08, the only identified like resident, was reassessed by the DON for elopement risk. Both residents remained at risk for elopement. • On 05/05/25, the Administrator reviewed and revised the elopement book to include information for residents who were identified to be at risk for elopement. • On 05/05/25, the DON reviewed all residents' elopement risk care plans to ensure accuracy. Any areas of concern were addressed immediately. • On 05/05/25, the DON completed a pain evaluation for Resident #53, with no concerns identified. • On 05/05/25, the Administrator and/or SSD #373 continued to seek a more appropriate alternative placement for Resident #53's safety and well-being. • (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/06/25, the Administrator or designee educated all staff on how to complete fifteen-minute supervision checks and how to document the checks. • On 05/06/25, the Administrator conducted an elopement drill on each shift to ensure staff knowledge and comprehension of the elopement and missing resident policy and procedure. • On 05/06/25, the Administrator completed a Root Cause Analysis and determined Resident #53 eloped without staff knowledge due to the CNAs providing care for other residents, leaving Resident #53 without supervision. • On 05/06/25, the DON, UM #302 and UM #304 reassessed all facility residents for elopement risk, with no new residents identified to be at risk. • On 05/06/25, RN #523 and LPN #503 reviewed Resident #53's care plan to ensure accuracy. • On 05/06/25, the Administrator and DON reviewed elopement policies and procedures and determined no changes were needed. • On 05/06/25, Resident #53 was placed on an on-going one-on-one staff supervision to ensure safety. The Administrator, or designee will be responsible for ensuring sufficient staff coverage to provide the supervision. This will continue until a more appropriate, alternative placement is found for the resident. • On 05/06/25, the Administrator or designee moved Resident #53's room to a less stimulating, more visible area of the building. • On 05/06/25, the Administrator placed signage on the front entry door to remind visitors to ensure no residents exited the facility upon entrance and the door closed securely behind them. • (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Beginning on 05/06/25, the DON or designee will complete a headcount on every resident, three times a week for four weeks then weekly for two months, then as determined by the Quality Assessment and Assurance (QAA) committee to ensure no missing residents. • Beginning on 05/06/25, the Administrator or designee will conduct random elopement drills on each shift weekly for four weeks to ensure staff knowledge and comprehension of elopement and missing resident policy and procedure, then as determined by the QAA committee. • The results of audits will be reviewed by the QAPI committee to ensure on-going compliance. • Review of one additional resident (#08), identified as the only other resident assessed to be at risk for elopement, revealed no concerns. Although the Immediate Jeopardy was removed on 05/06/25, the facility remains out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: 1) Review of the medical record revealed Resident #53 was admitted on [DATE]. Diagnoses included angina pectoris, depression, schizoaffective disorder, anxiety disorder, unspecified osteoarthritis, iron deficiency anemia secondary to blood loss, and unspecified hearing loss. Review of the Minimum Data Set (MDS) assessment, dated 04/09/25, revealed the resident was cognitively intact. Review of the elopement risk assessment, dated 02/01/25, revealed Resident #53 was at risk for elopement and a WanderGuard was placed to the right leg. Review of the care plan, dated 02/05/25, revealed Resident #53 was at risk for elopement. Interventions included to assess for fall risk, check device (WanderGuard) for function and location every shift, distract resident from wandering by offering pleasant diversions (structured activities, food, conversation, television, and books), monitor for fatigue and weight loss, provide structured activities (toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes), and wander alert (WanderGuard). Review of a nursing progress note, dated 02/17/25, revealed Resident #53 was outside without a coat, stating she wanted to see the police so they could take her to NorthStar (unknown what this is). Resident #53 stated she was attempting to go to NorthStar because that was where the voice told her she needed to go to be in the morgue. Resident #53 stated the voice told her to remove the WanderGuard. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a nursing progress note, dated 02/21/25, revealed Resident #53 had followed another resident out the front door. The WanderGuard alarmed; however, the doors did not lock due to another resident going out at the same time. Review of a nursing progress note, dated 02/25/25, revealed Resident #53 went outside and sat in a chair out front with her wheelchair next to her. The WanderGuard had alarmed, and Resident #53 had two bags of clothes packed and stated she was waiting for her son. Review of a physician order dated 03/03/25 revealed an order for Resident #53 to have every fifteen-minute safety checks, every day and night shift for monitoring. Review of a nursing progress note, dated 03/05/25, revealed Resident #53 was in a cab and would not exit. Resident #53 was upset about wanting to go to the bank. Resident #53 stated President [NAME] gave her authorization to go to the bank. Resident #53 admitted to having auditory hallucinations of voices telling her to leave and go to New York and had visual hallucinations of Italian females telling her it was ok to go. Review of an additional nursing progress note dated 03/05/25 revealed Resident #53 was noted to have elopement behaviors and required extensive monitoring. Resident #53 was on every 15-minute checks 24-hours a day, seven days a week. Review of an Interdisciplinary Team (IDT) progress note, dated 03/06/25, revealed Resident #53 had a history of schizoaffective disorder. Resident #53 had a WanderGuard applied to her wheelchair due to cutting it off from her ankle on previous occasions. Intervention in place to maintain fifteen-minute safety checks until further notice. Review of the elopement risk assessment, dated 03/25/25, revealed Resident #53 was at risk for elopement and every 15-minute supervision checks were implemented. Review of a behavior note, dated 04/07/25, revealed Resident #53 was outside of the facility doors. Review of a nursing progress note, dated 04/08/25, revealed Resident #53 was observed standing from her wheelchair, pressing the handicapped access button to open the front doors. Resident #53 was convinced to sit back down and not go outside due to the cold weather. The WanderGuard remained intact on the resident ' s wheelchair due to the resident cutting the WanderGuard off her leg numerous times. Review of a behavior note, dated 04/08/25, revealed Resident #53 was sitting out front this morning when staff arrived at work. Resident #53 was redirected back into the building. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a nursing progress note, dated 04/21/25, revealed Resident #53 exited the building around 5:30 P. M. and went to the carryout store. Resident #53 sat on the floor and refused to get up and stated she was being kidnapped. Extensive effort required as the resident refused until the store clerk told her she had to leave. Emergency services (911) were called to help. Resident #53 was delusional and stated she wanted to take a cab to [NAME] Road (a heavily traveled four-lane road). Resident #53 was encouraged to talk to her doctor that helped her with her voices and behaviors, who would assist her if she returned to the facility. Resident #53 finally got into the car with staff and returned to the facility. Emergency services were canceled due to prolonged wait. Facility management was aware; the physician was notified and attempted to call family three times with no answer. Psychiatric Nurse Practitioner (PNP) #500 to visit with resident this week. Review of the Resident Location Visual Check logs from 03/03/25 to 05/05/25 revealed visual checks were only documented as completed on 03/18/25, 03/19/25, 03/26/25, 03/27/25, 03/28/25, 03/30/25, 03/31/25, 04/01/25, and 04/02/25. There was no evidence 15-minute supervision checks were completed on 04/21/25, the date Resident #53 eloped from the facility. Review of the facility video surveillance from 04/21/25 revealed at 6:55 P.M., Resident #53 was seated in her wheelchair in the front lobby. At 6:56 P.M., an unknown visitor entered the door code from outside of the facility, unlocking the door, and entered the building. The visitor passed Resident #53, who abruptly stood up and walked out the front doors, leaving her wheelchair and attached WanderGuard in the lobby. No staff were seen on the video at the time of the elopement. Further review revealed Resident #53 returned to the facility at 7:59 P.M. with UM #302 and LPN #300. Review of CNA #301 ' s written statement revealed he took his lunch break at 7:31 P.M. (on 04/21/25). He went to the carryout to get something to drink and, upon entrance, saw Resident #53 sitting on the floor of the carryout. CNA #301 notified the DON, and two nurses arrived to assist with the resident. Review of CNA #319 ' s written statement, dated 05/06/25, revealed on 04/21/25, following dinner and after trays were picked up, she began rounds (checking on residents). After providing care to a resident, LPN #300 notified her that Resident #53 had left the building, went to the carryout and sat on the floor. One of the facility staff walked into the carryout to get something to drink and called the facility to inform them Resident #53 was at the carryout. An interview on 05/05/25 at 8:58 A.M. with LPN #305 confirmed Resident #53 had a WanderGuard placed on her wheelchair instead of her person due to the resident removing it from her body. An interview on 05/05/25 at 10:48 A.M. with UM #302 revealed Resident #53 was on 15-minute supervision checks for at least a month or more prior to the elopement on 04/21/25. UM #302 stated Resident #53 was not safe to leave the facility by herself and had been fixated on going outside. UM #302 stated Resident #53 walked well independently and had previously cut the WanderGuard off of her ankle. UM #302 confirmed that on 04/21/25, Resident #53 walked from the facility to the carryout. UM #302 was uncertain if CNA #301 had followed the resident to the carryout or if he found her there. UM #302 stated she responded to the carryout and found Resident #53 sitting on the floor. UM #302 stated it took extensive effort to get the resident into a car and back to the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview 05/05/25 at 11:05 A.M. with CNA #301 revealed on 04/21/25 he was on his break and went to a pizza shop then to the carryout, located in the same plaza, to get something to drink. Upon entering the carryout, he saw Resident #53 sitting on the floor. CNA #301 reported the resident was stating the facility had kidnapped her. CNA #301 stated he called the DON, who had two facility nursing staff come to the carryout to assist with returning the resident to the facility. CNA #301 confirmed he was not with the resident when she left the facility. An interview on 05/05/25 at 11:17 A.M. with the DON revealed Resident #53 found ways to cut the WanderGuard from her person but would not remove it from the wheelchair, so the facility decided to place the WanderGuard on the wheelchair. The DON stated the WanderGuard had been replaced at least five times after the resident had found ways to remove it from her wrists and ankles. Upon approaching the doors, the DON stated the WanderGuard should lock the doors to prevent exit. The DON reported Resident #53 had schizophrenia and the voices would tell her to leave. The DON verified Resident #53 left the faciity on [DATE] and went to the carryout, but her understanding was that a staff member (CNA #301) was right behind her. An interview on 05/05/25 at 4:30 P.M. with CA #521 revealed on 04/21/25, a woman (Resident #53) had come into the carryout, stated she was waiting for a ride, and sat on the floor. CA #521 verified the resident was alone and no one was with her. CA #521 reported a short time later, a male entered the carryout and appeared surprised to see her. Shortly after, two women came in and finally convinced her to return to the facility. An interview on 05/06/25 at 8:07 A.M. with MR #333 verified no 15-minute supervision checks had been documented as completed on 04/21/25. MR #333 verified the copies of the visual checks provided (03/18/25, 03/19/25, 03/26/25, 03/27/25, 03/28/25, 03/30/25, 03/31/25, 04/01/25, and 04/02/25) were all that she had. An interview on 05/06/25 at 8:09 A.M. with the DON revealed she was unaware Resident #53 eloped from the facility on 04/21/25 until 05/05/25, as she thought CNA #301 had been with the resident. The DON verified the facility had no evidence that 15-minute supervision checks were completed for Resident #53 on 04/21/25. An interview on 05/07/25 at 3:05 P.M. with CNA #319 verified she was assigned to Resident #53 ' s hall on 04/21/25 when the resident eloped. CNA #319 stated she did not know they were still doing 15-minute checks on Resident #53 at that time and was unaware the resident had eloped until she was informed by LPN #300, after the resident returned to the facility. Review of the facility policy titled, Elopements and Wandering Residents, dated 2024, revealed the facility ensured residents who exhibit wandering behavior and/or were at risk for elopement received adequate supervision to prevent accidents, and received care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. In addition, adequate supervision would be provided to help prevent accidents or elopements. Charge nurses and unit managers would monitor the implementation of interventions, response of interventions, and document accordingly. The effectiveness of interventions would be evaluated, and changes would be made as needed. Any changes or new interventions would be communicated to relevant staff. 2) Review of the medical record for Resident #48 revealed an admission date of 06/06/24 with a diagnosis of nicotine dependence. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the quarterly MDS assessment, dated 04/05/25, revealed Resident #48 was cognitively intact. Review of the care plan, initiated 08/11/24, revealed Resident #48 was care planned for smoking. Interventions included instruct resident on facility smoking policy for smoking location, time, and safety. Further review of the medical record revealed no evidence of a Smoking Safety Screen (assessment to determine supervision and safety needs while smoking) was completed until 03/25/25, approximately eight months after admission, when the resident was assessed to require no supervision. An interview on 05/13/25 at 12:03 P.M. with the Administrator verified Resident #48 was not assessed for smoking safety upon admission or quarterly thereafter. 3) Review of the medical record for Resident #58 revealed an admission date of 12/19/24. Diagnoses included hemiplegia and hemiparesis affecting the right side, assault by a sharp object, burns on head, face, neck, and trunk, and history of cocaine abuse. Resident #58 discharged from the facility on 05/05/25. Review of the quarterly MDS assessment dated [DATE] for Resident #58 revealed he was cognitively intact. Review of the care plan, initiated 12/19/24, revealed Resident #58 was care planned for smoking and to conduct a Smoking Safety Evaluation upon admission and as needed. Further review of the medical record revealed no evidence that a Smoking Safety Screen was completed upon admission. On 03/25/25, approximately three months after admission, Resident #58 was assessed to be able to smoke without supervision. An interview on 05/13/25 at 12:03 P.M. with the Administrator verified Resident #58 was not assessed for smoking safety upon admission. Review of the facility policy titled, Resident Smoking, undated, revealed all residents would be asked about tobacco use during the admission process, and during each quarterly or comprehensive MDS assessment process. Residents who smoked would be further assessed, using the Resident Safe Smoking Assessment, to determine whether or not supervision was required for smoking, or if a resident was safe to smoke at all, and all safe smoking measures would be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who would be responsible for supervising residents while smoking. This deficiency represents non-compliance investigated under Master Complaint Number OH00165791 and Complaint Numbers OH00165258 and OH00164697.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on resident interview, staff interview, observation, review of the medical record and review of facility policy, the facility failed to ensure timely incontinence care. This affected one (#1) of three residents reviewed for incontinence care. The facility census was 79. Findings include: Review of the medical record for Resident #1 revealed an admission date of 09/18/20 with diagnoses of congestive heart failure (CHF), diabetes mellitus, and chronic kidney disease. Review of the quarterly MDS assessment, dated 03/31/25, revealed Resident #1 was cognitively intact and was dependent on staff for toileting and was incontinent of bowel and bladder. Review of the care plan, revised 11/24/20, revealed Resident #1 was incontinent of bowel and bladder. Interventions included resident used disposable briefs and check and change every two hours and as needed. Interview on 05/08/25 at 9:59 A.M. with Resident #1 revealed she was incontinent of urine and relied on the staff to change her. Resident #1 reported the last time she received incontinence are was at approximately at 5:00 A.M., when the aide changed her before the end of her shift. Resident #1 stated she was soiled with urine, had not been checked on by staff since 5:00 A.M., and had not received incontinence care. Interview on 05/08/25 at 10:07 A.M. with Certified Nursing Assistant (CNA) #365 revealed she was responsible for the care of residents on the 200-Hall (the hall Resident #1 resided on). CNA #365 stated her shift began at 6:30 A.M. and verified she had not provided any care for Resident #1 since the beginning of her shift. CNA #365 confirmed the facility policy was to check residents every two hours for incontinence and change if needed. Observation on 05/08/25 at 10:33 A.M. of incontinence care provided to Resident #1, provided by CNA #347, revealed the resident had a heavily saturated incontinence brief. Concurrent interview with CNA #347 verified Resident #1's incontinence brief was heavily saturated with urine. CNA #347 stated if Resident #1 reported she had not been checked since third shift, she would believe her because the resident had a very sharp mind. Interview on 5/8/25 at 11:57 A.M. with CNA #328 revealed there had been a call off on the morning shift and she assisted with resident care from 6:30 A.M. until 9:00 A.M., until another CNA came in. CNA #328 verified she did not check Resident #1 for incontinence care while she assisted with covering resident care on the floor. Interview on 05/08/25 at 12:53 P.M. with CNA #333 revealed she arrived to work after 7:30 A.M. today. CNA #333 stated she was directed to assist with covering the call-off and the only thing she did was assist with passing breakfast trays. CNA #333 verified she did not provide incontinence care for Resident #1. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Activities of Daily Living (ADLs), dated 2024, revealed a resident that was unable to carry out ADLS would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This deficiency represents non-compliance investigated under Complaint Numbers OH00165492 and OH00163870.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on closed medical record review, staff interview and review of the facility policy, the facility failed to ensure total parenteral nutrition (TPN - intravenous nutrition) was administered per physician orders. This affected one (#101) of two residents review for TPN. The facility identified two (#101 and #102) residents who required TPN administration for nutritional support. The facility census was 79. Findings include: Review of the closed medical record for Resident #101 revealed an admission date of 04/17/25 and a discharge date of 05/04/25. Diagnoses included intestinal blockage, intestinal fistula (abnormal opening between the intestines and either the stomach or other parts of the body), colon cancer, hypertension (high blood pressure), and chronic kidney disease. Review of the admission Minimum Data Set (MDS) assessment for Resident #101 revealed it had not been submitted yet by the facility. Review of the admission Assessment, dated 04/17/25, revealed Resident #101 was alert and oriented to person, place, time, and situation. Resident #101 admitted for TPN therapy from intestinal blockage. Review of the physician orders for April 2025 revealed Resident #101 was ordered TPN Electrolytes Solution, use 1480 milliliter (ml) intravenously (IV) one time a day for 14 hours, the first hour to infuse at 55 ml/hour (hr), 12 hours to infuse at 110 ml/hr, and the last hour to infuse at 55 ml/hr. Review of the Medication Administration Record (MAR) for April 2025 revealed on 04/18/25, the documentation for the TPN Electrolytes Solution administration was indicated as an eight. Further review of the MAR revealed an eight indicated to see see nursing progress notes. Review of the nursing progress note dated 04/18/25 revealed Resident #101's TPN Electrolytes Solution was not administered due to medication on order; per pharmacy, Registered Nurse (RN) needed for administration, on-call aware. Interview on 05/07/25 at 2:30 P.M. with Licensed Practical Nurse (LPN) #302 revealed she was the on-call for after hours concerns on 04/18/25. LPN #302 stated she received a call from LPN #320 requesting to clarify the TPN orders for Resident #101. LPN #302 stated she directed LPN #320 to consult with the RNs who were in the building as the RNs were responsible for administering the TPN. LPN #302 stated the RNs were to clarify the TPN order if they had questions and they need to do so by contacting the on-call physician or the pharmacy. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/08/25 at 12:57 P.M. with the Director of Nursing (DON) verified the missed dose of TPN Electrolytes Solution on 04/18/25 for Resident #101. The DON stated on 04/18/25 the senior RN (RN #391) was responsible for the TPN administration and requested LPN #320 verify the TPN orders. LPN #320 called the on-call manager, LPN #302, to clarify the orders and was directed to consult with the RN on duty to clarify the orders with the on-call physician or the pharmacy. The DON further stated there were two RNs (#346 and #391) in the building that night and the RNs responsibility was to administer the TPN per the physicians orders. A follow-up interview on 05/08/25 at 2:33 P.M. with the DON verified the TPN was available and in the facility for administration to Resident #101 on 04/18/25. Review of the pharmacy inventory sheet, with the DON, confirmed the pharmacy delivered a total volume of 2960 ml of TPN, which was equal to two, 1480 ml bags of TPN for Resident #101's administration on 04/17/25 and 04/18/25. Review of the facility policy titled, Total Parenteral Nutrition (TPN), undated, revealed the facility may administer and monitor residents receiving TPN consistent with current standards of practice. TPN was a solution administered to provide nutritional support to a resident whose nutritional needs could not be met by oral or enteral feedings in order to manage and treat malnourishment. The nurse will verify the practitioners orders for the TPN. This deficiency represents non-compliance investigated under Complaint Number OH00165258.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of job descriptions, review of educational consultation forms and review of facility policy, the facility failed to ensure staff were competent related to the implementation of advanced directives and acted within their scope of practice. Additionally, the facility failed to ensure staff were knowledgeable of facility procedures related to radiology results. This affected two (#100 and #49) of four residents reviewed for staff compentancies. The facility census was 79. Findings include: 1. Review of the closed medical record for Resident #100 revealed an admission date of [DATE] and a discharge date of [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), dementia, prostate cancer, hypotension (low blood pressure), and hypertension (high blood pressure) with congestive heart failure. Review of a physician order dated [DATE] revealed Resident #100 was a Full Code status (implement life-saving measures if a person's heart stops beating). Review of the annual Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #100 was moderately cognitively impaired. Review of a nursing progress note dated [DATE] at 2:02 A.M. and completed by Licensed Practical Nurse (LPN) #300 revealed Resident #100 was absent of vital signs. This was verified by LPN #300 and LPN #501. Resident #100's time of death was 1:11 A.M. Review of the Educational Consultation form for LPN #300 and LPN #501, dated [DATE], revealed an incident for education related to the pronouncement of death by two LPNs on a Full Code resident and CPR protocol and policy not followed. Further education provided included Full Code residents must have CPR started and 911 notification, and two LPNs cannot pronounce a death. Review of the CPR certification for LPN #300 revealed she had a current CPR certification card that expired in [DATE]. Review of the CPR certification for LPN #501 revealed she had a current CPR certification card that expired in [DATE]. Interview on [DATE] at 12:23 P.M. with LPN #300 verified she did not perform CPR on Resident #100 when he was found to be not breathing and did not have a pulse. LPN #300 stated, I learned that even though a family says to not perform CPR, I cannot do that. I have to do it since they are a Full Code. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 8:00 A.M. with the Administrator verified two LPNs were not able to declare the time of death for a resident with a Full Code status. The Administrator confirmed LPN #300 and LPN #501 called Resident #100's time of death, which was outside of their scope of practice, and further failed to initiate CPR for Resident #100, who was a Full Code status, when he was found not breathing and absent of a pulse/heartbeat. Review of the facility policy titled, Cardiopulmonary Resuscitation, undated, revealed it was the policy of the facility to adhere to residents' rights to formulate advanced directives. In accordance to these rights, the facility would implement guidelines regarding CPR. If a resident experienced cardiac arrest, facility staff would provide basic life support, including CPR, prior to the arrival of emergency medical services in accordance with the residents advanced directives. Review of the Ohio Administrative Code (OAC) 4731-14-01 titled, Pronouncement of Death, dated [DATE], revealed only an individual holding one of the following current certificates or licenses may pronounce a person dead: certificate to practice medicine and surgery or osteopathic medicine and surgery, license to practice as a certified nurse practitioner or clinical nurse specialist, license to practice as a Registered Nurse, license to practice as a physician assistant, or a certificate to practice podiatric medicine and surgery. A physician holding a current certificate to practice medicine or surgery may pronounce a person dead without personally examining the body of the deceased only if a competent observer has recited the facts of the deceased 's present medical conditions. A competent observer is identified as licensed practical nurse, emergency medical technician (EMT) holding a basic, intermediate, and paramedic. 2. Review of the medical record revealed Resident #49 was admitted on [DATE]. Diagnoses included acute chronic systolic (congestive) heart failure, malignant neoplasm of prostate, cocaine use, major depressive disorder, and nonrheumatic aortic stenosis. Review of the MDS assessment, dated [DATE], revealed the resident was moderately cognitively impaired and required supervision assistance with toileting, shower/bathes, upper and body lower dressing, applying footwear, and personal hygiene. Review of a nursing progress note, dated [DATE] at 9:56 A.M., revealed Resident #49 complained of right hip pain when he moved. Resident #49 rated the pain as a 10 on a zero to 10 pain scale. The physician was notified and received an X-ray order for the right hip. An X-ray was completed. Review of a nursing progress note, dated [DATE] at 9:15 A.M., revealed X-ray results were received, the physician was notified, and an order was received to transport Resident #49 to the emergency room for evaluation. Review of the radiology results report, dated [DATE] at 9:55 A.M., revealed Resident #49 was diagnosed with an acute nondisplaced right femoral neck fracture. Review of electronic mail (e-mail) correspondence from the Administrator, received on [DATE] at 12:28 P.M., verified a stat X-ray was ordered for Resident #49 on [DATE] at 9:09 A.M. The technician arrived on [DATE] at 9:33 A.M., the X-ray was completed on [DATE] at 9:34 A.M., the X-ray was verified on [DATE] at 9:36 A.M. , and the final report was completed on [DATE] at 9:54 A.M. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 11:25 A.M. with the Director of Nursing (DON) verified Resident #49 had a stat X-ray of the right hip on the morning of [DATE] and the results were not received by the facility until the morning of [DATE]. A follow up interview on [DATE] at 2:27 P.M. with the DON revealed she had reviewed the facility's 24-hour report on [DATE], which showed that a stat X-ray to Resident #49's hip was completed on [DATE] and the facility had not received the results. The DON stated she accessed the radiology vendor's system and reviewed the results on [DATE]. The DON stated the results should have been faxed to the nurse's station and the primary fax in the copy room. The DON verified the nurse on shift would have been expected to follow-up on the results of a stat X-ray no later than four to six hours after the x-ray. Interview on [DATE] at 9:10 A.M. with Registered Nurse (RN) #317 verified providing care to Resident #49 on the day shift on [DATE]. RN #317 stated she never received the X-ray results on her shift and reported to the on-coming shift that the results were pending. RN #317 stated she knew the resident had a hip fracture and had been curious about the results all day. RN #317 stated she checked the radiology tab in the facility's medical record system throughout the day, with no findings. RN #317 stated she did not know where else to receive the results. Review of the facility job description titled, Charge Nurse, dated 2023, revealed the purpose of the charge nurse was to provide direct nursing care to the residents and supervise the day-to-day nursing activities performed by the certified nursing assistants in accordance with the current federal, state, and local regulations and guidelines and established facility policies and procedures. Requirements for the charge nurse included a nursing degree from an accredited college or university or a graduate of an approved Licensed Practical Nurse (LPN)/Licensed Vocational Nurse (LVN) program, current unrestricted license as a RN or LPN in practicing state. This deficiency was an incidental finding discovered during the complaint investigation.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview and staff interview, the facility failed to ensure adequate services were available to treat substance use disorders. This affected three (#49, #43, and #33) of three residents reviewed for substance use. The facility census was 79. Findings include: Review of the medical record revealed Resident #49 was admitted on [DATE]. Diagnoses included acute chronic systolic (congestive) heart failure, malignant neoplasm of the prostate, cocaine use, major depressive disorder, and nonrheumatic aortic stenosis. Review of the MDS assessment, dated 02/08/25, revealed the resident was moderately cognitively impaired. Review of the care plan, dated 12/03/24, revealed Resident #49 had a history of substance use disorder as evidence by the use of cocaine. Interventions included administer medications as prescribed, assist in attending support groups, educate the resident on the risks of leaving the facility to seek out substances, encourage and allow the resident to express feelings, encourage frequent contact with family and friends that are supportive of recovery, and encourage family to be an active part of care and discharge planning. Review of a nursing progress note, dated 11/01/24, revealed Resident #49 was caught smoking and it smelled of burnt plastic. The resident's nose was clamped with a clamp used for hair, and the room was suffocating because of the burnt plastic smell throughout the room. When asked, the aides reported they had observed the resident smoking something inside the room earlier. A plastic tube and lighter were confiscated when the resident tried to hide it in the trash and confiscated it while he was in the restroom. Review of a nursing progress note, dated 11/29/24, revealed an aide reported an odor coming from Resident #49's room and the roommate complained of the smell as well. The DON was notified. Review of nursing progress notes, dated 03/26/25, revealed the resident was found in his room by an aide smoking an unknown substance. Two staff completed a room check with no results, the DON was notified, and the resident stated he was smoking a cigarette. Review of a nursing progress note, dated 03/27/25, revealed the smell of smoke was in the air and the resident's room was checked. Upon entering, Resident #49 was sitting on his bed, surrounded by smoke and smoking an unknown substance. Resident #49 placed an object inside of his pocket and stated he was smoking a cigarette. The DON was notified, and statements were completed. Resident #49 was informed to smoke in designated areas. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an untitled facility provided document, dated 03/27/25, revealed a report was received on 03/27/25 regarding Resident #49 smoking in his room. Per the nurse and aide, it was unknown what was being smoked as it did not smell like cigarettes. Resident #49 stated it was a cigarette and the resident's roommate stated he did not smell anything. Resident #49 did not have anything on his person and refused a room search. The resident was re-educated regarding smoking in the facility. Review of a physician progress note, dated 04/01/25, revealed Resident #49 had a history of back pain and current concerns for back pain. Resident #49 was prescribed acetaminophen 650 milligrams (mg) every six hours as needed and a lidocaine patch for the left shoulder. Resident #49 was not prescribed narcotics due to concerns for illicit drug use and, after discussion with the resident, he continued to decline drug testing. Interview on 05/06/25 at 9:44 A.M. with CNA #363 revealed Resident #49 smoked crack in the building every day. CNA #363 stated it was known by facility staff and Administration that the resident smoked crack, both outside in the smoking area and in his room. Interview on 05/06/25 at 10:30 A.M. with Resident #31, who was Resident #49's roommate, verified Resident #49 used crack in their room. Resident #31 declined to elaborate further. Interview on 05/06/25 at 12:03 P.M. with the DON verified crack cocaine paraphernalia had been found in Resident #49's room, but never the drugs. The DON confirmed the resident's room had smelled of burning plastic, consistent with the odor produced by smoking crack, further adding she had a history of working in substance abuse and was familiar with the smell of crack. The DON stated the facility provided education to the resident and removed paraphernalia when they found it, but no other interventions had been implemented. Interview on 05/06/25 at 3:41 P.M. with CNA #338 verified Resident #49 has smoked crack in his room and bathroom. CNA #338 reported it was known that the resident smoked crack in the facility and the smell from the crack gave her a headache. A telephone interview on 05/07/25 at 5:47 A.M. with RN #346 revealed he had removed a hard tube from Resident #49's possession approximately two months ago. RN #346 stated the inside of the tube looked like it had black smoke in it, like it had been burnt, and smelled like burning plastic. RN #346 stated he did not recall who was on-call at the time but notified the on-call nurse of the incident. RN #346 stated he did not feel well after finding the tube as he was not used to smelling burning plastic. 2. Review of the medical record revealed Resident #43 was admitted on [DATE]. Diagnoses included dysarthria following unspecified cerebrovascular disease, acute kidney failure, cerebral infarction (stroke), heart failure, hypothyroidism, hyperlipidemia, anemia, and acute kidney failure. Review of the MDS assessment, dated 03/10/25, revealed Resident #43 was moderately cognitively impaired. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan, revised 10/09/24, revealed Resident #43 hid alcohol. Interventions included to administer medications as ordered, anticipate the resident's needs, caregivers to provide opportunity for positive interaction and attention, educated the resident on successful coping and interaction strategies, and to explain all procedures to the resident before starting and allow the resident to adjust to the change. Review of a nursing progress note, dated 11/01/25, revealed Resident #43 was observed near the vending machine and was attempting to receive another resident ' s bottle of alcohol. Review of a nursing progress note, dated 11/03/24, revealed alcohol was sitting on the resident's bedside table while giving medication. The alcohol was confiscated and the resident was educated. Review of a nursing progress note, dated 12/12/24, revealed Resident #43 was noted to have alcohol in her possession. The alcohol was removed and the resident was re-educated on the policy regarding drinking as well as dangers of drinking on medications. Review of a nursing progress note, dated 04/17/25, revealed an aide reported the resident had alcohol and was drinking it. The alcohol was confiscated and the Director of Nursing (DON) was made aware. Review of a nursing progress note, dated 05/06/25, revealed the resident was observed with a bottle of [NAME] Peach (whiskey) in her wheelchair pouch. The resident was educated regarding not drinking at the facility. The alcohol was removed from the resident's wheelchair with her approval and the provider was notified. No new orders at this time. Interview on 05/06/25 at 3:41 P.M. with CNA #338 revealed Resident #43 had a bottle of liquor in a pouch on the side of her wheelchair. Observation on 05/06/25 at 4:10 P.M. of Resident #43 revealed the resident was in her wheelchair in the hallway. Continued observation revealed a bottle of alcohol in a pouch on her wheelchair, with approximately one-fourth of the alcohol gone, as she moved about the facility. Interview on 05/06/25 at 4:13 P.M. with Unit Manager (UM) #302 verified Resident #43 had an open bottle of alcohol in her wheelchair. 3. Review of the medical record revealed Resident #33 was admitted on [DATE]. Diagnoses included muscle wasting and atrophy, cerebral infarction due to embolism of right middle cerebral artery, dysphagia following cerebral infarction, hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non-dominant side, hyperlipidemia, major depressive disorder moderate, schizophrenia, and type two diabetes mellitus without complications. Review of the MDS assessment, dated 04/07/25, revealed the resident was moderately cognitively impaired. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Divine Rehabilitation and Nursing at Toledo	1011 North Byrne Road Toledo, OH 43607

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Alcohol, Illegal Drugs, and Weapons Policy, signed 03/08/23, revealed while alcohol was not an illegal substance it did create a risk to individuals taking certain medications. It was the policy of the facility that alcohol should not be consumed on the premises on a routine basis. The physician would be notified, and the residents may be ordered a random alcohol/drug screen at the discretion of the provider. Review of the care plan, dated 07/24/24, revealed Resident #33's drug of choice was alcohol use of/addiction to illegal substances. Interventions included to encourage and allow me to openly express my feeling and express to fears and worries, encourage frequent contact with family and friends that are supportive of my recovery and do not encourage substance use. Observation on 05/05/25 at 4:15 P.M. revealed Resident #33 was on the back patio smoking area with a tall can of beer opened and next to him. Interview on 05/05/25 at 4:17 P.M. with UM #302 verified Resident #33 had an opened tall can of beer next to him while smoking outside. Review of a nursing progress note, dated 05/06/25, revealed the resident was observed drinking a tall boy can of beer in the resident smoking area. When the writer approached, the resident had one sip left in the can and approved the writer to dispose of the beer. The provider was notified and no new orders at this time. Interview on 05/13/25 at 12:03 P.M. with the Administrator revealed the facility was working on trying to get a local substance abuse treatment agency to come to the facility to conduct meetings, such as support groups, to help address concerns identified with substance use within the facility. This deficiency represents non-compliance investigated under Complaint Number OH00165258.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on medical record review, staff interview and review of facility policy, the facility failed to ensure insulin medications were administered per physician orders. This affected one resident (#27) of three residents reviewed for medication administration. The facility census was 79. Findings include: Review of the medical record for Resident #27 revealed an admission date of 10/04/21 with a diagnosis of diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/12/25, revealed Resident #27 was cognitively intact and received insulin injections. Review of the care plan, initiated 10/22/21, revealed Resident #27 had type II diabetes mellitus. Interventions included diabetes medication as ordered by the physician. Review of the current physician orders revealed Resident #27 was ordered insulin glargine (long acting insulin to treat diabetes) subcutaneous solution pen-injector 100 unit (U)/ milliliter (ml), inject 50 U twice daily; insulin lispro (fast acting insulin, used to cover carbohydrates at mealtime, must eat with this insulin) injection solution 100 U/ml, inject 14 U with meals, do not hold unless resident does not eat, scheduled at 7:30 A.M., 12:00 P.M., and 5:00 P.M.; and insulin lispro injection (fast acting insulin, used as sliding scale coverage to cover blood sugar prior to mealtime) solution 100 U/ml inject per sliding scale, if blood sugar 151-200 give two units of insulin, if blood sugar 201-300 give four units of insulin, if blood sugar 301-400 give eight units of insulin three times daily. Review of the Medication Administration Record (MAR) for March 2025 revealed Resident #27 was not administered insulin glargine solution 50 units on 03/12/25; insulin lispro injection 14 units three times daily was not administered on 03/11/25 at 5:00 P.M., 03/12/25 at 8:00 A.M., 12:00 P.M. and 5:00 P.M., 03/24/25 at 5:00 P.M., and 03/28/24 at 5:00 P.M.; insulin lispro sliding scale coverage at mealtime was not administered on 03/11/25 at 5:00 P.M., 03/12/25 at 8:00 A.M., 12:00 P.M. and 5:00 P.M., 03/24/25 at 5:00 P. M., and 03/28/24 at 5:00 P.M Review of the nursing progress notes for March 2025 revealed no documentation Resident #27 refused the administration of insulin. Interview on 05/07/25 at 2:27 P.M. with Registered Nurse (RN) #304 verified the missing nursing initials for Resident #27's insulin administration, including insulin glargine the morning dose on 03/11/25 and the evening dose at 5:00 P.M.; for insulin lispro 14 U and sliding scale coverage on 03/11/25; insulin lispro 14 U and lispro sliding scale coverage for all three doses at 7:30 A.M., 12:00 P.M., and 5:00 P.M. on 03/12/25; insulin lispro 14 U and insulin lispro sliding scale coverage for the 5:00 P.M. dose on 03/24/25; and insulin lispro 14 U and insulin lispro sliding scale coverage for the 5:00 P.M. dose on 03/28/25. RN #304 stated missing initials on the MAR indicated the medication was not administered. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy title, Medication Administration, undated, revealed medications were administered by licensed nurses or other staff who were legally authorized to do so in the state, as ordered by the physician and in accordance with professional standards of practice. This deficiency represents non-compliance investigated under Complaint Number OH00164417 and OH00164178.

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, resident interview, medical record review, review of personnel job descriptions, review of self-reported incidents (SRIs) and review of facility policies, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This had the potential to affect all 79 residents residing in the facility. The facility census was 79. Findings include: 1) Review of Resident #100's medical record revealed the resident had a Full Code status. On [DATE], Resident #100 was found absent from vital signs. Licensed Practical Nurse (LPN) #300 did not initiate cardiopulmonary resuscitation (CPR), did not call for emergency medical services (EMS) assistance, and LPN #300 and LPN #501 subsequently called the resident's time of death without contacting the physician or any other provider qualified to call a resident's time of death. Interview on [DATE] at 8:35 A.M., with the Administrator confirmed LPN #300 and LPN #501 should have initiated CPR for Resident #100 when he was found without vital signs. The Administrator further confirmed LPN #300 and LPN #501 acted outside of their scope of practice when they called the resident's time of death without contacting the physician. The Administrator stated LPN #300 and LPN #501 reported the resident's family was at bedside and refused the initiation of life-saving measures. The Administrator stated she had the Director of Nursing (DON) contact the resident's Power of Attorney (POA) to verify she was at the facility at the time of Resident #100's death. The Administrator confirmed that the DON reported to her that the POA was present. During the investigation of complaint, it was discovered the POA was not present, and the Administrator stated she had taken what was reported to her from the DON. Review of the undated facility policy titled, Cardiopulmonary Resuscitation, revealed it was the policy of the facility to adhere to residents' rights to formulate advanced directives. In accordance with these rights, this facility would implement guidelines regarding CPR. If a resident experienced cardiac arrest, facility staff would provide basic life support, including CPR, prior to the arrival of emergency medical services in accordance with the residents advanced directives. 2) Review of Resident #53's medical record revealed the resident had a history of elopement attempts, with interventions including a WanderGuard applied to her wheelchair (the resident was ambulatory) and 15-minute staff supervision checks. Further review revealed the resident eloped from the facility on [DATE], without staff knowledge. At the time of Resident #53's elopement, the resident left her wheelchair, with the attached WanderGuard, in the lobby area so that it did not activate the door alarm and ambulated through the front door. On [DATE], staff failed to provide 15-minute supervision checks and stated they were unaware the 15-minute supervision checks were still being done. Review of the facility submitted SRIs revealed Resident #53's elopement was not reported to the State Survey Agency (SSA) as potential neglect. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on [DATE] at 8:09 A.M., with the DON revealed she was unaware Resident #53 eloped from the facility on [DATE], until the complaint investigation was initiated on [DATE]. The DON had previously thought a staff member had been with the resident. The DON verified Resident #53's elopement was not reported to the SSA, the facility had not conducted an investigation, and no additional interventions had been implemented at the time of the elopement to ensure the resident's safety. Review of the facility policy titled, Elopements and Wandering Residents, dated 2024, revealed the facility ensured residents who exhibit wandering behavior and/or were at risk for elopement received adequate supervision to prevent accidents, and received care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. In addition, adequate supervision would be provided to help prevent accidents or elopements. Charge nurses and unit managers would monitor the implementation of interventions, response of interventions, and document accordingly. The effectiveness of interventions would be evaluated, and changes would be made as needed. Any changes or new interventions would be communicated to relevant staff. Review of the facility policy titled, Abuse, Neglect, and Exploitation, dated 2024, revealed neglect was defined as failure of the facility, its employees, or service providers to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility would report all alleged violations to the Administrator, state agency, adult protective services, and to all other required agencies immediately, but not later than two hours after the allegation was made, if the event that cause the allegation involve abuse or result in serious bodily harm or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in bodily injury. Additionally, the facility would complete an immediate investigation when there was suspicion or reports of abuse, neglect, or exploitation. 3) Review of Resident #39's medical record revealed she was cognitively intact and was dependent on staff for toileting, showering, lower body dressing, and personal hygiene. Interview on [DATE] at 3:41 P.M., with Certified Nursing Assistant (CNA) #338 revealed staff refused to provide care for Resident #39 and on [DATE]. CNA #338 received a telephone call, after her shift had ended, from Unit Manager (UM) #302. CNA #338 requested UM #302 to speak with CNA #319, who was responsible for providing care for Resident #39 but was refused. CNA #338 revealed she had to return to the facility to provide care for Resident #39 because CNA #319 refused. Interview on [DATE] at 4:02 P.M., with UM #302 verified the aides refused to provide care for Resident #39, adding it occurred so often that she could not track it. UM #302 confirmed Resident #39's care was delayed due to the aides' refusals. UM #302 verified the DON was aware of the concerns with CNAs refusing to provide care for Resident #39. 4) Review of Resident #49's medical record revealed the resident had a history of crack cocaine use, both inside and outside of the facility. Interview on [DATE] at 9:44 A.M., with CNA #363 revealed Resident #49 smoked crack in the building every day. CNA #363 confirmed facility administration was aware of the resident's substance use in the facility. Interview on [DATE] at 10:30 A.M., with Resident #31, Resident #49's roommate, verified Resident #49 used crack in the residents' room. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on [DATE] at 12:03 P.M., with the DON verified crack paraphernalia had been found in Resident #49's room, but never the drugs. The DON confirmed Resident #49's room had smelled of burning plastic, consistent with the odor produced by smoking crack, further adding she had a history of working in substance abuse and was familiar with the smell of crack. The DON stated the facility provided education to Resident #49 and removed the paraphernalia when they found it, but no other interventions had been implemented. 5) Review of Resident #43's medical record revealed a history of having hidden alcohol and used it out in the open. Observation during the complaint investigation revealed Resident #43 had a bottle of alcohol in a pouch on her wheelchair as she moved about the facility. Interview on [DATE] at 4:13 P.M., with UM #302 verified Resident #43 had an open bottle of alcohol in her wheelchair. 6) Review of Resident #33's medical record revealed the resident had a history of alcohol use. The resident signed a document titled, Alcohol, Illegal Drugs, and Weapons Policy on [DATE], which stated it was the policy of the facility that alcohol should not be consumed on the premises on a routine basis. Resident #33's care plan indicated the resident's drug of choice was alcohol with interventions including encourage frequent contact with family and friend that were supportive of recovery and did not encourage substance use. Observation on [DATE] at 4:15 P.M., revealed Resident #33 was on the back patio smoking area with a tall opened can of beer. Interview on [DATE] at 4:17 P.M., with UM #302 verified Resident #33 had an open can of beer while smoking on the smoking patio. Interview on [DATE] at 12:03 P.M., with the Administrator revealed the facility was working on trying to get a local substance abuse treatment agency to come to the facility to conduct meetings, such as support groups, to help concerns identified with substance use within the facility. Review of the facility document titled, Administrator, revealed the Administrator signed the job description on [DATE]. The job summary indicated the purpose of the position was to establish and maintain systems that were effective and efficient to operate the facility in a manner to safely meet residents' needs in compliance with federal, state and local requirements. Additionally, the purpose of the position was to ensure that the facility remained compliant with all policies and procedures as stated, including but not limited to operational, clinical, financial and integrity. Responsibilities and major duties included, but not limited to: ensure compliance with written policies regarding responsibilities and activities of individuals employed or acquired under arrangement; establish and/or maintain and comply with systems to enforce the facility policies and procedures; establish and/or maintain and comply with written personnel policies and individual job descriptions, supervise all department supervisors, administrative staff, the recruitment, employment, performance, evaluation, promotion and discharge of all staff; develop relationships with community agencies providing services of benefit to the facility; and establish and/or maintain and comply with systems to ensure compliance with all federal, state and local regulations. The Administrator was responsible for the direction and management of all processes and employees within the facility and was expected to display responsibility for the overall growth and management of the facility. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility document titled, Director of Nursing, revealed the DON signed the job description on [DATE]. The job summary indicated the DON was responsible for providing nursing management, set resident care standards for all direct care providers and provide complete supervision and management for the nursing department. Responsibilities and major duties included, but not limited to: direct, evaluate and supervise all resident care and initiate corrective action as necessary; direct and implement nursing service educational programs; assume responsibility for nursing service compliance with federal, state and local regulations; consistently work cooperatively with administration, all facility staff, ancillary personnel and consultants; demonstrate consistent management of nursing service problems, emergency situations, and initiate life-saving measures in the absence of a physician; and adhere to all facility policies and procedures and ensure they are adhere to by all responsible parties and carry out disciplinary action for non-compliance as appropriate. The DON was responsible for the direction and management of the clinical team. This deficiency represents non-compliance investigated under Master Complaint Number OH00165791 and Complaint Numbers OH00165258 and OH00164697.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, staff interview, and review of facility policy, the facility failed to ensure the environment was maintained in good repair. This had the potential to affect all residents, except 14 (#6, #23, #28, #35, #36, #38, #44, #45, #50, #51, #52, #60, #71, and #76) residents who resided on the secured memory care unit. The facility census was 79. Findings include: Observations on 05/06/25 at 2:10 P.M. of the hallways throughout the facility revealed a water stained ceiling tile surrounding a sprinkler head, wall paper peeling off the walls throughout the hallway, dirty stained flooring, and patches of flooring worn and discolored from use. Interview on 05/06/25 at 2:17 P.M. with Director of Maintenance (DOM) #369 verified the above findings. DOM #369 reported the sprinkler was no longer leaking, but the water stained ceiling tile could not be replaced until the sprinkler company replaced it. DOM #369 stated the date of service for the ceiling tile repair was unknown and further added it had been that way since he started at the facility approximately one and a half months ago. Review of the facility policy titled, Safe and Homelike Environment, dated 2024, verified the facility would provide a safe, clean, and comfortable homelike environment, including housekeeping and maintenance services provided as necessary to maintain a sanitary, orderly, and comfortable environment. This deficiency represents non-compliance investigated under Complaint Number OH00165258, OH00164697, and OH00163870.