STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366360	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vineyards at Concord, The	119 West High Street Frankfort, OH 45628

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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, record review, hospital record review, interviews and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 user's manual, the facility failed to ensure adequate fall risk/safety interventions were in place and functioning to prevent falls. Additionally, the facility failed to document and comprehensively investigate falls. Actual harm occurred on 02/11/26 when the facility failed to develop and implement an individualized fall program to prevent falls with injury for Resident #4, who exhibited severe cognitive impairment, had history of falls, and required substantial/maximal assistance with transfers, sustained a fall resulting in a displaced spiral fracture of the right femur requiring surgical repair. This affected two (Residents #4 and #18) of two residents reviewed for falls. The facility census was 27. Findings Include:1. Review of the medical record for Resident #4 revealed an initial admission date of 01/02/26 with the latest readmission date of 02/17/26 with the diagnoses including displaced spiral fracture of shaft of right femur, moderate protein calorie malnutrition, neuromuscular dysfunction of bladder, encounter for palliative care, anemia, osteoporosis, diabetes mellitus, insomnia, hypertensive heart disease, hyperlipidemia, delusional disorder, hypertension, history of falling, and history of nontraumatic fracture. Review of the fall risk assessment dated [DATE] revealed Resident #4 was at risk for falls. Review of the resident's admission comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The resident required supervision/touch assistance with ambulation. The resident also utilized a walker for ambulation. Review of the care plan, undated, revealed the resident was at risk for falls related to confusion, deconditioning, gait/balance problems, unaware of safety needs, fall/fracture history and medication use. Interventions included anticipate and meet the resident's needs, be sure resident's call light is within reach and encourage/remind resident to use it, for assistance as needed, educate the resident/family/caregivers about safety reminders and what to do if a fall occurs, ensure that resident is wearing appropriate footwear (hard sole or nonskid socks or slippers) when ambulating or mobilizing wheelchair and resident uses bed electronic alarm, ensure device is in place as needed. Review of the care plan, undated, revealed the resident had an actual fall with no injury, related to poor balance, poor communication/comprehension and unsteady gait. Interventions included to continue interventions on the at-risk care plan, for no apparent injury, determining and addressing causative factors of the fall, provide activities that promote exercise and strength building where possible and provide one on one activities if bedbound. Review of the fall risk assessment dated [DATE] revealed Resident #4 was at risk for falls. Review of the progress note dated 01/26/26 at 4:25 A.M. revealed the resident was heard yelling and upon entering her room she was discovered sitting on the floor. The resident stated she was coming back from the bathroom and fell. The resident's gait was unsteady and used a walker with ambulation, however she did not have the walker. The resident's slippers did not have non-skid soles. The resident was assisted up and into bed. Resident education was completed to use call light for assistance/supervision when up and needed to use her walker when up and about, despite known cognitive deficit and diagnoses of dementia. Review of the facility's incident report dated 01/26/26 at (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	4:25 P.M. revealed the resident was heard yelling out. The resident was found in her room sitting on the floor. The resident reported she was coming out of the bathroom and fell. The report indicated the resident's gait was unsteady and the resident was not utilizing her walker. The report documented the resident had forgetfulness and confusion. The report also documented the facility determined the root cause of the fall was ambulating without her walker and she lost her balance. The resident was instructed to use call light for assistance/supervision and to use walker with ambulation at all times, despite the known cognitive deficit. Review of the resident's discontinued physician orders identified an order dated 01/26/26 for pressure pad alarm to mattress to alert staff when resident is getting out of bed. The order was discontinued on 03/20/26. Review of the progress note dated 01/29/26 at 11:07 A.M. revealed the resident appeared to be climbing into her bed, unable to get up onto the bed and called for help. The resident was assisted to the floor safely and without injury. The resident was educated to wait for assistance, despite her known cognitive deficit and diagnoses of dementia. The progress note documented the sensor alarm was in place and functioning. The facility provided no facility investigation to determine the root cause of the falls or evaluation to determine if current fall interventions remained appropriate. Review of the medical record revealed no evidence the facility developed and implemented an individualized fall program to prevent further falls. Review of the February 2026 physician's orders revealed an order was in place for pressure pad alarm to mattress and Broda chair to alert staff when resident was getting up without assistance every shift for safety. Review of the progress note dated 02/11/26 at 6:00 A.M. revealed the staff heard the resident yelling and observed the resident lying on her right side at bedside. The resident was crying and reported she tried to get up without assistance and fell. She reported severe pain to her right lower extremity. Review of the facility's incident report dated 02/11/26 at 6:00 A.M. revealed the resident was heard yelling and staff observed the resident lying on her right side beside her bed. The resident stated, I was getting up and scooted to the bottom of the bed so I wouldn't make noise. I am sorry (resident was referring to pressure sensor alarm). The staff checked the pressure sensor alarm, and it was operational per staff assessment. The resident was crying out in pain to right lower extremity. The resident was transferred per two assists to a chair. The resident reported severe pain to her right lower extremity. The resident's son requested the resident to be sent to the local emergency room (ER) For an evaluation. Review of the resident's hospital Discharge summary dated [DATE] revealed the resident presented to the ER following a fall from her bed at the facility resulting with a traumatic spiral fracture (a type of bone break caused by a twisting or rotational force resulting in a corkscrew like fracture along the bone) of the right distal femur with some displacement. An open reduction and internal fixation of the right femoral shaft fracture with plate and screw system was performed on 02/22/26 and was complicated with acute blood loss anemia post surgery requiring a transfusion of one unit of packed red blood cells (PRBC). Review of the resident's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The resident required supervision or touching assistance with eating, was dependent for toileting needs, bathing, dressing, personal hygiene, required partial/moderate assistance with bed mobility and substantial/maximal assistance with transfers. The assessment indicated the resident had not had a fall since the prior assessment, although coded as having repair of fractures of the pelvis, hip, leg, knee or ankle. On 04/15/26 at 2:26 P.M., observation of the resident revealed she was sitting on the edge of her Broda chair trying to get out of her chair. The resident had a personal tab alarm in place and not the physician ordered sensor alarm. The string attached from the tab alarm to the resident was long enough for the resident to attempt to get out of the chair without disconnecting to alert the staff. On 04/16/26 at 4:32 P.M., an interview with the Director of Nursing (DON) verified the sensor alarm was not functioning (did not sound) when the resident was found on the floor on 02/11/26. She verified the resident had no physician's order for the personal tab alarm and failed to implement the correct fall intervention while the resident was up in her Broda chair. 2. Review of the medical record for Resident #18 revealed an initial admission date of 02/19/26 with the diagnoses including atrial (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	fibrillation, allergic rhinitis, hyperlipidemia, osteoarthritis, constipation, atherosclerotic heart disease, anxiety disorder, hypertension, chronic pain syndrome, diabetes mellitus, chronic kidney disease, chronic obstructive pulmonary disease (COPD), gastro-esophageal reflux disease and obstructive sleep apnea. Review of the assessment for falls for 02/19/26 revealed the resident was at high risk for falls. Review of the resident's comprehensive MDS assessment dated [DATE] revealed the resident had no cognitive deficit and had no falls since admission to the facility. Review of the plan of care dated 03/18/26 revealed the resident was at risk for falls related to osteoarthritis, obesity, shoulder dislocation, history of falls, impaired balance skills, avoids movement, decreased stamina, family states years of resisting/refusing to ambulate/move, inability to ambulate safely, limited range of motion, resident tries to insist on one staff member transfer, refuses bed in low position and demands one aide for transfers. Interventions included monitor level of consciousness and level of orientation every shift and as needed, reorients as needed and as able, keep halls and resident pathways cleaned, dry, free from clutter and debris as possible, keep call light close while in bed and in chair in room, encourage resident to use call light before attempting to get up and for needs, keep resident bed in lowest position while in bed as resident will allow, inform resident of his/her role in transfers and ambulation, provide simple cues, assist with transfers using two assists through completion, avoid one person transfers, notify physician or any significant changes, avoid fall matt, encourage to participate in therapy per orders and in active range of motion in chair at leisure. Review of the resident's medical record revealed no documented evidence the resident was lowered to the floor by a staff member of the facility. On 04/13/26 at 11:15 A.M., an interview with Resident #18 revealed she had fallen since being admitted to the facility when the aide placed the bedside commode too far away from her and made her transfer when she told her it was too far away. She stated, I was about halfway turned around and my knees gave out. On 04/15/26 at 10:15 A.M., an interview with Licensed Nursing Home Administrator (LNHA) revealed the resident had never had a fall, however the resident was assisted onto the floor by a Certified Nursing Assistant (CNA). She said they do not consider an assist to the floor a fall, so no documentation or investigation was completed. She said the facility goes by what is in the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 user's manual dated 10/24 for falls. On 04/15/26 at 11:10 A.M., an interview with the Facility Manager (FM) #100 revealed the facility went by the Long-Term Care Facility Resident Assessment Instrument (RIA) 3.0 user's manual dated 10/24 and did not realize when a resident is assisted to the floor it was considered a fall. On 04/15/26 at 1:53 P.M., an interview with Certified Nursing Assistant (CNA) #106 revealed she was the CNA who lowered the resident onto the floor at the end of March 2026. She revealed she was assisting the resident onto the bedside commode and the resident stated, I am going down. She said she gently lowered the resident onto the floor, obtained assistance to help the resident up from the floor and reported to the nurse what had happened. Review of the Long-Term Care Facility RAI 3.0 user's manual dated 10/25 revealed an intercepted fall occurs when the resident would have fallen if they had not caught themselves or had not been intercepted by another person is still considered a fall.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, and utilization of the staffing tool the facility failed to maintain sufficient staffing to provide for resident care needs. This affected all residents in the facility. The facility census was 27 at the time of survey. Findings include: Observation of meals during survey from 04/13/26 through 04/15/26 revealed meals were being passed late.Observation on 04/13/26 at 3:20 P.M., of Certified Nursing Assistant (CNA) #117 and CNA #127 provide incontinence care for Resident #19 revealed they wheeled her to her room from the dining room where she had been sitting since 8:00 A.M. upon entry to the facility. The resident's pants were pulled down and revealed the resident had a blue brief on and a large liner that was completely saturated with a strong ammonia smelling urine. Interview on 04/13/26 at 3:20 P.M. with CNA #117 revealed the resident was supposed to be toileted every hour and a half. CNA #127 stated, the resident had not been toileted for quite some time. Interview with Director of Nursing on 04/14/26 at 12:05 P.M. reveals that We need help so bad. We don't have enough staff to take care of our patients. We are understaffed and we need more help, resident care is missed because of it. Interview on 04/15/26 at 3:15 P.M. with Administrator confirmed meals are not being served on time. Interview on 04/16/26 at 8:40 A.M. with [NAME] #129 confirmed breakfast was ready but waiting on staff to serve. Utilization of the Survey Staffing Tool completed for 04/07/26 through 04/13/26 revealed that on two of the days in the look back period, 04/07/2026 and 04/10/2026, that direct care staffing levels were below the minimum staffing requirement.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observations, record reviews, interviews and review of job descriptions, the facility failed to be administrated in a manner that uses it's resources effectively and efficiently to ensure resident safety, failed to maintain an activities program directed by a qualified activities professional, failed to maintain sufficient staffing to provide for resident care needs and failed to ensure the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) and the Registered Dietician (RD) were permitted to work enough hours to effectively complete their job. This deficient practice demonstrated significant breakdowns in administrative oversight and had the potential to affect all 27 residents residing in the facility. Findings include:1. Interview with Director of Nursing (DON) on 04/14/26 at 12:05 P.M. reveals that We need help so bad. We don't have enough staff to take care of our patients. We are understaffed and we need more help, resident care is missed because of it. Utilization of the Survey Staffing Tool completed for 04/07/2026 through 04/13/2026 revealed that on two of the days in the look back period, 04/07/2026 and 04/10/2026, had direct care staffing levels that were below the minimum staffing requirement. 2. Observation throughout the days of annual survey that concluded on 04/20/26 revealed activities of music playing throughout the days in the common area and one activity on 04/15/26 of snack making with residents. No other activities were observed. Interview on 04/14/2026 at 3:15 P.M. with Administrator and staff #100 confirmed that the facility does not have a current activities director and does not employ anyone with the required qualifications for an Activities Director (AD). Administrator states we do not have an activities director currently, we haven't had one for a while. We have someone who helps us out on the weekends, but we don't have anyone with the required qualifications. 3. Observations made on 04/13/26 upon entry to the facility for the annual inspection revealed the facility's Administrator was not present at the facility. On 04/15/26 at 4:16 P.M., an interview with the Administrator revealed she is only permitted to work 16 hours a week at the facility per Facility Manager (FM) #100, who is one of the owners of the facility. On 04/13/26 at 8:30 A.M., an interview with the DON revealed she works the floor at least every Monday and Tuesday but would get requested items as time permitted. The DON alerted to the fact she filled in for call offs and time off for other nursing staff as well. The DON revealed it was difficult to juggle the two positions and the position was not what she thought it would be. 4. Observations made during the survey from 04/13/26 to 04/20/26 revealed no sightings of the dietary manager (DM) overseeing the dietary staff or ability to interview the dietary manager for requested information related to the facility's supplements. On 04/15/26 at 4:16 P.M., interview with the Administrator revealed the DM position was part-time and she was only permitted to work three days a week. The Administrator stated, her hands were tied.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on medical record review and interview, the facility failed to establish, maintain and implement written policies and procedures regarding the resident's right to formulate an advance directive. Additionally, the facility failed to develop and implement a comprehensive plan of care for do not resuscitate (DNR) code status. This affected four residents (#3, #4, #15 and #18) of four residents reviewed for advanced directives. The facility census was 27. Findings Include:1. Review of the medical record for Resident #3 revealed an initial admission date of 05/06/24 with the diagnoses including but not limited to schizoaffective disorder, bipolar type, dysphagia, osteoarthritis, Parkinson's disease, irritable bowel syndrome, hypertension, diabetes mellitus, cirrhosis of liver, fatty liver, hyperlipidemia, anemia, diverticulosis of intestine, overactive bladder, esophageal varices and gastro-esophageal reflux disease. Review of the resident's DNR form dated 09/16/25 revealed the resident had elected the code status of do not resuscitate comfort care (DNRCC)-arrest which indicated the facility would treat the resident as any other without a DNR order until the point of cardiac or respiratory arrest at which point all interventions will cease and the DNRCC protocol will be implemented. Review of the resident's monthly physician orders for April 2026 identified an order dated 09/16/25 DNRCC-Arrest. Review of the resident's plan of care revealed no care plan related to the resident's DNRCC Arrest status. 2. Review of the medical record for Resident #4 revealed an initial admission date of 01/02/26 with the latest readmission date of 02/17/26 with the diagnoses including but not limited to displaced spiral fracture of shaft of right femur, moderate protein calorie malnutrition, neuromuscular dysfunction of bladder, encounter for palliative care, anemia, osteoporosis, diabetes mellitus, insomnia, hypertensive heart disease, hyperlipidemia, delusional disorder, hypertension, history of falling, history of nontraumatic fracture. Review of the resident's DNR form dated 02/20/26 revealed the resident had elected the code status of do not resuscitate comfort care (DNRCC). Review of the resident's monthly physician orders identified an order dated 02/20/26 DNRCC. Review of the resident's plan of care revealed no care plan related to the resident's DNRCC status. 3. Review of the medical record for Resident #15 revealed an initial admission date of 04/20/25 with the latest readmission of 05/25/25 with the diagnoses including but not limited to neuropathy, peripheral vascular disease, hypertensive heart disease, vascular dementia, major depressive disorder, cerebral infarction, dementia, hypertension, gout, insomnia and anxiety disorder. Review of the resident's DNR form dated 05/27/25 revealed the resident had elected the code status of do not resuscitate comfort care (DNRCC)- do not intubate (DNI). Review of the resident's monthly physician orders for April 2026 identified an order dated 05/27/25 for DNRCC-DNI. Review of the resident's plan of care revealed no care plan related to the resident's DNRCC-DNI status. 4. Review of the medical record for Resident #18 revealed an initial admission date of 02/19/26 with the diagnoses including but not limited to atrial fibrillation, allergic rhinitis, hyperlipidemia, osteoarthritis, constipation, atherosclerotic heart disease, anxiety disorder, hypertension, chronic pain syndrome, diabetes mellitus, chronic kidney disease, chronic obstructive pulmonary disease (COPD), gastro-esophageal reflux disease and obstructive sleep apnea. Review of the resident's DNR form dated 02/24/26 revealed the resident had elected the code status of do not resuscitate comfort care (DNRCC)-arrest which indicated the facility would treat the resident as any other without a DNR order until the point of cardiac or respiratory arrest at which point all interventions will cease and the DNRCC protocol will be implemented. Review of the resident's monthly physician orders for April 2026 identified an order dated 02/24/26 DNRCC-Arrest. Review of the resident's plan of care revealed no care plan related to the resident's DNRCC Arrest status. On 04/15/26 at 12:47 P.M., an interview with Facility Manager (FM) #100 verified the facility did not develop comprehensive advanced care plans and was unfamiliar with the regulation. On 04/15/26 at 4:16 P.M., an interview with the Licensed Nursing Home Administrator (LNHA) verified the facility had not established, maintained and (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	implemented written policies and procedures regarding the resident's right to formulate an advance directive.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure the activities program is directed by a qualified professional. Based on interview and observation, the facility failed to maintain an activities program directed by a qualified activities professional. This had the potential to affect all residents with the exception of one (Resident #2). The facility census was 27.Observation throughout the annual survey from 04/13/26 through 04/20/2026 revealed activities of music playing throughout the days in the common area and one activity on 04/15/26 of snack making with residents. No other activities were observed and no activity director was observed in the facility.Interview on 04/13/26 at 2:40 P.M. with Resident #2 stated that she didn't have an issue with the activities because she mostly stays in her room and watches TV and does not wish to attend any activities. Interview on 04/14/26 at 3:15 P.M. with Administrator and Facility Manager #100 confirmed that the facility does not have a current activities director and does not employ anyone with the required qualifications for an activities director. Administrator states we do not have an activities director currently, we haven't had one for a while. We have someone who helps us out on the weekends but we don't have anyone with the required qualifications. We're trying to hire someone. The Facility Manager #100 also verified they have someone on the weekends to provide activities however, did not meet the required qualifications. Interview on 04/20/26 with Resident #26 revealed that he was often bored and there's not much to do here.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, medical record review and interview, the facility failed to ensure medications were stored securely for Resident #18. Additionally, the facility failed to dispose of expired medications on the medication cart. This affected five residents (#2, #4, #7, #15 and #18). The facility census was 27. Findings Include:1. Review of the medical record for Resident #18 revealed an initial admission date of 02/19/26 with the diagnoses including but not limited to atrial fibrillation, allergic rhinitis, hyperlipidemia, osteoarthritis, constipation, atherosclerotic heart disease, anxiety disorder, hypertension, chronic pain syndrome, diabetes mellitus, chronic kidney disease, chronic obstructive pulmonary disease (COPD), gastro-esophageal reflux disease and obstructive sleep apnea. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the resident's monthly physician orders for April 2026 identified orders dated 02/20/26 B-Complex with Biotin and Folic Acid one tablet by mouth daily, Vitamin E 400 capsule by mouth daily and Fluticasone Propionate Nasal Suspension 50 micrograms (mcg) with the special instructions of one spray in each nostril twice daily for allergies. Review of the Deferment of Self-Administration dated 02/19/26 revealed the resident deferred the responsibility of drug administration to the licensed staff of the facility. Review of the medical record revealed no self-medication administration assessment to determine if the resident was capable of self-administration of medication. Review of the progress note created on 02/02/26 at 6:30 P.M. for 03/01/26 at 12:21 P.M. revealed the resident kept her Fluticasone Propionate Nasal Suspension 50 mcg in her purse at bedside, along with Symbicort inhaler. The resident verbalized good knowledge of all her medications. On 04/15/26 at 9:11 A.M., observation of Licensed Practical Nurse (LPN) #102 prepare the resident's morning medication revealed the facility had no Fluticasone Propionate Nasal Suspension 50 mcg on hand to administer to the resident. On 04/15/26 at 9:14 A.M., during the observation of LPN #102 administer the resident her medication revealed the resident alerted LPN #102 she kept the Fluticasone Propionate Nasal Suspension 50 mcg in her purse and used the medication every morning and every night. On 04/15/26 at 9:40 A.M., an interview with the Director of Nursing (DON) verified the resident had no physician's order or assessments to keep the Fluticasone Propionate Nasal Suspension 50 mcg at bedside and self-administer the medication. On 04/15/26 at 4:16 P.M., an interview with the Licensed Nursing Home Administrator (LNHA) verified the facility had no policy addressing self-administration of medications or medication storage. 2. On 04/15/26 at 9:16 A.M., observation of the facility's only medication cart revealed seven expired medications as follows: Vitamin B1 250 milligrams (mg) with the expiration date of 2/2025 Cranberry 500 mg with Vitamin C 200 mg with the expiration date of 11/2024 Cranberry 15,000 mg with the expiration date of 09/24 Probiotic 100 billion with the expiration date of 01/26 Zinc 50 mg with the expiration date of 01/26 Omega 3 2,000 mg with expiration date of 02/26 Senokot 8.6 mg with the expiration date of 01/26Omeprazole 20 mg capsules with the expiration date of 03/26 Interview with LPN #102 verified the medications were expired and should have been discarded. Verified five residents (#2, #4, #7, #15 and #18) had orders for the medications that were found to be expired in the medication cart. On 04/15/26 at 4:16 P.M., an interview with the Licensed Nursing Home Administrator (LNHA) verified the facility had no policy addressing self-administration of medications or medication storage.

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	366360	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vineyards at Concord, The	119 West High Street Frankfort, OH 45628

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

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation and staff interviews the facility failed to follow diet orders when dietary staff served mechanical textured meat to residents on a regular diet during lunch meal. This had the potential to affect 18 (#1, #2, #4, #6, #7, # 8, #11, #13, #14, #18, #21, #22, #23, #24, #25, #26, #27, and #29) who receive a regular diet. The facility census was 27. Observation on 04/15/26 at 12:15 P.M. with [NAME] #118 revealed the lunch meal was pork and sauerkraut, mashed potatoes and bread pudding. The pork and sauerkraut were made into mechanical texture and served to residents who are on a regular diet. Associate #118 confirmed pork was mechanical texture and she does this so residents receive the same looking meat and to reduce choking hazard. Pureed pork and sauerkraut was made with milk. Associate #118 confirmed she used milk to puree pork and sauerkraut because it adds calories and nutrients. Review of the medical records revealed 18 (#1, #2, #4, #6, #7, # 8, #11, #13, #14, #18, #21, #22, #23, #24, #25, #26, #27, and #29) residents received a regular diet. Interview on 04/15/26 at 1:58 P.M. with Administrator confirmed mechanical textured meat served to all regular diet residents is not appropriate and confirmed puree recipe exists for lunch meal but was not followed. This deficiency represents noncompliance investigated under Complaint Number 2984105.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observations and staff interviews the facility failed to prepare and deliver meals timely according to dining schedule. This had the potential to affect affect 26 residents receiving food in the facility. The facility identified one resident (#5) who received nothing by mouth (NPO). The facility census was 27. Interview on 04/13/26 at 8:30 A.M. with [NAME] #118 regarding meal times-breakfast is served at 7:45/8:00 A.M., lunch is served at 11:45/12:00 P.M. and dinner at 4:30/5:30 P.M. Dining staff consist of cook and occasionally a hospitality aide. Observation on 04/13/26 at 12:21 P.M. lunch has not started to be served to 11 residents sitting in dining room. Hospitality aide present to assist. Observation on 4/14/26 at 9:00 A.M. breakfast starting to be served to residents in dining room. Observation on 4/15/26 at 8:50 A.M. breakfast was not being served yet. Interview on 04/15/26 at 8:55 A.M. with [NAME] #118 confirmed waiting on hall trays to be served to residents before serving dining room. Dining room had eight residents (Resident #4, Resident #7, Resident #11, Resident #12, Resident #15, Resident #19, Resident #23 and Resident #26) present and waiting to be served. Interview on 04/15/26 at 9:06 A.M with Certified Nursing Assistant (CNA) #125 confirmed facility was running behind but we normally start around 8:00/8:15 A.M. CNA #125 confirmed B and C hallways still needed served. Observation on 04/15/26 at 12:50 P.M. with [NAME] #118 revealed A-Hall lunch serving started at 12:50 P.M., B-Hall lunch serving started at 1:00 P.M., dining room serving started at 1:03 P.M. [NAME] #118 acknowledged she was running behind. Interview on 04/15/26 at 3:15 P.M. with Administrator confirmed meals are not being served on time. Interview on 04/16/26 at 8:40 A.M. with [NAME] #129 confirmed breakfast was ready but waiting on staff to serve.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, record review, and staff interviews the facility failed to follow the menu, complete substitution log as needed and prepare meal with appropriate diet order. This had the potential to affect 26 residents receiving food in the facility. The facility identified one resident (#5) who received nothing by mouth (NPO). The facility census is 27. Review of the menu revealed lunch for 04/15/26 consisted of pork and sauerkraut, mashed potatoes, and pumpkin bread pudding. Observation on 04/15/26 at 12:15 P.M. with [NAME] #118 revealed lunch meal was being prepared that included pork and sauerkraut, mashed potatoes (instead of scalloped potatoes per menu) and apple bread pudding (instead of pumpkin bread pudding per menu). The pork and sauerkraut were made into mechanical texture and was prepared for residents who are on a regular diet. Interview on 04/15/26 at 12:30 P.M. with [NAME] #118 confirmed the pork was mechanical texture and she does this so residents receive the same looking meat and to reduce choking hazard. [NAME] #118 also verified she did not follow a menu and pureed pork and sauerkraut was with milk. [NAME] #118 confirmed she used milk to puree pork and sauerkraut because it adds calories and nutrients. Interview on 04/15/26 at 1:00 P.M. with [NAME] #118 verified the lunch meal did not follow the menu and she did not complete a substitution log. Observation on 04/15/26 at 1:10 P.M. revealed pork and sauerkraut were served mechanical soft instead of regular diet. Substitution of mashed potatoes instead of scalloped potatoes and apple bread pudding instead of pumpkin bread pudding was served to residents. Observation on 04/16/26 at 11:45 A.M. revealed lunch menu was ravioli with meat sauce. [NAME] #129 confirmed there was no ravioli and would use a pasta substitute. Substitution log could not be located and was confirmed with [NAME] #129.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interviews the facility failed to store food appropriately and ensure a sanitary environment. This had the potential to affect 26 residents who receive food from the kitchen. The facility had one resident (#5) who received nothing by mouth (NPO). The facility census was 27.Observation on 04/13/26 at 8:30 A.M. with [NAME] #118 during walk through revealed in the dry storage areas of concern included scoop in sugar container, 50-lb oats bag not sealed or dated and was located on the floor, no dates on beans, sugar and rice containers. Freezer areas of concern included no dates on bags of green beans, cauliflower, broccoli, carrots, tater tots or hashbrowns. Refrigerator areas of concern included pepperoni dated 01/26/26, deli cheese with no date, veggie and fruit tray with no date, and mustard with no label or date. Resident food brought in by family or visitors included cubed cheese no date, grapes no date or label, cuties no date, red seedless grapes no date, and a styrofoam box of food with no date. Drink containers of juice, house shake, tea and lemonade not labeled or dated. Observation on 04/15/26 at 10:40 A.M. with [NAME] #118 revealed the dish machine sanitizer tested and was not registering chemical. Testing strips discovered to be expired 08/01/24. [NAME] #118 got another set of testing strips and chemical was not registering. Second batch of testing strips expired 02/22. [NAME] #118 was unsure how long its not been working. Sanitizing hose was in sanitizer container, which had sanitizer present. Sanitizer container changed and still no sanitizer registering. Dish machine primed by [NAME] #129 and sanitizer present. Further observation of the kitchen revealed on 04/15/26 around 10:40 A.M. with [NAME] #118 revealed vegetable and potato bags not dated in freezer and a half gallon bag of what looked like kielbasa with no date or label. Food for residents brought in by family or visitors and located in refrigeratorcontinued to be not dated. [NAME] #118 confirmed aides will mark resident name but not date on food. Drink containers with juice, house shake, tea and lemonade continued to have no labels or dates. Spices not dated included onion powder, salt, cinnamon, cayenne pepper, dill weed, granulated garlic and paprika. Continued observation with [NAME] #118 revealed the Lunch meal food revealed temperatures obtained after multiple failed attempts at temping mashed potatoes. The thermometer was recalibrated but still did not measure correctly. [NAME] #118 unsure how long thermometer was not working accurately. Thermometer was changed and pork and sauerkraut were at 170 degrees, mashed potatoes were at 150 degrees and apple bread pudding at 190 degrees. Food temperature log was prefilled out by [NAME] #118 for 04/15/26. Review of the food temperature log revealed it to be filled out ahead of time (prefilled in) by [NAME] #118 for 04/15/26. There was also no meal temperatures logged for 03/30/26 and 03/31/26. Interview at the time of the observation with [NAME] #118 revealed she had made a mistake.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, policy review and staff and resident interviews, the facility failed to ensure dignity and respect were shown to resident who needed assistance to eat. This affected one (#16) of one resident reviewed for assistance with eating. The facility census was 27.Medical record review for Resident #16 was admitted on [DATE]. Medical diagnoses included Huntington's disease, anxiety and depression.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16's Brief Interview for Mental Status (BIMS) was 09 out of 15 indicating resident has moderate cognitive impairment. His functional status for eating was maximum assistance. Observation of the dining room on 04/13/26 at 12:00 P.M. revealed Resident #16 was among 11 unidentified residents sitting at the dining table waiting for lunch. Observation of the dining room on 04/13/26 at 12:26 P.M. lunch meal was served to these unidentified 11 residents and not to Resident #16, and they started eating. Observation of the dining room on 04/13/26 at 1:30 P.M. revealed Resident #16 received meal and Certified Nursing Assistant (CNA) #127 was sitting to assist Resident #16 with meal. Observation of the dining room on 04/13/26 at 1:34 P.M. revealed Resident #16 with meal but no staff was present to assist in eating lunch.Observation of the dining room on 04/13/26 at 1:36 P.M. revealed CNA #127 saying to Resident #16 to give her a second. Observation of the dining room on 04/13/26 at 1:39 P.M. revealed CNA #127 was obtaining tea for Resident #16 to drink.Observation of the dining room on 04/13/26 at 1:40 P.M. revealed CNA #127 stopped feeding Resident #16 and left dining room table to assist Resident #8. Observation of the dining room on 04/13/26 at 1:44 P.M. revealed CNA #127 returned to dining room table and left immediately.Observation of the dining room on 04/13/26 at 1:47 P.M. revealed CNA #127 returned to dining room table and left to redirect another unidentified resident.Observation of the dining room on 04/13/26 at 1:58 P.M. revealed CNA #127 asked Resident #16 if he was done with his food. Response could not be heard by Resident #16. CNA #127 proceeded to wheel Resident #16 out of dining room. Resident #16 one bowl of food offered during meal time was removed from dining table.Interview with CNA #127 on 04/13/26 P.M. at 1:10 P.M., verified she was the only aide in the dining room and was feeding another unidentified resident. There were two more residents who ate their meals in their rooms that needed fed by the other CNA on duty. CNA #127 confirmed it was taking a while to feed other resident and Resident #16 had been waiting since Noon for lunch.Interview on 04/14/26 at 10:33 A.M. with Resident #16 confirmed it is routine for him to wait a long time to be fed and watching other residents eat upsets resident. Yes/no questions were used at interview.Review of Dietary Policy DT.1-Meal Service, Supplements, and Substitutions dated 05/93, revealed residents will be provided with dignity, assistance and patience at meal times as well as all other times. Nursing personnel will monitor meal times and record intake.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to notify the physician of significant weight loss. This affected two residents (#4 and #15) of three residents reviewed for nutrition. The facility census was 27. Findings Include:1. Review of the medical record for Resident #4 revealed an initial admission date of 01/02/26 with the latest readmission date of 02/17/26 with the diagnoses including but not limited to displaced spiral fracture of shaft of right femur, moderate protein calorie malnutrition, neuromuscular dysfunction of bladder, encounter for palliative care, anemia, osteoporosis, diabetes mellitus, insomnia, hypertensive heart disease, hyperlipidemia, delusional disorder, hypertension, history of falling, history of nontraumatic fracture. Review of the resident's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The resident required supervision or touching assistance with eating. The resident's weight was 103 pounds with a significant weight loss and not on a prescribed weight loss regimen. The assessment indicated the resident received a therapeutic diet. Review of the resident's weights revealed on 01/02/26 109 pounds on admission to the facility, the resident weighed 103.5 pounds on 01/25/26, indicating a 5.5 pound or 5.05% weight loss in less than 30 days, the resident weighed 102.5 pounds on 02/27/26, the resident weighed 89.5 pounds on 03/02/26, indicating a 13 pound or 12.68% weight loss in five days, and on 04/26 the resident weighed 90 pounds. Review of the resident's medical record revealed no documented evidence the resident's physician or Certified Nurse Practitioner (CNP) was notified of the weight loss on 01/25/26, and 03/02/26. On 04/16/26 at 12:40 P.M., an interview with the Licensed Nursing Home Administrator (LNHA) verified the resident's physician and/or CNP was not notified of the weight loss on 01/25/26 and 03/02/26. 2. Review of the medical record for Resident #15 revealed an initial admission date of 04/20/25 with the latest readmission of 05/25/25 with the diagnoses including but not limited to neuropathy, peripheral vascular disease, hypertensive heart disease, vascular dementia, major depressive disorder, cerebral infarction, dementia, hypertension, gout, insomnia and anxiety disorder. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The resident's weight was 169 pounds and had a weight gain and was not on a physician prescribed weight gain regimen. The resident received a mechanically altered and therapeutic diet. Review of the plan of care dated 03/17/26 revealed the resident had the potential for nutrition/hydration risk related to chronic disease, modified diet, mood changes, confusion, history of weight changes and skin integrity issues. Interventions included provide diet as ordered, preferences per dietary, therapies as ordered, medications as ordered, monitor weight as ordered, notifications as ordered, monitor intakes, monitor for changes in eating, Registered Dietician (RD) to assess as needed and monitor skin integrity as needed. Review of the resident's weights revealed an admission weight on 05/15/25 205.0 pounds, on 05/21/25 the resident weighed 195 pounds, the resident had no documented weight for June 2025, on 07/07/25 the resident weighed 181 pounds, on 07/21/25 the resident weighed 176 pounds, indicating a 19 pound or 9.74% weight loss in 60 days, 08/03/25 the resident weighed 177 pounds, on 09/12/25 the resident weighed 180 pounds, the resident weighed 178.5 pounds in October 2025, on 11/01/25 the resident weighed 177 pounds, the resident weighed 165 pounds in December 2025, on 01/27/26 the resident weighed 161.2 pounds, 0n 02/27/26 the resident weighed 168.5 pounds and 03/02/26 the resident weighed 168.5 pounds and review of the April 2026 weight the resident weighed 167 pounds. Review of the resident's medical record revealed no documented evidence the resident's physician or Certified Nurse Practitioner (CNP) was notified of the weight loss on 07/21/25. On 04/16/26 at 12:40 P.M., an interview with the Licensed Nursing Home Administrator (LNHA) verified the resident's physician and/or CNP was not notified of the weight loss on 07/21/25. Review of the facility policy titled, Change In Resident Weight Policy, last (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revised in 11/1993 revealed any five pound weight change within one month period shall immediately be reported to the physician.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview and facility policy review, the facility failed to provide a written bed hold notice upon transfer to an acute care setting. Additionally, the facility failed to provide a comprehensive discharge summary upon a planned discharge from the facility. This affected two residents (#10 and #20) of four residents reviewed discharge. The facility census was 27. Findings Include:1. Review of the medical record for Resident #10 revealed an initial admission date of 03/24/25 with the last readmission date of 02/12/26 with the diagnoses including but not limited to anxiety disorder, heart failure, osteoarthritis, atrial fibrillation, dementia, with behavioral disturbances, chronic pain, Alzheimer's disease, polycythemia vera, polyneuropathy, peripheral venous insufficiency, depression, hypertensive heart disease, hypertension, gastro-esophageal reflux disease, insomnia and peripheral vascular disease. The resident was discharged to an in-patient psychiatric hospital on [DATE]. Review of the resident's discharge summary revealed the resident was given the facility's bed hold policy instead of written information with the duration of the state bed hold policy, the reserve bed payment policy, the amount of bed holds left and the rate to continue the bed hold in the event the resident runs out of state paid bed hold days. On 04/16/26 at 12:40 P.M., an interview with the Licensed Nursing Home Administrator (LNHA) verified the resident had not received a bed hold notice containing all required components. Review of the facility's policy titled, Vineyards of Concord Bed Hold Policy, last revised 11/07/25 revealed the facility would hold a bed for a resident who is hospitalized or on therapeutic leave for a total of 30 days, in accordance with state regulations. Medicaid may pay the facility to hold a recipients bed during the 30 days of bed hold. 2. Review of the medical record for Resident #20 revealed an initial admission date 03/27/26 with the diagnoses of including but not limited to pyothorax, anemia, elevated white blood cell count, presence of heart valve replacement, presence of prosthetic heart valve, osteoporosis, nicotine dependence, convulsions, hyperlipidemia, depression, pleural effusion, hypothyroidism, mood disorder, atrial fibrillation and generalized anxiety disorder. Review of the resident's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The resident expressed the desire to discharge to the community and the facility had already began discharge planning. Review of the resident's discharge record revealed the resident was discharged on 04/13/26 at 11:25 A.M. with a family member per the resident's request. The discharge record contained the medications sent with the resident and the resident initialed the document as receiving the medications. Review of the medical record revealed no evidence of a sent a discharge summary containing a recapitulation of the resident's stay, a final summary of the resident's status, a reconciliation of all pre-discharge medications with the resident's post discharge medications or resident education on discharge instructions. On 04/13/26 at 12:35 P.M., an interview with the Director of Nursing (DON) revealed she had the resident initial the discharge summary that contained a list of the home medications she brought to the facility with her and a list of appointments. On 04/14/26 at 12:46 P.M., an interview with the DON verified she had no sent a discharge summary containing a recapitulation of the resident's stay, a final summary of the resident's status and a reconciliation of all pre-discharge medications with the resident's post discharge medications. On 04/16/26 at 10:08 A.M., an interview with the Medical Director (MD) revealed he would expect the facility to send with the resident a list of medications, scheduled appointments and the last progress note from either himself or the Certified Nurse Practitioner (CNP) which documents the course of treatment in the hospital prior to the admission to the facility.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, interview and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 user's manual the facility failed to ensure the comprehensive Minimum Data Set (MDS) assessment was completed within the first 14 days. This affected one resident (#20) of 15 sampled residents. The facility census was 27. Findings Include: 1. Review of the medical record for Resident #20 revealed an initial admission date 03/27/26 with the diagnoses of including but not limited to pyothorax, anemia, elevated white blood cell count, presence of heart valve replacement, presence of prosthetic heart valve, osteoporosis, nicotine dependence, convulsions, hyperlipidemia, depression, pleural effusion, hypothyroidism, mood disorder, atrial fibrillation and generalized anxiety disorder. Review of the resident's admission comprehensive MDS assessment dated [DATE] revealed the assessment was still in progress more than 14 days following the resident's admission. On 04/14/26 at 10:51 A.M., an interview with Facility Manager (FM) verified the resident's comprehensive MDS was still in progress and not completed within the first 14 days of the resident's stay. Review of the Long-Term Care Facility RAI 3.0 user's manual dated 10/25 revealed the admission comprehensive assessment must be completed no later than the fourteenth calendar day of the resident's stay at the facility.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review and interview, the facility failed to develop a comprehensive plan of care to address resident needs and conditions. This affected two residents (#4 and #18) of 15 sampled residents. The facility census was 27. Findings Include:1. Review of the medical record for Resident #4 revealed an initial admission date of 01/02/26 with the latest readmission date of 02/17/26 with the diagnoses including but not limited to displaced spiral fracture of shaft of right femur, moderate protein calorie malnutrition, neuromuscular dysfunction of bladder, encounter for palliative care, anemia, osteoporosis, diabetes mellitus, insomnia, hypertensive heart disease, hyperlipidemia, delusional disorder, hypertension, history of falling, history of nontraumatic fracture. Review of the resident's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident was using a bed alarm daily. Review of the resident's monthly physician orders identified an order dated 03/20/26 pressure pad alarm to mattress and Broda chair to alert staff when resident was getting out of bed every shift for safety. Review of the plan of care not dated revealed the resident was at risk for falls related to confusion, deconditioning, gait/balance problems, unaware of safety needs, fall/fracture history and medication use. Interventions included uses bed electronic alarm, ensure device is in place as needed. Further review revealed no intervention addressing the use of the [NAME] alarm in the resident's Broda chair or ensure the sensor alarms were functioning. On 04/15/26 at 2:26 P.M., observation of the resident revealed she was sitting on the edge of her Broda chair seat trying to get out of her chair. The resident had a personal tab alarm in place and not the physician ordered sensor alarm. The string attached from the tab alarm to the resident was long enough for the resident to attempt to get out of the chair without disconnecting to alert the staff. On 04/20/26 at 8:56 A.M., an interview with the Director of Nursing (DON) verified the resident's plan of care did not adequately address the use of the sensor alarm. 2. Review of the medical record for Resident #18 revealed an initial admission date of 02/19/26 with the diagnoses including but not limited to atrial fibrillation, allergic rhinitis, hyperlipidemia, osteoarthritis, constipation, atherosclerotic heart disease, anxiety disorder, hypertension, chronic pain syndrome, diabetes mellitus, chronic kidney disease, chronic obstructive pulmonary disease (COPD), gastro-esophageal reflux disease and obstructive sleep apnea. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The MDS indicated the resident did not utilize a CPAP machine. Review of the resident's monthly physician orders for April 2026 identified orders dated 02/21/26 CPAP in place during hours of sleep to improve respiratory quality during sleep related to diagnosis of obstructive sleep apnea and COPD. Review of the resident's plan of care revealed no care plan addressing the resident's use of the CPAP machine for obstructive sleep apnea. On 04/15/26 at 12:47 P.M., an interview Facility Manager (FM) #100 verified the resident had no comprehensive plan of care addressing the use of the CPAP machine.

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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	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 observation, medical record review and interview, the facility failed to provide residents who were dependent on staff for nail care. This affected two residents (#15 and #19) of five residents reviewed for activities of daily living (ADL). The facility census was 27. Findings Include:1. Review of the medical record for Resident #15 revealed an initial admission date of 04/20/25 with the latest readmission of 05/25/25 with the diagnoses including but not limited to neuropathy, peripheral vascular disease, hypertensive heart disease, vascular dementia, major depressive disorder, cerebral infarction, dementia, hypertension, gout, insomnia and anxiety disorder. Review of the plan of care not dated revealed the resident had an activity of daily living (ADL) self-care performance deficit related to cerebrovascular accident, restlessness and dementia. Interventions check nail length, trim and clean on bath day and as necessary. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The resident was dependent on staff for personal hygiene. On 4/13/26 at 10:46 A.M., observation of the resident revealed his nails were long, jagged with a brown substance under the nail bed. On 04/14/26 at 12:41 P.M., observation of the resident's nails remained long, jagged with a brown substance under the nail bed. On 04/14/26 at 12:43 P.M., an interview with the Director of Nursing (DON) verified the resident's nails were long, jagged with a brown substance under the nail bed and in need of nail care. 2. Review of the medical record for Resident #19 revealed an initial admission date of 04/19/22 with the latest readmission of 06/30/24 with the diagnoses including but not limited to hypertensive heart disease, pain, hypertension, resistance to multiple antibiotics, atrial fibrillation, dementia with anxiety, insomnia, major depressive disorder, Alzheimer's disease, anxiety disorder, psychosis, gastro-esophageal reflux disease, gastritis, fatty liver, major depressive disorder and constipation. Review of the plan of care dated 04/20/22 revealed the resident had altered activities of daily living (ADL) function. Interventions included notify resident of ADL needed to be completed before starting, assess level of orientation and reorient as needed and able, provide set-up, supervision, cues and assist thru completion as warranted and as needed, allow and encourage resident to participate in own ADL at own optimum level of function as resident is able, praise efforts and compliment appearance as warranted, notify physician of any significant changes, when resident resists/refuses ADL completion redirect or provide rest break and reapproach, assist with clothing choices as needed and oral care daily and as needed. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed had a server cognitive deficit. Review of the mood and behavior revealed the resident had no indicators for depression and displayed no behaviors including rejection of care. The resident was dependent on staff for toileting and personal hygiene. On 04/13/26 at 10:46 A.M., observation of the resident revealed her nails were long, jagged and dirty with a brown substance under the nails. On 04/14/26 at 12:41 P.M., observation of the resident revealed her nails were long, jagged and dirty with a brown substance under the nails. On 04/14/26 at 12:43 P.M., an interview with the Director of Nursing (DON) verified the resident's nails were long, jagged with a brown substance under the nail bed and in need of nail care. On 04/15/26 at 4:16 P.M., an interview with the Licensed Nursing Home Administrator (LNHA) revealed the facility had no policy related to care of the resident's nails. This deficiency represents noncompliance investigated under Complaint Number 2984105.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to comprehensively assess skin impairment upon discovery and subsequently weekly assessment thereafter. This affected one resident (#18) of one resident reviewed for skin impairment. The facility census was 27. Findings Include:Review of the medical record for Resident #18 revealed an initial admission date of 02/19/26 with the diagnoses including but not limited to atrial fibrillation, allergic rhinitis, hyperlipidemia, osteoarthritis, constipation, atherosclerotic heart disease, anxiety disorder, hypertension, chronic pain syndrome, diabetes mellitus, chronic kidney disease, chronic obstructive pulmonary disease (COPD), gastro-esophageal reflux disease and obstructive sleep apnea. Review of the medical record revealed no documented evidence a comprehensive admission assessment was completed on admission to the facility. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the mood and behavior revealed the resident had indicators of depression and displayed no behaviors, including refusal of care. The assessment indicated the resident was at risk for skin breakdown and had moisture associated skin damage (MASD). The facility implemented the interventions pressure reducing device for bed/chair, turning/repositioning program and applications of ointments/medications other than to feet. Review of the resident's plan of care dated 03/04/26 revealed the resident was at risk for alteration in skin integrity. Interventions included provide prompt thorough peri-care as necessary with toileting, assess skin with every shower, inspect perineum with each opportunity, notify physician of skin conditions as needed, utilize barrier cream/ointment as needed, treatments as ordered, utilize pressure relief devices to mattress and chair as resident will allow, turn and reposition while in bed every one to two hours, encourage resident to rest in bed at bedtime and as needed. Review of the progress note dated 03/20/26 at 5:26 A.M. revealed the resident's buttocks/coccyx was assessed for wounds. A small spit in skin, left inner buttocks and a small abrasion on the right outer labia was observed. An order for skin prep topically to areas twice daily. Review of the progress note dated 04/05/26 at 6:31 A.M. revealed the resident's buttocks/coccyx was assessed for wounds. A small spit in skin, left inner buttocks and a small abrasion on the right outer labia was observed. An order for skin prep topically to areas twice daily. Review of the medical record revealed no documented evidence of an initial comprehensive assessment of the skin split to the left inner buttocks or abrasion to the right outer labia. Further review revealed no documented weekly assessment of the wounds. Review of the resident's monthly physician orders for April 2026 identified orders dated 03/18/26 assess buttocks/coccyx for wound, resident reports small split in skin, left inner buttock and small abrasion on right outer labia, apply skin prep to areas twice daily, areas can be viewed and treated when resident is laying in bed on left side, resident is aware and agrees to be in bed for twice daily application. On 04/15/26 at 2:20 P.M., an interview with the Director of Nursing (DON) verified the resident had no initial comprehensive and subsequent weekly assessment of the skin split to the left inner buttocks and the abrasion to the right outer labia. On 04/15/26 at 4:16 P.M., an interview with the Licensed Nursing Home Administrator (LNHA) verified the facility had no policy to address wounds that were not pressure ulcers or stasis ulcer.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review and interview, the facility failed to provide routine incontinence care. This affected two residents (#15 and #19) of three residents reviewed for bowel and bladder. The facility census was 27. Findings Include:1.Review of the medical record for Resident #15 revealed an initial admission date of 04/20/25 with the latest readmission of 05/25/25 with the diagnoses including but not limited to neuropathy, peripheral vascular disease, hypertensive heart disease, vascular dementia, major depressive disorder, cerebral infarction, dementia, hypertension, gout, insomnia and anxiety disorder. Review of the plan of care not dated revealed the resident had bladder incontinence related to dementia. Interventions included notify nursing if incontinent during activities, encourage fluids during the day to promote promoted voiding responses, establish voiding patterns, monitor and document intake and output as per facility policy, monitor fluid intake to determine if natural diuretics are contributing to increased urination and incontinence, monitor for sign/symptoms for urinary tract infection (UTI) and monitor/document/report to physician as needed possible medical causes of incontinence. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The resident was dependent on staff for toileting needs and personal hygiene. The resident was always incontinent of bladder and frequently incontinent of bowel. On 4/13/26 at 10:46 A.M., observation of the resident revealed he was sitting at the dining room table finishing his breakfast. On 04/13/26 at 12:57 P.M., observation of the resident revealed he remains at the dining room table and had been sitting at the dining room table since entrance for the survey at 8:00 A.M. On 04/13/26 at 1:40 P.M., observation of the resident revealed he remains at dining room table. On 04/13/26 at 3:15 P.M., observation of the resident revealed he remained sitting in the dining room with his pants notably wet near his groins. On 04/13/26 at 3:20 P.M., an interview with Certified Nursing Assistant (CNA) #117 verified the resident's pants were saturated with urine and routine incontinence care had not been provided. 2. Review of the medical record for Resident #19 revealed an initial admission date of 04/19/22 with the latest readmission of 06/30/24 with the diagnoses including but not limited to hypertensive heart disease, pain, hypertension, resistance to multiple antibiotics, atrial fibrillation, dementia with anxiety, insomnia, major depressive disorder, Alzheimer's disease, anxiety disorder, psychosis, gastro-esophageal reflux disease, gastritis, fatty liver, major depressive disorder and constipation. Review of the plan of care dated 05/01/23 revealed the resident had actual bladder incontinence related to dementia, Alzheimer's disease, need for assistance with personal care. Interventions included resident to toilet every two hours, provide set-up, supervision and assist as needed with toileting/cleansing, therapy services as physician ordered, may utilize double briefs depends during the day to protect dignity, provide peri-care as necessary to maintain proper hygiene for clean, dry and odor free and observe for signs/symptoms of urinary tract infection (UTI). Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed had a server cognitive deficit. Review of the mood and behavior revealed the resident had no indicators for depression and displayed no behaviors including rejection of care. The resident was dependent on staff for toileting and personal hygiene. The resident was always incontinent of both bowel and bladder. Review of the progress notes for 04/13/26 revealed no documented evidence the resident refused toileting on day shift. On 4/13/26 at 10:46 A.M., observation of the resident revealed he was sitting at the dining room table finishing his breakfast. On 04/13/26 at 12:57 P.M., observation of the resident revealed he remains at the dining room table and had been sitting at the dining room table since entrance for the survey at 8:00 A.M. On 04/13/26 at 1:40 P.M., observation of the resident revealed he remains at dining room table. On 04/13/26 at 3:20 P.M., observation of CNA #117 and #127 provide incontinence care for the resident revealed they wheeled her to her room from the dining (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room where she had been sitting since 8:00 A.M. upon entry to the facility. The staff sanitized their hands and donned gloves. The resident was placed on the toilet in the bathroom via two assists and the resident using the grab bar. The resident's pants were pulled down and revealed the resident had a blue brief on and a large liner that was completely saturated with a strong ammonia smelling urine. CNA #117 revealed the resident was supposed to be toileted every hour and a half. CNA #127 stated, the resident had not been toileted for quite some time. The resident was provided incontinence care and an incontinence pull-up brief was placed on the resident. This deficiency represents noncompliance investigated under Complaint Number 2984105.

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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, record review, interview, hospital record review and policy review, the facility failed to provide a comprehensive, resident centered plan of care to prevent, timely identify, and treat weight loss for residents. Additionally, the facility failed to ensure weights were obtained, documented, and monitored for weight loss, failed to ensure meal intake percentages were documented at every meal, and failed to ensure supplements were provided per order and failed to follow the recipe for supplements to ensure residents received the proper nutritional support. This affected two (Residents #4 and #8) of three residents reviewed for nutrition/weight loss. The facility census was 27.Findings include:1.Review of Resident #8's medical record revealed an admission date of 12/23/25 with diagnoses including Alzheimer's disease, general anxiety, and abnormal weight loss. Review of a physician's order dated 12/23/25 revealed Resident #8 received a regular diet with thin liquids. Review of Resident #8's nutrition assessment dated [DATE] revealed a diagnosis of abnormal weight loss. The Administrator (LNHA), who is also a registered dietician (RD) and was serving as RD at that time, recommended the addition of four ounces of a nutritional supplement between meals or with meals as tolerated. There was no mention of what type of supplement in the nutritional assessment. Further review revealed Resident #8 had a decline in meal intakes and refuses to eat before admission and low appetite continues due to fast paced dementia/Alzheimers and refusals and is hospice appropriate. Resident #8 is easily agitated. Review of the medical record revealed there was no order for a nutritional supplement as recommended on 12/26/25. Review of the progress note dated 12/30/25 by Family Nurse Practitioner (FNP) #132 documented Resident #8 was in no acute distress. FNP #132 acknowledged Resident #8 had an abnormal weight loss of 14.8 pounds, from 171.6 lbs. on 11/07/25 to 156.8 lbs. on 12/22/25 while admitted to hospital prior to facility admission. The plan was to continue to monitor weight. No other specific interventions were discussed in the note. Review of the progress note dated 01/06/26 by FNP #132 documented Resident #8 was in no acute distress. The follow-up visit was for abnormal weight loss prior to admission and mental health issues. The etiology of the weight loss was likely due to her mental disorders. The plan was to continue monitoring weight and nutritional intake as indicated and further workup to be considered if weight loss continued. Review of the History and Physical dated 01/08/26 written by Medical Director #131 documented Resident #8 had experienced a significant weight loss prior to admission. The assessment and plan did not address abnormal weight loss. Review of the progress notes dated 01/13/26, 01/20/26, and 02/19/26 by FNP #132 did not mention or address weight loss. Review of the weights revealed Resident #8 weighed 132 lbs. in February 2026. This was a 25 lb. weight loss from admission. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician visit note dated 02/19/26 written by Medical Director #131 did not address weight loss. Review of progress note dated 02/24/26 by FNP #132 did not mention or address weight loss. Review of a nutrition note dated 02/27/26 by RD #120 documented Resident #8 triggered for significant weight loss of 13.2 percent in 30 days. RD #120 to add house shakes three times a day 120 milliliters (ml) for additional 240 kilocalories (kCals) and 10 grams (g) of protein to help stabilize weight. Review of progress note dated 03/10/26 by FNP #132 did not mention or address weight loss. Review of the physician visit note dated 03/19/26 at 12:27 P.M. and written by Medical Director (MD) #131 did not address significant weight loss. Review of progress notes dated 03/24/26 and 04/07/26 by FNP #132 did not mention or address continued weight loss. Review of weights for Resident #8 weighed 125.5 lbs. in April 2026, a loss of 7.5 lbs. since March 2026. Review of Resident #8's physician orders for February, March and April 2026 revealed no order for the supplements as recommended on 02/27/26 by RD #120. Review of Resident #8's meal ticket revealed a regular diet with no order for nutritional supplements written on the meal ticket. Review of Resident #8's care plan revealed a nutrition care plan revised on 03/28/26 for a nutritional problem related to weight loss prior to admission. The goal was for Resident #8 to maintain adequate nutritional status. Interventions for Resident #8 included encourage resident to remain compliant with diet/orders. Blood sugar checks as necessary, monitor for signs or symptoms of hypo/hyperglycemia, follow endocrine plan of care if warranted, encourage compliance with medications and treatment orders, follow up with specialty physician, monitor weights as necessary, monitor for choking hazards/episodes, notify Medical Director as warranted if any significant changes. Provide and encourage resident to drink supplements when awake and when resident consumes less than 75 percent, utilize nosey cup when able, and feed her meals or hardy snacks when up and out of bed during night and non-mealtimes. Review of Resident #8's Minimum Data Set (MDS) assessment, dated 04/07/26, revealed Resident #8 was severely cognitively impaired. She required supervision with eating. No weight loss was reflected in the assessment. Review of the resident's meal percentages for breakfast, lunch and dinner from 02/27/26 through 04/12/25 revealed the resident's meal intake varied from day to day and meal to meal. There were no percentages of meals eaten written down for 02/27/26, 02/28/26, 03/01/26 through 03/10/26 and again from 03/13/26 through 03/31/26. There was no documentation of meals on 04/11/26 and 04/12/26. Further review of the meal percentage sheets revealed some inconsistencies if Resident #8 received (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or accepted any type of dietary supplement. Observation on 04/13/26 during lunch meal revealed Resident #8 got up from tabel a couple of times and teh kitchen gave her a sandwhich and grapes and she ate them in the lobby area. No observations of Resident #8 with supplements. During an interview on 04/15/26 at 4:25 P.M., RD #120 stated resident meal intake documentation was not consistently filled out by staff. During an interview on 04/16/26 at 10:08 A.M MD #131 stated he deferred to the RD's decision regarding supplements offered. MD #131 was not aware Resident #8 had severe weight loss due to current weights not updated in the resident's electronic record. In the system it looked as if weight had stabilized. MD #131 stated weight loss notifications would be made to FNPP #132. 2. Review of the medical record for Resident #4 revealed an initial admission date of 01/02/26 with a readmission date of 02/17/26 following a fall at the facility resulting in a displaced spiral fracture of shaft of right femur. Diagnoses included displaced spiral fracture of shaft of right femur, moderate protein calorie malnutrition, neuromuscular dysfunction of bladder, encounter for palliative care, anemia, osteoporosis, diabetes mellitus, insomnia, hypertensive heart disease, hyperlipidemia, delusional disorder, hypertension, history of falling, history of nontraumatic fracture Review of the hospital summary dated 02/17/26 the resident's family requested the resident to return to the facility with hospice services. Review of the resident's significant change MDS assessment dated [DATE] revealed the resident had a severe cognitive deficit. The resident required supervision or touching assistance with eating. Resident #4's weight was 103 lbs. with a significant weight loss and not on a prescribed weight loss regimen. The resident was on a therapeutic diet. Review of the resident's weights revealed on 01/02/26, Resident #4 weighed 109 lbs on admission. On 01/15/26, the resident weighed 103.5 lbs, which was a five percent loss in 30 days. On 02/27/26, the resident weighed 102.5 lbs . Review of the nutrition progress note dated 02/27/26 revealed the resident's current body weight was 102.5 pounds with a body mass index (BMI) of 20, which was underweight for age greater than 65 years. Weight review indicates significant weight loss of 5.9 percent in thirty days. The resident was receiving a regular diet and meal intakes were 10 to 50 percent of meals. The resident was receiving hospice care services, and the weight loss was anticipated due to six month or less prognosis. The goal was for dignity and comfort at this time. The RD was to continue to monitor and follow up as needed. Review of the progress note dated 02/27/26 revealed the RD recommended adding house shakes twice daily for an additional 240 calories and 10 grams of protein per serving. The dietary manager was made aware, and the resident was added to the supplement list. On 03/02/26, the resident weighed 89.5 lbs., which was a 12.68 percent loss in five days. Residen#4's weight for April 2026 was 90 lbs. Review of the medical record revealed no evidence the resident was reweighed to determine if the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weight loss of 12.68 percent in five days was accurate. Review of the medical record revealed no evidence that an initial nutritional assessment from the 01/02/26 admission was completed to determine the resident's nutritional needs. Review of the medical record revealed no evidence the RD recommendations for house supplement twice daily was implemented. Review of the resident's plan of care revealed no care plan addressing the resident's nutritional status, including weight loss. On 04/15/26 at 3:30 P.M., an interview with [NAME] #118 revealed the house supplement is made with milk and a Whey protein powder blend supplement with creatine and ammino acids. The cook revealed the house supplement was not for weight loss, but for extra protein. [NAME] #118 revealed she had no recipe she followed to make the supplement from the whey protein powder and at times will add ice cream, fruit or peanut butter. The cook revealed she made a gallon of the supplement at a time. [NAME] #118 verified the facility does stock Ready Pass. On 04/15/26 at 4:41 P.M., an interview with the RD, revealed she was aware the facility was using the whey protein powder and recommended to stop the use due to the inconsistency of how the supplement was prepared. The RD revealed she recommended all residents who were to receive the house supplement was to receive Ready Pass supplement for preventative and/or actual weight loss. On 04/16/26 at 8:40 A.M., an interview with [NAME] #129 revealed the facility only had two residents (#8 and #16) who received the Ready Pass. The [NAME] revealed all other residents receive the house supplement made from the Whey protein powder blend supplement with creatine and ammino acids. On 04/16/26 at 10:08 A.M., an interview with the Medical Director (MD) revealed he was not aware of the facility using the whey protein powder and recommended the use of supplements the RD recommended. During an interview on 04/16/26 at 12:40 P.M., the Administrator verified the resident had no plan of care addressing the resident's nutritional status and weight loss, no initial comprehensive nutritional assessment at the RD recommendations were not implemented. This deficiency represents non-compliance investigated under Complaint Number 2984105.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366360	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vineyards at Concord, The	119 West High Street Frankfort, OH 45628

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review and interview, the facility failed to ensure continuous positive airway pressure (CPAP) had physician ordered settings, cleansing and was stored in a manner to prevent potential infection. This affected one resident (#18) of one resident reviewed for respiratory care. The facility census was 27. Findings Include:Review of the medical record for Resident #18 revealed an initial admission date of 02/19/26 with the diagnoses including but not limited to atrial fibrillation, allergic rhinitis, hyperlipidemia, osteoarthritis, constipation, atherosclerotic heart disease, anxiety disorder, hypertension, chronic pain syndrome, diabetes mellitus, chronic kidney disease, chronic obstructive pulmonary disease (COPD), gastro-esophageal reflux disease and obstructive sleep apnea. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the resident's monthly physician orders for April 2026 identified orders dated 02/21/26 CPAP in place during hours of sleep to improve respiratory quality during sleep related to diagnosis of obstructive sleep apnea and COPD. Further review revealed no physician order for settings of the machine or the cleansing of the CPAP delivery mask or tubing. Review of the resident's plan of care revealed no care plan addressing the resident's use of the CPAP machine for obstructive sleep apnea. On 04/15/26 at 9:45 A.M., observation of the resident's CPAP machine revealed the machine was sitting on the resident's nightstand with no protective covering. Licensed Practical Nurse (LPN) #102 verified the CPAP delivery mask was not stored in a protective covering. On 04/15/26 at 12:47 P.M., an interview with the Facility Manager (FM) #100 verified the resident had no physician orders for the settings of the CPAP machine and no cleansing instructions for the CPAP delivery mask and tubing. On 04/15/16 at 4:16 P.M., an interview with the Licensed Nursing Home Administrator (LNHA) verified the facility had no policy addressing the use of a CPAP machine.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review and interview, the facility failed to ensure medications were available for administration. This affected one resident (#18) of two residents observed for medication administration. The facility census was 27. Findings Include:Review of the medical record for Resident #18 revealed an initial admission date of 02/19/26 with the diagnoses including but not limited to atrial fibrillation, allergic rhinitis, hyperlipidemia, osteoarthritis, constipation, atherosclerotic heart disease, anxiety disorder, hypertension, chronic pain syndrome, diabetes mellitus, chronic kidney disease, chronic obstructive pulmonary disease (COPD), gastro-esophageal reflux disease and obstructive sleep apnea. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the resident's monthly physician orders for April 2026 identified orders dated 02/20/26 B-Complex with Biotin and Folic Acid one tablet by mouth daily, Vitamin E 400 capsule by mouth daily and Fluticasone Propionate Nasal Suspension 50 micrograms (mcg) with the special instructions of one spray in each nostril twice daily for alleriges. On 04/15/26 at 9:11 A.M., observation of Licensed Practical Nurse (LPN) #102 prepare the resident's morning medication revealed the facility had no B-Complex with Biotin and Folic Acid, Vitamin E 400 capsule or Fluticasone Propionate Nasal Suspension 50 mcg on hand to administer to the resident. On 04/15/26 at 9:16 A.M., an interview with LPN #102 verified the medication was not on hand to administer to the resident.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review and interview, the facility failed to ensure a medication error rate of less than five percent. Twenty-five opportunities for error were observed with three medication errors made resulting in a 12 percent error rate. This affected one resident (#18) of two residents observed during the medication pass. The facility census was 27. Findings Include:Review of the resident's monthly physician orders for [DATE] identified orders dated [DATE] Omeprazole 40 milligrams (mg) by mouth daily and [DATE] B-Complex with Biotin and Folic Acid one tablet by mouth daily, Vitamin E 400 capsule by mouth daily. On [DATE] at 9:11 A.M., observation of Licensed Practical Nurse (LPN) #102 prepare the resident's morning medication revealed she placed two Omeprazole 20 mg capsules from a stock bottle with the expiration date of 03/26 in a clear plastic cup. Further observation revealed the LPN #102 had no Complex with Biotin and Folic Acid or Vitamin E 400 capsule on hand to administer to the resident. On [DATE] at 9:14 A.M., observation of LPN #102 administer the resident her medications revealed the LPN administered the expired Omeprazole 20 mg two capsules. On [DATE] at 9:16 A.M., an interview with LPN #102 verified the Omeprazole 20 mg capsules administered to the resident were expired and the medication was not on hand to administer to the resident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, interview and facility policy review revealed the facility failed to maintain infection control practices to prevent the potential spread of infection. This affected two residents (#5 and #20) of 15 residents reviewed for infection control. The facility census was 27.Findings Include: 1.Review of the medical record revealed Resident #5, specified, was admitted to the facility on [DATE]. Diagnoses included metabolic encephalopathy, severe dementia with anxiety, Alzheimer's disease, essential hypertension, and dysphagia. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition with hallucinations and delusions, rejected care, and did not wander. Resident #5 is dependent for all care and has a gastric feeding tube placed. Observation of gastric tube feed for Resident #5 on 04/14/2026 at 11:59 A.M. revealed that no personal protective equipment (PPE) was available outside of or inside the room and no gown was worn during tube feed procedure. Interview with staff #132 on 04/14/2026 at 12:05 P.M. confirmed that proper PPE was not worn during tube feed, no gown and gloves are set up outside or inside the room and Resident #5 does not have enhanced barrier precaution orders placed The enhanced barrier precautions sign on the door of Resident #5 states providers and staff must also: wear gloves and a gown for the following high-contact resident care activities Device care or use: .feeding tube. Review of the medical chart for Resident #5 reveals no orders for enhanced barrier precautions exists. 2. Review of the medical record for Resident #20 revealed an initial admission date 03/27/26 with the diagnoses of including but not limited to pyothorax, anemia, elevated white blood cell count, presence of heart valve replacement, presence of prosthetic heart valve, osteoporosis, nicotine dependence, convulsions, hyperlipidemia, depression, pleural effusion, hypothyroidism, mood disorder, atrial fibrillation and generalized anxiety disorder. Review of the plan of care dated 03/28/26 revealed the resident had a pneumonia like condition related to empyema, as evidenced by both lungs infiltrated with pus upon presentation to the hospital and intravenous antibiotic therapy. Interventions included monitor vital signs every shift, as needed and with any noted changes, monitor for fever every shift, observe for signs/symptoms persisting or onset of fever, increased cough, moist/loose cough, rales/rhonchi/wheezing, change in vital signs, increased pulse, increased respirations or changes in respiration, decreased oxygen saturation, sallow breathing, shortness of breath or change in level of consciousness, encourage fluids every two hours, keep head of bed elevated to assist with breathing, encourage deep breathing and coughing to assist with keeping lungs as clear as possible, courage to sit up out of bed as tolerated, encourage resident, monitor lung sounds every shift and as needed, document progress in nurses notes with (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	respiratory assessments, administer medications and treatments as ordered and follow up with repeat chest x-ray in 20 days or after antibiotic treatment unless doctor contraindicates or decides not to order. Review of the resident's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident's primary diagnosis was pyothorax and received antibiotic medications. The assessment indicated the resident was receiving intravenous medications. Review of the resident's monthly physician orders for April 2026 identified orders dated 03/27/26 maintain midline intravenous (IV) patency, flush IV line with normal saline (NS) per policy for antibiotic infusion, 03/30/26 assess midline site every shift, maintain dressing to IV site, change dressing every seven days and as needed, 04/07/26 Ceftriaxone Sodium IV solution 2 grams IV daily for pyothorax until 04/19/26. Further review of the resident's physician orders both active and discontinued revealed no physician order for enhanced barrier precautions related to the midline IV therapy. On 04/13/26 at 10:06 A.M., observation of the Director of Nursing (DON) administered the physician ordered medication Ceftriaxone Sodium IV solution 2 grams IV revealed she washed her hands, administered the resident her by mouth medications and set-up IV medication to administer. The DON then washed her hands, donned gloves and flushed the resident's peripherally inserted central catheter (PICC) line with five milliliters (ml) of normal saline (NS). She then connected the medication. The DON had donned no gown or mask for enhanced barrier precautions (EBP). On 04/13/26 at 10:42 A.M., an interview with the DON verified she had not donned personal protection equipment for EBP while administering the IV medications. She verified the resident had not been on EBP, although should have been. Review of facility policy titled Enhanced Barrier Precautions dated 01/25, states Appropriate PPE of gowns and gloves shall be worn when coming in close contact with residents whom have open routes to their interior body and or colonized MDRO infections. This includes but is not limited to: Feeding tubes, IV and PPE stations shall be set up with gowns and gloves outside or right inside the doorway of rooms. This deficiency represents noncompliance investigated under Complaint Number 2984105.