STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366396	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Athens, The	70 Columbus Circle Athens, OH 45701

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, hospital record review, review of information on www.lung.org, review of facility policy, and interview, the facility failed to provide a safe environment, appropriate supervision and implement safe smoking practices for Resident #11, a resident who had been incorrectly identified as a safe/independent smoker despite being noncompliant and unable to manage safe smoking interventions independently. This resulted in Immediate Jeopardy and Actual Harm on 03/21/26 when Resident #11 smoked in the designated smoking area while oxygen was in use via nasal cannula, resulting in ignition caused by smoking in the presence of oxygen. The resident sustained facial burns requiring emergency medical intervention. The resident was subsequently transferred to the hospital where she received treatment for the burns to her face and mouth. The emergency room determined the resident should be intubated and placed on mechanical ventilation due to her burns (the resident's mouth was charred); however, the resident refused and returned to the facility after monitoring in the emergency room was completed. A concern that did not rise to an Immediate Jeopardy was identified when the facility failed to ensure fall interventions were in place per Resident #12's plan of care to prevent falls. This affected two residents (#11 and #12) of seven residents reviewed for accidents. The facility identified Resident #11 as the only resident who wore oxygen and smoked and eight additional residents, Resident #22, #3, #47, #50, #60, #150, #86, and #10 who smoked in the facility. The facility census was 98. On 04/09/26 at 5:00 P.M., the Administrator and the Director of Nursing (DON) were notified Immediate Jeopardy began on 03/21/26 when the facility failed to maintain a safe smoking environment for Resident #11. As a result, Resident #11 sustained facial burns due to ignition caused by smoking in the presence of oxygen use. The Immediate Jeopardy was removed on 03/23/26 when the facility implemented the following corrective actions: On 03/21/26 at 3:16 P.M. 911 response was activated for Resident #11 and Medical Director #601 was notified by Registered Nurse (RN) #322. On 03/21/26 at 3:18 P.M. on-call Nurse/Social Services #423 immediately notified the Administrator and Director of Nursing (DON) #304 of the incident involving Resident #11. On 03/21/26 at 3:22 P.M. Emergency Medical Services (EMS) arrived onsite. At 3:30 P.M. Resident #11 was transported to the emergency room. On 03/21/26 at 3:30 P.M. RN #322 completed a smoking re-assessment of Resident #11 assessing the resident to be an unsafe smoker requiring supervision due to failure to remove oxygen prior to entering designated smoking area. On 03/21/26 from 3:38 P.M. through 7:57 P.M. Licensed Practical Nurse (LPN) #337, #336, #335, #338; RN #334, and DON #304 re-assessed residents (who smoke). This included Resident #22, Resident #3, Resident #47, Resident #50, Resident #60, Resident #150, Resident #86, and Resident #10 to determine smoking safety (via smoking assessment). Each resident was re-educated regarding the facility smoking policy and staff verified there were no smoking materials on their person. The residents' smoking materials would be maintained by facility staff and distributed per policy. On 03/21/26 at 4:30 P.M. DON #304 responded to facility and an Ad Hoc (not scheduled) Quality Assurance (QA) meeting was held via telephone with the Administrator, DON #304 and Medical Director #601 to review investigative findings and plan of action. A root cause (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	analysis was completed and determined Resident #11 had smoking materials on her person (believed to be obtained from family without staff knowledge) and failed to remove her oxygen. The QA team discussed a corrective action plan. On 03/21/26 from 5:00 P.M through 03/22/26 at 3:00 P.M. 26 RNs, 13 LPNs, one medical technician (MT), 54 Certified Nursing Assistants (CNA) four activities staff, one central supply staff, 11 dietary staff, 12 housekeeping staff, three laundry staff, one medical records staff, two social designees, two maintenance staff, nine administrative staff, and 19 therapy staff (158 staff at the time of the incident) were provided education regarding the facility smoking policy by DON #304 and the Administrator. This was completed via 1:1, small group in-services or via phone. Newly hired staff would receive education during general orientation regarding the facility's smoking policy. On 03/21/26 at 5:00 P.M. DON #304 completed an audit of all residents who smoke (Resident #22, Resident #3, Resident #47, Resident #50, Resident #60, Resident #150, Resident #86, and Resident #10) to verify smoking evaluations and plans of care accurately reflected the residents' smoking safety needs. The residents were educated on the facility smoking policy, and smoking materials were to be maintained at the nurses' station. An audit was completed which included verification of required safety measures present in designated smoking areas, including an ash can, fire extinguisher, fire blanket, ash trays and no oxygen signs. There were no identified concerns or changes made because of the audits. On 03/21/26 at 8:55 P.M. Resident #11 returned from the ED. LPN #332 verbally educated the resident regarding the facility smoking policy which included the need for supervision, a smoking apron (to be worn) and the facility smoke times. LPN #332 verified no smoking materials were on the resident's person or in her room at this time. On 03/23/26 at 11:00 A.M. the Interdisciplinary Team (IDT) (Administrator, DON #304, Medical Director #601, RN #302, Social Services #427, Social Services #423, DON #300, and Maintenance #436) met in-person to review the plan of action with DON #304/designee to complete weekly monitoring of residents who smoke and designated smoking areas weekly for four weeks with Housekeeping responsible to complete the cleaning. Housekeeping staff were responsible for cleaning ashtrays and the designated smoking area daily. Audits to be reviewed and any further actions required to be directed by the Quality Assurance and Performance Improvement (QAPI) Committee during scheduled meetings. The IDT also reviewed all current smoking assessments and care plans for residents who smoke. Resident #50 required a change in supervision levels with smoking due to cognition levels and her plan of care as well as Resident #11's plan of care was updated to reflect supervision/safety. On 03/23/26 from 3:45 P.M. to 8:55 P.M. Social Services #423 re-educated residents who smoke (Resident #22, Resident #3, Resident #47, Resident #50, Resident #60, Resident #150, Resident #86, Resident #10) and responsible parties, if applicable regarding the facility smoking policy and supervision levels. On 03/23/26 at12:13 P.M. Social Services #427 contacted Resident #11's family member (#602) to schedule a care conference. Family member #602 and Family Member #603 were not available to meet until 03/27/26. On 03/23/26 at 1:00 P.M. staff education related to smoking areas, removal of oxygen prior to entering smoking area and maintaining smoking materials at the nurses' station for residents who smoke was initiated by DON #304 and the Administrator via 1:1, small group in-services or via phone call. Education was completed for all 158 staff by 03/24/26 at 1:00 P.M. Newly hired staff would be educated during general orientation regarding the facility smoking policy. The facility does not utilize agency staff. On 03/27/26 at 11:00 A.M. a care conference was held with Resident #11 and Family Members #602 and #603, the Administrator, Social Services #423 and Social Services #427. The facility smoking policy was reviewed. The resident and family were informed an involuntary discharge would be initiated should the resident exhibit non-compliance moving forward and supervision would be increased beyond the two-hour standard of care to monitor more closely for non-compliance with the facility smoking policy. Family Member #602 stated he educated his siblings as well. On 04/10/26 at 2:00 P.M, DON #304 initiated education with 26 RNs and 13 LPNs (100% of nurses educated) regarding completion of the smoking evaluation via 1:1, small group in-services, or phone. The education was completed by 6:00 P.M. on 04/10/26. A new resident who smokes must (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	products. The resident was assessed to have no cognitive loss, visual deficits, or dexterity problems. The documentation on this assessment noted Resident #11 was assessed to be safe to smoke without supervision. (This assessment was completed as a result of the resident's re-admission to the facility after a three-day hospital stay). Record review revealed no additional information related to how this conclusion was reached or evidence the resident's plan of care was updated as a result of the assessment. Review of physician's orders revealed an order for dialysis on Tuesdays, Thursdays and Saturdays in the morning and an order for oxygen via nasal cannula at 2-4 liters per minute as needed dated 03/21/26. Further review of the physician orders revealed no order for oxygen prior to 03/21/26. Review of the progress note for Resident #11 dated 03/21/26 at 3:15 P.M. authored by RN #322 revealed CNA #362 was observed outside yelling for help and (the LPN) went outside. The note indicated Resident #11's face and hands appeared black in color. RN #322 asked what happened, CNA #362 stated she witnessed the resident's oxygen nasal cannula tubing with a flame coming out. The CNA turned off the (oxygen) tank and removed the (resident's oxygen) tubing. Then she began yelling for help. Record review revealed there was no comprehensive assessment of the resident, including a respiratory assessment or assessment of pain as a result of the incident documented in the resident's medical record at this time. Review of an Emergency Medical Services (EMS) report for Resident #11 dated 03/21/26 timed 3:16 P.M. revealed upon (EMS) arrival to the facility the resident had sustained first degree burns to her head and face. The resident rated her pain as zero on a scale of 0 to 10 with 10 being the worst pain. EMS report revealed that she lit a cigarette with her nasal cannula on which caused a flame which caused the burn. Review of a hospital note for Resident #11 dated 03/21/26 revealed Resident #11 presented from facility for evaluation of a burn to her face. Patient went outside to smoke with oxygen on and her face/lips were burned. The resident denied any difficulty breathing/swallowing. No current pain. The patient's face was black from smoke and lips and mouth appeared to be burnt and charred. It was recommended the resident be intubated due to the burns to the face/mouth but the resident refused. The resident was monitored for six hours and then was discharged back to the facility with orders to continue applying antibiotic ointment to the face where burns occurred and monitor for signs of infection. Review of a facility incident report dated 03/21/26 revealed nursing description: resident went outside with oxygen on to smoke without notifying staff which caused the nasal cannula to catch on fire. Staff witnessed occurrence as she walked through dining room door out to courtyard and ran to assist resident by shutting oxygen off and alerting nurse. Resident description revealed I thought I turned my oxygen off, guess I didn't. Resident also stated family had just given her cigarettes and lighter before they left from visiting. Review of a smoking observation/assessment for Resident #11, dated 03/21/26 and completed by RN #322, revealed the resident was a smoker or user of tobacco products. The resident was assessed to have no cognitive loss, visual deficits, and some diminished response to fallen ashes. The resident was assessed to be unsafe to smoke without supervision due to not holding smoking materials safely, does not remove oxygen tubing/oxygen not brought into smoking area and does not follow guidelines per policy. Review of the smoking observation/assessment for Resident #11 dated 03/21/26 completed by the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the article Oxygen Therapy: Using Oxygen Safely updated 01/28/26 located on www.lung.org revealed oxygen is a safe gas and is non-flammable, however, it supports combustion. Materials burn more readily in oxygen-enriched environments. Keep away from heat and flame. Don't smoke or allow others to smoke near you. Keep sources of heat and flame at least five feet away from where your oxygen unit is being stored or used. Review of the facility smoking policy titled Smoking Policy, revised on 06/16/25 revealed based upon the interdisciplinary evaluation, a decision would be made whether the resident was a safe or unsafe smoker. If the interdisciplinary team determined the resident was an unsafe smoker, the resident may be required to wear a protective smoking vest/apron and was supervised while smoking. The degree of supervision was determined by the team and was based on the smoking evaluation, the physical attributes of the smoking area, and other relevant factors. Staff members maintain all smoking paraphernalia for all unsafe and safe smokers. Staff members distribute smoking materials to residents that are unsafe to smoke at the designated smoking times, and to residents who are deemed safe to smoke and may smoke independently, at their request. Smoking paraphernalia would be retrieved by staff when smoking activity was concluded. The first violation of this smoking policy by a resident who smokes would result in a warning (verbal or written) to the resident and their resident representative and documented in the medical record. A second violation by a resident who smokes would result in a) immediate revocation of the privilege to smoke under this policy and b) involuntary discharge procedures initiated and pursued upon completion. 2.Review of Resident #12's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including difficulty walking, muscle weakness, unspecified dementia, anxiety disorder, adult-onset diabetes mellitus, hypertension, and osteoporosis. Review of Resident #12's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognition was severely impaired. She used a walker and wheelchair for mobility devices and required supervision/ touching assistance with transfers and ambulation up to 50 feet. The assessment revealed the resident had two or more falls without injury since her prior MDS assessment. Review of Resident #12's active care plans revealed the resident had a care plan in place for being at risk for falls related to a history of falls. The care plan originated on 06/21/25. The goal was for the resident to be free from injury related to falls through the review date. The interventions included the use of non-skid strips on the floor in front of the resident's recliner. That intervention was initiated on 11/17/25. On 04/08/26 at 4:35 P.M. an interview with RN #326 revealed Resident #12 was considered to be at risk for falls. She reported the resident had fallen multiple times while in the facility and usually involved her trying to get up without assistance. The RN revealed she was not familiar with all the fall prevention interventions that had been put in place for the resident without checking the resident's medical record. On 04/08/26 at 4:38 P.M., an observation of Resident #12's room revealed two recliner chairs in her room between the bed and her window. There was no evidence of any non-skid strips being applied to the floor in front of the recliner as per her fall care plan. On 04/09/26 at 11:32 A.M., LPN #427 confirmed Resident #12 did not have non-skid strips on the floor in front of her recliner. She verified the resident's fall risk care plan still included the use of non-skid strips on the floor in front of her recliner, as one of her fall prevention interventions. She slid the two recliners back to make sure the recliners had not been moved forward to cover the non-skid strips but did not see any on the floor even after the recliners were moved. Review of the facility's Fall Management policy revised 07/08/25 revealed the facility would identify hazards and resident risk factors and implement interventions to minimize falls and risk of injuries related to falls. Each resident was to be assisted in attaining/ maintaining his or her highest practical level of function by providing the resident adequate supervision, assistive devices, and/ or functional programs as appropriate to minimize the risk for falls. The residents would be evaluated by th

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, record review, interviews, and policy review, the facility failed to ensure residents who required assistance with hygiene received showers/bathing and shaving as per their preference/plan of care/schedule. The affected five (#5, #8, #9, #70, and #76) of 12 residents reviewed for activities of daily living (ADLs). The facility census was 98.Findings include: 1.Record review revealed Resident #8 admitted to the facility on [DATE] with diagnoses including spinal stenosis and radiculopathy. Review of a care plan dated 02/08/24 revealed Resident #8 had a functional ability deficit and required assistance with self-care/mobility related to status-post L2-L5 decompression fixation fusion. The goals included discharge home to prior living arrangements, improving current level of functioning, and improve mobility. Interventions included but were not limited to encourage resident to participate in self-care as much as able, provide positive reinforcement for all activities attempted, praise resident for all efforts and accomplishments; and substantial/maximum assistance with upper body dressing, shower/bath, and toileting hygiene. Review of a shower schedule revealed Resident #8 received showers on Tuesdays and Fridays. Review of shower/bathing documentation from 01/01/26 to 04/09/26 revealed Resident #8 did not receive a shower/bed bath on 01/02/26, 01/15/26, 01/29/26, 02/05/26, 02/12/26, 02/17/26, 03/02/26, 03/20/26, 03/31/26, 04/03/26, and 04/07/26 as scheduled. Interview on 04/07/26 at 8:52 A.M. with Resident #8 revealed she does not always receive her bed baths (her preferred type of bathing). Interview on 04/13/26 at 2:33 P.M. with Director of Nursing (DON) confirmed Resident #8 had 11 missing bathing/showers per her documentation. 2.Record review revealed Resident #76 admitted to the facility on [DATE] with diagnoses including dysphagia and unspecified lack of expected normal physiological development in childhood. Review of care plan dated 01/04/24 revealed Resident #76 had a functional ability deficit and required assistance with self-care/mobility related to weakness and unsteady gait. The goals included to maintain current level of functioning in self-care and mobility. Interventions included but were not limited to encourage to participate in self-care as much as possible, provide positive reinforcement for all activities attempted, and praise resident for all efforts and accomplishments. Interview on 04/07/26 at 11:49 A.M. with Resident #76 revealed she asked for staff to shave her and they do not which really bothered her. Observation and interview on 04/14/26 at 1:15 P.M. with Resident #76 revealed she received her shower on Saturday (04/11/26) but was not shaved and it was bothered her because it itched. The resident was noted to have small gray hairs along her chin. Interview on 04/14/26 with Certified Nursing Assistant (CNA) #350 confirmed Resident #76 had gray hairs on her chin and needed shaved. The CNA stated the resident's shower was the following day and it would be taken care of. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #9's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included chronic respiratory failure with hypoxia, tracheostomy status, heart failure, moderate intellectual disabilities, anxiety disorder, depression, and Post Traumatic Stress Disorder (PTSD). Review of Resident #9's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had adequate hearing with the use of a hearing aid and no speech. She was usually able to make herself understood and was able to understand others. Her vision was adequate with the use of corrective lenses. She was cognitively intact and was not known to display any behaviors or reject care. She required a substantial/ maximum assist with her personal hygiene. Review of Resident #9's active care plans revealed she had a care plan in place for having a functional ability deficit requiring assistance with self-care related to impaired mobility, muscle weakness, pain, depression, anxiety, PTSD, heart failure, respiratory failure, and tracheostomy status. The goal was for the resident to improve or maintain her current level of function in personal hygiene through the review date. The interventions included allowing adequate time for completion of task, attempt to use consistent routines as much as possible, break task into smaller subtasks, encourage to participate in self-care as much as able, provide positive reinforcement for all activities attempted, praise resident for all efforts and accomplishments, explain all procedures/tasks before starting, reporting refusals of activities of daily living (ADL) care (personal hygiene, nail care, bathing, and showers) to the nurse, and provide substantial/ maximum assist with personal hygiene. Her care plans did not identify any non-compliance with personal care. Review of the shower schedule for the 100- 400 halls revealed the resident was to receive her scheduled showers on Mondays and Thursdays on the 7:00 P.M. to 7:00 A.M. shift. The shower schedule indicated complete shaves were to be completed for men and women. Review of Resident #9's shower/ bath documentation, under the task tab of the EMR, revealed the resident's last documented shower/ bath was on 04/10/25 (Friday). There was no indication of any additional personal hygiene care being provided on that day to include shaving of any unwanted facial hair. On 04/07/26 at 3:59 P.M., an observation of Resident #9 noted her to be lying in bed with the head of bed elevated. She had a tracheostomy cover over her tracheostomy stoma with 28% humidified oxygen being administered at 8 liters per minute (LPM). She was noted to have long white hairs on her chin and around her jaw-line. On 04/13/26 at 1:35 P.M., an observation of Resident #9 noted her to be in bed turned onto her right side. She continued to have long, white hairs on her chin and jaw area. On 04/13/26 at 3:08 P.M., an interview with CNA #354 revealed Resident #9 required a total assist with her personal care. She was asked about the resident's preferences on things like the length of her finger nails and the removal of any facial hair. She reported the resident would want facial hair removed, if she had it. She was asked when the removal of any unwanted facial hair would be completed. She reported it was done as part of the resident's bath/ shower or on an as needed basis. She was asked to go to the resident's room to verify the presence of facial hair on Resident #9. She went to the resident's room and confirmed the resident had some long, white hairs on her chin and jaw line. She reported she would have to return to assist the resident with the removal of her facial hair, but wanted to check and see when she was scheduled for a shower. She checked the shower schedule and reported the resident was scheduled to receive a shower every Monday and Thursday night and should be getting one later that evening. 4.Review of the medical record for Resident #5 revealed an initial admission date of 02/28/26 with diagnoses including end stage renal disease, respiratory failure, hyperlipidemia, and congestive heart failure. Review of the resident's most recent Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition and required partial/moderate assistance with bathing/showering and personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #5 shower documentation revealed Resident #5 shower days are scheduled on Wednesdays and Saturdays on day shift. Review of the plan of care last reviewed/revised 03/18/26 revealed the resident has a functional ability deficit and requires assistance with self-care/mobility in regard to acquired absence of left great toe, atherosclerosis of native arteries of extremities with gangrene (left leg). Interventions included partial/moderate assistance with personal hygiene and shower/bath. Review of shower documentation since admission date of 02/28/26 revealed no showers were provided or showers being refused on 03/04/26, 03/07/26, 03/11/26, 03/14/26, 03/21/26, 03/25/26, 03/28/26, 04/04/26, and 04/08/26. Interviews on 04/06/26 at 4:17 P.M. and 04/13/26 at 12:11 P.M. with Resident #5 revealed he did not get scheduled showers and was not sure when his shower days were. Resident #5 stated I could really use a good scrub down, I asked a couple of aides, and they did not have time. Interview on 04/13/26 at 1:09P.M. with CNA #393 revealed we have shower sheets in our book and it is also in the computer, they show up in our daily documentation if it is a residents' shower day. We are supposed to document before we leave every day and the nurses are supposed to check it. Interview on 04/13/26 1:13 P.M. with the DON verified Resident #5 had not received showers per schedule and per resident preference/request. 5. Review of Resident #70's medical record revealed an admission date of 01/21/26 with diagnosis including unspecified fracture of the lower end of the left humerus, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, rheumatoid arthritis, hypertensive heart disease, retention of urine unspecified, and primary osteoarthritis. Review of Resident #70's care plan created on 01/22/26 revealed the resident has a functional ability deficit and requires assistance with self care/mobility, was non weight bearing to LUE, and required substantial/maximal assistance with showering/bathing from staff. Review of Resident #70's showering task in the electronic healthcare record from 01/24/26 to 04/08/26 revealed the resident was to receive showers on Wednesdays and Saturdays. Further review of the showering task revealed the question did the resident receive a shower/bath//bed bath? was answered as no on 01/28/26, 03/11/26 and 04/08/26, and not answered on 02/11/26, 02/14/26 and 02/28/26. Review of Resident #70's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had a brief interview for mental status score of 15 indicating the resident was cognitively intact. Further review of the MDS revealed the resident required substantial/maximal assistance with showering/bathing. In an interview on 04/14/2026 at 4:30 P.M. Director of Nursing (DON) #304 verified that on 01/28/26 the resident did not receive a shower because she was out of the facility at an appointment. DON #304 further verified that the question did the resident receive a shower/bath//bed bath? was answered as no on 03/11/26 and 04/08/26 meaning a shower/bath/bed bath was not completed for the resident, and that on 02/11/26, 02/14/26 and 02/28/26 no documentation for the question did the resident receive a shower/bath//bed bath? was recorded. In an interview on 04/15/2026 at 8:00 A.M. Resident #70 indicated that when she missed her shower it made her feel like she was unimportant to the staff because everyone else was getting (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a shower but she was not and the resident further stated that she did not feel clean if she missed her shower. Review of facility policy titled Routine Resident Care, dated 03/12/25 revealed showers, tub baths, and/or shampoos are scheduled according to person centered care or state specific guidelines, bed linens are changed at this time. Additional showers are given as requested.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record review, interview, and policy review the facility failed to ensure a resident's right to privacy and dignity were maintained when a urinary catheter drainage bag was not covered and urine was exposed. This affected one (#92) of one resident reviewed for catheters. The facility census was 98.Findings include:Record review revealed Resident #92 admitted to the facility on [DATE] with diagnoses including malignant neoplasm of esophagus and type II diabetes mellitus.Review of a care plan dated 03/31/26 revealed Resident #92 was at risk for a urinary tract infection and catheter-related trauma related to having an indwelling catheter in place for urinary retention. The goals included showing no signs and symptoms of urinary infection through review date and the catheter would remain patent and without complications through the review date. Interventions included but were not limited to ensure catheter tubing is secured and ensure the drainage bag is secured properly with a dignity cover in place.Review of an orders revealed an order dated 03/31/26 for Resident #92's 16 French indwelling urinary catheter to be changed every 30 days and as needed.Review of the comprehensive Minimum Data Set, dated [DATE] revealed Resident #92 had an indwelling catheter in place and was cognitively intact.Observation on 04/06/26 at 11:36 A.M. revealed Resident #92 was in his room, seated in a chair. The indwelling urinary catheter drainage bag was hanging from the chair and the bag was not covered. Dark yellow urine was observed in the drainage bag, visible from the hallway.Observation and interview on 04/06/26 at 2:46 P.M. with Licensed Practical Nurse (LPN) #324 confirmed Resident #92's catheter bag was lying directly on the floor and did not have a dignity cover. Attempts to interview the resident on 04/06/26 were attempted however the resident was unable to answer screening questions to determine if the resident was cognitively intact Review of a policy title Resident Dignity & Personal Privacy dated 03/28/24 revealed the facility should provide care for residents in a matter that respects and enhances each resident's dignity, individuality, and right to personal property.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of a self-reported incident, review of the facility investigation and policy review, the facility failed to prevent misappropriation of resident narcotics. This affected one resident (Resident #99) of two residents reviewed for misappropriation. The facility census was 98. Findings include: Record review revealed Resident #99 admitted to the facility on [DATE] with diagnoses including hypertension and anemia.Review of orders revealed Resident #99 had an order in place dated 11/14/25 for oxycodone oral tablet 5 milligrams (mg) give one tablet by mouth every four hours as needed for pain.Review of a care plan dated 11/17/25 revealed Resident #99 was at risk for pain and has chronic pain related to internal orthopedic device and left knee pain. Goals included verbalizing adequate relief of pain or ability to cope with incompletely resolved pain through the review date and state relief of pain daily through the review date. Interventions included but were not limited to administer medications as ordered and observe for effectiveness and side effects.Review of a Minimum Data Set, dated [DATE] revealed Resident #99's cognition was intact and the resident rated her pain level at a 7 on a 1-10 pain scale (a rating of 1 is little pain and a rating of 10 is the worst pain the resident has felt). The resident received opioid medication.Review of Resident #99's February 2026 Medication Administration Record (MAR) and Narcotic Log (dated 02/06/26) revealed the following:a. Review of a narcotic log for oxycodone tablet five mg one tablet by mouth every four hours as needed revealed oxycodone was signed out by RN #722 on 02/17/26 at 9:30 P.M.Review of the Medication Administration Record (MAR) revealed oxycodone tablet five mg one tablet by mouth every four hours as needed was not signed as administered from RN #722 at 9:30 P.M. on 02/17/26.b. Review of a narcotic log for oxycodone tablet five mg one tablet revealed medication was signed out by RN #722 on 02/18/26 at 1:30 A.M. and 5:30 A.M.Review of MAR revealed oxycodone tablet five mg one tablet was not signed as administered on 02/18/26 at 1:30 A.M. or 5:30 A.M. c. Review of a narcotic log for oxycodone tablet five mg one tablet revealed medication was signed out by RN #722 on 02/18/26 at 9:00 P.M. Review of the MAR for 02/2026 revealed oxycodone 5 mg one tablet was signed as administered by RN #722 on 02/18/26 at 10:16 P.M. (Please note, the MAR read 10:16 P.M. but the narcotic log indicated 9:00 P.M.)d. Review of a narcotic log for oxycodone tablet five mg one tablet revealed medication was signed out by RN #722 on 02/19/26 at 5:30 A.M.Review of MAR revealed oxycodone tablet five mg one tablet was signed as administered by RN #722 on 02/19/26 at 5:30 A.M.Review of a facility investigation dated 02/25/26 revealed a statement from Certified Nursing Assistant/Med Tech (CNA) #710. CNA #710 stated she had taken the keys from RN #722 frequently and more times than not, she would frantically be trying to recall when she gave narcotics because she either did not sign off the MAR or the narcotic log and there had been multiple times the count was incorrect solely from lack of proper documentation. CNA #710 stated RN #722's behavior was very erratic every time she worked and she was uncomfortable taking the keys from her because there had been too many interactions of improper narcotic count and documentation.Review of a statement by the Director of Nursing (DON) dated 02/25/26 revealed she contacted RN #722 with Registered Nurse (RN) #302 as a witness. RN #722 was asked if she ever pulled multiple as needed narcotics and administered them at night. RN #722 stated she never pulled narcotics multiple times on a nightshift. When asked about Resident #99's oxycodone being given multiple times throughout a shift, RN #722 stated she never gave anyone more than one or two as needed medications a shift. A follow up call on 03/02/26 was completed to RN #722 to follow up on a statement medications were never pulled multiple times a night. RN #722 stated she shouldn't say never because there were two residents who ask for as needed medications frequently. When asked why she signed out Resident #99's oxycodone five times without signing the MAR, RN #722 stated she had never given it five times, maybe two to three times at most a shift and she did not know why she had not signed them out of the MAR. RN #722 stated she had struggled with the new system and went on to say Oh, I know (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	why Resident #99 says she never gets them in the middle of the night, it is because I gave her PRN (as needed) tizanidine (a muscle relaxer), that's why she doesn't remember getting her pain medications.An undated statement by the DON revealed Resident #99 was asked if she had been receiving oxycodone multiple times per shift as needed as they are ordered and resident stated, Lord, no, I would never be able to have a bowel movement if I took them more than once or twice in a day. The rest of the time I take Tylenol.Review of a Self-Reported Incident Tracking Number 271369, initiated 02/25/26 and completed 03/02/26 revealed the evidence was inconclusive. Abuse, neglect or misappropriation is suspected but the facility was unable to determine if the medications were misappropriated or were a lack of documentation of the MAR (for administration). The local police, State Board of Nursing and Pharmacy were notified.On 04/14/26 at 11:18 A.M. interview with the DON confirmed there was no evidence Resident #99 received all doses of the medication signed out on the narcotic log as all doses were not documented on the MAR. The DON verified Resident #99 stated she did not take more than one or two doses of oxycodone per day as she would not be able to have a bowel movement if she did. (Please note, along with no documentation of administration of the prn opioid medication, there was no assessment of the resident's pain levels pre or post pain medication administration). When asked, the DON had no additional information to provide regarding misappropriation. The DON verified RN #722 was terminated and reported to the Board of Nursing as a result of the incident.Review of a Board of Nursing employer report form revealed RN #722 was terminated for removing controlled substances without documentation that medication was given. The form was signed by the DON on 03/20/26 and was reported to the State Board of Nursing.Review of the Abuse Prohibition Policy, originated 12/01/12 and last revised 09/09/22 revealed Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. Abuse shall include freedom from verbal, mental, sexual, physical abuse, corporal punishment, involuntary seclusion and any physical or chemical restraint imposed for purposes of discipline or convenience that are not required to treat the guest's/resident's medical symptoms.To assure guests/residents are free from abuse, neglect, exploitation, or mistreatment, the facility shall monitor guest/resident care and treatments on an on-going basis. It is the responsibility of all staff to provide a safe environment for the guests/residents.Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychological well-being. Instances of abuse of all guests/residents, irrespective of any mental or physical condition, may cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.Misappropriation of guest/resident property means that deliberate misplacement, exploitation, or wrongful, temporary or permanent use of guest's/resident's belongings or money without the guest's/ resident's consent.For verified (facility-substantiated allegations) incidents of abuse, neglect, mistreatment, exploitation, and misappropriation of property, corrective action shall be taken and documented. Any employee shall be subject to immediate termination, if complaint is substantiated by the facility. Any resident verified for perpetrating abuse may be subject to discharge from the facility.Nurses will be reported to the State Board of Nursing for violations that are substantiated.

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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 record review and staff interview, the facility failed to ensure a resident had an active care plan in place to address her diagnosis of anxiety disorder requiring the use of anti-anxiety medications. This affected one (Resident #100) of 30 residents reviewed for care plans. Findings include Review of Resident #100's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included the diagnosis of depression. Review of Resident #100's physician's orders revealed the resident had an order to receive Buspirone (an anti-anxiety medication) 5 milligrams by mouth twice a day for anxiety. The order originated on 02/11/26. She also had an order to receive Vistaril (an antihistamine medication used in the treatment of anxiety disorder) 25 mg by mouth three times a day for anxiety. That order originated on 02/12/26. Review of Resident #100's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was coded on the MDS assessment as having received an anti-anxiety medication during the seven day assessment period. Section (I.) Active Diagnoses did not include the diagnosis of anxiety disorder despite the resident receiving two medications to treat anxiety. Review of Resident #100's active care plans revealed she did not have a care plan in place to address her anxiety disorder. She had a care plan for the potential for fluctuations in her mood, but it only addressed her depression and the use of an antidepressant. Her care plan for being at risk for adverse reactions and side effects related to receiving psychotropic medications. That care plan only indicated the resident was receiving an antidepressant for depression. It did not include the use of an antianxiety medication for the treatment of anxiety disorder. Review of Resident #100's medication administration record (MAR) for April 2026 revealed the resident was receiving Buspirone (Buspar) 5 mg by mouth twice a day for anxiety as ordered. She was also receiving Vistaril 25 mg by mouth three times a day for anxiety as ordered. On 04/13/26 at 10:20 A.M., an interview with the facility's Director of Nursing (DON) confirmed Resident #100's active care plans did not address her use of antianxiety medication for the treatment of anxiety. She acknowledged the resident was receiving Buspirone and Vistaril for the treatment of anxiety and should have a care plan in place that addressed anxiety.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review the facility failed to ensure care plans were revised to accurately reflect current fall interventions. This affected one (#86) of six residents reviewed for falls. The facility census was 98. Findings include: Record review revealed Resident #86 admitted to the facility on [DATE] with diagnoses including acute osteomyelitis of right ankle and foot, type II diabetes, and dementia.Review of a care plan dated 03/10/26 revealed Resident #86 was at risk for fall related injury and falls related to history and fear of falling. The goal was to be free from injury related to falls through the review date. Review of a nursing note dated 03/25/26 at 9:03 P.M. by Licensed Practical Nurse (LPN) #336 revealed Resident #86 went to the hospital. The note did not contain additional information.Interview on 04/07/26 at 12:50 P.M. with Resident #86 revealed he had a fall and had to be sent to the hospital. Resident #86 did not specify a date.Further review of the care plan revealed fall interventions included, but were not limited to, reacher at bedside and visual cue to use call light for assistance, created on 04/09/26 and related to the fall on 03/25/26. Interview on 04/09/26 at 1:38 P.M. with Director of Nursing (DON) verified care plan interventions from the 03/25/26 fall were added to the care plan on this date, however the interventions had been implemented immediately. The DON confirmed the care plan was not up to date until today (04/09/26). Review of a policy titled Care Planning dated 03/03/25 revealed every resident will have a person-centered care plan developed and implemented that is consistent with the resident rights, based on the comprehensive assessment that includes measurable objectives and time frames to meet a residents medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment and prepared by an interdisciplinary team.

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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 record review, interview, and policy review, the facility failed to identify and treat new skin areas. This affected one (#8) of two residents reviewed for skin conditions. Additionally, the facility failed to ensure residents did not go more than three days without a bowel movement without receiving interventions. This affected one (#99) of five residents reviewed for unnecessary medications. The facility census was 98. Findings include:1.Record review revealed Resident #8 admitted to the facility on [DATE] with diagnoses including spinal stenosis and radiculopathy. Review of a care plan dated 11/10/25 revealed Resident #8 was at risk for impaired skin integrity/pressure injury related to decreased mobility, current surgical wound, type II diabetes, hypertension, history of moisture associated skin damage (MASD), anemia, and morbid obesity. The goal was to minimize risk in an effort to reduce likelihood of pressure injury development through the review date. Interventions included but were not limited to conduct a weekly head to toe skin assessment and document/report abnormal findings to provider; follow facility policies/protocols for the prevention/treatment of impaired skin integrity; observe for sliding down in the chair and assist to reposition in chair as needed; observed skin with showers/care, notify nurse immediately of any new areas of skin breakdown, and treatment for prevention per orders. Review of a weekly skin assessment dated [DATE] revealed Resident #8 had no skin issues. Interview on 04/07/26 at 8:37 A.M. with Resident #8 revealed she had what she believed to be a blister on the back of her left thigh and during a mechanical lift transfer from her chair to the bed, the skin tore off and she had a wound to the left thigh now, which had not been addressed by staff, even after she requested a nurse to come assess the area. Observation on 04/08/26 at 10:18 A.M. of Resident #8 revealed she had an area to the back of her left thigh which presented as dry and peeling. The area was approximately two inches by three inches in size, and presented to be healing. Licensed Practical Nurse (LPN) #324 was in the room and confirmed the area to the back of Resident #8's left thigh. Interview on 04/08/26 at 10:33 A.M. with Registered Nurse (RN) #330 revealed Resident #8 had mentioned to her a couple weeks ago she had a blister on her thigh but she looked and did not see any area. Review of a nursing note dated 04/08/26 at 12:12 P.M. by LPN #324 revealed Resident #8 was provided education on proper peri-care and educated on the risks of her refusing proper care, prevention measurements applied to areas, resident agreed to let an aide complete proper peri-care. Wound nurse, RN #330, was notified and assessed resident. Review of a skin issue note dated 04/08/26 at 12:16 P.M. by RN #330 revealed Resident #8 had a new skin issue to the back of her left thigh which was MASD measuring eight centimeters by 12 centimeters. Review of an order dated 04/08/26 revealed the following treatment for Resident #8: cleanse left posterior thigh with soap and water, pat dry and apply barrier ointment every shift for MASD. Review of a nursing note dated 04/08/26 at 12:35 P.M. by LPN #324 revealed wound nurse uploaded (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	photos with wound phone to resident's chart, no open areas, all areas were blanchable redness, barrier cream applied per treatment orders. Resident #8 had zinc at bedside which was removed and educated barrier cream needed to be applied rather than zinc. Wound nurse to notify provider to a skin round on resident the next wound care day. Physician was notified. Interview on 04/14/26 at 8:20 A.M. with Resident #8 revealed she had a staff member, Certified Nursing Assistant (CNA) #373, take a picture of the back of her left thigh. Resident #8 shared the picture which was taken with her phone, and the photo was dated 04/03/26 at 4:09 A.M. Interview on 04/14/26 at 8:44 A.M. with RN #305 confirmed if a wound was found and a photo was taken on 04/03/26 by staff, it should have been identified and treatment prior to 04/08/26 when the facility was made aware of the skin alteration, by the surveyor. Review of a policy titled Skin Management dated 01/28/26 revealed the resident with wounds and/or pressure injury and those at risk for skin compromise are identified, evaluated, and provided appropriate treatment to promote prevention and healing. Ongoing monitoring and evaluation are provided to ensure optimal resident outcomes. A skin check is completed by a licensed nurse weekly, and will be documented. Aides should reported any new skin impairment to the licensed nurse that is identified during daily care. If a new area of skin impairment is identified, notify the resident, responsible part, provider, director of nursing and treatment team if applicable. 2. Review of Resident #99's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included adult-onset diabetes mellitus, generalized osteoarthritis, hypokalemia (low potassium level in the blood), depression, and anxiety disorder. Review of Resident #99's physician's orders revealed the resident had an order to receive Oxycodone (narcotic opioid pain medication) 5 milligrams (mg) by mouth (po) every four hours as needed (prn) for pain. The resident had been on that medication since 11/14/25. Her orders did not include the use of any stool softeners or laxatives to be given on a prn basis when the resident had not had a bowel movement for more than three days. Review of Resident #99's active care plans revealed she had a care plan in place for being at risk for constipation related to opioid use. The care plan originated on 11/17/25. The goal was for the resident to have a normal bowel movement at least every three days. The interventions included the need to observe for signs/ symptoms of constipation to include a change in the consistency of her bowel movement or difficulty in expulsion. Review of Resident #99's bowel movement record for the past 30 days (03/15/26 to 04/13/26) revealed the resident was not documented as having had a bowel movement (BM) for more than three days on three separate occasions. There was no BM recorded as having occurred for the resident between 03/15/26- 03/18/26 (4 days), 03/20/26- 03/27/26 (8 days), and 03/29/26- 04/01/26 (4 days). Further review of Resident #99's medical record revealed there was no documented evidence of the resident receiving any intervention by the facility's nurses to help promote the resident to have a bowel movement. Her MAR for April 2026 did not show any laxatives had been administered when the resident went longer than three days with no BM. There was no documented evidence in the progress notes of the facility nurses contacting the resident's physician to get orders for interventions to help the resident have a BM. The MAR's for March 2026 and April 2026 did show the resident had received (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her prn Oxycodone 27 times in March 2026 and seven times in April 2026. On 04/13/26 at 12:45 P.M., an interview with Resident #99 revealed there had been times where her bowels had not moved for over three days. She stated it sounded about right when she was informed the bowel movement record indicated there were two four day periods where she did not have a recorded bowel movement and another eight day period where she was not recorded as having had a bowel movement. She indicated during that eight day period she was on an antibiotic and was also receiving a potassium supplement, which she contributed to her constipation. She reported she was able to take herself to the bathroom and would inform the nurses when her bowels moved. She denied any of the nursing staff had asked her if her bowels had moved, after three days of no BM, when she went eight days without a bowel movement. She did not think her constipation had anything to do with the Oxycodone she was taking on a prn basis despite it being known to cause constipation. On 04/13/26 at 12:55 P.M., an interview with the facility's DON confirmed Resident #99 bowel movement recorded during the past 30 days showed she went four days without a recorded bowel movement twice during that 30 day period and eight days once during that same 30 day period. She further acknowledged there was no evidence of the resident having received any intervention to help promote her to have a bowel movement during those three occasions. She denied the facility had a bowel protocol that they followed. She stated it was an expectation that the resident have a bowel movement every three to four days, and if no bowel movement was noted, then the nurse should reach out to the physician for orders to administer a laxative.

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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 record review, policy review and staff interview, the facility failed to ensure residents, who had significant weight loss and/ or were at nutritional risk, had their meal consumption amounts recorded to show adequate monitoring of their nutritional status. This affected two (Resident #5 and #12) of three residents reviewed for nutrition/ weight loss. Findings include: 1.Review of Resident #12's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included unspecified dementia, adult-onset diabetes mellitus, major depressive disorder, anxiety disorder, and Vitamin B-12 and D deficiencies. Review of Resident #12's weights revealed her weights were trending down. She weighed 154.4 pounds when she was admitted to the facility on [DATE]. Her weight three months later on 09/04/25 was 140 pounds. Her last weight on 04/02/26 was 130 pounds. Review of Resident #12's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues but her cognition was severely impaired. She required set-up/ clean up assistance for eating. Her height was 66 inches and her weight was 132 pounds. She was not identified as having had a significant weight loss at that time. Review of Resident #12's active care plans revealed she had a care plan in place for being at risk for nutrition related to her diagnoses and a history of a significant weight loss noted at one month, three months, and six months between August and December of 2025. The goal was for the resident to not have any unplanned significant weight changes. The interventions included the need to provide her with the diet as ordered (regular) and to offer substitutes as needed. She was also to receive supplements as ordered and to document consumption. They were to follow up with the dietician as needed. Review of Resident #12's active physician's orders revealed the resident was on a regular diet. She had an order to receive house supplement (237 milliliters) two times a day for a supplement. Her physician's orders indicated she was at risk for malnutrition. Review of Resident #12's meal intakes for the past 30 days (03/12/26- 04/08/26) revealed only 29 meals out of 90 meals served had been recorded to reflect the amount of the meal the resident consumed. The resident's meal consumption was not recorded for any of the three meals served for 16 days of that 30 day period. No meals were recorded for 03/14/26, 03/15, 03/18, 03/19, 03/22, 03/23, 03/24, 03/27, 03/28, 03/29, 04/01, 04/02, 04/04, 04/05, 04/06, and 04/07/26. Only one of the three meals were documented on 03/17/26 and 03/21/26. Only two of the three meals were documented on 03/12, 03/13, 03/16, 03/25, 03/26, 03/30, and 03/31/26. On 04/09/26 at 9:54 A.M., an interview with Certified Nursing Assistant (CNA) #350 revealed the resident was on a regular diet. She would eat in the dining room for breakfast. The family was usually with her during the lunch and supper meals and would eat them with the resident back in her room. They would also go on drives with the resident and get her something to eat when out. She was not aware of the resident receiving any supplements. She reported house supplements were usually sent out with meals. They had some in a container that was brought to the nurses station but the resident did not have any in that container to be given out today. She reported her appetite depended on the day. She would tell them she did not want to eat breakfast but would then eat 100%. She did better with breakfast than she did for lunch. If she ate less than 50% they would offer her something else to eat. She was not aware of any food items the resident was more likely to eat than what she refused when served. She was not aware of the resident having any weight loss. On 04/09/26 at 11:32 A.M., findings were verified by Licensed Practical Nurse (LPN) #427 that Resident #12's meal percentages were not being consistently recorded in the electronic medical record (EMR) to show evidence of the facility adequately monitoring the resident's nutritional intake. She acknowledged only a third of the meals the resident received were documented in the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EMR. She further acknowledged the amount of meals the resident was consuming would be important piece of the resident's overall nutritional status for the dietician to be able to review when deciding what nutritional interventions should implemented to address any weight loss. 2.Review of the medical record for Resident #5 revealed an initial admission date of 02/28/26 with diagnoses including end stage renal disease, respiratory failure, hyperlipidemia, and congestive heart failure. Review of the resident's most recent Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition and required set up/clean up assistance with meals. Review of the plan of care last reviewed/revised 04/07/26 revealed the resident was at nutritional and/or dehydration risk in regard to recent surgical procedure, diagnoses of congestive heart failure, dialysis, increased needs and skin alteration. Interventions included assist resident with meals as needed, and provide diet as ordered. Review of Resident #5's physicians orders dated 04/07/26 revealed an order for dialysis on Tuesdays, Thursdays and Saturdays with an arrival time of 11:15 A.M. Review of the resident's meal percentage for March 2026 revealed no documented meal percentage intakes for 03/05/26, 03/06/26, 03/09/26, 03/10/26, 03/14/26, 03/20/26, 03/27/27/26, and 03/29/26 for breakfast, lunch and dinner; 03/04/26 for lunch; 03/12/26 for breakfast and lunch; 03/28/26 for dinner; and 03/23/26 for lunch and dinner. Review of the resident's meal percentages for April 2026 revealed no documented meal percentage intakes for 04/01/26 for breakfast and lunch; and 04/06/26 for dinner. Interview on 04/09/26 at 12:58 P.M. with Diet Tech #700 revealed expectations for staff would be to return a resident's tray to the kitchen if they were not available during the meal delivery time and document meal intakes in the medical record. Interview on 04/09/26 at 1:05 P.M. Dietary Staff #407 revealed for residents who go to dialysis the facility can send a sack lunch if they request one or snacks such as peanut butter crackers. Dietary sends a tray to the hall and staff should put it in the fridge until they return from appointments. The kitchen also has soups or sandwiches available. Interview on 04/13/26 at 1:50 P.M. with CNA #399 revealed if a resident was not at the facility when their tray was delivered, the staff would put it in the server room and someone would get it when the resident get back. Lasty, the CNA stated meal intakes should be documented in the computer. Interview on 04/13/26 at 1:56 P.M. with Administrator and Director of Nursing #304 confirmed the meal percentages missing from the resident's record. Review of facility policy titled Food Acceptance, last revised 09/22/23, revealed an accurate record of appropriate resident's food intake will be completed by the assigned personnel.

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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 record review, observation, interview, and policy review, the facility failed to ensure a resident with a tracheostomy tube had appropriate medical emergency equipment at her bedside to include an Ambu bag (resuscitation bag). The facility also failed to ensure another resident had a physician's order for the administration of oxygen, prior to its use. This affected two (Resident #9 and #39) of three residents reviewed for respiratory care. Findings include: 1.Review of Resident #9's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included chronic respiratory failure with hypoxia (low oxygen levels in the blood), tracheostomy status, chronic obstructive pulmonary disease, heart failure, and chronic pulmonary edema. Review of Resident #9's active physician's orders revealed she had an order in place for 28% humidified oxygen set up with oxygen bleed via a tracheostomy collar to keep his oxygen saturation levels in his blood greater than 90%. Tracheostomy care was to be provided every shift. The resident's code status was a full code. Review of Resident #9's active care plans revealed she had a care plan in place for being at risk for respiratory distress, decannulation (accidental dislodgement of her tracheostomy tube, and infection related to her having a tracheostomy. The goal was for her not to experience any respiratory distress. The interventions included administering humidified oxygen as ordered and to provide tracheostomy care/ dressing changes per order and facility protocol. On 04/15/26 at 9:00 A.M., an observation of Resident #9's tracheostomy care was made. Tracheostomy care was performed by RN #334. After completion of the tracheostomy care procedure, the nurse was asked to confirm what emergency medical supplies were being maintained in the resident's room in the event there was an emergency related to her tracheostomy. The resident was noted to have all necessary emergency medical equipment in her room, with the exception of an Ambu bag. The nurse searched the room and was unable to locate the Ambu bag. RN #334 acknowledged that an Ambu bag should be part of the emergency medical equipment kept readily accessible in the resident's room in the event she had complications related to her tracheostomy or respiratory/ cardiovascular problems requiring artificial resuscitation. She reported she would have to leave the room or have someone obtain an Ambu bag from the crash cart in the event it was needed. Review of the facility's policy on Tracheostomy Tube Cannula and Stoma Care (not dated) revealed the facility was to make sure an extra tracheostomy tube, obturator, as well as a hand held resuscitation bag with an attached oxygen source were readily available for easy access in case of n emergency. 2.Record review revealed Resident #39 admitted to the facility on [DATE] with diagnoses including major depression and hypertension. Review of an MDS dated [DATE] revealed Resident #39 received continuous oxygen therapy. Observation on 04/06/26 at 12:37 P.M. revealed Resident #39 had oxygen in place at three liters per minutes via nasal cannula. Review of the current orders revealed no orders for Resident #39 to receive oxygen. Observation and interview on 04/07/26 at 9:25 A.M. with Social Services (SS) #423 (who is also a licensed practical nurse) revealed Resident #39 was resting in bed with oxygen in place. SS #423 confirmed there was no order in place for Resident #39 to receive oxygen.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview, record review, and review of facility policy the facility failed to identify and document trauma triggers on the care plans of residents with post traumatic stress disorder. This affected two residents (#78 and #109) of three sampled for behavioral/emotional concerns. The facility census was 98.Findings include: 1.Review of Resident #78's medical record revealed an admission date of 08/30/19 and diagnoses including Alzheimer's disease, dementia, wandering in diseases classified elsewhere, delusional disorders, insomnia, major depressive disorder, post traumatic stress disorder (PTSD), psychotic disorder with delusions, anxiety disorder, and drug induced subacute dyskinesia (erratic, uncontrollable and involuntary movements caused by some medications after long-term use). Review of Resident #78's trauma care plan, initiated 07/14/23 revealed Resident #78 had experienced trauma at some point in the past via a past abusive relationship. Further review of the care plan revealed no identified triggers for trauma. Review of Resident #78's medical record revealed a social services re-evaluation dated 03/14/25 completed by Social Services Worker #423 that indicated the resident had not suffered from PTSD since the last social services assessment. Review of Resident #78's medical record revealed a social services re-evaluation dated 09/12/25 completed by Social Services Worker #423 that indicated the resident had not suffered from PTSD since the last social services assessment. Review of Resident #78's medical record revealed a social services re-evaluation dated 11/13/25 completed by Social Services Worker #423 that indicated the resident had not suffered from PTSD since the last social services assessment. Review of Resident #78's medical record revealed a social services re-evaluation was not completed after the 11/13/25 evaluation. Review of Resident #78's quarterly Minimum Data Set (MDS) dated [DATE] revealed a brief interview for mental status score of three (of a possible 15 points) indicating the resident had severe cognitive impairment. Further review of the MDS revealed the resident had an active diagnoses of PTSD. In an interview on 04/14/26 at 11:05 A.M. Social Services worker #427 verified no triggers were identified on Resident #78's care plan and there was no indication on the care plan the resident had denied having triggers. In an interview on 04/14/26 at 3:15 P.M. Social Services worker #427 verified she was unable to find a social services re-evaluation completed after the 11/13/25 evaluation. 2.Review of Resident #109's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included major depressive disorder and Post Traumatic Stress Disorder (PTSD). His diagnosis of PTSD was added to his diagnoses list on 04/01/26 Review of Resident #109's trauma evaluation assessment completed on 02/26/26 revealed the resident was asked a series of six different questions with yes or no responses recorded to identify any past traumas. The questions asked and the resident's response included the following: 1.) Have you ever experienced an event that was unusually or especially frightening, horrible, or traumatic? His response was yes. 2.) In (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the past month, have you had nightmares about the event(s) or thought about the event(s) when you did not want to? His response was yes. 3.) In the past month, have you tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)? His response was yes 4.) In the past month, have you been constantly on guard, watchful, or easily startled? His response was no. 5.) In the past month, have you felt numb or detached from people, activities, or your surroundings? His response was no. 6.) In the past month, have you felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused? His response was no. The resident's overall score was 2. There was no indication on the trauma evaluation to indicate what a score of 2 meant. No other comments or information was included on the trauma evaluation. Review of Resident #109's progress notes revealed he was sent out to the hospital on [DATE] for a cough and shortness of breath. He was admitted for pneumonia and returned to the facility on [DATE]. Review of Resident #109's hospital History and Physical (H&P) dated 03/28/26 revealed depression and PTSD were included under his active diagnoses. He was indicated to be receiving Effexor for the treatment of his depression and PTSD. Review of Resident #109's re-admission H&P completed at the facility by the resident's attending physician on 04/03/26 revealed the physician included the diagnosis of PTSD as one of his active diagnosis. It was not previously included when the attending physician completed the initial H&P on 02/25/26 following the resident's original admission into the facility on [DATE]. Review of Resident #109's Social Service Re-Evaluation dated 04/07/26 revealed the resident's diagnoses included PTSD. LPN #423, who was one of the facility's social service designees, completed the Social Service Re-Evaluation assessment and acknowledged the resident's diagnosis of PTSD under the additional comments section. She indicated his PTSD was due to the Vietnam War and the resident reported difficulty sleeping almost every night. The resident stated loud noises and closed spaces trigger him, however he did report his medications were effective. He also was followed by psychiatric services through the local Veteran's Affairs (VA) branch and did telehealth visits every three weeks. Review of Resident #109's active care plans revealed he had a care plan in place for experiencing trauma at some point during the past. The care plan indicated his trauma may be expressed by hypervigilance, social isolation, and flashbacks. The care plan further indicated his PTSD was from the Vietnam War and that he was followed by psychiatric services through the Veteran's Association (VA). The goals included his care and current situation would not be influenced by past trauma, he would feel safe in his current situation, would not be re-traumatized, and would share trauma history as comfortable. The interventions included avoiding (the word specify was in the parenthesis) as much as possible. The care plan was not clear on what trauma related triggers to avoid. On 04/14/26 at 9:20 A.M., an interview with Resident #109 revealed he did have the diagnosis of PTSD that was related to his time in the military and serving during the Vietnam War. He was asked if he had any known triggers and reported that he did not like loud/ sudden noises or being in enclosed spaces. He stated, when he was triggered, he felt the need to go hide somewhere. He indicated as long as he was getting his medication (Effexor) he was doing fine and had not had any issues during the time he spent in the facility. On 04/14/26 at 11:20 A.M., an interview with LPN #430 revealed Resident #430 had a Social Service Re-Evaluation completed on 04/07/26 that indicated he had a diagnosis of PTSD due to Vietnam War. The re-evaluation assessment did identify triggers, which included loud noises and closed spaces. She provided an updated care plan for the resident having experienced trauma at some point during the past that was initiated on 04/07/26. The resident's known triggers related to his PTSD were not added to that care plan until 04/14/26, when the facility was asked to provide the initial trauma evaluation and the resident's active care plans. LPN #430 confirmed she just added the resident's known triggers to the PTSD care plan on 04/14/26 and they were not included, as part of his trauma informed plan of care prior to that. Review of the policy titled Social Services Documentation, revised 08/01/24, revealed that if trauma (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was identified care plans would be written to address the trauma including the triggers. Further review of the policy revealed the social services reevaluation was to be completed with each MDS or at least every 90 days.

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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 record review, interview, and policy review, the facility failed to ensure controlled substances were documented accurately in the medical record. This affected one (#99) of two residents reviewed for misappropriation. The facility census was 98.Findings include:Record review revealed Resident #99 admitted to the facility on [DATE] with diagnoses including hypertension and anemia.Review of orders revealed Resident #99 had an order in place dated 11/14/25 for oxycodone oral tablet 5 milligrams (mg) give one tablet by mouth every four hours as needed for pain.Review of a care plan dated 11/17/25 revealed Resident #99 was at risk for pain and has chronic pain related to internal orthopedic device and left knee pain. Goals included verbalizing adequate relief of pain or ability to cope with incompletely resolved pain through the review date and state relief of pain daily through the review date. Interventions included but were not limited to administer medications as ordered and observe for effectiveness and side effects.Review of a Minimum Data Set, dated [DATE] revealed Resident #99's cognition was intact and had pain. The resident received opioid medication.Review of the narcotic log for 02/2026 revealed oxycodone tablet five mg one tablet by mouth every four hours as needed was signed out on 02/21/26 at 8:20 A.M. by Licensed Practical Nurse (LPN) #335.Review of the MAR for 02/2026 revealed oxycodone tablet five mg one tablet by mouth every four hours as needed was not signed as administered on 02/21/26 at 8:20 A.M.Review of the narcotic log for 02/2026 revealed oxycodone tablet five mg one tablet by mouth every four hours as needed was signed out on 02/22/26 at 9:30 A.M. by LPN #335.Review of the MAR for 02/2026 revealed oxycodone tablet five mg one tablet by mouth every four hours as needed was not signed as administered on 02/22/26 at 9:30 A.M.Interview on 04/14/26 at 11:18 A.M. with the DON revealed they had identified LPN #335 had signed out the medication from the narcotic log but did not sign the medication as administered on the MAR but did not think there was a concern of medication diversion or misappropriation because Resident #99 was interviewed and said she received those medications and there should be a statement from the resident (included in a misappropriation investigation involving Resident #99 but related to a different nurse).There were no statement in the investigation with Resident #99 indicating she had been interviewed about other staff or incidents of medications being signed out on the log without being on the MAR as administered.Interview on 04/14/26 at 1:27 P.M. with Resident #99 revealed she got her medications as requested and had no concerns with any of the other nurses. Review of a policy titled Controlled Substances dated 10/26/23 revealed when a controlled substance is received from the pharmacy, the nurse will open the controlled substance bag and confirm resident name, name and strength of the medication, and quantity of the medication. The pharmacy log is signed that the substance was received, and the controlled substance proof of use sheet with be completed for amount received, date received, and a nurse signature. The sheet will be added to an appropriate binder and the medication is placed in the medication cart controlled substance lock box.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of meal times, and staff interview, the facility failed to ensure a medication that was given to a resident for the treatment of osteoporosis was administered in accordance with the physician's orders and on an empty stomach to increase the absorption of the medication. They also failed to ensure a resident receiving a beta-blocker for the treatment of hypertension had her apical pulse checked prior to the administration of the medication as ordered by the physician with parameters in place to hold the medication if the resident's heart rate was less than 60 beats per minute (bpm). This affected two (Resident #12 and #100) of five residents reviewed for unnecessary medications. Findings include:1. Review of Resident #100's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included hypertensive heart disease with heart failure, atrial fibrillation, and hypertension. Review of Resident #100's active physician's orders revealed the resident had an order to receive Metoprolol Succinate (a beta-blocker used in the treatment of hypertension) Extended Release (ER) 25 milligrams (mg) every night at bedtime for hypertension. The order originated on 02/14/26 and included parameters to hold the medication if the resident's systolic blood pressure was less than 100 mmHg or her heart rate was less than 60. Review of Resident #100's medication administration records for March and April 2026 revealed the resident was receiving Metoprolol Succinate ER 25 mg by mouth (po) every night at bedtime as ordered. The MAR's had the medication scheduled to be administered at 9:00 P.M. The nurses initialed the MAR to reflect the medication had been given and also recorded a blood pressure obtained prior to the medication being administered. There was no documented evidence to show the resident's apical pulse was being checked prior to the medications administration despite the order for the medication included parameters to hold the medication if the resident's heart rate was less than 60 bpm. Further review of Resident #100's electronic medical record (EMR) revealed there was no evidence of an apical pulse being checked and recorded under the vital sign tab of the EMR that coincided with the administration times of the Metoprolol Succinate. Findings were verified by the facility's Director of Nursing (DON). On 04/13/26 at 10:20 A.M., an interview with the DON confirmed she was not able to find any evidence of Resident #100's apical pulse (heart rate) being checked prior to the administration of the resident's Metoprolol Succinate ER that was scheduled to be administered every night at 9:00 P.M. The DON reported the resident's heart rate should have been checked, as the medication was known to slow the heart rate. 2.) Review of Resident #12's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included age-related osteoporosis. Review of Resident #12's active physician's orders revealed she had an order in place to receive alendronate sodium (Fosamax) 70 mg once daily every Friday for osteoporosis. The order included instructions to give with a full glass of water and on an empty stomach. The order originated on 06/22/25. Review of Resident #12's MAR for March and April 2026 revealed the resident was receiving Fosamax 70 mg po once a day every Friday as ordered. The administration time for the Fosamax was scheduled for 9:00 A.M. Four doses had been given in March 2026 and one dose had been given so far in April 2026. Review of a Medication Administration Audit Report for the administration of Resident #12's Fosamax for the past 30 days revealed the resident was receiving her Fosamax between 8:25 A.M. and 8:53 A.M. Only four doses had been given during that 30 day report and administration times were 8:25 A.M., 8:37 A.M., 8:42 A.M., and 8:53 A.M. Review of the meal times for Resident #12's hall (600 Hall) revealed the breakfast meal was served at 8:50 A.M. If she chose to eat her meal in the dining room for breakfast, her meal would be served at 8:30 A.M. On 04/08/26 at 1:30 P.M., an interview with LPN #430 confirmed Resident #12's Fosamax was scheduled to be given every Friday at 9:00 A.M. She also confirmed that the breakfast meal was to be served at 8:30 A.M. in the North dining room where Resident #12 was known to eat her breakfast or at 8:50 A.M. on the days she received her breakfast meal in her room. She acknowledged the physician's orders included instructions for the Fosamax to (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be given with a full glass of water and on an empty stomach. She further acknowledged, with the times noted on the Fosamax Administration Audit Report, the Fosamax was not being administered on an empty stomach as the resident would have received her breakfast tray before or at around the time the Fosamax was being given. She also acknowledged not taking the medication on an empty stomach would result in poor absorption of the medication. Review of drug information for Fosamax included under Medscape revealed Fosamax should be taken upon rising for the day. It further indicated that the medication should be taken at least 30 minutes before the first food, beverage, or medication of the day with plain water only. Waiting less than 30 minutes, or taking with food, beverages (other than plain water), or other medications would reduce the efficacy by decreasing its absorption.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy, the facility failed to ensure a urinalysis with culture and sensitivity (UA C&S) was obtained per orders. This affected one resident (Resident #8) of one resident reviewed for urinary tract infection (UTI). The facility census was 98. Findings include: Record review revealed Resident #8 admitted to the facility on [DATE] with diagnoses including spinal stenosis and radiculopathy.Review of a care plan dated 02/09/24 revealed Resident #8 was at risk for incontinence of bladder, skin breakdown, and UTI due to diagnoses of overactive bladder. The goal was for risk of septicemia to be minimized/prevented via prompt recognition and treatment of symptoms of UTI through the review date. Interventions included but were not limited to administer medications as ordered, observe for/document for signs and symptoms of UTI and report to physician if indicated.Review of an orders revealed an order dated 10/17/25 for Resident #8 to receive a UA C&S one time only for dysuria (painful urination).Review of a care plan dated 10/20/25 revealed Resident #8 was at risk for a UTI due to complaints of dysuria. The goal was for resident to show no signs or symptoms of infection. Interventions included encourage fluids, labs per orders, and obtain vitals as ordered or per facility protocol.Review of a nursing note dated 10/22/25 at 10:00 A.M. by Licensed Practical Nurse (LPN) #338 revealed an attempt was made to straight cath (catheterization) (insert a tube through the urethra to obtain urine for a specimen and then the tube is removed) Resident #8 for a UA sample, unable to obtain at this time related to resident's positioning. LPN would attempt again after resident was repositioned.Review of a nursing note dated 10/22/25 at 10:30 A.M. by LPN #338 revealed Resident #8 was repositioned and started yelling she did not want to be straight cath, she wanted to use a bed pan to obtain the sample. Resident #8 refused.There was no evidence in the medical record to show attempts were made to collect a sample for a UA prior to 10/22/25 or evidence the provider was notified of resident's refusal. The medical record contained no evidence the urine was obtained per orders.Interview on 04/09/26 with Physician Assistant (PA) #600 revealed he had given an order on 10/17/25 for Resident #8 to receive a UA C&S but there were no results in the record so he was unsure if the tests were done or not. PA #600 stated he would hope the staff would collect a sample as fast as possible and would prefer for it to be completed by the following Monday (10/22/25).Interview on 04/13/26 at 2:33 P.M. with Director of Nursing (DON) confirmed the order for Resident #8's UA C&C was given on 10/17/25 and not attempted to collect until 10/22/25, which was five days later.Review of an undated policy titled Laboratory Services revealed lab services would be provided only when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist and ensure the labs are completed and results are provided to the facility within timeframes normal for appropriate intervention.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a complete and accurate medical record was maintained. This affected four (#9, #12, #76, and #86) of 30 resident records reviewed for a complete and accurate medical record. The facility census was 98. Findings include:1.Record review revealed Resident #86 admitted to the facility on [DATE] with diagnoses including acute osteomyelitis of right ankle and foot, type II diabetes, and dementia. Review of a care plan dated 03/10/26 revealed Resident #86 was at risk for fall related injury and falls related to history and fear of falling. The goal was to be free from injury related to falls through the review date. Review of a nursing note dated 03/25/26 at 9:03 P.M. by Licensed Practical Nurse (LPN) #336 revealed Resident #86 went to the hospital. The note did not contain additional information. Review of an eInteract Change in Condition assessment dated [DATE] revealed the assessment had been opened but was blank. Review of a fall investigation requested from the facility revealed the investigation had been opened on 03/25/26 but was not signed until 04/09/26. Interview on 04/07/26 at 12:50 P.M. with Resident #86 revealed he had a fall and had to be sent to the hospital. Resident #86 did not specify a date. Interview on 04/09/26 at 12:53 P.M. with Licensed Practical Nurse (LPN) #336 revealed documentation should be signed right away as best practice. LPN #336 stated she signed the fall assessment/investigation on 04/09/26 because she was notified by the Director of Nursing (DON) things were not completed. Interview on 04/09/26 at 1:04 P.M. with the DON revealed Resident #86's fall investigation was on paper and just needed input to the assessment. A follow-up interview with the DON at 1:22 P.M. revealed the paper investigation was not part of the medical record because it was meant to be used for Quality Assurance Performance Improvement (QAPI). 2.Record review revealed Resident #76 admitted to the facility on [DATE] with diagnoses including dysphagia and unspecified lack of expected normal physiological development in childhood. a. Review of Resident #76's shower documentation revealed missing entries for 01/10/26, 01/24/26, 01/28/26, 01/31/26, 02/14/26, 02/18/26, 02/21/26, 02/25,26, 03/11/26, 03/14/26, 03/18/26, 03/21/26, 03/25/26, 03/28/26, 04/01/26, 04/04/26, and 04/11/26. Interview on 04/14/26 at 11:17 A.M. with the DON confirmed missing shower documentation on the dates identified. Interview on 04/14/26 at 1:15 P.M. with Resident #76 revealed she received her showers, but staff did not assist her with shaving. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Review of Resident #76's meal intake documentation revealed missing documentation on 03/17/26 for lunch and dinner; 03/18/26 and 03/19/26; 03/21/26 for lunch and dinner; 03/22/26 and 03/23/26; 03/24/26 for lunch; 03/27/26-03/29/26; 04/03/26 for dinner; and 04/11/26. Interview on 04/14/26 at 4:32 P.M. with the DON confirmed missing meal documentation on the dates identified. 3. Review of Resident #12's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included unspecified dementia, difficulty walking, and low back pain. Review of Resident #12's bowel movement report for the past 30 days revealed the resident was not documented as having had a bowel movement (BM) for seven days between 03/26/26 and 04/01/26. Her BM report also indicated she went another five days between 04/03/26 and 04/07/26 with no recorded bowel movement. Review of Resident #12's active physician's orders revealed the resident had an order to receive Bisacodyl (a laxative) 10 milligrams (mg) rectal suppository as needed for constipation. The order had been in place since 06/21/25. Review of Resident #12's medication administration records (MAR's) for March and April 2026 revealed there was no evidence of the resident receiving her Bisacodyl 10 mg suppository rectally for constipation. She had not received the Bisacodyl when her BM report indicated she went without a bowel movement for that seven day period or the five day period indicated above. On 04/08/26 at 1:30 P.M., an interview with LPN #430 confirmed Resident #12 was not documented as having had a bowel movement between 03/26/26 and 04/01/26 (seven days) or between 04/03/26 and 04/07/26 (five days). She further confirmed the resident's MAR's for March and April 2026 did not show the resident was given a Bisacodyl 10 mg suppository during those time frames when she had an order to receive it on an as needed basis for constipation. On 04/08/26 at 4:35 P.M., an interview with RN #326 revealed she felt like Resident #12's bowels moved regularly and did not feel she would have went five to seven days without a bowel movement. She was asked what the facility's protocol was with monitoring BM's and when to administer as needed (prn) laxatives. She reported, if the resident's bowels did not move for three days, they would offer a laxative. On 04/08/26 at 4:50 P.M. RN #326 approached this surveyor and reported she forgot that the resident's family had reported to her that Resident #12 had a BM on Monday (04/06/26). She confirmed she did not document the resident's bowel movement under the bowel elimination report, which was under the task tab of the electronic medical record (EMR). On 04/09/26 at 11:32 A.M., an interview with Resident #12's daughter revealed the resident's bowels moved pretty regularly when the family was in the facility daily. She stated they keep a pretty close eye on that and if the resident did not go after two days they would be reporting it to the nurses. She was confident the resident had a BM between 03/26/26 and 04/01/26, despite her BM record showing no BM had been recorded. LPN #430 was present with the surveyor when the family was interviewed. LPN #430 confirmed it was a lack of documentation of the resident's BM's in the EMR on their part partly due to the resident's family not always communicating to the facility staff when the resident had a bowel movement. She stated they would have to come up with a book or something the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	family could log BM's in when they occur that would also allow their staff to monitor and ensure the resident did in fact have a BM at least every three days. 4. Review of Resident #9's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included chronic respiratory failure with hypoxia (low oxygen level in the blood), chronic obstructive pulmonary disease, unspecified asthma, chronic pulmonary edema, and tracheostomy status. Review of Resident #9's physician's orders revealed she had an order in place to receive tracheostomy care every shift. There was also an order for the nurse to clean/ change the resident's inner cannula every shift as part of the tracheostomy care performed. Both orders had been in place since 04/27/25. Review of Resident #9's treatment administration record (TAR's) for March 2026 revealed there were several missing initials on the TAR, where the nurses were to be signing to show documented evidence of the tracheostomy care and the cleaning/changing of the inner cannula was completed. The dates with missing initials included 03/17/26 (nights), 03/20/26 (afternoon/ evening shift), 3/21/26 (nights), and 03/25/26 (nights). On 04/13/26 at 4:38 P.M., an interview with RN #305 confirmed Resident #9's TAR's for March 2026 did not provide documented evidence of tracheostomy care having been completed for the resident on the dates indicated above. She reported, on the dates that were missing the nurses' initials to show documented evidence of the resident being provided with tracheostomy care, they had a medication technician assigned to work the resident's hall. She indicated a nurse from the 100 or the 400 hall would have been the one to complete the tracheostomy care for the resident on those dates where a nurse's initial was missing. She identified the nurses that would have completed the tracheostomy care on those dates and had them confirm through interview that the tracheostomy care was completed, but just wasn't signed off as completed. Review of a policy titled Documentation Expectations dated 07/11/23 revealed healthcare personnel should complete documentation requirements as outlined by the company and recorded in the medical record using accepted principle of documentation. Nursing assistant documentation is completed per the electronic medical system or paper flow sheets as necessary. Documentation should be audited by the licensed nurses to assure completeness and accuracy.

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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 record review, observation, interview, and policy review, the facility failed to ensure hand hygiene was performed in between glove changes during tracheostomy care, failed to ensure a resident's indwelling urinary catheter's collection bag was maintained off the floor, and failed to ensure shared glucometers were properly disinfected between each use. This affected one (Resident #9) of three residents reviewed for respiratory care, one (Resident #92) of two residents reviewed for indwelling urinary catheters, and had the potential to affect three residents (Resident #19, #28, and #79), who the facility identified as having the use of the shared glucometer on the 700 Hall. Findings include: 1. Review of Resident #9's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included chronic respiratory failure with hypoxia (low oxygen level in the blood), chronic obstructive pulmonary disease, unspecified asthma, chronic pulmonary edema, and tracheostomy status. Review of Resident #9's physician's orders revealed she had an order in place to receive tracheostomy care every shift. There was also an order for the nurse to change the resident's inner cannula every day shift as part of the tracheostomy care being performed. Both orders had been in place since 04/27/25. Review of Resident #9's active care plans revealed the resident had a care plan in place for being at risk for respiratory distress, decannulation (accidental dislodgement of a tracheostomy tube), and infection related to a tracheostomy. The goals included not having any signs or symptoms of infection. The interventions included the need to follow enhanced barrier precautions related to the resident's invasive medical devices, to provide tracheostomy care/dressing changes per order/ facility protocol, and to use universal precautions. On 04/15/26 at 9:00 A.M., an observation of Resident #9's tracheostomy care was completed, as performed by RN #334. The nurse was noted to don personal protective equipment (PPE), prior to entering the room, to include a gown and surgical mask. She then went to the resident's bathroom to wash her hands before setting up the supplies she needed for performing tracheostomy care. The nurse donned gloves that were included in the tracheostomy care kit and finished setting up all the other supplies she would need to perform tracheostomy care and to change out the resident's disposable inner cannula. She removed the old inner cannula with her gloved hand and disposed of it in the trash that was next to the resident's bed. She obtained the new inner cannula and placed it into the opening of the tracheostomy tube. She removed the old dressing from around the tracheostomy site and disposed of it in the trash next to the bed, after assessing the drainage that was on the old dressing. She then removed her disposable gloves and donned a pair of sterile gloves that was inside the tracheostomy care kit, without performing hand hygiene. She cleaned around the stoma with cotton tip applicators that had been moistened with a saline solution. After cleaning around all sides of the stoma, she used gauze to dry the area. She then applied a new split gauze around the stoma to complete the procedure. It was not until after the procedure was completed that she removed her gloves and performed hand hygiene by washing her hands with soap and water before leaving the room. On 04/15/26 at 9:20 A.M., an interview with RN #334 confirmed she did not perform hand hygiene when she removed her gloves, after taking out Resident #9's inner cannula and replacing it with a new one, and removing the resident's old split gauze dressing around her tracheostomy tube, before she proceeded to clean around the tracheostomy site, after donning the new pair of sterile gloves. She acknowledged the removal of gloves and donning of new gloves did not negate the need to perform hand hygiene between glove changes, as per the facility's tracheostomy care policy. Review of the facility's policy on Tracheostomy Tube Cannula and Stoma Care (not dated) revealed, when caring for a disposable inner cannula, after removing and replacing the inner cannula with a new one, the nurse was instructed to remove and discard their gloves and perform hand hygiene, before proceeding with putting on new gloves to clean around the tracheostomy stoma. Review of Resident #79's medical record revealed an admission date of 06/17/25 and diagnoses including unspecified mononeuropathy (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366396	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Athens, The	70 Columbus Circle Athens, OH 45701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of bilateral lower limbs, morbid obesity, diabetes, chronic kidney disease stage 5, and atherosclerotic heart disease. 2. Review of Resident #79's quarterly Minimum Data Set (MDS) dated [DATE] revealed a brief interview for mental status score of 15 indicating the resident's cognition was intact. Further review of the MDS revealed the resident used walker for mobility, had an active diagnosis for diabetes, and received insulin for seven days in the lookback period. An observation made on 04/08/26 at 11:28 A.M. revealed Registered Nurse (RN) #325 entered Resident #79's room to check her blood sugar via her Dexcom G7 receiver device (continuous glucose system receiver). Resident #79 stated that her device sensor needed changed and RN #325 asked if he could do a finger stick to check her blood sugar. The resident consented and RN #325 completed the finger stick to check her blood sugar. Upon returning to the cart, RN #325 placed the glucometer on the cart and then, after unlocking the cart, replaced the glucometer in the cart without cleaning it. In an interview on 04/08/2026 at 11:41 A.M. RN #325 confirmed he did not clean the glucometer after using it for Resident #325 and before placing it back into the medication cart to be used for the next resident when needed. The RN verified the glucometer should have been cleaned after it was used for Resident #79's blood sugar/blood glucose test since it is used for multiple residents. In an interview on 04/08/2026 at 12:30 P.M. RN #325 stated Residents #28, and #19 were the only other residents that might use the glucometer on the 700 hall and that glucometer was used on the 700 hall. Review of the facility policy titled Glucometer and PT/INR Decontamination, revised 09/01/19, revealed the glucometer was to be disinfected on all external parts of the machine following the directions of the disinfectant. 3.Record review revealed Resident #92 admitted to the facility on [DATE] with diagnoses including malignant neoplasm of esophagus and type II diabetes mellitus. Review of a care plan dated 03/31/26 revealed Resident #92 was at risk for a urinary tract infection and catheter-related trauma related to having an indwelling catheter in place for urinary retention. The goals included showing no signs and symptoms of urinary infection through review date and the catheter would remain patent and without complications through the review date. Interventions included but were not limited to ensure catheter tubing is secured and ensure the drainage bag is secured properly with a dignity cover in place. Review of the physician orders revealed an order dated 03/31/26 for Resident #92's #16 French indwelling urinary catheter to be changed every 30 days and as needed. Review of the comprehensive MDS dated [DATE] revealed Resident #92 had an indwelling catheter in place. Observation on 04/06/26 at 11:14 A.M. revealed Resident #92 was seated in a chair with a catheter in place and the catheter bag was lying directly on the floor. Observation and interview on 04/06/26 at 2:46 P.M. with Licensed Practical Nurse (LPN) #324 confirmed Resident #92's catheter bag was lying directly on the floor and no barrier was in place. (continued on next page)

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	366396	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Athens, The	70 Columbus Circle Athens, OH 45701

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a policy title Catheter Associated Urinary Tract Infection Prevention dated 02/28/25 revealed the catheter bag and tubing should be kept off the floor.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to inform and obtain consent from Resident #44's guardian before administration of a COVID-19 vaccination. This affected one resident of six sampled for vaccinations. The facility census was 98.Findings include:Review of Resident #44's medical record revealed an admission date of 03/23/21, a re-entry date of 11/18/25 and diagnoses including Alzheimer's disease with late onset, dementia, atherosclerotic heart disease, hypertensive heart disease without heart failure, and a history of falling.Review of Resident #44's consent/declination of COVID-19 vaccination form revealed a consent for the vaccination signed on 04/15/25 by Resident #44's former guardian.Review of Resident #44's immunization record revealed the resident received a COVID-19 vaccination on 04/15/25.Review of Resident #44's guardianship paperwork revealed the resident's nephew became his guardian on 07/10/25.Review of Resident #44's immunization record revealed the resident received a COVID-19 vaccination on 11/13/25. Review of Resident #44's medical record revealed no consent signed by the resident's current guardian for the resident to receive a COVID-19 vaccination on 11/13/25.Review of Resident #44's quarterly Minimum Data Set (MDS) dated [DATE] revealed a brief interview for mental status score of three indicating the resident was severely cognitively impaired. Further review of the MDS revealed the resident was independent with activities of daily living, always continent of bladder and bowel, had no pain, and had no skin issues during the review period of the MDS. In an interview on 04/06/26 at 4:00 P.M. with Resident #44's current guardian, the guardian stated he had not been informed of the resident being eligible for a COVID-19 vaccine prior to the vaccine being given. The guardian further stated that he would not have given consent for the vaccine because Resident #44 had a reaction to the shingles vaccine and he did not want to risk him having another reaction.In an interview on 04/13/2026 at 12:28 P.M. the Director of Nursing (DON) #304 verified the guardian for Resident #44 changed in July of 2025 and there was not a consent signed by the current guardian when Resident #44 was given the COVID-19 Vaccination on 11/13/25. The facility used a contracted company to do vaccinations at that time and the company used the consent that was signed on 04/15/25 and did not check with the facility before giving the 11/13/25 vaccination.