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	03/05/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, resident interview, review of a facility policy, and review of a glucometer manufacturer instructions, the facility failed to ensure glucometers were properly disinfected after use and failed to ensure bedpans were properly stored for residents with urinary infections. This affected three (#35, #49, and #54) of four residents observed for infection control practices with the potential to affected two additional residents (#22 and #42) who have their blood glucose level checked using the same glucometer as Resident #35 and #49. The facility census was 60. Findings include:1. Review of the medical record for Resident #49 revealed an admission date of 03/28/24. Diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease, and type two diabetes mellitus.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #49 had severe cognitive impairment. Review of the physician orders dated 09/28/24 revealed Resident #49 had an order for insulin glargine 14 units subcutaneously two times a day for diabetes mellitus. Further review of the physician orders revealed no orders for blood glucose monitoring. The resident had an order dated 01/12/26 for admission to hospice. Review of the medication administration record revealed the resident's glucose levels were monitored twice daily. Observations on 03/04/26 at 7:54 A.M. revealed Registered Nurse (RN) #500 used a glucometer to obtain Resident #49's glucose level. RN #500 returned to the medication cart and cleaned the glucometer with an alcohol swab. Interview on 03/04/26 at 7:56 A.M., with RN #500 verified an alcohol swab was used to clean the glucometer. RN #500 revealed she was an agency nurse and was not aware of the facility policy for glucometer cleaning. 2. Review of the medical record for Resident #35 revealed an admission date of 01/24/25. Diagnoses included vascular dementia and metabolic encephalopathy. Review of the quarterly MDS assessment dated [DATE] revealed Resident #35 had severe cognitive impairment. Observation on 03/04/26 at 8:00 A.M. revealed RN #500 used a glucometer to obtain Resident #35's blood glucose level. RN #500 used the same glucometer she had used to obtain Resident #49's blood glucose level. RN #500 returned to the medication cart and cleansed the glucometer with an alcohol swab. Observation and interview on 03/04/26 at 8:05 A.M., RN #500 verified if she had used an alcohol swab to clean the glucometer. RN #500 was asked if there were disinfectant wipes in the medication cart. RN #500 opened the bottom drawer of the medication cart and verified there were disinfectant wipes in the bottom drawer of the medication cart. Interview on 03/04/26 at 9:21 A.M., with the Director of Nursing (DON) verified staff should not be using alcohol swabs to clean and disinfect glucometers. The DON verified the four (#35, #49, #22, and #42) residents using the glucometer had no known blood borne pathogens. Review of the facility policy titled, Glucometer Disinfection, dated 2025, revealed the facility would ensure blood glucometers would be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use. The glucometers would be disinfected with a wipe pre-saturated with an EPA (Environmental Protection Agency) registered healthcare disinfectant that is effective against Human Immunodeficiency Virus (HIV), Hepatitis C, and Hepatitis B virus. Review of the manufacturer's instruction manual for the blood glucose monitoring system revealed contact with blood presented a potential infection risk. The glucometer should be cleaned and disinfected between patient use. (continued on next page)

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Option one for the cleaning and disinfecting should be completed by using a commercially available EPA-registered disinfect detergent or germicidal wipe. If blood was present on the meter, then two wipes must be used by using one wipe to clean and a second wipe to disinfect. Option two revealed to clean the glucometer with soapy water or isopropyl alcohol then disinfect with one milliliter of household bleach (five to six percent sodium hypochlorite solution) in nine milliliters of water to achieve a one to ten dilution (final concentration of 0.5 to 0.6 percent sodium hypochlorite). 3. Review of the medical record for Resident #54 revealed an admission date of 07/29/21 and a readmission date of 04/15/25. Diagnoses included schizophrenia, osteoarthritis, hypertension, and chronic pain. Review of the quarterly MDS assessment dated [DATE] revealed Resident #54 had impaired cognition. The resident was always incontinent of bowel and bladder and was dependent on staff for toileting hygiene. Review of a nurse's note dated 01/31/26 at 4:48 P.M. revealed Resident #54 had a multidrug resistant urinary tract infection and the resident was receiving antibiotic therapy. Observation on 03/02/26 at 10:34 A.M. revealed there were two soiled bedpans on Resident #54's bathroom sink and one soiled bedpan on the floor underneath the bathroom sink. The bedpans had not been placed inside a plastic barrier. Interview on 03/02/26 at 10:34 A.M. with Resident #54 revealed the staff had been using the bedpans to collect urine samples. Resident #54 revealed she had a urinary tract infection. Observation on 03/03/26 at 7:52 A.M. revealed the three uncovered bedpans remained in the same locations in Resident #54's bathroom. Interview on 03/03/26 at 7:52 A.M., with Licensed Practical Nurse (LPN) #421 verified there were two uncovered soiled bed pans on Resident #54's bathroom sink and one soiled uncovered bedpan on the floor underneath the bathroom sink. LPN #421 revealed the bedpans were used to collect urine specimens and the staff should have discarded the bedpans. Interview on 03/03/26 at 2:12 P.M., with the Administrator revealed staff should store urinary bed pans in a plastic bag.Review of the facility policy titled, Disinfection of Bedpans and Urinals, dated 2025, revealed bedpans and urinals would be handled in a manner to prevent the spread of infection through personal equipment. Staff were to place bedpans and urinals in the resident's bathroom after placing in a plastic bag.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and staff interview, the facility failed to ensure a resident's urinary catheter bag was covered and placed in a manner to ensure dignity was maintained. This affected one (#5) of one residents reviewed with an indwelling catheter in place. The facility identified six current residents with indwelling urinary catheters in place in a facility census of 60. Findings include:Review of the medical record revealed Resident #5 admitted to the facility on [DATE] with diagnosis including, obstructive and reflux uropathy, obstructive hydrocephalus, vascular dementia, edema, chronic kidney disease, and abscess of prostate. Review of the most current Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 was assessed with severe cognitive impairment, was dependent on staff for the completion of activities of daily living, and had an indwelling urinary catheter in place. Review of a nursing plan of care revised on 01/22/25 addressed Resident #5's diagnosis of obstructive uropathy with a indwelling urinary catheter (Foley) in place. Interventions included to position the catheter bag and tubing below the level of the bladder and away from entrance room door. Review of a physician order dated 12/16/25 revealed to ensure the indwelling urinary (Foley) catheter was covered with a dignity bag and/or cover and was to be completed every shift. Observations on 03/03/26 at 9:20 A.M., 10:29 A.M., 11:52 A.M., and 12:25 P.M., and on 03/04/26 at 5:41 A.M., 8:04 A.M., and 10:45 A.M. revealed Resident #5 was in bed with an indwelling catheter drainage bag hanging from the bed frame draining yellow urine. There was no privacy bag in place and the drainage bag was visible from the common corridor. On 03/04/26 at 10:52 A.M. interview with Registered Nurse (RN) #500 verified Resident #5's indwelling catheter drainage bags are to be kept in a privacy bag or our of common sight to maintain dignity. On 03/04/26 at 10:54 AM interview with Certified Nurse Aide (CNA) #454 verified Resident #5's indwelling catheter drainage bag was exposed to the common corridor while he was in bed on 03/03/26 and 03/04/26. CNA #454 confirmed a privacy bag was installed on the resident's high back chair; however, no privacy bag was in place for the bag while the resident was in bed. On 03/04/26 at 11:21 A.M. interview with the Administrator verified the facility did not have a policy or procedure instructing placement of collection bags or associated personal drainage devices to ensure dignity.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on medical record review, staff interview, and policy review, the facility failed to ensure residents prescribed psychotropic medications were monitored for behaviors and medication side effects. This affected three (#1, #48, and #66) of five residents reviewed for psychotropic medications. The facility census was 60.Findings include:1. Review of the medical record for Resident #1 revealed an admission date of 01/26/25 with diagnoses of congestive heart failure, bipolar disorder, parkinsonism, type II diabetes mellitus, and anxiety. Review of the annual comprehensive Minimum Data Set (MDS) assessment, dated 02/05/26, revealed Resident #1 had intact cognition and received an antianxiety medication.Review of the physician order, dated 12/30/25, revealed Resident #1 received clonazepam (an antianxiety medication) one (1) milligram (mg) one tablet by mouth twice daily for anxiety.Review of the care plan, initiated 01/02/26, revealed Resident #1 had a mood problem related to anxiety, depression, and bipolar disorder. Interventions included administering medications as ordered and monitor/document for side effects and effectiveness.2. Review of the medical record for Resident #48 revealed an admission date of 09/16/25 with diagnoses of depression, type II diabetes mellitus, heart disease, and peripheral vascular disease. Review of the quarterly MDS assessment, dated 02/03/26, revealed Resident #48 had intact cognition.Review of the physician order, dated 12/15/25, revealed Resident #48 received sertraline hydrochloride (Hcl) (an antidepressant) oral tablet 25 mg one tablet once daily for depression.3. Review of the medical record for Resident #66 revealed an admission date of 02/24/26 with diagnoses of pelvic fractures, cerebral infarction, dementia, bariatric surgery, and Raynaud's syndrome.Review of the nursing admission assessment, dated 02/24/26, revealed Resident #66 was alert and oriented to person, place, time, and situation.Review of Resident #66's baseline care plan, initiated 02/24/26, revealed Resident #66 should be monitored for medications and side effects.Review of the physician order dated 02/26/26 revealed Resident #66 received aripiprazole (an antipsychotic) oral tablet 10 mg once daily for depression.Review of the physician order date 02/24/26 revealed Resident #66 received Lexapro (an antidepressant) oral tablet 20 mg once daily for antidepressant.Interview on 03/05/26 at 11:19 A.M. and at approximately 11:45 A.M. with Registered Nurse Clinical Consultant (RNCC) #502, and concurrent review of the electronic medical records for Resident #1, Resident #48, and Resident #66, revealed no behavior monitoring was in place to monitor for efficacy and/or side effects of psychotropic medications received by Resident #1, Resident #48, and Resident #66.Review of the policy, Use of Psychotropic Medications, copyright 2025, revealed psychotropic medications were to be used only when a practitioner determined the medication(s) was appropriate to treat a resident's specific, diagnosed, and documented condition and the medication(s) was beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s).

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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. Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure dependent residents received adequate oral care as ordered. This affected one (#23) of one residents reviewed for oral care. The facility census was 60. Findings include:Review of the medical record for Resident #23 revealed an admission date of 07/14/20 with diagnoses including epilepsy, dysphagia, type II diabetes mellitus, bipolar disorder, dementia, and gastrostomy status.Review of the quarterly Minimum Data Set assessment, dated 01/02/26, revealed Resident #23 had severely impaired cognition, had a feeding tube, and was dependent on staff for oral hygiene and personal hygiene.Review of the physician order dated 07/07/24 revealed Resident #23 should receive Chapstick (lip balm) to her lips every shift (twice daily).Review of the physician order dated 01/21/26 revealed Resident #23 should receive oral care twice daily because she was received no food or drink by mouth.Observation on 03/02/26 at 2:22 P.M. revealed Resident #23 lying in bed with her eyes closed. Resident #23's mouth was open and her lips appeared to be dry and peeling. Observation on 03/03/26 at 7:44 A.M. revealed Resident #23 lying in bed with her eyes open. Resident #23's mouth was open and her lips appeared to be dry and peeling. An attempted interview with Resident #23 at the time of the observation was unsuccessful.Observation on 03/03/26 at 4:06 P.M. revealed Resident #23 lying in bed with her eyes open. Her lips appeared moist and hydrated and no evidence of peeling was observed.Interview on 03/04/26 at 7:55 A.M. with Licensed Practical Nurse (LPN) #419 confirmed LPN #419 provided oral care to Resident #23 on 03/03/26. LPN #419 confirmed Resident #23 had a white substance on her lips but they were not peeling. LPN #419 stated the white substance easily wiped off with the application of lip balm. LPN #419 stated when LPN #419 returns to work after a day off, Resident #23's lips were often not well cared for. Interview on 03/04/26 at 9:08 A.M. with Certified Nurse Aide (CNA) #406 stated she worked on 03/03/26 during first shift and provided oral and lip care to Resident #23. CNA #406 confirmed Resident #23's lips were peeling on 03/03/26, and the excess skin wiped off without difficulty. CNA #406 stated the condition of Resident #23's lips on 03/03/26 would have taken more than one shift's lack of lip/oral care to become as dry and peeled as they were on 03/03/26.Review of the policy, Activities of Daily Living (ADLs), copyright 2024, revealed a resident who was unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, medical record review, and staff interview, the facility failed to ensure residents compression stockings were applied as ordered. This affected one (#6) of one residents reviewed for application of compression stockings. The facility census was 60.Findings include:Review of the medical record for Resident #6 revealed an admission date of 07/08/21 with diagnoses including viral hepatitis B, chronic viral hepatitis C, nontraumatic intracranial hemorrhage, and hemiplegia.Review of the quarterly Minimum Data Set assessment, dated 01/13/26, revealed Resident #6 had impaired cognition and was dependent on staff for lower body dressing.Review of a physician order dated 12/30/24 revealed Resident #6 was to wear compression stockings to bilateral lower extremities every morning.Observation on 03/02/26 at 9:59 A.M. revealed Resident #6 lying in bed without wearing compression stockings to his lower extremities. Concurrent interview with Licensed Practical Nurse (LPN) #421 confirmed Resident #6 was not wearing compression stockings. LPN #421 stated possibly Resident #6 had removed the compression stockings, then confirmed the stockings were not in Resident #6's bed and not on the floor.Interview on 03/05/26 at 2:57 P.M. with LPN #419, who worked routinely with Resident #6, revealed he was dependent on staff for lower body dressing, and could probably push down the compression stockings but would not be able to remove them.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure pressure ulcers were assessed thoroughly and accurately, failed to ensure wound care orders were implemented, and failed to ensure devices used to prevent pressure ulcer development were implemented as ordered. This affected two (#48 and #6) of three residents reviewed for pressure ulcers. The facility census was 60.Findings include:1. Review of the medical record for Resident #48 revealed an admission date of 09/16/25 with diagnoses including heart failure, acquired absence of the left leg above the knee, type II diabetes mellitus, heart disease, and peripheral vascular disease. Resident #48 was admitted with an unstageable pressure ulcer (obscured full-thickness skin and tissue loss) to his right heel.Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/03/26, revealed Resident #48 had intact cognition and had one unstageable pressure ulcer.Review of the modified quarterly MDS assessment, dated 02/03/26, revealed Resident #48 had intact cognition and did not have a pressure ulcer.Review of the medical record for Resident #48 revealed the resident went to an offsite wound care clinic for treatment of the right heel pressure ulcer on 09/25/25, 10/09/25, 11/06/25, 12/18/25, 01/21/26, 01/28/26 and 02/25/26. Further review revealed the offsite wound care clinic completed a comprehensive assessment of Resident #48's right heel pressure ulcer on those dates.Review of Resident #48's weekly wound evaluations completed by facility staff, during concurrent interview with Registered Nurse Clinical Consultant (RNCC) #502 and Regional Registered Nurse (RRN) #501 on 03/04/26 at 10:50 A.M., revealed no evaluation was completed on Resident #48's right heel pressure ulcer between 10/09/25 and 10/23/25, between 10/23/25 and 11/06/25, and between 11/06/25 and 11/24/25. Further interview with RNCC #502 confirmed Resident #48's pressure ulcer should have been assessed weekly. Continued review of Resident #48's weekly skin assessment documentation revealed the facility used a skin observation tool on 11/24/25, 12/02/25, 12/11/25, and 12/18/25. Review of the skin observation tools for these dates, and continued interview with RNCC #502, revealed the documentation of Resident #48's right heel pressure ulcer included no measurements of the wound on 12/02/25, 12/11/25, and 12/28/25. Further review and interview confirmed all four skin observation tools provided no description of the wound bed, the surrounding tissue, odor, or drainage of Resident #48's right heel pressure ulcer.Continued interview with RNCC #502 revealed the facility changed from using the weekly wound evaluation form to using a skin grid pressure assessment form on 12/29/25. A skin grid pressure assessment was completed by staff on 12/29/25, 01/05/26, 01/12/26, 01/19/26, 01/26/26, 02/26/26, 02/09/26, 02/16/26, and 02/23/26. Further review of Resident #48's skin grid pressure assessments and continued interview with RNCC #502 confirmed the assessment provided no description of the wound bed and the surrounding tissue of Resident #48's right heel PU. Additionally, no indication of the stage of the wound was documented on the assessments.Interview on 03/05/26 at 2:25 P.M. with Registered Nurse Clinical Director of Reimbursement (RNCDR) #503 regarding Resident #48's modified quarterly MDS assessment dated [DATE] revealed Resident #48's quarterly MDS assessment dated [DATE] was originally completed to indicate Resident #48 had one unstageable pressure ulcer. RNCDR #503 stated upon review of the MDS assessment, and review of the facility's documentation of Resident #48's wound, RNCDR #503 could not find adequate evidence in the facility's documentation of Resident #48's wound to determine whether Resident #48 had a pressure ulcer and directed facility staff to modify the quarterly MDS assessment dated [DATE] to reflect Resident #48 did not have a pressure ulcer. RNCDR #503 stated the offsite wound clinic notes, documenting Resident #48's right heel PU, were unavailable to review at the time of the MDS assessment.Review of the facility's policy titled, Documentation of Wound Treatments, copyright 2025, revealed wound assessments were documented upon admission, weekly, and as needed. The following elements are documented as part of a complete wound assessment: (a) type of wound (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(pressure injury, surgical, etc.) and the anatomical location; (b) stage of the wound, if pressure injury, and (c) measurements. Additional documentation shall include, but is not limited to: description of wound characteristics: color of the wound bed, type of tissue in the wound bed, condition of the peri-wound skin, presence or absence of pain, date and time of wound management treatments, any treatment for pain, if present, and modifications of treatments or interventions.2. Review of Resident #48's offsite wound clinic treatment orders, dated 10/09/25, revealed treatment orders for his right heel pressure ulcer to be completed once daily and as needed.Review of the facility's physician order initiated 10/09/25 and discontinued 11/24/25, revealed directions to complete the treatment twice daily.Review of two facility treatment orders, initiated 11/30/25, revealed Resident #48 should receive right heel wound treatments once daily on day shift and once daily on night shift. Further review revealed the order for the day shift treatment was discontinued on 12/19/25 and the order for the night shift treatment was discontinued 12/31/25.Review of Resident #48's offsite wound clinic treatment order, dated 12/18/25, revealed twice daily treatment orders to Resident #48's right heel pressure ulcer. Interview on 03/05/26 at 11:19 A.M. with RNCC #502 confirmed Resident #48's treatment orders dated 10/09/25 were ordered twice daily versus once daily as ordered by the offsite wound clinic. Additionally, RNCC #502 confirmed Resident #48's night shift wound treatment, initiated 11/30/25, should have been discontinued on 12/19/25 when the new treatment orders from the offsite wound clinic were implemented. RNCC #502 further confirmed the two different wound treatments were documented as being provided concurrently.Review of Resident #48's offsite wound clinic treatment order, dated 02/25/26, revealed a section titled, Items to Follow Up On, with indication an x-ray of the right foot had been ordered and to complete as soon as possible.Interview on 03/05/26 at 3:19 P.M. with RNCC #502 confirmed the facility did not complete a right foot x-ray for Resident #48 after receiving the order on 02/25/26. RNCC #502 further stated Resident #48 began seeing the in-house wound care provider on 03/02/26. RNCC #502 stated she spoke with the in-house wound provider who stated after they assessed Resident #48's right heel pressure ulcer, they did not see any indication for an x-ray and did not feel an x-ray should be obtained.3. Review of the medical record for Resident #6 revealed an admission date of 07/08/21 with diagnoses of viral hepatitis B, chronic viral hepatitis C, nontraumatic intracranial hemorrhage, and hemiplegia.Review of the quarterly MDS assessment, dated 01/13/26, revealed Resident #6 had impaired cognition and was dependent on staff for lower body dressing. Further review revealed Resident #6 had no pressure ulcers.Review of the physician order dated 09/15/25 revealed Resident #6 was to wear offloading pressure boots to bilateral lower extremities at all times while resident in bed as tolerated. Further review revealed instructions to document all refusals.Observation on 03/02/26 at 9:59 A.M. revealed Resident #6 lying in bed. One offloading boot was on the floor near the head of the bed. Concurrent interview with Licensed Practical Nurse (LPN) #421 confirmed Resident #6 had an order to wear offloading boots as tolerated. LPN #421 confirmed Resident #6 was not wearing the offloading boot.Observation on 03/03/26 at 9:28 A.M. revealed Resident #6 lying in bed wearing an offloading boot on his left foot. Concurrent interview with LPN #419 confirmed Resident #6 was wearing only one boot and verified Resident #6's physician order indicated Resident #6 should wear offloading boots to both feet. LPN #419 looked through two closets before finding and applying, with Resident #6's consent, the right foot offloading boot.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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 observation, staff interview, medical record review, and policy review, the facility failed to ensure smoking materials were stored in a safe manner, failed to ensure resident smoking assessments were accurate, and failed to ensure fall interventions were in place as care planned. This affected two (#58 and #11) of three residents reviewed for accidents and hazards. The facility census was 60. Findings include:1. Review of the medical record revealed Resident #58 was admitted to the facility on [DATE]. Diagnoses included type II diabetes mellitus with chronic kidney disease, essential hypertension, unspecified intellectual disabilities, schizophrenia, anxiety disorder, bipolar disease, chronic obstructive pulmonary disease. Review of Resident #58's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMs) score of eight indicating moderate cognitive deficits. Further review revealed behaviors documented included rejection of care occurring one to three days a week during the seven day look back period, and functional abilities included partial/moderate assistance with toileting hygiene, shower/bathing, upper and lower body dressing, and personal hygiene. Review of the care plan for Resident #58, revised on 01/05/26, revealed interventions to instruct the resident on the risk of smoking, to instruct the resident on the facility policy for smoking, and for staff to observe clothing and skin for signs of cigarette burns. Also the resident could smoke unsupervised. There were no interventions allowing the resident to keep smoking material in his possession. Review of Resident #58's smoking safety screen assessment dated [DATE] revealed the resident had no cognitive loss, no dexterity problems, and the resident needed the facility to store lighter and cigarettes. Further review of the assessment revealed the resident was safe to smoke without supervision. Observation and interview on 03/02/26 at 8:52 A.M., Resident #58 revealed he was upset due to someone stealing his cigarettes. Certified Nurse Aide (CNA) #448 then came over to Resident #58 and stated Resident #58 sometimes had cigarettes on him. CNA #448 then reached into the front pocket of Resident #58's sweatshirt and removed a box of cigarettes, opened the box, and revealed two lighters inside the empty box of cigarettes. CNA #448 stated Resident #58 probably smoked all his cigarettes and the nurse would notify the resident's representative. CNA #448 then returned the box containing the two lighters back into Resident #58's sweatshirt pocket. Observation and interview on 03/02/26 at 9:24 A.M., the Administrator verified Resident #58 should not have lighters on his person. The Administrator then removed the box and two lighters from Resident #58's sweatshirt pocket. Further interview with the Administrator revealed the resident had cognitive impairment and it should have been noted on his smoking assessment. Interview on 03/02/26 at 9:27 A.M., with CNA #448 verified she removed a cigarette box containing two lighters from the pocket of Resident #58 and then returned both the box and two lighters back into Resident #58's pocket. CNA #448 stated she was not sure why she gave the lighters back to Resident #58 because he was not supposed to have them. Interview on 03/04/26 at 11:56 A.M., the Director of Nursing (DON) verified Resident #58 should not have cigarette lighters on his person due to his cognition. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy titled, Smoking Policy/Consent, dated 01/29/26, revealed all smoking materials would be maintained by the facility staff and provided to the residents/patients on request for supervised/unsupervised smokers. Further review revealed smoking materials will be returned to the facility staff upon completion of smoking by supervised/unsupervised smokers. 2. Review of the medical record revealed Resident #11 admitted to the facility on [DATE] with diagnoses including dementia, repeated falls, injury of the left lower leg, hypertension, and anxiety disorder. Review of the most current MDS assessment dated [DATE] revealed Resident #11 had severely impaired cognition, behaviors directed at others, and rejection of care. Resident #11 required substantial to maximal assistance with activities of daily living including bed mobility and transfer, utilized a wheelchair for mobility propelled by staff, was incontinent of bowel and bladder, and sustained falls since admission. Review of a fall risk assessment dated [DATE] assessed Resident #11 at risk for falling as the resident sustained three or more falls over the last 90 days. Review of a nursing plan of care dated 12/11/25 revealed the care plan was revised to address Resident #11's high risk for falls related to confusion, gait/balance problems, incontinence, psychoactive drug use, and the resident being unaware of safety needs. Falls were listed on 03/07/24, 04/11/24, 05/25/24, 06/02/24, 06/13/24, 06/28/24, 11/27/24, 11/30/24, 12/10/24, 12/18/24, 12/30/24, 02/10/25, 02/25/25, 03/30/25, 05/20/25, 07/18/25, 07/25/25, 08/22/25, 09/6/25, and 12/11/25. An intervention included the placement of a mat to the bedside with no documentation included indicating which side of the bed the mat was to be placed. Observations on 03/02/26 at 10:32 A.M., and on 03/03/26 at 11:54 A.M. and 12:23 P.M., revealed Resident #11 in bed with a mat to the floor on the right side of the bed and no mat to the left side of bed. Further observation revealed exposed floor between bed and wall on the left side of then bed measuring approximately 24 inches. Observation on 03/04/26 at 5:40 A.M. revealed Resident #11 in bed with bilateral half grab rails applied to the bed frame and a defined parameter mattress was applied to the bed. Further observation revealed the fall mat was observed under the bed and not on the floor at the bedside. On 03/04/26 6:43 A.M. interview with Licensed Practical Nurse (LPN) #452 verified Resident #11's fall mat was not placed at the bedside as indicated. Continued observation on 03/04/26 at 8:02 A.M. and 9:58 A.M., and on 03/05/26 at 6:10 A.M., revealed Resident #11 in bed with a mat to floor at the right side of the bed and the left side of bed had no mat with exposed floor between the bed and wall measuring approximately 24 inches. On 03/05/26 at 8:45 A.M. interview with LPN #421 verified Resident #11 had a mat to floor on the right side of the bed and no mat to the floor on the left side of bed. LPN #421 confirmed the left side of the bed was noted with exposed floor between the bed and wall measuring approximately two feet. Review of facility fall prevention program policy, dated 2024, revealed the nurse will indicate on the (specify location) the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. The nurse will refer to the facility's high risk or low/moderate risk protocols when determining primary interventions. High risk protocols include, the resident will be placed on the facility's fall prevention program and will indicate fall risk on the care plan. The staff will implement interventions from low/moderate risk protocols and provide additional interventions as directed by the resident's assessment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and resident and staff interview, the facility failed to ensure residents received diets as ordered. This affected one (#1) of three residents reviewed for diet. The facility census was 60.Findings include:Review of the medical record for Resident #1 revealed an admission date of 01/26/25 with diagnoses including congestive heart failure, bipolar disorder, parkinsonism, type II diabetes mellitus, and anxiety. Review of the annual Minimum Data Set assessment, dated 02/05/26, revealed Resident #1 had intact cognition and required setup for eating.Review of Resident #1's weight history from 11/02/25 through 03/05/26 revealed his weight was stable.Review of the physician order dated 12/24/25 revealed Resident #1 should receive double portions.Review of the nutrition assessment dated [DATE] revealed Resident #1 had weight loss due to a recent hospitalization. Further review revealed Resident #1 would benefit from re-implementing double portions. Interview on 03/02/26 at 10:22 A.M. with Resident #1 revealed he was not receiving double portions and felt he should be.Observation on 03/03/26 at 12:28 P.M. revealed [NAME] #525 plating Resident #1's noon meal. [NAME] #525 did not provide double portions. Concurrent interview with [NAME] #525 confirmed Resident #1's meal ticket did not indicate he received double portions.Interview on 03/04/26 at 4:00 P.M. with Dietary Manager (DM) #530 revealed the kitchen used a separate computer system than the electronic medical record system used by the clinical staff. DM #530 stated the two computer systems were linked and diet orders were imported into the kitchen computer system. Further interview with DM #530, and concurrent review of the physician order for Resident #1, revealed Resident #1 should be receiving double portions. Further interview with DM #530 and concurrent review of the kitchen computer system's diet order for Resident #1 revealed double portions were not indicated. DM #530 stated the kitchen's computer system was implemented approximately in early January 2026 and some diet orders prior to January 2026 may not have merged correctly.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, medical record review, and staff interview the facility failed to ensure residents received tube feeding nutrition as ordered by the physician. This affected one (#23) of two residents reviewed for tube feeding. The facility census was 60. Findings include: Review of the medical record for Resident #23 revealed an admission date of 07/14/20 with diagnoses including epilepsy, dysphagia, type II diabetes mellitus, bipolar disorder, dementia, and gastrostomy status. Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/02/26, revealed Resident #23 had significantly impaired cognition, had a feeding tube, and relied on tube feeding to receive 51 percent (%) or more of nutrition and fluid needs. Review of Resident #23's weights from September 2025 through March 2026 revealed the resident's weights were stable. Review of the physician order dated 01/24/26 revealed Resident #23 received Jevity 1.2 at 60 milliliters per hour (ml/hr) for 21 hours per day starting at 10:00 A.M. and discontinued at 6:00 A.M. Observation on 03/04/26 at 9:47 A.M., and concurrent interview with Licensed Practical Nurse (LPN) #419, revealed she hung Resident #23's one-liter (1000 ml) bottle of Jevity 1.2 and it was running at 60 ml/hour. Observation on 03/05/26 at 7:00 A.M. revealed Resident #23's tube feeding bottle was empty and the pump was off. Further observation revealed the bottle was dated 03/04/26. Concurrent interview with LPN #419 confirmed the tube feeding bottle was the same one LPN #419 hung the previous morning. LPN #419 confirmed Resident #23 received only one liter of tube feeding instead of the ordered 1260 ml. LPN #419 stated a second bottle of Jevity 1.2 should have been hung to provide the full amount of tube feeding as ordered by the physician.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, medical record review, and policy review, the facility failed to safely store medications. This affected one (#43) out of five residents reviewed for medication storage. The facility census was 60. Findings include:Review of the medical record revealed Resident #43 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, arteriovenous malformation of the digestive system, paranoid schizophrenia, and disorganized schizophrenia. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] for Resident #43 revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. Resident #43 was assessed with functional abilities to included supervision or touching assistance needed for showering/bathing, personal hygiene, upper and lower body dressing. Review of Resident #43's care plan last revised 02/27/26 revealed interventions allowing the resident to keep medications at bedside. Review of the current monthly physician orders revealed the resident had no orders to keep medications at the bedside and no orders to self-administer medications. Observation on 03/02/26 at 9:08 A.M revealed Resident #43 had blood coming from his nose. Licensed Practical Nurse (LPN) #421 entered the resident's room to assess the resident. Resident #43 stated he had medications in his dresser. LPN #421 opened the top drawer of Resident #43's dresser to reveal four unsecured medications including two nasal sprays and two respiratory inhalers. LPN #421 removed the unsecured medications. Interview on 03/02/26 at 9:37 A.M., with LPN #421 stated unsecured medications found in Resident #43's room included one bottle of over-the-counter saline nasal spray, one bottle of oxymetazoline hydrochloride 0.05 percent (%) 12-hour nasal spray, Asmanex inhaler, and Combivent inhaler 20 micrograms (mcg) per 100 mcg. Further interview revealed Oxymetazoline hydrochloride nasal spray, Asmanex inhaler, and Combivent inhaler had no patient name listed on the medications. LPN #421 furthermore confirmed Resident #43 had no order for saline nasal spray, Oxymetazoline hydrochloride 0.05% 12-hour nasal spray, or Asmanex nasal spray. Review of the facility policy titled, Medication Storage, dated 2025, revealed all drugs and biologicals will be stored in locked compartments.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on medical record review and staff interview, the facility failed to ensure laboratory tests were completed per physician orders. This affected one (#23) of five residents reviewed for laboratory tests. The facility census was 60.Findings include:Review of the medical record for Resident #23 revealed an admission date of 07/14/20 with diagnoses including epilepsy, dysphagia, type II diabetes mellitus, bipolar disorder, dementia, and gastrostomy status.Review of the quarterly Minimum Data Set assessment, dated 01/02/26, revealed Resident #23 had significantly impaired cognition, had a feeding tube, and relied on tube feeding to receive 51 percent (%) or more of nutrition and fluid needs. Review of the physician order dated 01/08/24 revealed Resident #23 received no food or water by mouth.Review of the physician order dated 10/03/24 and discontinued 02/26/26 revealed Resident #23 should have laboratory tests of a complete blood count (CBC) with differential, basic metabolic panel (BMP), and hemoglobin A1C every six months.Review of Resident #23's record revealed the most recent laboratory tests were completed on 06/02/25.Interview on 03/05/26 at 3:12 P.M. with the Administrator confirmed no laboratory tests were completed for Resident #23 since 06/02/25 and before the physician's order discontinued on 02/26/26.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on medical record review and staff interview, the facility failed to ensure skin assessments were completed accurately. This affected one (#48) of two people reviewed for skin assessments. The facility census was 60.Findings include:Review of the medical record for Resident #48 revealed an admission date of 09/16/25 with diagnoses including heart failure, acquired absence of the left leg above knee, type II diabetes mellitus, heart disease, and peripheral vascular disease. Resident #48 was admitted with an unstageable pressure ulcer (obscured full-thickness skin and tissue loss) to his right heel.Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/03/26, revealed Resident #48 had intact cognition and had one unstageable pressure ulcer.Review of Resident #48's skin grid pressure assessments dated 12/29/25, 01/05/26, 01/12/26, 01/19/26, 01/26/26, 02/02/26, 02/09/26, and 02/16/26 revealed all the assessments were completed and signed by Wound Care Licensed Practical Nurse (LPN) #407 on 02/16/26. Interview on 03/03/26 at 3:37 P.M. with LPN #407 revealed she was new to the wound care role on 12/29/25. LPN #407 stated she was aware Resident #48 was seeing an outside wound clinic for his right heel unstageable pressure ulcer and was not aware Resident #48's right heel pressure ulcer needed to be assessed weekly at the facility. LPN #407 stated she was recently informed she needed to complete weekly wound assessments for Resident #48's right heel pressure ulcer even though he went to an offsite wound clinic. LPN #407 stated she used measurements from the wound clinic's assessment to complete the facility skin grid pressure assessments.Follow-up interview on 03/04/26 at 12:07 P.M. with LPN #407 confirmed she created Resident #48's skin grid pressure assessments dated 12/29/25, 01/05/26, 01/12/26, 01/19/26, 01/26/26, 02/02/26, and 02/09/26, on 02/16/26 using measurements from the offsite clinic's documentation. LPN #407 confirmed she did not complete a visual assessment of Resident #48's right heel on those dates. LPN #407 stated she measured Resident #48's heel wound on 02/16/26 and the measurements were consistent with the size she documented on all the previous assessments.