STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366394	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue Care and Rehabilitation Center, The	4120 Interchange Corporate Center Road Warrensville Heights, OH 44128

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, medical record review, and review of the facility policy, the facility failed to ensure residents were provided with a dignified dining experience. This affected two (#25 and #95) out of three reviewed for respect and dignity. The facility census was 87. Findings include: 1. Review of Resident #95's medical record revealed an admission date of 06/18/24 and diagnoses included type two diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral, end stage renal disease (ESRD), and depression.Review of Resident #95's care plan revised 04/16/25 included Resident #95 had a self care deficit related to weakness, ESRD with hemodialysis, blindness to both eyes and limited mobility. Resident #95 would maintain the highest level of independence possible through the review date. Interventions included to provide eating set up and supervision. Observation on 08/05/25 at 8:44 A.M. of Certified Nurse Aide (CNA) #772 revealed she carried Resident #95's meal tray in his room and set the tray up but did not offer to assist Resident #95 and did not stay in the room to supervise him while he was eating. CNA #772 did not return to the room to check on Resident #95 after she set his tray up and left the room.Observation on 08/05/25 at 1:13 P.M. revealed CNA #772 delivered Resident #95's meal tray to his room, set the tray up and did not stay in the room to assist Resident #95. CNA #772 did not show Resident #95 where his silverware was and did not ensure a piece of meat with gravy on top was cut up before she left Resident #95's room. Further observation revealed there was no knife on the tray and no way to cut the piece of meat into bite size pieces. Resident #95 began eating his mashed potatoes with his fingers and interview with the resident during the observation confirmed he was using his fingers and stated no was assisting him. When asked about the whole piece of meat and no knife on the meal tray and Resident #95 eating his mashed potatoes with his fingers, interview with Licensed Practical Nurse (LPN) #733 during the observation confirmed there was no way to cut the meat up and left the room to find a knife. LPN #733 confirmed Resident #95 was eating mashed potatoes with his fingers and showed him where the spoon was.2. Review of Resident #25's medical record revealed an admission date of 07/03/23 and diagnoses included cerebral infarction due to embolism of unspecified cerebral artery, hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction affecting the right dominant side, and dysphagia following cerebral infarction.Review of Resident #25's annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status was not conducted due to Resident #25 being rarely or never understood. Resident #25 had impairment on both sides of her upper extremities and impairment on one side of her lower extremities. Resident #25 required substantial to maximal assistance with eating and was dependent for toileting hygiene, bathing, and oral hygiene. Resident #25 was always incontinent of urine and bowel. Review of Resident #25's care plan revised 08/06/25 included Resident #25 had a self-care deficit related to dementia, history of cerebrovascular accident with hemiplegia, impaired mobility, dysphagia. Resident #25's activities of daily living (ADL) needs would be met by staff while allowing her to participate as able. Interventions included the resident needed dependent assistance of one for eating and was dependent on the assistance of one for incontinence care.Observation on 08/05/25 at 8:47 A.M. of Resident #25 revealed she was lying in bed and the head of the bed was elevated at approximately a 30-degree angle. Interview during the observation with LPN #733 stated Resident #25 required assistance with feeding and if the nurse aides had enough time they assisted her out of bed into her wheelchair and took her to the dining room to eat, but otherwise she was fed in her room. Certified Nurse Aide (CNA) #772 carried Resident #25's meal tray in the room and stated she was going to feed her. CNA #772 set Resident #25's meal tray up, stood next to her, did not raise the height of Resident #25's bed and began feeding her while the head of her bed was still at a 30-degree angle. CNA #772 dropped food on Resident #25's gown and continued to feed her while Resident #25's head of the bed was at a 30-degree angle. After a few minutes, CNA #772 raised Resident #25's head of bed to about a 90-degree angle and continued to stand next to her while she was assisting her with eating. CNA #772 confirmed she was standing while feeding Resident #25 and dropped food on her gown. CNA #772 stated she always stood when she fed Resident #25 in the room and when she was in the dining room she sat while she fed her. Review of the facility policy titled, Resident Rights and Facility Responsibilities, dated 10/03/23, revealed the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, medical record review, review of an invoice, and review of the facility policy, the facility failed to ensure a resident's bed was appropriate to accommodate his height and weight and failed to ensure call lights were within reach for resident use. This affected three (#76, #44, and #95) out of seven residents reviewed for appropriate accommodation of needs. The facility census was 87. Findings include:1. Review of Resident #76's medical record revealed an admission date of 02/22/24 and diagnoses included paroxysmal atrial fibrillation, muscle weakness, difficulty walking, and pain. Review of Resident #76's height dated 02/22/24 revealed he was 81.0 inches (six (6) feet nine (9) inches) tall. Review of Resident #76's care plan dated 03/06/24 included Resident #76 had an alteration in musculoskeletal status related to muscle spasms, muscle weakness, and osteoarthritis. Resident #76 would remain free of complications related to fracture, such as contracture formation, embolism and immobility through the review date. Resident #76 would remain free from pain or at a level of discomfort acceptable to the resident. Interventions included to anticipate and meet needs and Resident #76 needed to change position every two hours and as needed. Review of Resident #76's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #76 was cognitively intact. Resident #76 used a motorized wheelchair. Resident #76 required substantial to maximal assistance for toileting hygiene, personal hygiene, bathing and upper body dressing. Resident #76 was dependent for lower body dressing and chair-to-bed-to-chair transfer. Review of Resident #76's weight dated 07/09/25 revealed Resident #76 weighed 387.2 pounds. Observation on 08/04/25 at 10:17 A.M. of Resident #76 revealed he was lying in bed, the head of the bed was elevated about 45-degrees and Resident #76's head was even with the top of the mattress. Resident #76's pillow was on the floor at the head of the bed. Interview during the observation with Resident #76 stated he was 6 feet 9 inches, he was too tall for the bed, and did not fit in the bed. Resident #76 confirmed his pillow fell off the bed and it happened often. Resident #76 stated he had been begging for a bigger bed and the nurses and aides say they would be back and they do not come back. Resident #76 stated it was hard for him to roll side-to-side in the bed because it was not wide enough. Resident #76 rolled from side-to-side to show how hard it was for him. Observation showed Resident #76 could not roll freely. Observation on 08/05/25 at 8:32 A.M. of Resident #76 with the Administrator revealed Resident #76 was lying in bed and the foot of the bed was extended. There was a gap of about eight to twelve inches between the end of the mattress and the footboard. A long vinyl wrapped foam piece was placed in the gap between the mattress and the footboard, but the foam piece did not fit the area and was not tall enough for Resident #76 to rest his heels on it. The foam piece did not fit across the width of the gap between the mattress and the footboard. The Administrator confirmed the foam piece did not fit the open area between the mattress and the footboard and was not helping in any way. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #76's invoice dated 08/05/25 included a bed was ordered and shipped to the facility and would arrive to the facility on [DATE]. The bed description was multi-layered pressure reduction mattress with firm perimeter and fire barrier, 650 pound cap. The bed dimensions were 48 inches by 84 inches. Interview on 08/06/25 at 11:11 A.M. of the Administrator revealed she ordered another bed for Resident #76. The Administrator stated Resident #76's current bed dimensions were 36 inches by 80 inches (three (3) feet by 6 feet eight (8) inches). The new bed dimensions were 48 inches (four (4) feet) by 84 inches (seven (7) feet). Review of the facility policy titled, Resident Rights and Facility Responsibilities, included the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. 2. Review of the medical record revealed Resident #44 was admitted to the facility on [DATE] with diagnoses that included depression, chronic obstructive pulmonary disease, and hemiplegia. Review of the most recent MDS assessment dated [DATE] revealed Resident #95 was moderately cognitively impaired and required extensive assistance of one staff person for completing his activities of daily living Observation of Resident #44 on 08/04/25 at 11:59 A.M. revealed Resident #44 was up in her wheelchair and his call light was on the floor and out of reach. Interview with Certified Nurse Aide (CNA) #764 verified the placement of the call light at the time of observation. 3. Review of the medical record revealed Resident #95 was admitted to the facility on [DATE] with diagnoses that included type two diabetes, end stage renal disease, and chronic pain. Review of the most recent MDS assessment dated [DATE] revealed Resident #95 was moderately cognitively impaired and required extensive assistance of one staff person for completing his activities of daily living. The assessment also noted Resident #95 as completely blind with zero visual perception noted. Observation of Resident #95 on 08/05/25 at 8:06 A.M. revealed Resident #95 was up in his wheelchair and his call light was on the floor and out of reach. Interview with Licensed Practical Nurse (LPN) #741 verified the placement of the call light at the time of observation. This deficiency represents non-compliance investigated under Complaint Number OH00167095 (1254634).

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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, staff interview, and review of a facility policy, the facility failed to ensure a resident's family or responsible party were notified of changes in condition. This affected one (#6) of two residents reviewed for change in condition. The census was 87.Findings include:Record review for Resident #6 revealed admission to the facility on [DATE]. Diagnoses included end stage renal disease, gastrointestinal hemorrhage, diabetes mellitus II and paroxysmal atrial fibrillation.Review of Resident #6's electronic medical record (EMR) revealed a nurse note dated 02/14/25 at 6:57 P.M. that Resident #6 was ordered to be sent to the hospital. There was no indication the family was notified. Further review revealed a note dated 02/19/25 at 4:10 P.M. that Resident #6 returned to the facility. There is no indication the family was notified.Review of Resident #6's EMR revealed a nurse note dated 02/26/25 at 2:29 P.M. that Resident #6 was ordered to be sent to the hospital. There was no indication the family was notified.Review of Resident #6's EMR revealed a nurse note dated 03/05/25 at 4:04 P.M. that Resident #6 was sent to the hospital from dialysis. There was no indication the family was notified.Review of Resident #6's EMR revealed a nurse note dated 03/13/25 at 12:37 P.M. that Resident #6 went to the hospital from the doctor's office. There was no indication the family was notified. Further review revealed she was sent out again on 03/13/25 at 1:22 A.M. and returned same day at 4:49 A.M. There was no indication the family was notified when Resident #6 left or returned to the facility.Review of Resident #6's EMR revealed a nurse note dated 03/15/25 at 3:11 P.M. that Resident #6 was ordered to go to the hospital. There was no indication the family was notified. Further review revealed a physician note dated 03/21/25 that Resident #6 was readmitted . There was no documentation that the family was notified.Interview with the Unit Manager Licensed Practical Nurse (LPN) #745 on 08/13/25 at 11:29 A.M. verified there was no documentation informing Resident #6's family was notified of her being sent out of the facility and to the hospital on [DATE], 02/26/25, 03/05/25, 03/13/25, or 03/15/25.Review of the facility policy titled, Resident Change in Condition, dated 07/28/22, revealed the purpose was to ensure staff provided timely and appropriate care and services when residents experience a change in condition that had or was likely to cause adverse negative health outcomes. The facility would promptly notify the resident, his or her attending physician and responsible party of changes in the resident's condition and, or status. This deficiency represents non-compliance investigated under Complaint Number OH00163811 (1254630).

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, review of self-reported incidents, review of discharge notices, and review of a policy review, the facility failed to ensure residents were permitted to return to the facility following a hospitalization and failed to ensure documentation of the need for discharge was reflected in the medical record to establish the need for discharge from the facility. This affected three residents (#18, #26 and #89) out of five residents reviewed for discharge. The facility census was 87.Findings include:1. Review of the medical record revealed Resident #18 was admitted to the facility on [DATE] with diagnoses that included Parkinson’s disease, borderline intellectual functioning, and dementia. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 was severely cognitively impaired and required the assistance of one staff member for completing activities of daily living (ADLs). Review of the discharge notice issued on 07/31/25 revealed Resident #18 would be discharged to another nursing facility on 08/30/25 for, “violating the rights of others to have a homelike environment.” 2. Review of the medical record revealed Resident #89 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease, cannabis use disorder, and high cholesterol. Review of the most recent MDS assessment dated [DATE] revealed Resident #89 was cognitively intact and required supervision to complete ADLs. Review of facility self-reported incidents (SRIs) revealed on 07/28/25 Resident #89 was found in possession of another resident’s cell phone, which he promptly returned without incident. Further review of the SRIs revealed no prior incidents involving abuse, neglect, or misappropriation by Resident #89 since 08/21/08. Review of the discharge notice provided to Resident #89 on 07/31/25 revealed Resident #89 would be discharged to another nursing facility on 08/30/25, the resident is violating the rights of others to privacy/personal possessions, respect, and the right to be free from abuse. Interview with the Administrator on 08/06/25 at 10:15 A.M. confirmed the discharge notices issued for Resident #18 and Resident #89 were not supported by appropriate documentation. 3. Review of the medical record revealed Resident #26 was admitted to the facility on [DATE] with diagnoses including encephalopathy (any condition that affects the brain's structure or function, leading to impaired mental state), diabetes, dementia without behavioral disturbance, and anxiety disorder. Review of the comprehensive admission MDS assessment, dated 07/25/25, revealed Resident #26 was moderately cognitively impaired and had no behaviors during the assessment period. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nurses’ notes dated 08/08/25 at 7:58 P.M. revealed Resident #26 was restless and became extremely agitated after dinner. The resident unbuttoned his pants to urinate in a trash can. Registered Nurse (RN) #799 attempted to redirect the resident to his room as the common area was not an appropriate place to urinate. The resident refused redirection and attempted to remove other residents dinner plates while they ate. Other attempts at redirection were ineffective. The resident started walking the halls heading toward the lobby stating he was going to get to his car as he needed to work on it. RN #799 and a certified nurse aide (CNA) continued to try and redirect the resident to his room. Resident #26 attempted to open the secured door to the main entrance. RN #799 held the door shut and the resident became more agitated and attempted to hit RN #799. A second nurse notified Nurse Practitioner (NP) #811 of the resident’s aggressive behavior and gave an order to transport the resident to a local emergency room (ER) for evaluation. At 7:15 P.M. Resident #26 was transferred to the ER. No further documentation was noted regarding what occurred with the resident after transport. Interview with the Mobile Director of Nursing on 08/11/25 at 3:35 P.M. revealed Resident #26 was admitted to the hospital. When he was discharged he would be transferred to another facility with a secured unit. He will not be returning to the facility. Interview with the Director of Nursing (DON) on 08/11/25 at 5:10 P.M. revealed anyone who was sent to the ER for evaluation was considered discharged . The DON was unable to explain why no further documentation was in the chart regarding what happened to Resident #26 after his transfer. The DON was unable to provide any discharge paperwork regarding the resident or where he went. No immediate discharge documentation was provided regarding Resident #26 not being able to return to the facility. Review of the facility’s policy titled, “Discharge Planning & Managing Length of Stay,” dated 12/01/22, revealed discharge planning should involve identifying each resident’s discharge goals and needs, implementing appropriate interventions, and regularly evaluating those interventions throughout the resident’s stay. When a facility anticipates discharge, a discharge summary includes a recapitulation history will be completed. A final discharge summary will be completed upon discharge that should be given to the resident or responsible party including medication reconciliation, discharge medication orders, and a post discharge plan of care including where the resident plans to reside, any appointments made for follow up care and any post discharge medical services. This deficiency represents non-compliance investigated under Complaint Number OH00166711 (1254468) and Complaint Number OH00167217 (1254635).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, and review of the facility policy, the facility failed to ensure resident finger nail care was provided in an adequate manner. This affected one (#29) of six residents reviewed for activities of daily living (ADLs). The facility census was 87.Findings include:Review of Resident #29's medical record revealed an admission date of 12/21/21 and a re-entry date of 08/15/22. Resident #29's diagnoses included senile degeneration of the brain, anxiety disorder, and embolism and thrombosis of unspecified parts of the aorta. Review of Resident #29's care plan revised 03/25/25 included Resident #29 was resistive to care related to dementia and refused personal hygiene care and ADL management including showers. Resident #29 would cooperate with care through the next review date. Interventions included to give a clear explanation of all care activities prior to and as they occurred during each contact; if possible negotiate a time for ADLs so Resident #29 participated in the decision making process and return at the agreed upon time; if Resident #29 resisted with ADLs, reassure the resident, leave, and return five to ten minutes later and try again. Review of Resident #29's annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29 had severe cognitive impairment. Resident #29 was dependent for toileting hygiene, bathing, dressing and personal hygiene. Resident #29 was always incontinent of urine and bowel. Resident #29 did not reject care during the seven-day assessment look-back period. Review of Resident #29's progress notes dated 07/15/25 through 08/07/25 did not reveal evidence Resident #29 refused to have her fingernails cleaned and trimmed. Review of Resident #29's shower sheets dated 07/29/25 and 08/01/25 revealed Resident #29 had a bed bath. There were no notes on the shower sheets indicating Resident #29's fingernails were long, dirty and needed trimmed. Observation on 08/04/25 at 10:26 A.M. of Resident #29 with Certified Nurse Aide (CNA) #764 revealed Resident #29 had long dirty fingernails. CNA #764 confirmed Resident #29's fingernails were long, about a half inch to three quarters of an inch, and had dark brown material underneath the nails. Review of Resident #29's shower sheet dated 08/05/25 revealed Resident #29 had a bed bath. There were no notes on the shower sheet indicating Resident #29 needed her fingernails trimmed and cleaned. Observation on 08/07/25 at 7:34 A.M. of Resident #29 revealed her fingernails were about a half inch to three quarters of an inch, and had dark brown material underneath the nails. Interview on 08/07/25 at 8:07 A.M. of the Director of Nursing (DON) revealed the nurse aides should check Resident #29's fingernails on bath days and it should be documented on the shower sheet if Resident #29's fingernails were long, dirty and needed trimmed. The DON stated the aides should also report it to the nurse. The DON indicated the nurse's cut resident fingernails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/07/25 at 11:38 A.M. of CNA #752 confirmed Resident #29's fingernails were about a half inch to three quarters of an inch, and had dark brown material underneath the nails. CNA #752 stated she was not sure if Resident #29's fingernails should be cleaned when she was bathed. CNA #752 indicated she was going to soak Resident #29's fingernails now to help clean them. Interview on 08/07/25 at 11:42 A.M. of Licensed Practical Nurse (LPN) #743 revealed he was not told Resident #29's fingernails needed trimmed, and he would make sure they were trimmed today. Interview on 08/11/25 at 10:31 A.M. of CNA #788 revealed she had no issues with Resident #29 refusing care, she did not refuse care, and it was all in the way Resident #29 was approached when care was provided. Review of the facility policy titled, Activities of Daily Living (ADLs), dated 03/2023, included the purpose was to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided were person-centered, and honor and support each resident's preferences, choices, values and beliefs. A resident who was unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This deficiency represents non-compliance investigated under Master Complaint 2564323, Complaint Number OH00162468 (1254628), Complaint Number OH00164532 (1254632), and Complaint Number OH00167217 (1254635).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility policy review, the facility failed to ensure Resident #31's unstageable pressure ulcer to the coccyx was accurately identified and treated timely. This affected one (Resident #31) of three residents reviewed for pressure ulcers. The facility census was 87.Findings include:Review of Resident #31's medical record revealed an admission date of 03/14/25 and diagnoses included heart failure, chronic kidney disease, and unspecified intellectual abilities.Review of Resident #31's admission Minimum Data Set assessment dated [DATE] revealed Resident #31 had severe cognitive impairment. Resident #31 required substantial to maximal assistance with toileting hygiene and bathing. Resident #31 required partial to moderate assistance for dressing and personal hygiene. Resident #31 had an indwelling catheter and was occasionally incontinent of bowel. Resident #31 did not reject care during the seven-day assessment look-back period.Review of Resident #31's admission assessment dated [DATE] included Resident #31 had a right arm skin tear. There was no evidence Resident #31 had an open area to the coccyx.Review of Resident #31's progress notes dated 03/14/25 through 03/25/25 did not reveal documentation related to Resident #31's unstageable pressure ulcer (obscured full-thickness skin and tissue loss) on the coccyx.Review of Resident #31's admission care plan dated 03/16/25 at 3:00 P.M. revealed it was not completed and did not have any documentation recorded.Review of Resident #31's Braden Scale for Predicting Pressure Sore Risk assessment dated [DATE] revealed Resident #31 was at mild risk for developing a pressure sore injury/ulcer.Review of Resident #31's late entry progress note dated 03/18/25 at 3:38 P.M. included on 03/18/25 at 12:54 P.M. Resident #31 arrived to the facility via stretcher (Resident #31 was admitted on [DATE]). Resident #31 was admitted to the facility for acute kidney failure, congestive heart failure (CHF), and other diagnoses. Resident #31 was a one assist for bed mobility, required two staff for transfers, and required a mechanical lift for transfers.Review of Resident #31's pressure ulcer and wound record dated 03/23/25 at 6:12 A.M. included Resident #31 had a pressure area first observed on 03/23/25. Resident #31 had a stage one pressure wound (non-blanchable erythema of intact skin) to the sacrum (coccyx). Measurements were 2.0 centimeters (cm) long by 1.0 cm wide. There was no description of the appearance of the open area. Review of Resident #31's physician orders dated 03/23/25 through 03/25/25 did not reveal treatment orders for Resident #31's stage one pressure ulcer.Review of Resident #31's wound care notes dated 03/25/25 completed by Wound Nurse Practitioner (WNP) #809 included Resident #31 was seen for an initial evaluation of his wound. Resident #31 had limited mobility, incontinence, relied on facility staff for repositioning and activities of daily living (ADLs). Resident #31 had an indwelling catheter. Resident #31 was alert, confused, calm, cooperative and agreeable to care. Resident #31 had an unstageable pressure ulcer of the coccyx, it was acquired in-house, was full thickness and had a length of 3.0 cm, width of 6.7 cm, and depth was unable to be determined. Treatment was to cleanse with normal saline, apply Medihoney and calcium alginate, and cover with a silicone super absorbent dressing daily and as needed. Education was provided to Resident #31 and the nursing staff including the importance of offloading to promote wound healing and the importance of keeping the wound site clean and dry, avoiding contamination and changing dressings as instructed. Review of Resident #31's skin and wound progress notes dated 03/25/25 at 2:23 P.M. included Resident #31 was seen for an initial visit for an unstageable pressure ulcer to the coccyx. Measurements were length of 3.0 cm, width of 6.7 cm, and depth was unable to be determined. There was 80 percent slough, 20 percent pink tissue, and moderate serosanguinous drainage. A new order was to cleanse with normal saline, apply Medihoney and calcium alginate, and cover with a silicone super absorbent dressing daily and as needed. Review of Resident #31's care plan dated 03/26/25 included a care plan for pressure sores, skin care risk related to decreased mobility, incontinence, and assistance needed with ADLs with a goal to prevent and heal pressure sores and skin breakdown. Interventions included treatments as ordered and turn and reposition during care rounds and as needed. Review of Resident #31's care plan dated 03/14/25 through 03/26/25 did not reveal a care plan for pressure ulcer, injuries or risk for pressure ulcers, injuries.Review of Resident #31's treatment administration record (TAR) dated 03/31/25 revealed a physician treatment order to cleanse Resident #31's coccyx with normal saline, apply Medihoney and calcium alginate, and a silicone super absorbent dressing at bedtime and as needed was not completed as ordered. Review of Resident #31's progress notes dated 03/31/25 did not reveal evidence why Resident #31's coccyx treatment was not completed.Review of Resident #31's TAR dated 08/03/25 and 08/04/25

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, medical record review, resident and staff interview, review of fall investigations, review of an incident log, and review of facility policies, the facility failed to ensure thorough fall investigations were completed, resident care plans were revised to reflect current fall interventions, and fall interventions were in place as ordered. This affected three (#20, #24, and #25) of three residents reviewed for falls. The facility census was 87. Findings include:1. Review of Resident #25's medical record revealed an admission date of 07/03/23 with diagnoses that included cerebral infarction, hemiplegia and hemiparesis, dysphagia, chronic respiratory failure, paranoid schizophrenia, bipolar disorder, anxiety disorder, and muscle weakness. Review of the most recent annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 was assessed by staff as severely cognitively impaired. The resident had a functional limitation in range of motion (ROM) to both sides of the upper extremities and impairment on one side of the lower extremities. The resident required maximal assistance to roll left and right, was dependent on staff for transferring from the chair to the bed, and moving from lying to sitting on the side of the bed was not attempted due to medical or safety concerns. The resident required a mechanical (Hoyer) lift for transfers. Review of the nurse’s notes dated 05/31/25 at 6:55 A.M. revealed Resident #25 was found on the floor as Licensed Practical Nurse (LPN) #734 walked into the resident’s room to give morning medication. An assessment and neurological checks were done before putting the resident back in bed. No injuries were noted at that time. Resident #25 was put back in bed, the bed lowered, the call light was within reach, and the resident was educated to call for help before getting out of bed. The physician and family were notified about her fall. Review of the fall investigation dated 05/31/25 at 5:40 A.M. revealed Resident #88's fall was unwitnessed. Resident #25 was observed on the floor as the nurse walked into resident room to give morning medication. An assessment and neurological checks were done and no injuries were noted at the time. The resident was she was trying to get out of bed when she fell to the floor and denied hitting her head. Resident #88 was oriented to person and place and no predisposing factors were noted. On 06/02/25 the interdisciplinary team (IDT) met in regard to the fall on 05/31/25. Immediate intervention was for Resident #88 to be brought out to the common area; and a long-term intervention was for bilateral floor mats. The physician and family were made aware and the facility would continue to monitor. Review of the fall risk assessment dated [DATE] revealed Resident #25 was at risk for falls and had one to two falls in the last 90 days. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care dated 06/05/25, and reviewed on 08/06/25, revealed Resident #25 was at risk for falls related to impaired cognition, poor safety awareness and psychotropic medications daily. Interventions included bilateral grab bars to the bed for mobility and positioning (initiated 06/05/25), call light within reach and encourage the resident to use it for assistance as needed (initiated 06/05/25), Hoyer lift times two staff for all transfers (initiated 06/05/25), review information on past falls and attempt to determine cause of falls; record possible root causes and alter/remove any potential causes if possible; educate resident/family/caregivers/interdisciplinary team (IDT) as to causes (initiated 06/05/25), and therapy to evaluate and treat as ordered or as needed (initiated 06/05/25). Further review of the care plan revealed no interventions related to the resident's bed being in low position, the resident being in the common area, or fall mats. Review of the plan of care dated 06/05/25, and reviewed on 08/11/25, revealed Resident #25 was at risk for falls related to impaired cognition, poor safety awareness and psychotropic medications daily. Interventions included keep the bed in lowest position when occupied (06/02/25), bilateral floor mats when the resident was in bed (06/02/25), bilateral grab bars to the bed for mobility and positioning (06/05/25), keep the call light within reach and encourage the resident to use it for assistance as needed (06/05/25), Hoyer lift times two staff for all transfers (06/05/25), review information on past falls and attempt to determine cause of falls; record possible root causes and alter/remove any potential causes if possible; educate resident/family/caregivers/IDT as to causes (06/05/25), and therapy to evaluate and treat as ordered or as needed (06/05/25). Review of the nurse’s notes dated 06/13/25 at 8:01 P.M. revealed LPN #742 was notified by a certified nurse aide (CNA) at 2:50 P.M. that Resident #25 was on the floor lying on her stomach with her legs extended alongside her bed. LPN #742 obtained the resident's vital signs then assisted the resident to bed. Resident #25 was not able to recall how she fell out of bed. The resident's range of motion was assessed and the resident complained of pain all over. LPN #742 contacted emergency medical services (EMS) and Resident #25 was transported to the hospital at 3:52 P.M. The Assistant Director of Nursing (ADON), the resident’s son, and the physician were notified. An intervention was implemented for floor mats and the resident was educated on the use of the call light. Review of the fall risk assessments dated 06/13/25 and 07/23/25 revealed Resident #25 was not at risk for falls and had no falls in the last 90 days. Review of the fall investigation for the fall dated 06/13/25 at 2:50 P.M. revealed the fall was unwitnessed in Resident #25's room Resident #25 was on the floor lying on her stomach with her legs extended, lying alongside her bed. Resident #25's vital signs were obtained and staff assisted the resident back to bed. The resident's range of motion was assessed and the resident complained of pain. Resident #25 was transported to the hospital and notifications were made. Resident #25 was oriented to person and situation and predisposing factors included incontinence and gait imbalance. On 06/16/25, the IDT team met to discuss the fall from 06/13/25. A long-term intervention was implemented to encourage Resident #25 to be in the common area when awake and the facility would continue to monitor and follow up. Review of Resident #25's current physician orders for August 2025 on 08/06/25 revealed no orders for fall prevention. Further review of the physician orders revealed on 08/08/25, order were added to Resident #25's physician orders to include use of a Hoyer lift for all transfers and bilateral floor mats. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/07/25 at 7:29 A.M. revealed Resident #25 had fall mats in place, the bed was in low position, and the resident was lying in the middle of the bed. An interview on 08/07/25 at 4:33 P.M. with the Director of Nursing (DON), regarding falls, revealed after a fall the nurse should go to the Risk Management tab and the form will prompt them to do a fall assessment and a pain assessment as part of the fall report. The DON stated the facility had a road map book located on each unit with interventions that could be used and falls were reviewed every morning in the morning meeting. The DON stated the majority of the time the MDS assessment updated the care plan immediately or when the IDT note was done. The DON verified the fall notes did not include what interventions were in place during either of Resident #25’s falls. On 08/07/25 at 4:42 P.M. the DON verified the fall intervention in the current care plan did not include low bed or fall mats; however, she was sure those interventions had been added to the care plan after Resident #25’s fall on 05/31/25. On 08/07/25 at 4:58 P.M., the DON verified there were no orders for a low bed or fall mats for Resident #25 and she would have them re-entered. Observation on 08/08/25 at 10:44 A.M. revealed Resident #25 was in the common area with four other residents. On 08/08/25 at 11:03 A.M., LPN #742 and ADON #704 looked through Resident #25’s electronic medical record and could not find the fall interventions of fall mats, low beds, or encouraging Resident #25 to be in the common room when out of bed. They looked under risk management, orders, and on the medication administration record (MAR) and treatment administration record (TAR). On 08/11/25 at 4:51 P.M., the DON revealed Resident #25's fall care plan was marked Resolved by accident for all the intervention added on 06/02/25 after Resident #25’s fall on 05/31/25, and believe it happened on 06/06/25, but were not sure how it happened. On 08/11/25 at 4:57 P.M., the DON verified the Resident #25's fall risk assessments for 06/13/25 and 07/23/25 were not accurate as the resident had falls in the previous 90 days at the time the assessments were completed. On 08/12/25 at 10:48 A.M., the DON revealed the fall care plan had been accidentally marked resolved. The issue had been corrected after the surveyor pointed out the interventions were not in the current care plan. On 08/12/25 at 11:09 A.M., an interview with LPN MDS Nurse #744 revealed after the IDT meeting on 06/02/25 the interventions including bilateral floor mats were added to the care plan. A new MDS nurse went in and resolved the care plans a few days later so, when the care plan was opened it would not show the resolved interventions. 2. Review of Resident #20's medical record revealed an admission date of 06/05/25 and diagnoses included unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence, major depressive disorder, anxiety disorder, and congestive heart failure. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #20's care plan dated 06/06/25 included Resident #20 was a fall/safety risk related to decreased mobility and behavioral disturbance. Resident #20 would remain free of injuries and falls. Interventions included to keep call bell in reach and encourage use of call light, and instruct Resident #20 on safety measures. Review of Resident #20's annual MDS assessment dated [DATE] revealed Resident #20 had moderate cognitive impairment. Resident #20 did not reject care during the seven-day assessment look-back period. Resident #20 used a manual wheelchair. Resident #20 required partial to moderate assistance for toileting hygiene, bathing, dressing, and personal hygiene. Resident #20 required supervision or touching assistance for the ability to transfer to and from a bed to a chair or wheelchair and toilet transfers. Resident #20 had a fall in the last month prior to admission to the facility. Resident #20 had an indwelling catheter and was always continent of bowel. Review of Resident #20's fall risk assessment dated [DATE] revealed Resident #20 was at risk for falls. Review of the facility incident log dated 07/28/25 at 11:30 A.M. revealed Resident #20 experienced a fall. Review of Resident #20's progress notes dated 07/28/25 did not reveal evidence Resident #20 experienced a fall at 11:30 A.M. Review of Resident #20's pain assessment dated [DATE] revealed the pain assessment was not completed and did not have anything documented regarding Resident #20's fall and if he had pain. Review of Resident #20's medical record did not reveal a fall risk assessment was completed on 07/28/25. Review of Resident #20's progress notes dated 07/28/25 at 11:48 A.M. revealed the pain medication Tylenol tablet 325 milligrams with instructions to given two tablets by mouth every six hours as needed for pain was administered for complaints of pain to bilateral shoulders. Review of Resident #20's incident report dated 07/28/25 at 11:30 A.M. included Resident #20 had a fall and was found sitting on the floor between his bed and the wheelchair in his room. Resident #20 was wearing non-skid slippers to his feet and was seated on his buttocks with his bilateral lower extremities and feet on the floor mat. There were no visible signs of injury. Resident #20 reported he was trying to use his cane to get into his wheelchair and transfer into the bathroom and complained of pain to his bilateral shoulders and bilateral knees. Resident #20 reported it was chronic pain and denied hitting his head. Resident #20's pain level was reported as a three out of ten, zero being no pain and ten being the worst pain. The report did not reveal if Resident #20's call light was in reach when he fell or if it was activated. Resident #20 was assisted into his wheelchair, vital signs were obtained, and Resident #20 was toileted and assisted back into his wheelchair. There were no vital signs documented in the incident report or progress notes or vital sign record. Resident #20 had a gait imbalance and impaired memory. There were no witness statements provided. The incident report revealed Nurse Practitioner (NP) #811 was notified of Resident #20's fall on 07/28/25 at 12:00 P.M. and Family Member (FM) #812 was notified of Resident #20's fall on 07/28/25 at 2:00 P.M. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #20's progress notes dated 07/28/25 at 5:10 P.M. revealed Resident #20's follow-up pain was zero. This was documented more than five hours after the Tylenol was administered. Review of Resident #20's progress notes dated 07/29/25 at 5:01 A.M. included Resident #20 refused neurological checks and would not allow vital signs to be checked throughout the night. Review of Resident #20's incident report dated 07/29/25 revealed the IDT met regarding the fall on 07/28/25 at 11:30 A.M. and the notes included Resident #20 was observed on the floor on his buttocks with legs extended and Resident #20 stated, I was trying to go to the bathroom. Resident #20 was educated on the importance of using the call light for help. The notes did not indicate Resident #20's call light was in reach when he experienced a fall. The long term intervention was for Resident #20 to be toileted prior to lunch. Review of Resident #20's fall risk assessment dated [DATE] revealed Resident #20 was at risk for falls. Observation and interview on 08/06/25 at 9:00 A.M. of Resident #20 revealed he was laying in bed with his eyes closed. Fall mats were observed on each side of his bed. Resident #20 stated he was trying to get his thoughts together and would talk later. Interview on 08/07/25 at 4:31 P.M. of the DON revealed after a fall, a fall risk management form was completed by the nurses. When an incident report was initiated the nurses were prompted to do a pain assessment, fall assessment, and notes were written regarding the fall incident. The DON stated the IDT note was not placed in the resident's medical record, but was found at the bottom of the Risk Management form. The DON stated she would have to print IDT notes for the surveyors because they did not have access to the Risk Management form. The DON stated she would have to print witness statements as well. The DON stated the IDT team met every morning to review things like falls and the residents care plan was updated when the fall was reviewed. The DON indicated when Resident #20 had the fall on 07/28/25 the fall and pain assessments should have been done right after the fall. A reasonable amount of time would be the assessments should be completed up to 72 hours after a fall. The DON said she preferred the fall and pain assessments to be completed immediately. The DON stated post fall assessments used to be completed after a resident fall, but they were not required to be completed at the time Resident #20 had his fall on 07/28/25. Interview on 08/11/25 at 10:31 A.M. of Certified Nurse Aide (CNA) #788 revealed she had no issues caring for Resident #20. CNA #788 stated Resident #20 was not difficult to care for, and it was all in the way a resident was approached. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/13/25 at 10:53 A.M. of Unit Manager/Fall Nurse (UM/FN) #745 revealed she was the Fall Nurse. UM/FN #745 confirmed Resident #20 had a fall on 07/28/25 and there was no progress note documenting the fall. UM/FN #745 stated the nurse filled out a progress note on Resident #20's Risk Management form, but the progress note did not automatically transfer to the his electronic health record (EHR). UM/FN #745 stated the nurse would have to manually transfer the progress note from the Risk Management form to Resident #20's progress notes. UM/FN #745 stated Resident #20's fall was unwitnessed and neurological checks were initiated. UM/FN #745 stated she would expect to see a pain assessment and a fall assessment completed after Resident #20's fall and confirmed there was no pain or fall assessment completed on 07/28/25. UM/FN #745 stated Resident #20's pain must have progressed and confirmed there should have been a comprehensive pain assessment completed. UM/FN/#745 confirmed there was no fall risk assessment completed until 08/05/25. UM/FN #745 indicated, I was closing out my falls and I completed a post fall assessment on 08/05/25 and that was from the 07/28/25 fall. UM/FN #745 stated vital signs should be taken and documented at the time of the fall and confirmed Resident #20 did not have vital signs documented in his EHR or on the Fall Risk Management form. UM/FN #745 stated, I think the nurse probably did a pain assessment but did not fill out the form. UM/FN #745 indicated she interviewed the staff involved in a fall and took verbal witness statements, but did not write anything down. UM/FN #745 confirmed she could not provide witness statements for Resident #20's fall on 07/28/25. UM/FN #745 indicated, I do not document verbal statements except for what the nurse says and what the nurse aide says. The IDT reviewed falls the next day and an intervention was put in place. UM/FN #745 revealed she did not always have interviews with the nurse and nurse aides involved in falls before the IDT clinical meeting, but followed up after and made sure everything lined up. 3. Record review revealed Resident #24 was most recently admitted to the facility on [DATE]. Diagnoses include acute respiratory failure with hypoxia, syncope and collapse, and end stage renal disease. Review of the MDS assessment dated [DATE] revealed Resident #24 had moderately impaired cognitive deficit. He required substantial to maximal assistance from staff for toileting hygiene, shower, upper and lower body dressing, and donning and doffing footwear. Review of Resident #24’s care plan dated 06/24/25 revealed he was at risk for falls related to gait/balance problems and history of falls. An interventions included bilateral floor mats, ensure the call light was within reach and encourage to use it for assistance as needed, and sit in the common area when out of bed. Observation on 08/06/25 at 10:13 A.M. revealed a fall mat to one side of Resident #24’s bed that was situated in the middle of the wall leaving the other side of the bed with no fall mat. Observation on 08/07/25 at 11:15 A.M. revealed Resident #24 had one fall mat on one side of his bed and no fall mat on the other side of the bed. His bed was not against the wall but was situated in the middle of the wall. Observation and interview on 08/11/25 at 2:25 P.M. revealed Resident #24 was going to take a nap and the bed was situated in the middle of the wall with one fall mat on one side of the bed and no fall mat on the other side of the bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/12/25 at 9:15 A.M. revealed one fall mat by one side of the bed and no fall mat on the other side of the bed. Resident #24 was in bed resting. Observation on 08/12/25 at 10:18 A.M. revealed Resident #24 had only one fall mat on one side of bed with no fall mat on the other side of his bed. Interview on 08/12/25 at 10:18 A.M. with LPN #738 and Registered Nurse (RN) #799 verified there was only one fall mat on one of Resident #24's bed and no fall mat on the other side of the bed. Review of the facility policy titled, Fall Management, revised 12/2022, revealed if a fall occurred the licensed nurse would assess the resident for injury from the fall immediately and initiate an investigation of the reason for the fall and implement an immediate intervention to attempt in preventing future falls. The licensed nurse would update the Fall Risk and Pain Assessment at the time of the fall. Review of the facility policy titled, Accidents and Hazards, revised 11/2022, included when an unusual occurrence or accident/hazard occurred within the facility, the licensed nurse would immediately assess the resident for injury. The licensed nurse would open a risk management report and gather interview statements from the appropriate facility staff, resident and, or family, visitor. The licensed nurse would document a brief description of the accident, incident in the medical record. The licensed nurse would notify the physician and the resident, responsible party and document the notification in the medical record. This deficiency represents non-compliance investigated under Master Complaint Number 2564323, Complaint Number OH00166853 (1254633), and Complaint Number OH00166806 (1254522).

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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. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and policy review, the facility failed to ensure residents were provided with timely incontinence care. This affected two (#5 and #77) of four residents reviewed for bowel and bladder incontinence. The census was 87. Findings include:1. Review of Resident #5's medical record revealed an admission date of 08/19/22 and diagnoses included cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, and type two diabetes mellitus without complications.Review of Resident #5's care plan revised 06/19/24 included Resident #5 had bowel and bladder incontinence related to decreased mobility, use of diuretic therapy, and cognitive impairment. Resident #5 would establish an individual bowel and bladder routine. Interventions included bowel protocol as ordered; briefs, depends or pantiliners when out of bed; check for incontinence every two hours and as needed; and toileting per request and as needed.Review of Resident #5's care plan revised 11/25/22 included Resident #5 had a behavior problem related to aggression and verbal threatening of nursing staff. Resident #5 would have fewer episodes by the review date of 10/18/25. Interventions included to anticipate and meet needs; educate family and caregivers on successful coping and interaction strategies; explain all procedures before starting; and allow Resident #5 to adjust to changes. Review of Resident #5's annual Minimum Data Set (MDS) assessment dated [DATE] included Resident #5 had severe cognitive impairment. Resident #5 had upper and lower extremity impairment on one side. Resident #5 used a wheelchair. Resident #5 required substantial to maximal assistance for toileting hygiene, upper body dressing, and personal hygiene. Resident #5 was dependent for lower body dressing, bathing and the ability to transfer to and from a bed to a chair or wheelchair. Resident #5 was always incontinent of urine and bowel. Resident #5 did not reject care during the seven-day assessment look-back period.Observation on 08/06/25 at 9:49 A.M. of Registered Nurse (RN) #798 revealed she was standing at the medication cart in the hall of the lower level nursing unit and was preparing resident medications for administration. Resident #5 was heard yelling out for help and RN #798 was in the middle of a resident medication administration and did not indicate she heard Resident #5 yelling for help. Continued observation for the next ten minutes revealed Resident #5 periodically yelled for help. During the ten minutes, Certified Nurse Aide (CNA) #785 walked by Resident #5's room several times, and he yelled for help when CNA #785 walked by the room, but CNA #785 did not enter his room to find out why he was yelling. CNA #785 did not find RN #798 to let her know Resident #5 was yelling for help. Interview with RN #798 during the observation on 08/06/25 at 9:49 A.M. RN #798 stated Resident #5 probably needed changed, and the nurse walked into Resident #5's room and asked Resident #5 what she could do to help him. Resident #5 stated he had a bowel movement and needed his incontinence brief changed. Resident #5 was very upset and angry, and stated he needed changed and had been asking for awhile to get changed. Resident #5 stated he had been waiting since last night for someone to help him. RN #798 stated she would provide his incontinence care right now and proceeded to gather supplies to change his brief. Further observation revealed Resident #5 had a moderate sized formed bowel movement and his buttocks were excoriated and reddened. RN #798 provided appropriate incontinence care and applied barrier cream to his buttocks including the reddened and excoriated areas. Interview on 08/06/25 at 10:17 A.M. of CNA #785 revealed Resident #5 had behaviors if something did not go his way. CNA #785 stated she heard Resident #5 yelling for help but Resident #5 did not want her in his room and she did not go in his room. CNA #785 indicated the nurse took care of him or someone from the other side. CNA #785 confirmed no nurse aide went in Resident #5's room since she arrived for work at 7:00 A.M. CNA #785 stated she walked by his room that morning and did not go in even when he was yelling. Interview on 08/06/25 at 4:27 P.M. of RN #798 revealed when she was asked about CNA #785 walking by Resident #5's room without going in to see what he needed RN #798 stated the young nurse aides a lot of the time do not have patience and try to hurry the resident along and it upset him. Interview on 08/07/25 at 8:07 A.M. of the Director of Nursing (DON) revealed if Resident #5 was rude to a nurse aide it was not okay for the aide to not provide care for him. The DON stated it was not okay for CNA #785 to walk by his room, and not go in to see what he needed if he was screaming for help. The DON indicated at that point CNA #785 should find the nurse. The DON stated someone should have gone in Resident #5's room to see what he needed and make sure he was safe. The DON stated CNA #785 should not walk past someone yelling for help.Review of Resident #5's nurse aide charting dated 08/05/25 at 6:59 P.M. revealed Resident #5 was provided care for

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on review of staffing schedules and staff interview, the facility failed to maintain the services of a registered nurse (RN) for at least eight consecutive hours a day, seven days a week as required. This had the potential to affect all 87 residents currently residing in the facility. The census was 87.Findings include: Review of the nursing staff information and staff schedules for 06/28/25 and 07/04/26 revealed no RNs were present working in the facility during those days.On 08/13/25 at 3:15 P.M., interview with Human Resources Director (HRD) #890 verified the facility did not have an RN on duty on 06/28/25 and 07/04/26.This deficiency represents non-compliance investigated under Complaint Number OH00161573 (1254625), Complaint Number OH00164532 (1254632), and Complaint Number OH00166711 (1254468).

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on medical record review and staff interview, the facility failed to ensure an antibiotic medication was administered as ordered. This affected one (#102) of two residents reviewed for urinary tract infections. The census was 87.Findings include: Review of the medical record for Resident #102 revealed an admission date of 05/01/25. Diagnoses included cellulitis of the left lower limb, pain in the left and right legs, anxiety disorder, and glaucoma. The resident discharged against medical advice (AMA) to an independent living facility on 07/22/25. Review of the Minimum Data Set (MDS) assessment, dated 05/08/25, revealed Resident #102 had intact cognition. The resident required supervision or touching assistance for dressing and mobility, used a walker and a wheelchair, and was occasionally incontinent.Review of Resident #102's physician orders for June 2025 revealed the resident was ordered a urinary analysis (UA) collection one time only for possible urinary tract infection (UTI) on 06/07/25 at 8:00 P.M.; the medication to treat UTI symptoms Pyridium oral tablet 100 milligrams (mg) with instructions to take by mouth two times a day for urinary urgency for two days on 06/13/25 at 8:00 P.M.; and the antibiotic Fosfomycin tromethamine oral packet three (3) grams (gm) with instructions to give one packet by mouth in the morning every Tuesday, Friday, and Sunday for three admissions ordered on 06/13/25 at 7:00 A.M. and discontinued on 06/16/25. The Fosfomycin tromethamine 3 gm oral packet was reordered on 06/16/25 and started 06/17/25. Review of Resident #102's laboratory report revealed a urine sample was collected on 06/07/25 and received on 06/10/25. Further review of the a report revealed on 06/12/25 the resident's urine was positive for a UTI and antibiotic recommendations were given. Review of the nurse's notes dated 06/12/25 at 3:17 P.M. revealed Resident #102 was educated on the new order for an antibiotic and the medication would be in that night. Review of Resident #102's nurse's notes dated 06/15/25 at 12:07 P.M. noted Fosfomycin tromethamine 3 gm oral packet was not available.Review of Resident #102's medication administration record (MAR) for June 2025 revealed Fosfomycin tromethamine 3 gm oral packet was marked as See nurse notes on Friday 06/13/25 and Sunday 06/15/25. The medication was not available and the resident did not receive the medication until 06/17/25. On 08/11/25 at 10:21 A.M. Assistant Director of Nursing (ADON) #704 revealed on Friday, 06/13/25 Resident #102's Fosfomycin tromethamine was to be started and given Tuesday, Friday, and Sunday and stated it was not available. ADON #704 confirmed the medication was given Friday, 06/13/25 or Sunday, 6/15/25. On Monday, 6/16/25 ADON #704 caught the problem, contacted the nurse practitioner (NP),, had the medication reordered, and the first dose was given on Tuesday, 06/17/25. On 08/11/25 at 4:51 P.M. the Director of Nursing (DON) verified the antibiotic for Resident #102 had not been given until 06/17/25. This deficiency represents non-compliance investigated under Complaint Number OH00166711 (1254468), Complaint Number OH00164532 (1254632), Complaint Number OH00163811 (1254630), and Complaint Number OH00166806 (1254522).

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to obtain laboratory values as ordered and failed to notify the physician of laboratory results as required. This affected one (#59) of two residents reviewed for urinary tract infections. The census was 87.Findings include:Review of Resident #59's medical record revealed an admission date of 10/20/17 and a re-entry date of 04/10/25. Resident #59's diagnoses included chronic obstructive pulmonary disease, asthma, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side.Review of Resident #59's care plan dated 11/05/24 included Resident #59 had a suprapubic catheter related to obstructive uropathy diagnosis. Resident #59 would remain free from catheter related trauma through the review date. Interventions included to monitor, record, and report to the physician signs and symptoms of a urinary tract infection such as pain, burning, blood tinged urine, cloudiness etcetera; and monitor for signs and symptoms of discomfort on urination and frequency.Review of Resident #59's physician orders dated 11/22/24 revealed staff were to obtain Resident #59's urine and send it to the laboratory for a urinalysis with culture and sensitivity.Review of Resident #59's progress notes and medication and treatment administration record's dated 11/11/24 through 11/26/24 did not reveal evidence Resident #59 had a urine culture ordered and did not reveal evidence a urine specimen was collected and sent to the laboratory for a culture and sensitivity.Review of Resident #59's physician orders dated 11/26/24 revealed for staff to collect urine for a urinalysis and culture and sensitivity. Discontinue the order once the urine was collected.Review of Resident #59's progress notes dated 11/26/24 at 1:06 P.M. included, per the family request, a urine specimen for urinalysis and culture and sensitivity was ordered by an unidentified nurse practitioner.Review of Resident #59's laboratory report revealed a urine swab was collected on 11/27/24, received at the laboratory on 11/30/24 and the report dated was 12/01/24. Pathogens detected were enterococcus faecalis 1 x 10^7 copies per uL (10,000,000 copies per microliter). The first line medication recommended was the antibiotic doxycycline by mouth 100 milligrams (mg) every twelve hours for ten days. Review of Resident #59's progress notes dated 12/03/24 at 5:59 P.M. included Resident #59's urine culture and sensitivity results from 12/01/24 were reported to the nurse practitioner and new orders were given for doxycycline 100 mg with instructions give two times a day for ten days.Review of Resident #59's physician orders dated 12/03/24 revealed doxycycline hyclate oral tablet 100 mg with instructions to give one capsule by mouth two times a day for a urinary tract infection (UTI) for ten days until 12/13/24.Review of Resident #59's medication administration record (MAR) dated 12/03/24 revealed Resident #59's first tablet of doxycycline 100 mg (doxycycline hyclate) was administered at bedtime.Review of Resident #59's progress notes and physician orders dated 12/03/24 through 12/17/24 did not reveal evidence a urine specimen for urinalysis and culture and sensitivity was ordered and collected. There was no evidence the physician or nurse practitioner were notified of the laboratory results for Resident #59's urine culture reported on 12/06/24. Review of Resident #59's laboratory results report revealed a urine for urinalysis and culture and sensitivity was collected on 12/03/24, received at the laboratory on 12/03/24, and the report date was 12/06/24. The report included Resident #59's urine had greater than 100,000 CFU per ml (colony forming units) of enterococcus faecalis. Review of Resident #59's physician progress notes dated 12/07/24 and written by Nurse Practitioner (NP) #810 included Resident #59's urine culture was positive for a urinary tract infection and he was started on doxycycline. Resident #59 had an indwelling catheter.Review of Resident #59's quarterly Minimum Data Set (MDS) assessment dated [DATE] included Resident #59 was cognitively intact. Resident #59 did not reject care during the seven-day assessment look-back period. Resident #59 used a wheelchair. Resident #59 used a mechanical lift and was a two staff assist for transfers. Resident #59 required the assistance of one staff member for bathing and bed mobility. Interview on 08/12/25 at 10:19 A.M. of the Director of Nursing (DON) revealed Resident #59's physician should have been notified as soon as possible after his urine culture results were reported by the laboratory. The DON confirmed Resident #59's urine culture results were reported on 12/01/25, but the physician was not notified until 12/03/25. The DON did not know why there was a two day delay for Resident #59's urine culture results to be reported to the physician, and there should have been a progress note about it. The DON confirmed Resident #59 had a urine specimen for urinalysis and culture and sensitivity collected on 12/03/25 and there was no order in his record or progress note regarding the urine specimen. The DON was unable to explain why the urine specimen was collected on 12/03/25. The DON confirmed Resident #59 had a urine for

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed to ensure outdated drinks and food and beverage additives were stored in a manner to prevent spoilage. This had the potential to affect four (#3, #28, #70, and #77) of four residents identified by the facility as receiving on thickened liquids. The facility census was 87.Findings include:Observation during a tour of the facility on 08/06/25 from 8:40 A.M. to 9:35 A.M. revealed two 46 ounce containers of nectar thickened orange juice were found in the [NAME] panties on the units. There was no date written on them to show when they had been opened. The use by date was June 2025. Further observation revealed eight individual thick and easy instant food and beverage thickener packets with a use by date of 10/29/23 found in the [NAME] pantries. On 08/06/25 at 9:41 A.M., Regional Director of Clinical Operations #808 verified the two containers of outdated nectar thickened orange juice and the eight outdated thick and easy instant food and beverage thickener packets. This deficiency represents non-compliance investigated under Complaint Number OH00166853 (1254633).

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to ensure medical records were accurate and complete. This affected five (#1, #6, #30, #105, and #112) of 33 resident records reviewed. The facility census was 87.Findings include:1. Record review revealed Resident #1 was admitted [DATE] with diagnoses of sepsis, malignant neoplasm of left kidney, end stage renal disease, and dependance on renal dialysis. Review of the hospital admission referral packet dated [DATE] revealed Resident #1 was an end stage renal disease patient on a dialysis regimen with a Tuesday, Thursday, and Saturday schedule. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had moderate cognitive impairment, required hemodialysis, and required maximal assistance with toileting hygiene, showers, dressing, and personal hygiene. Review of the physician orders for [DATE] revealed Resident #1 had orders for atorvastatin calcium 10 milligrams (mg), donepezil five (5) mg, tamsulosin 0.4 mg, apaxiban 5 mg two times a day, aspirin 81 mg, midodrine three times a day. The physician orders did not include an order for dialysis. Review of Resident #1's medication administration record (MAR) and the treatment administration record (TAR) for [DATE] revealed documentation was not completed on [DATE] and [DATE] for the administration of the aforementioned medications at bedtime and treatments during the shift including turning/repositioning rounds, monitoring for signs/symptoms of infection every shift, and pressure reducing mattress and wheelchair cushion every shift. The TAR was broken down into two shifts, 7:00 A.M. to 7:00 P.M. and 7:00 P. M. to 7:00 A.M. The documentation was not completed on the 7:00 P.M. to 7:00 A.M. shift. Interview on [DATE] at 9:56 A.M. with Licensed Practical Nurse (LPN) Unit Manager #745 confirmed there was no physician order for dialysis in the electronic record for Resident #1; however, dialysis was received at the facility Monday, Wednesday, and Friday. Interview on [DATE] at 3:50 P.M. with Resident #1 confirmed dialysis was received as scheduled and evening medications were received on [DATE] and [DATE]. Interview on [DATE] at 10:13 A.M. with the Director of Nursing (DON) confirmed there was no physician order for dialysis in the electronic record for Resident #1. Interview on [DATE] at 7:58 A.M. with LPN #732 confirmed she worked the evening of [DATE] but was unable to recall if the medications were administered or if documentation was completed. Interview on [DATE] at 8:02 A.M. with LPN #724 confirmed she worked the night shift on [DATE] and did administer Resident #1’s evening medications but admitted to forgetting to complete documentation at times. 2. Review of the medical record revealed Resident #30 was admitted to the facility on [DATE] with diagnoses including emphysema, cerebral palsy, diabetes, and post traumatic stress syndrome. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly MDS assessment dated [DATE] revealed Resident #30 was cognitively intact and used a noninvasive ventilator (NIV). Review of the nurses notes for Resident #30 from June through [DATE] revealed respiratory therapy routinely documented the hours of use for the NIV. The pharmacist documented monthly regarding the review of the resident’s medications. Registered Nurse (RN) Unit Manager #801 documented on [DATE] regarding an update on a computed tomography (CT) scan the resident was scheduled for of the abdomen and pelvis. No other documentation regarding the resident’s care or the results of the CT scan and when it was completed were documented. Interview with the Director of Nursing (DON) on [DATE] at 1:10 P.M. confirmed the nurses should be documenting any changes regarding the resident and confirmed there was no documentation in Resident #30's medical record regarding results of the CT scan. 3. Review of the medical record revealed Resident #105 was admitted to the facility on [DATE] with diagnoses including senile degeneration of the brain, end stage renal disease dependent on hemodialysis, diabetes, a stroke, and vascular dementia without behavioral disturbance. The resident was admitted to hospice on [DATE] with a diagnosis of end stage renal disease after refusing to attend any further dialysis treatments. Resident #105 died on [DATE]. Review of the nurses notes for Resident #105 revealed on [DATE] the resident requested to be sent to the hospital for diarrhea. The nurse practitioner approved the transfer to the local emergency room (ER). The next note dated [DATE] revealed Resident #105 returned from the hospital positive for clostridium difficile. Review of the nursing admission assessment completed on [DATE] revealed Resident #105’s vital signs were documented but the rest of the admission assessment was left blank. Interview with the DON on [DATE] at 2:00 P.M. revealed she does not know why Resident #105’s admission assessment on [DATE] was blank, but stated there was probably a glitch in the facility's electronic health record that removed the assessment information. The DON said she was planning on in-servicing nursing on documentation. 4. Record review for Resident #6 revealed an admission date of [DATE]. Diagnoses included end stage renal disease, diabetes mellitus II, and paroxysmal atrial fibrillation. Review of Resident #6’s electronic medical record (EMR) revealed a physician note dated [DATE] at 1:58 P.M. for Resident #112 and on [DATE] at 3:14 P.M. a physician note was found for Resident #112. On [DATE] at 8:00 A.M. the DON verified two physician notes for Resident #112 were found in the EMR for Resident #6. Review of the facility policy titled, “EHR Records and Documentation,” dated 12/22, revealed the facility the facility must maintain medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized. The medical record must reflect the resident’s condition and the care and services provided across all disciplines to ensure information is available to facilitate communication among the interdisciplinary team. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This deficiency represents non-compliance investigated under Master Complaint Number 2564323, Complaint Number OH00167217 (1254635), and Complaint Number OH00166806 (1254522).

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, staff interview, and policy review, the facility failed to maintain a clean, sanitary, and safe environment. This deficient practice had the potential to affect all 87 residents residing in the facility. The facility census was 87.Findings included:Observation during an environmental tour conducted on 08/06/25 between 1:00 P.M. and 1:55 P.M. with Maintenance Supervisor (MS) #748 revealed carpeted areas throughout resident rooms and common areas were noted with stains and debris, the room occupied by Resident #59 had a two-inch long hole in the wall, the air conditioning cover in Resident #124's room was dislodged and on the floor, the wall trim on the bathroom door in Resident #31's room was half secured to the wall, the outlet for the telephone line in Resident #25's room was broken in half, the supplemental tube feeding poles used by Resident #19 and Resident #72 had residual dried tube feed on the pole and base, the private bathroom used by Resident #33 had multiple brown stains on the tub floor, the pillowcases and blankets on Resident #27's bed were stained brown, Resident #77's bathroom contained approximately ten to fifteen articles of wet clothing on the floor producing a strong musty odor, Resident #36, Resident #82, and Resident #83's rooms had multiple areas of water stains on the ceiling, the closed closet door in Resident #81's room had multiple brown spots, the walls in Resident #14 and Resident #83's rooms were severely scratched with chipped paint, the wall above the air conditioning unit in Resident #4 and Resident #13's rooms was starting to crumble, Resident #67's bed had a blanket with multiple brown and orange stains, and the fall mats used by Resident #14 and Resident #65 were dirty, torn, and tattered.Interview with MS #748 during the observations on 08/06/25 between 1:00 P.M. and 1:55 P.M. verified all the above findings at the time of discovery. Review of the facility policy titled, Environmental Services Cleaning Guidebook, dated 04/20/23, revealed the guidebook was provided to all housekeeping employees to maximize efficiency, outline preferred cleaning methods for infection control and presentation, and emphasize the proper use of chemicals as critical to the success of maintaining a safe and sanitary environment.This deficiency represents non-compliance investigated under Complaint Number OH00166853 (1254633) and Complaint Number OH00164532 (1254632).