STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366430	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein Gahanna	402 Liberty Way Gahanna, OH 43230

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and facility policy review, the facility failed to ensure food was stored in a safe and sanitary manner. This had the potential to affect 16 (#7, #8, #12, #13, #14, #16, #20, #22, #28, #31, #35, #40, #44, #46, #49, and #51) of 16 residents residing in houses with 300 and 500 numbered rooms. The facility census was 52.Findings include: 1. Observation on 05/04/26 at 10:07 A.M., of one of the five campus kitchen refrigerators was conducted with Certified Nurse Aide (CNA) #165. Observation revealed multiple cheese products in the refrigerator were stored without open dates and the packaging was noted to use the cheese within three to five days after opening. The Italian cheese was received on 03/26/26 with no open date and expired 09/13/26. The whole milk mozzarella cheese was received on 04/04/26 with no open date. The nonˆsmoked provolone cheese was received on 04/17/26 with no open date. The finely cut Parmesan cheese was received on 04/17/26 with no open date and expired 09/01/26. The thickˆcut Mexican cheese was received on 04/24/26 with no open date, and the expiration date could not be seen. Additional refrigerated items also lacked complete labeling. The margarine was received on 05/01/26 with no open date and expired 09/19/26. The cottage cheese was received on 05/01/26 with no open date and a useˆby date of 05/27/26. The Amish potato salad was received on 04/24/26 with no open date and a useˆby date of 05/15/26. The hashbrowns and peas were received on 04/20/26 with no open date and no expiration date. Dry goods, including flour, powdered sugar, and brown sugar, were stored in containers that had no labels or dates. Interview on 05/04/26 at 10:30 A.M. with CNA #165 confirmed the items found in the refrigerator did not have open dates. She reported labels were placed on the items but were not fully filled out, and she was unsure of the correct process for labeling food. On 05/04/26 at 10:31 A.M. interview was conducted with Dietary Technician #499 and stated information about specific facility policies regarding food labeling could not be provided. During the interview, Dietary Technician #499 then instructed CNA #165 that all food items in the refrigerator must have a completed label with the received date, open date, and useˆby date. Review of food storage best practice policy, dated 09/2022, revealed foods that fall outside the given guidelines of four to seven days are to follow disposal guidelines per united states department of agricultural guidelines revealing butter at two months, salad dressing at three months, ketchup at one year, mayonnaise at two months. 2. Observation of the one of the five campus kitchens was conducted between 11:50 A.M. and 1:10 P.M. on 05/04/26. The kitchen storage room contained a package of Hawaiian sweet rolls that were dated with an expiration of 05/02/26 and a package of delicatessen (deli) rolls dated with an expiration of 04/29/26. The refrigerator in the resident facing part of the kitchen housed a container (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of cottage cheese labeled with an expiration of 04/28/26, an opened package of diced ham with no open date, and an open package of bacon with no open date. Interview with Dietary Technician #119 was conducted between 11:50 A.M. and 12:41 P.M. on 05/04/26. Dietary Technician #119 confirmed the expiration dates on the Hawaiian sweet rolls, deli rolls, and cottage cheese. Interview was conducted with Dietary Technician #119 at approximately 1:01 P.M. on 05/04/26 and confirmed the open package of diced ham and open package of bacon had no open date. Review of the facility food storage policy and procedure, revised May 2013, revealed all food was (to be) labeled and dated properly to assure stock rotation and prevent food illnesses.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, and medical record review, the facility failed to maintain a homelike environment by ensuring interventions were in place per the care plan to prevent repeated uninvited and unwanted visitors into resident rooms. This affected one (Resident #17) of three residents reviewed for resident rights. The facility census was 52. Findings include:Review of the medical record for Resident #17 revealed an admission date of 05/26/21. Diagnoses included other sequelae of cerebral infarction, hemiplegia affecting the left non-dominate side, type II diabetes mellitus with diabetic neuropathy, major depressive disorder, chronic obstructive pulmonary disease.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 was cognitively intact. The resident was assessed to require setup or cleanup assistance for eating, required dependent care for toileting, showering/bathing, upper body dressing, lower body dressing, and putting on/taking off footwear, required and substantial/maximal assistance for personal hygiene.Review of care plan for Resident #17, revised 12/16/21, revealed a focus area of activities of daily living (ADL) self-care and/or physical mobility performance deficit due to fatigue, hemiplegia, impaired balance, and shortness of breath. The focus noted Resident #17 had a right leg above the knee amputation. An intervention initiated 01/24/23 included a Velcro stop sign placed across the resident's door to deter wandering elders from coming in her room.Review of a care conference summary for Resident #17 dated 04/09/26 at 11:09 A.M. revealed a summary of social services included she just wanted an elder to stay out of her room.Observation on 05/05/26 at 4:34 P.M. revealed Resident #48 was in a wheelchair in Resident #17's room. Resident #17 was in bed. Resident #48 left the room upon surveyor arrival. The only sign on the door to the room belonging to Resident #17 was a sign for enhanced barrier precautions. Resident #48 did not sanitize his hands when he left the room.During an interview on 05/05/26 at 4:38 P.M., Resident #17 stated she did not want Resident #48 in her room. She stated did not matter whether the door was closed, he would just open it and come in. Resident #17 stated sometimes Resident #48 said he was going to bed but then he would not leave her room. Resident #17 stated Resident #48 did not touch her but he would talk and she could not hear her television.Review of the medical record for Resident #48 revealed he was admitted to the facility on [DATE]. Diagnoses included cerebral atherosclerosis, dementia, Alzheimer's disease with late onset, chronic obstructive pulmonary disease, major depressive disorder, generalized anxiety disorder, psychotic disorder with delusions due to known physiological condition, peripheral vascular disease, human immunodeficiency virus (HIV).Review of the most recent MDS assessment dated [DATE] for Resident #48 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. The resident was assessed to be independent on transfers, used a manual wheelchair, and required setup or clean-up assistance for wheeling 50 feet.Review of a care conference summary for Resident #48 dated 03/31/26 at 12:10 P.M. revealed in the social services section there was discussion about not going into other people stuff and room without gaining permission.During an interview on 05/06/26 at 11:45 A.M. Coach #108 (who manages nurse aides) stated Resident #48 was going into Resident #17's every night about a month ago and told him not to go in her room but the resident continued doing it. Coach #108 stated the nurse aides are supposed to check every hour and they should have caught that Resident #48 was in Resident #17's room. Coach #108 stated in the beginning Resident #17 liked Resident #48 being in her room. She stated she did not know why they were no longer using the Velcro barrier or why it was listed under ADLs on the care plan.During an interview on 05/06/26 at 3:08 P.M. Resident #17 stated she never said she liked or wanted Resident #48 to come into her room. She stated Resident #48 gets on her nerves and she cannot hear the television. Resident #17 stated the facility management told her they were going to address it and it still continued happening.During an interview on 05/07/26 at (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7:02 A.M. Certified Nurse Aide (CNA) #186 stated he worked third shift and had seen Resident #48 in Resident #17's room after 11:00 P.M. more than twice. CNA #186 stated he was told by management to tell Resident #48 not to do that. CNA #186 stated when he would find Resident #48 in Resident #17's room, he would ask Resident #48 to leave. CNA #186 stated he knew Resident #17 did not want Resident #48 in her room, especially late at night when she was trying to sleep.During an interview on 05/07/26 at 11:02 A.M., the Administrator confirmed there had been previous discussion regarding how Resident #48 would go into the room of Resident #17. The Administrator denied that it was an ongoing concern and stated Resident #17 gave conflicting messages.Observation and interview on 05/07/26 at 12:49 P.M. revealed Resident #17 had an 8.5 inch wide by 11 inch long paper stop sign taped to her door. The door was open and Resident #17 was not in the room. CNA #191 confirmed the stop sign was to deter Resident #48 from entering the room. CNA #191 confirmed he could open doors and had a habit of going into Resident #17's room. During an interview on 05/11/26 at 5:26 P.M. CNA #188 stated Resident #48 had habit of going into Resident #17's room at least once per shift on most days. CNA #188 stated knew Resident #17 did not like it, so he would go in and ask Resident #48 to leave the room. CNA #188 stated it was the past couple of months that it had been happening.Observation and interview on 05/11/26 at 10:48 A.M. revealed a Velcro stop sign across the doorway of Resident #17's room. CNA #191 confirmed Resident #17 was unavailable for interview due to hospitalization.This deficiency represents non-compliance investigated under Complaint Number 2590038.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on medical record review, staff interview, and review of the Resident Assessment Instrument manual, the facility failed to complete a significant change Minimum Data Set assessment in a timely manner following the identification of a significant change in condition. This affected one (Resident #53) of one residents reviewed for significant changes. The facility census was 52.Findings include: Review of Resident #53's medical record revealed an admission date of 01/09/24 with diagnoses including cerebrovascular disease, hypertension, anxiety, and epilepsy. Review of a document titled, Residential Hospice Agreement, revealed Resident #53 was enrolled in hospice services on 03/03/26 with a terminal diagnosis of cerebrovascular disease.Review of current physician orders revealed Resident #53 had an order to admit to hospice with a terminal diagnosis of cerebrovascular disease on 03/04/26.Review of the significant change Minimum Data Set (MDS), with assessment reference date (ARD) 03/25/26, revealed Resident #53 had severe cognitive impairment. Continued review of the MDS assessment revealed Resident #53 experienced signs and symptoms of delirium including inattention and altered level of consciousness which fluctuated in frequency and severity during the seven day lookback period, which was indicated as a worsening in condition. Resident #53 was dependent on staff for all care. Resident #53 was receiving hospice services, which was indicated as a new service since the last MDS assessment.Review of the Resident Assessment Instrument (RAI) manual revealed a significant change in status assessment should be completed on the 14th day after determining that a significant change in resident condition occurred. The RAI manual provided guidance that the ARD should be no later than the determination date plus 14 calendar days.Interview on 05/11/26 at 4:33 P.M. with the Director of Nursing (DON) confirmed the significant change MDS assessment for Resident #53 should have had an ARD 03/18/26, which would have been the maximum of 14 calendar days after the identification of the significant change event on 03/03/26. The DON stated the facility did not have a MDS policy and followed the guidelines in the RAI manual.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to accurately complete a level one Pre-admission Screening and Resident Review (PASARR) documents for residents with serious mental illness diagnoses as required. This affected two (#5 and #36) of two residents reviewed for PASRRs. The facility census was 52.Findings include:1. Review of the medical record for Resident #5 revealed an admission date of 03/04/25. Diagnoses included unspecified dementia, bipolar disorder (dated 04/15/25), and muscle weakness.Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 was cognitively intact. The resident was assessed to require supervision or touching assistance for showering/bathing, setup or clean-up assistance for upper body dressing, supervision or touching assistance for lower body dressing and putting on/taking off footwear, and setup or cleanup assistance for personal hygiene. Resident #5 was noted to have bipolar disorder. Review of the care plan entry dated 11/10/25 for Resident #5 revealed the resident had a mood problem due to bipolar disorder.Review of the physician orders for Resident #5 revealed an order dated 11/13/25 for quetiapine fumarate (antipsychotic) tablet 25 milligrams (mg) to be given a half tablet (12.5 mg) at bedtime.Review of the PASARR form for Resident #5 dated 03/03/25 revealed, under Section E: Indications of serious mental illness, had no boxes checked. Additionally, under the question regarding psychotropic medications, no boxes were checked.2. Review of the medical record for Resident #36 revealed an admission date of 01/04/24. Diagnoses included hypothyroidism, disorganized schizophrenia (dated 01/04/24), hypertensive hear disease without heart failure, generalized anxiety, drug induced subacute dyskinesia, other specified phobia.Review of the MDS assessment dated [DATE] revealed Resident #36 had moderate cognitive impaired. The resident was assessed to require setup or cleanup assistance for eating and required dependent care for oral hygiene, toileting, showering, upper body dressing, lower body dressing, putting on footwear, and personal hygiene. Review of active diagnoses list revealed a diagnosis of schizophrenia.Review of facility medical record documentation for Resident #36 revealed the most recent PASARR on file was completed on 01/03/24. The document listed Resident #36 had a mood disorder and no other mental health diagnoses.Interview on 05/07/26 4:10 P.M. with Quality of Life Coordinator #183 and the Administrator confirmed the most recent PASRR for Resident #5 was completed on 03/03/25 and did not note the resident had bipolar disorder. They also confirmed Resident #5 had an order for quetiapine fumarate tablet 25 mg and the PASARR did not have anti-psychotics checked. Quality of Life Coordinator #183 also confirmed the most recent PASARR completed for Resident #36 was on 01/03/24, and it did not include the resident's diagnosis of schizophrenia. Quality of Life Coordinator #183 confirmed both Resident #5 and Resident #36's PASARR documents should have been completed and/or updated with accurate diagnoses and medications.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, medical record review, and review of a facility procedure, the facility failed to ensure residents received adequate and routine hair care. This affected one (#17) of three residents reviewed for personal care. The facility census was 52.Findings include:Review of the medical record for Resident #17 revealed an admission date of 05/26/21. Diagnoses included other sequelae of cerebral infarction, hemiplegia affecting the left non-dominate side, type II diabetes mellitus with diabetic neuropathy, major depressive disorder, chronic obstructive pulmonary disease, and atherosclarotic heart disease of a native coronary artery without angina pectoris.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 was cognitively intact. The resident was assessed to require setup or cleanup assistance for eating, was dependent care for toileting, showering/bathing, upper body dressing, lower body dressing, putting on/taking off footwear, and required substantial/maximal assistance for personal hygiene. The MDS assessment indicated there was no rejection of care behavior exhibited.Review of care plan for Resident #17, revised 12/16/21, revealed a focus area for activities of daily living (ADL) self-care and/or physical mobility performance deficit due to fatigue, hemiplegia, impaired balance, and shortness of breath. The focus noted Resident #17 had a right leg above the knee amputation. Interventions noted Resident #17 required assistance with bathing/showering and she wanted a sponge bath when a full bath or shower could not be tolerated. The care plan also noted Resident #17 required staff assist with personal hygiene and oral care.Observation and interview on 05/04/26 at 4:09 P.M. revealed Resident #17 was laying in bed and her primary care concern was her hair. Resident #17 stated her hair was matted and she could not sleep on it. She stated anytime the staff want to wash her hair she would tell them it was matted and she needed it fixed, but the staff never fix it. Observation of Resident #17's hair appeared uncombed and unwashed.Observation and interview on 05/05/26 at 4:34 P.M. revealed Resident #17 still had uncombed, unwashed hair. She stated she usually received bed baths but she did not remember on which days. Resident #17 stated she did not have one that day.Observation and interview on 05/06/26 at 11:12 A.M. revealed Resident #17 was in her room in bed with her hair remaining uncombed, unstyled, and sticking straight up in the air. She confirmed her hair was not washed the previous day when she had a bed bath. Resident #17 gave permission for the surveyor to bring a nurse aide into room to talk about her hair.On 05/06/26 at 11:35 A.M. a review of the shower sheet for Resident #17 dated 05/05/26 revealed no mention of hair care.Observation and interview on 05/06/26 at 11:33 A.M., revealed Certified Nurse Aide (CNA) #191 went into Resident #17's room with the surveyor and confirmed Resident #17 appeared to have unwashed hair and it should have been cared for when she had her bed bath the previous evening. CNA #191 confirmed the shower sheet did not have reference to hair care. CNA #191 stated she told Resident #17 she would help her get dressed. CNA #191 confirmed she had not done anything with the resident's hair that morning but would give Resident #17 a shampoo shortly.Observation and interview on 05/06/26 at 11:45 A.M. with Coach #108 confirmed resident hair should be washed as part of bathing. The surveyor and Coach #108 went to Resident #17's room to see her hair and Coach #108 confirmed it did not appear that her hair had been washed and it should have been as part of the bed bath. Coach #108 confirmed neither the online tracking for baths and showers nor the shower sheets had a space to indicate that a resident's hair was washed. Review of facility procedure titled, Tub baths and showers, revised 05/19/25, revealed no instructions regarding hair care.This deficiency represents non-compliance investigated under Complaint Number 2786179, Complaint Number 2581715, and Complaint Number 2682720.

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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 observation, staff interview, and medical record review, the facility failed to ensure skin integrity interventions were implemented as careˆplanned and ordered and failed to ensure medical appointments were scheduled and completed as required. This affected one (#22) of two residents reviewed for skin integrity and one (#40) of one residents reviewed for medical appointments. The facility census was 52.Findings include:1. Review of the medical record for Resident #22 revealed an admission date of 03/31/26 with diagnoses including metabolic encephalopathy, proteinˆcalorie malnutrition, type II diabetes mellitus, chronic kidney disease, anxiety, pressure ulcers of the left hip and other sites, and a history of falls.Review of the Minimum Data Set (MDS) assessment completed 03/31/26 indicated Resident #22 was severely cognitively impaired, dependent on staff for all activities of daily living (ADLs) care needs, at risk for pressure injuries, and utilized a pressureˆreducing mattress with ongoing wound care.Review of the care plan dated 03/31/26 revealed Resident #22 had impaired skin integrity and was at risk for further impairment due to diabetes mellitus, impaired cognition, altered nutritional status, weakness, decreased functional mobility, poor safety awareness, and a history of recurrent falls. Interventions included administering treatments as ordered and monitoring for effectiveness.Review of the Braden Scale document dated 04/30/26 revealed Resident #22 had slightly limited sensory perception, was constantly moist, was chairfast, had very limited mobility, probably inadequate nutrition, and had a potential problem with friction and shear, placing the resident at high risk for pressure injury.Review of the weekly skin observation document dated 04/29/26 revealed Resident #22 sustained a left antecubital skin tear measuring 0.75 centimeters (cm) in length by 0.5 cm in width, with treatment orders given.Review of Resident #22's physician order dated 04/30/26 revealed instructions to cleanse the left forearm wound with saline or wound cleanser, pat dry, apply calcium alginate with silver directly into the wound bed, and cover with a bordered foam gauze dressing every day shift.Review of the progress note dated 05/01/26 at 5:04 P.M. revealed a new skin alteration measuring 0.5 cm in length by 0.5 cm in width and 0.1 cm in depth. Treatment orders were received, and an order was obtained for geriˆsleeves (protective sleeves) to both upper extremities every shift.Review of Resident #22's physician order dated 05/01/26 confirmed geriˆsleeves were ordered to the bilateral arms each shift.Review of Resident #22's physician order dated 05/02/26 revealed a right lower arm alteration with instructions to cleanse the wound with saline or wound cleanser, pat dry, apply calcium alginate with silver directly into the wound, and cover with a bordered gauze dressing every shift.Observation on 05/04/26 at 10:33 A.M. of Resident #22 revealed bilateral arm dressings were in place and labeled 05/02/25. The resident was seated upright in a geriˆchair without protective sleeves in place as ordered.Interview on 05/04/26 at 12:20 p.m. with Certified Nursing Assistant (CNA) #165 confirmed the resident's dressings were dated 05/02/26 and that the resident was not wearing geriˆsleeves as ordered. CNA #165 reported she was unaware of how the resident obtained the skin alterations and did not know the resident was ordered to wear geriˆsleeves for skin protection.Interview on 05/04/26 at 12:21 p.m. with Neighborhood Concierge (NC) #177 confirmed Resident #22's dressing was dated 05/02/26 and the resident was not wearing geriˆsleeves. NC #177 stated she was unaware the resident required those devices.Interview on 05/04/26 at 12:22 P.M. with Social Worker #183 revealed Resident #22 had bilateral skin tears and the physician order required daily dressing changes. Social Worker #183 reported she was unsure if hospice had changed the order.2. Record review for Resident #40 revealed the resident was admitted to the facility on [DATE] with diagnoses including chronic kidney disease, diabetes, depression, and neuropathy.Review of the MDS assessment dated [DATE] revealed Resident #40 had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 14. The resident was assessed to require staff assistance for bathing and grooming, and was independent for mobility.Review of the nursing progress notes for Resident #40 revealed the resident (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was admitted directly from a hospitalization from 12/17/25 through 12/22/25. Review of Resident #40's after visit summary dated 12/22/25 revealed the resident was directed to follow-up with a nephrologist within one month. Review of the nursing progress notes from 12/22/25 through 04/11/26 did not reveal any nephrology appointments for Resident #40.Review of Resident #40's medical record revealed the resident was hospitalized on [DATE] through 04/07/26.During an interview with the Director of Nursing (DON) on 05/11/2026 at 4:34 P.M. she confirmed she was not able to locate a nephrology or urology appointment for Resident #40 between 12/22/25, when she was discharged from the hospital to the facility, and 03/29/26, when she was re-admitted to the hospital.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on medical record review and staff interview, the facility failed to ensure treatments for pressure ulcers were completed as ordered. This affected one (Residents #22) of three residents reviewed for skin integrity. The facility census was 52.Findings include:Review of the medical record for Resident #22 revealed an admission date of 03/31/26 with diagnoses including metabolic encephalopathy, proteinˆcalorie malnutrition, type II diabetes mellitus, chronic kidney disease, anxiety, pressure ulcers of the left hip and other sites, and a history of falls.Review of the Minimum Data Set (MDS) assessment completed 03/31/26 revealed Resident #22 was severely cognitively impaired, was dependent on staff for all activities of daily living (ADL) care needs, was always incontinent, was at risk for pressure injuries, had five unstageable pressure ulcers (obscured full-thickness skin and tissue loss) and diabetic foot ulcers, and utilized a pressureˆreducing mattress with ongoing wound care.Review of Resident #22's nutritional screening document dated 04/06/26 revealed no nutritional concerns.Review of the wound physician note dated 04/22/26 revealed Resident #22 had an unstageable right lateral knee pressure ulcer measuring 1.5 centimeters (cm) long (L) by 1.6 cm wide (W) by 0.1 cm and deep (D) with a total surface area of 2.40 cm2. An updated order was entered for calcium alginate with silver and silicone foam border dressing to be changed once daily.Review of Resident #22's physician order dated 04/23/26 revealed instructions to cleanse the right knee with normal saline or wound cleanser, apply calcium alginate with silver directly into the wound bed ensuring full contact, and cover with a bordered foam dressing.Review of the Resident #22's April 2026 treatment administration record (TAR) revealed missed treatments for the right knee on 04/25/26, 04/26/26, 04/27/26, and 04/28/26.Review of the wound physician note dated 04/29/26 revealed Resident #22's right lateral knee ulcer measured 2.4 cm L by 2.2 cm W by 0.1 cm D with a total surface area of 5.28 cm2., and a change in treatment was ordered.Review of the Braden Scale document dated 04/30/26 revealed Resident #22 was slightly limited in sensory perception, constantly moist, chairfast, has very limited mobility, probably inadequate nutrition, and a potential problem with friction and shear, placing the resident at high risk for pressure injury.Review of Resident #22's physician order dated 05/02/26 revealed the resident was admitted to hospice services.Interview on 05/06/26 at 2:30 P.M. with the facility Wound Nurse and the Regional Nurse confirmed all information related to Resident #22's wound on the right knee, including the treatment frequency changed per the 04/22/26 wound physician note and that daily dressings were not documented as completed from 04/25/26 through 04/28/26. The Wound Nurse confirmed she was the nurse who rounded weekly with the Wound Nurse Practitioner and was responsible for entering wound care orders into the medical record. Interview on 05/06/26 at 4:54 P.M. with the Wound Nurse Practitioner revealed he was aware documentation did not show completion of the 04/25/26 through 04/28/26 right knee dressings for Resident #22's wound. He denied concerns, stating the dressing appeared clean and intact, and he believed treatments were completed. He confirmed the wound increased in surface area but felt it was related to the resident's decline and subsequent hospice admission. He denied concerns with the facility's wound treatment practices.This deficiency represents non-compliance investigated under Master Complaint Number 2963198, Complaint Number 2682720, Complaint Number 2581724, and Complaint Number 2581715.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, and medical record review, the facility failed to ensure residents received appropriate care and services related to maintain adequate foot care. This affected one (#20) of one residents reviewed for foot care services. The facility's census was 52.Findings include:Record review for Resident #20 revealed the resident was admitted to the facility on [DATE] with diagnoses including depression, diabetes mellitus, hypertension, congestive heart failure, Parkinson's disease, history of falling, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed this resident had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 13. This resident was assessed as dependent for toileting ,and bathing, moderate assistance for upper body dressing and dependent on staff for lower body dressing. Review of the care plan dated 02/06/26 revealed Resident #20 had a self-care deficit related to congestive heart failure, heart disease, and hypertension and required staff assistance with activities of daily living tasks.During an interview with Resident #20 on 05/04/26 at 4:05 P.M. she stated she had not had her toe nails cut in about a year. Resident #20 denied having a podiatrist visit during her facility stay. Observation of the toe nails on each of the resident's big toes revealed they had grown about 1/2 inch past the resident's toe.Review of the care conference notes dated 03/09/26 and 11/06/25 reflect no mention of podiatry services.During an interview with Social Worker (SW) #183 on 05/07/26 at 4:06 P.M., she confirmed Resident #20 had not been seen for any podiatry services because her son had not signed a release for the provider. SW #183 stated she sent the consent form to the resident's son on 08/08/25, but denied inquiring about the consent form since then. When asked why Resident #20 could not sign the consent herself based on her intact cognition, SW #183 stated she just noticed that and she had not considered the option.During a conversation on 05/11/26 at 11:21 A.M., with Resident #20 and Licensed Practical Nurse (LPN) #163, the resident mentioned her toe nails had gone so long without a trim that they have broken. She said the toe nails were causing her discomfort by scratching the skin on the sides of her toes. LPN #163 confirmed the resident's toe nails were long in length and said she would see about having someone cut her toenails. LPN #163 said due to the resident having diabetes mellitus, the facility's policy was that a provider must cut them.This deficiency represents non-compliance investigated under Complaint Number 2590038.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of dialysis documents, staff interview, and facility policy review, the facility failed to ensure required preˆ and postˆdialysis vital signs were completed as ordered. This affected one (Resident #1)of one residents reviewed for dialysis services. The facility census was 52. Findings include:Record review revealed Resident #1 was admitted on [DATE] with diagnoses including endˆstage renal disease, type II diabetes mellitus, morbid obesity, and acquired absence of the right leg below the knee.Review of the physician order dated 02/02/26 documented Resident #1 was to attend dialysis on Monday, Wednesday, and Friday, with a scheduled pickˆup time of 11:10 A.M. and treatment starting at 12:00 P.M.Review of the Minimum Data Set (MDS) assessment completed 03/31/26 indicated Resident #1 was severely cognitively impaired and dependent on staff for all activities of daily living (ADL) care needs.Review of the care plan initiated 11/10/25 revealed Resident #1 required monitoring of vital signs as directed, encouragement to attend scheduled dialysis appointments, monitoring for bleeding, infection, or complications at the dialysis access site, and monitoring and reporting of changes in condition related to renal disease and dialysis, including abnormal laboratory values, shortness of breath, edema, weight changes, and mental status changes.Review of physician orders dated 02/06/26 revealed Resident #1 was required to have a Preˆ Dialysis Communication Form completed every Monday, Wednesday, and Friday in the morning, and a Postˆ Dialysis Communication Form completed every Monday, Wednesday, and Friday in the evening, with dialysis records received by the facility.Review of Resident #1's dialysis forms revealed no documentation of postˆdialysis vital sign assessments on 04/29/26, 04/24/26, 04/22/26, and 04/08/26, and no documentation preˆdialysis vital signs on 04/24/26.Interview with the Director of Nursing (DON) on 05/11/26 at 5:43 P.M. confirmed Resident #1 had missed postˆdialysis vital signs on 04/29/26, 04/24/26, 04/22/26, and 04/08/26, and missed preˆdialysis vital signs on 04/24/26. The DON further confirmed the resident's medical record did not contain documentation explaining why the vital signs were not completed. The DON also confirmed Resident #1 attended dialysis on all dates where vital signs were missed and the vital signs were required per physician order.Review of the dialysis policy, dated 11/17/25, revealed the facility was required to provide ongoing assessment and oversight of the resident before and after dialysis treatment, including monitoring for complications, implementing appropriate interventions, and using appropriate infection control practices.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, review of pharmacy recommendations, and staff interviews, the facility failed to ensure pharmacy recommendations were reviewed and acted upon timely. This affected two (Resident #2 and Resident #8) of five residents reviewed for unnecessary medications. The facility census was 52.Findings include: 1. Review of the electronic medical record for Resident #2 revealed an admission date of 06/09/23 with diagnoses including dementia of unspecified severity without behaviors, bipolar disorder, insomnia, and major depressive disorder. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had moderate cognitive impairment with signs and symptoms of delirium present during the seven day lookback period. Further review of the MDS assessment revealed during the seven day lookback period, the resident experienced delusions indicating psychosis and physical, verbal, and other behaviors which impacted himself and other residents. Review of the pharmacist recommendation dated 10/17/25 revealed a recommendation to trial discontinue the medication bupropion 150 milligrams (mg) one tablet daily in the morning for depression and monitor the resident's response. On 10/22/25 the physician signed the recommendation agreeing to reduce the dosage to 100 mg daily. Review of the medication administration record (MAR) for October 2025 and November 2025 revealed Resident #2 continued to receive bupropion 100 mg daily until 11/20/25. Review of the pharmacist recommendation for Resident #2 dated 12/19/25 revealed a recommendation to change the dosage of divalproex 375 mg one tablet twice per day for bipolar disorder to 250 mg in the morning and 375 mg at bedtime and monitor the resident's response. The recommendation was signed by the Director of Nursing (DON) but was not dated and did not indicate agreement or disagreement with the recommendation. On 02/03/26, the recommendation was signed by Certified Nurse Practitioner (CNP) #419 agreeing with the pharmacist's recommendation. Review of Resident #2's MARs from December 2025 through May 2026 revealed on 02/03/26 the divalproex order was changed to 250 mg in the morning and 375 mg in the evening. Review of Resident #2's pharmacist recommendation date 03/25/26 revealed a recommendation to reduce the dosage of melatonin three (3) mg two tabs at bedtime (six (6) mg total) to five (5) mg total at bedtime. The recommendation was not responded to or signed by the physician. Review of Resident #2's MARs from March 2026 and April 2026 revealed Resident #2 continued to received melatonin 6 mg at bedtime until 04/06/26. On 04/07/26, the resident began receiving melatonin 5 mg at bedtime. Interview on 05/11/26 at 4:11 P.M. with the DON confirmed the recommended dosage reduction of bupropion was not completed until 30 days after the physician agreed to the recommendation. The DON confirmed the previous DON signed the pharmacy recommendation for divalproex and confirmed CNP #419 agreed with the recommendation and signed it on 02/03/26. The DON confirmed the (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	divalproex reduction began on 02/03/26. The DON confirmed there was not a signed copy of the recommendation to reduce melatonin to 5 mg at bedtime. 2. Record review for Resident #8 revealed the resident was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, dementia, hypertension, hyperlipemia, anxiety, bipolar disorder, and obstructive and reflux uropathy. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 had severely impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 6. Review of Resident #8's pharmacist recommendation dated 08/20/25 revealed a recommendation to trial a reduction the prescribed clonazepam 0.25 mg twice daily to once daily. The undated prescriber's response to the recommendation was an agreement of the recommendation. Review of Resident #8's physician orders revealed the order of clonazepam was changed to once daily on 04/28/26. Review of Resident #8's pharmacist recommendation dated 06/18/25 revealed a recommendation to trial a reduction of the prescribed divalproex 250 mg twice daily to once daily. The prescriber's response to the recommendation, dated 07/18/25, was an agreement of the recommendation. Review of Resident #8's physician orders revealed the order of divalproex was changed to once daily on 08/24/25. During an interview on 05/11/26 at 4:11 P.M. with the DON, she confirmed the reduction of Resident #8's clonazepam 0.25 mg was not completed until six months after the recommendation was sent. The DON also confirmed the recommendation to reduce the frequency of divalproex to once daily did not occur for Resident #8 until greater than 60 days after the recommendation was made. Review of the facility policy titled, Medical Regimen Review Policy, approved 11/13/17, revealed the physician or designee should respond to the recommendations within fourteen days of the pharmacist's review date, but no longer than the next regularly scheduled physician visit.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure medications were administered as ordered to prevent significant medication errors. This affected two (Resident #13 and Resident #1) of three residents reviewed for medication management. The facility census was 52.Findings include:1. Review of the medical record for Resident #13 revealed an admission date of 12/16/25 and a readmission date of 04/25/26. Diagnoses included encephalopathy, osteomyelitis of the left ankle and foot, type one diabetes mellitus, acute kidney failure, and a nonˆpressure chronic ulcer of the left foot with necrosis of bone.Review of hospital records dated 04/21/26 revealed Resident #13's hemoglobin A1C was 8.5 milligrams per deciliter (mg/dl).Review of Resident #13's hospital afterˆvisit summary dated 04/25/26 included an order for insulin thirty units injected once each morning.Review of Resident #13's care plan dated 04/25/26 documented a diagnosis of diabetes mellitus and interventions to administer diabetes medications as ordered, monitor for side effects and effectiveness, check blood sugar as ordered, and maintain the prescribed diet.Review of a progress note dated 04/26/26 at 6:48 A.M. documented Resident #13 arrived with the hospital order for insulin thirty units every morning. The nurse wrote she was concerned about the high dose, notified the onˆcall provider, and was instructed to hold the insulin until the rounding provider clarified the order.Review of a physician order dated 04/26/26 revealed staff were to check Resident #13's blood sugar two times a day.Review of Resident #13's medication administration record (MAR) from 04/25/26 through 04/30/26 showed that no insulin was administered during this period.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 was cognitively impaired, had one venous or arterial ulcer, and has a diagnosis of diabetes mellitus.Review of Resident #13's blood sugar results revealed blood sugar levels beginning immediately readmission to the facility on [DATE] included 171 mg/dL on 04/25/26 at 6:25 P.M.; on 04/26/26 the results were 200 mg/dL at 2:49 P.M. and 198 mg/dL at 7:27 P.M.; on 04/27/26 the results were 176 mg/dL at 10:53 A.M. and 364 mg/dL at 7:55 P.M.; on 04/28/26 the results were 215 mg/dL at 9:04 A.M. and 289 mg/dL at 8:26 A.M.; on 04/29/26 the results were 224 mg/dL at 10:05 A.M. and 247 mg/dL at 8:03 A.M.; on 04/30/26 the results were 243 mg/dL at 8:46 A.M. and 319 mg/dL at 9:40 A.M.; on 05/01/26 the results were 218 mg/dL at 10:09 A.M. and 270 mg/dL at 9:22 A.M.; on 05/02/26 the results were 148 mg/dL at 7:47 A.M. and 257 mg/dL at 8:43 P.M.; and on 05/03/26 the results were 228 mg/dL at 8:38 A.M., 228 mg/dL at 8:39 A.M., and 345 mg/dL at 8:18 A.M. All of these reading indicated elevated levels of blood sugar values.Review of a progress note dated 05/03/26 at 3:06 P.M. documented Resident #13 had a blood sugar of 323 mg/dL. The provider was notified and issued a oneˆtime sliding scale order, and four units of insulin were administered.Review of Resident #13's progress note dated 05/04/26 at 12:03 A.M. documented a blood sugar of 345 mg/dL. The provider was notified and eight units of insulin were given. At that time, a routine insulin order still had not been entered into the resident's medical record.Review of a physician order dated 05/04/26 was entered for Resident #13 to reveive Novolog FlexPen 100 units per milliliter to be used on a sliding scale. The order instructed staff to give two units when blood sugar was between 151 and 200 mg/dL, four units for 201 to 250 mg/dL, six units for 251 to 300 mg/dL, eight units for 301 to 350 mg/dL, and ten units for 351 to 400 mg/dL, and to notify the provider if the blood sugar was above 400 mg/dL.Review of Resident #13's medication administration record (MAR) showed insulin was administered routinely starting on 05/04/26 at 8:00 A.M.Interview on 05/07/26 at 3:43 P.M. with the Administrator and Assistant [NAME] President of Quality (AVPQ) #193 confirmed Resident #13's routine insulin was not followed up on upon readmission when the nurse identified insulin order was excessive until 05/04/26, and they confirmed two as needed insulin orders were placed on 05/03/26 and 05/04/26.Interview conducted on 05/11/26 at 3:59 P.M. with the Director of Nursing (DON) confirmed an insulin order for Resident #13 was not routinely administered until 05/04/26, and confirmed blood (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sugars acquired prior to that date would require insulin coverage per physician order. 2. Review of the medical record for Resident #1 revealed an admission date of 11/04/25 with diagnoses of endˆstage renal disease, type II diabetes mellitus, hypertension, and morbid obesity.Review of the care plan dated 11/10/25 revealed Resident #1 had altered cardiovascular status related to hypertension. Interventions included administering medications as ordered. The care plan also identified the resident received anticoagulant therapy and was at increased risk for bleeding. Interventions included administering medications as ordered and monitoring for side effects and effectiveness.Review of the physician order dated 11/04/26 revealed Eliquis 2.5 milligram (mg) oral tablet, one tablet by mouth two times a day for atrial fibrillation, with administration scheduled in the morning and evening.Review of Resident #1's MAR for January 2026 revealed Eliquis 2.5 mg was not administered during the evening administration on 01/26/26.Review of Resident #1's MAR for February 2026 revealed Eliquis 2.5 mg was not administered on 02/09/26 and 02/23/26 during morning administration.Review of Resident #1's MAR for April 2026 revealed Eliquis 2.5 mg was not administered on 04/24/26 during morning administration.Review of Resident #1's MAR for May 2026 revealed Eliquis 2.5 mg was not administered on 05/05/26 during morning administration.Interview with the DON on 05/11/26 at 5:43 P.M. confirmed she was unable to obtain additional information regarding Resident #1's missed Eliquis administrations on 01/26/26, 02/09/26, 02/23/26, 04/24/26, and 05/05/26. This deficiency represents non-compliance investigated under Complaint Number 2786179, Complaint Number 2734185, and Complaint Number 268270.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, review of a drug manufacturer instructions, and facility policy review, the facility failed to ensure insulin pens were appropriately stored in medication cart. This affected one (#12) of one residents reviewed for insulin storage. The facility census was 52.Findings include:Review of the medical record revealed Resident #12 was admitted on [DATE] and had diagnoses that included type II diabetes, hemiplegia, and anemia. Review of Resident #12's Minimum Data Set (MDS) assessment dated [DATE] indicated the resident was cognitively intact.Observation of the room temperature medication cart in one of the five campus houses was conducted at 9:15 A.M. on 05/05/26. There were two Novolog FlexPen insulin aspart 100 units per milliliter (u/mL) injector pens found in the medication cart. Both pens were labeled as belonging to Resident #12 and both were labeled as being opened 02/28/26.Interview with Licensed Practical Nurse (LPN) #163 at approximately 9:15 A.M. on 05/05/26 confirmed the Resident #12's insulin pens were labeled as opened on 02/28/26.Review of the manufacture information for Novolog FlexPens 100 u/mL, dated 2023, revealed that in-use (opened) products should be stored at room temperature for (up to) 28 days.Review of facility policy titled, Storage of Medications, dated January 2026, revealed medications are (to be) stored safely, securely, and properly following manufacturer's recommendations. Further review revealed outdated, contaminated, or deteriorated medications are (to be) immediately removed from inventory.

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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 observation, medical record review, and resident and staff interview, the facility failed to ensure laboratory (lab) services were timely in reporting lab results to meet resident needs. This affected one (#42) of three residents reviewed for bowel and bladder care needs. The census was 52.Findings include: Review of the electronic medical record for Resident #42 revealed an admission date of 12/19/24. Diagnoses included parkinsonism, type II diabetes, protein-calorie malnutrition, acute kidney failure, and retention of urine.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #42 had moderate cognitive impairment, was always incontinent of bowel and bladder, and was dependent on staff for personal hygiene, toileting, and showering tasks.Review of nursing progress notes on 05/03/26 at 3:45 P.M. revealed Resident #42 complained of a burning sensation during urination. Vital signs were obtained and were reported to be within normal limits. The on-call physician was notified, and new orders were given to promote hydration, administer UTI-STAT (supplement to support urinary tract health), and to obtain a urinalysis with culture and sensitivity (UA C&S) to check for a urinary tract infection (UTI). The progress note revealed the UA C&S would be collected on regular lab day without indication of the specific date. The progress note also included education for nurses and nurse aides to monitor for changes including urination patterns, discomfort, altered mental status, and signs and symptoms of infection.Continued review of nursing progress notes on 05/05/26 at 2:10 A.M. (created and entered on 05/06/26 at 5:31 A.M.) revealed a urine sample was obtained from Resident #42 via straight catheterization and was sent to the lab. Further review of Resident #42's progress notes revealed no other notes related to possible UTI.Interview on 05/05/26 at 1:51 P.M. with Resident #42 revealed she had had a history of frequent UTIs but had not had any in the past two weeks. Resident #42 confirmed she had burning during urination recently and was tested for a UTI. Resident #42 stated she was feeling okay on this date.Observation on 05/07/26 at 12:52 P.M. revealed Resident #42 experienced nausea and vomiting during lunch. Certified Nurse Aide (CNA) #180 called the nurse, who administered anti-nausea medication at 1:12 P.M. and was reported as effective at 5:42 P.M.Review of Resident #42's medical record on 05/11/26 revealed lab results for UA C&S had not returned. Continued review revealed no other progress notes regarding Resident #42's status.Interview on 05/11/26 at 4:00 P.M. with the DON confirmed Resident #42's UA C&S had not been returned and confirmed lab results do not normally take that long to return. The DON confirmed she was not aware Resident #42 experienced vomiting on 05/07/26 and was not aware of Resident #42's current condition. At the time of exit on 05/13/26 at 10:50 A.M. the facility had not provided the results of Resident #42's UA C&S and the resident was not receiving further monitoring or treatment for a suspected UTI.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, emergency medical services run report review, hospital documentation review, staff interview, resident representative interview, and review of meal menus and food recipes, the facility failed to ensure a thorough procedure was implemented to ensure staff members did not serve food items to residents with specific food allergies and intolerances. This affected two (#64 and #23) of three residents reviewed for food allergies. The facility census was 52.Findings include: 1. Review of the medical record for Resident #64 revealed an initial admission date of 03/13/25 and discharge date of 04/04/25 with a readmission date of 06/27/25 and second discharge date of 07/12/25. Diagnoses included urinary tract infection, calculus of a kidney, type II diabetes mellitus with diabetic autonomic polyneuropathy, autoimmune thyroiditis, generalized anxiety disorder, and depression. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] for Resident #64 revealed she was cognitively intact. The resident was assessed to be independent on eating and oral hygiene and needed substantial/maximal assistance for toileting and showering; supervision or touching assistance for upper body dressing; and partial/moderate assistance for lower body dressing. Review of Resident #64' care plan initiated 03/13/25 revealed no care plan focus of food allergy in care plan. Review of the nutritional screen dated 03/24/25 at 1:49 P.M. revealed Resident #64 was noted to have an allergy to strawberries. Review of the physician progress note dated 03/17/25 revealed Resident #64 was allergic to sumatriptan, sulfasalazine, sulfamethozazole/trimethorprim, sulfa antibiotics, strawberry, penicillin G, and penicillin. Review of the progress note dated 03/20/26 at 5:01 P.M. revealed Resident #64 alerted a nurse to her face getting hot and her throat and tongue feeling swollen. The resident was questioned and Resident #64 informed the nurse of her eating ice cream of three flavors which included strawberries. The nurse alerted the certified nurse practitioner (CNP) with an order for epinephrine one (1) milliliter (mL) stat (immediately) given. The note revealed Resident #64 was resting in bed with symptoms improved and the physician, the Director of Nursing (DON), and family were all notified. Review of the progress note dated 03/20/25 at 6:49 P.M. revealed the nurse spoke with Resident #64's daughter about the swelling to the resident's mouth and tongue and spoke with the CNP and ordered stat 25 milligrams Benadryl and 40 milligrams prednisone. The nurse spoke with daughter about sending Resident #64 to the hospital, and the daughter stated they should monitor the resident and if anything changes they will send her to the hospital. Review of the progress note dated 03/21/25 at 6:53 A.M. revealed the nurse monitored Resident #64 all night with symptoms improving and the resident slept through night with no discomfort. (continued on next page)

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	366430	A. Building B. Wing	05/13/2026

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 03/24/25 at 2:35 P.M. revealed a nutrition note that Resident #64 had an allergy to strawberries. Review of the after visit summary dated 06/27/25 from Resident #64's hospitalization prior to her move back into the facility revealed the resident was noted to have an allergy to strawberry with facial swelling. Review of the care conference summary dated 07/02/25 for Resident #64 revealed in the nursing section a notation that said no strawberry as the resident was allergic to them. Review of progress note dated 07/06/25 at 6:38 P.M. for Resident #64 revealed the resident was alert and oriented with tingling of the tongue and slurred speech after dinner. Resident #64 and a family member requested to be sent to local hospital for evaluation and treatment. Review of the emergency department notes dated 07/06/25 for Resident #64 revealed the resident received 50 milligrams of Benadryl via intravenous (IV) route via emergency medical services (EMS) prior to arriving at the emergency department. Resident #64 arrived at the emergency department at 6:49 P.M. and was noted to have some wheezing. She was diagnosed as having an allergic reaction and was given a breathing treatment, Pepcid, and 125 milligrams of Solu-Medrol (fast-acting corticosteroid used to treat acute inflammation and severe allergies). Resident #64 was kept at the emergency room until 11:39 P.M. for monitoring. Per the after visit summary, Resident #64 was given new prescriptions for diphenhydramine (Benadryl), epinephrine 0.3 milligrams (Epipen), and famotidine (Pepcid). The after visit summary noted resident had allergy to strawberries with facial swelling. Review of the physician progress note dated 07/07/25 by Physician #300 revealed the notation that Resident #64 had an allergic reaction to strawberries the prior day. He noted she went to the hospital and was given IV Benadryl and breathing treatments. He wrote he asked the staff to put up a sign indicating the resident was allergic to strawberries. He documented the resident still had a scratchy throat that day and he would have her take an additional dose of Benadryl and additional vitamin C 1000 milligrams. Review of the provider progress note dated 07/08/25 at 8:00 A.M. revealed the provider saw Resident #64 as a follow up after a recent emergency room visit due to concerns for allergic reaction after drinking four to five ounces of strawberry juice. Per the note, the resident was told it was artificial flavoring but the resident felt her tongue was swelling and was having difficulty swallowing. Resident #64 was given Benadryl via EMS with improvement in symptoms once arriving to the emergency department. Review of the nutritional screen dated 07/08/25 at 4:18 P.M. revealed Resident #64 was noted to have an allergy to strawberries. During a telephone interview on 05/05/26 at 9:07 A.M., the daughter of Resident #64 stated when her mom was in the facility in March 2025, Resident #64 was served strawberries but did not eat them and then Neapolitan ice cream (chocolate, vanilla, strawberry). She said Resident #64 knew she was allergic to strawberries but her mom did not know the ice cream would affect her and when she had a reaction, the nurse was responsive and got an order for EpiPen and Benadryl. She said when Resident #64 returned to the facility in June 2025 she was served strawberry flavored juice and only took a sip and had a small reaction and so she told staff about it. The daughter stated the staff assured her they removed all the strawberry products. Then a few days later on 07/06/25, Resident #64 was served (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the juice again and had a more severe reaction from the juice. The daughter stated the nurse did not have Benadryl or an EpiPen and did not want to send her to the hospital. During an interview on 05/05/26 at 5:06 P.M., Dietary Technician (DT) #119 stated the Diet Type Report listed a resident's name, room number, diet type, consistency, allergies and any additional directions, and was printed on Thursdays or if there are changes and put in the front of the dietary binder at each house. DT #119 stated food coordinators meet with the elders on Tuesdays and order groceries on Wednesdays for new menus that start on Fridays. DT #119 stated with the Greenhouse Model (nursing home model with homelike setting), they still will have food that a resident was allergic to within the house and i was everyone's responsibility to make sure they check the list to ensure they are not giving a resident a food they are allergic to. During an interview on 05/07/26 at 1:08 P.M. Certified Nurse Aide (CNA) #191 stated she had the allergies memorized, but noted there are agency workers who may not check the binder for the resident's allergies. During an interview on 05/07/26 at 4:47 P.M. Coach #108 (who manages the CNAs) stated she knew about the situation with Resident #64's strawberry allergy but did not remember the dates. She stated she heard the resident who was allergic to strawberries was given fruit punch that had strawberries in it. Coach #108 did not know about the incident with the strawberry ice cream; she had only heard about the time the resident was served a bowl of strawberries and the punch. She stated they cleaned out the refrigerator and the pantry to remove the strawberries because they did not want any mistakes to be made. Coach #108 remembered talking to the nurse aides about checking the dietary sheets. Review of the undated four page instruction document for the CNAs on family style dining titled, Convivium (Family Style Dining), revealed a section titled, From start to finish, which included detailed instructions such as cook according to menu, cook enough food to serve your residents, modified diet textures get prepared and placed into their own serving dishes, and the dining room table gets wiped down and sanitized. Another section titled, Workflow of Elder Assistant duties, (with elder assistant (EA) the title given to this facility's CNAs) listed details such as both EAs start preparing and making meal in kitchen, one EA gets called to assist the elder, and the other EA continues with kitchen tasks. Another section titled, Diets and preferences, suggested alternate menu items for elders (residents) who do not like the primary menu item. The final page had a checklist of the elements that should be reviewed when serving with a yes or no column checklist. Items listed included questions about food appearance, whether the meal was passed family style, whether second helpings offered. Further review of the Convivium Family Style Dining instructions revealed no mention of checking food allergies while preparing or serving meals. During an interview on 05/11/26 at 10:30 A.M. the Administrator confirmed nurse aides and nurses were agency when the strawberry items were served last summer. She stated they did change the process, she just was not able to find the root cause analysis or the documentation of how the process changed. During an interview on 05/11/26 at 10:41 A.M., Dietician #305 confirmed there was no mention of checking allergies in the step-by-step instruction sheet on the Convivium documentation or checklist. He stated they take allergies very seriously and the training on allergies was covered in orientation. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	He was unsure of whether there was anything in orientation regarding how to identify signs of allergic reaction. Review of the undated Nutrition and Food Service orientation training on allergies included a single slide that revealed there were three places to check if the elder has food allergies including to check the diet order in the binder to see if the resident has any allergies, check the nutrition task in the electronic charting system, and ask the nurse as this was critical with new residents on the weekends and the dietary technician had not been in the neighborhood to print the new diet orders; this can be deadly so please check. During an interview on 05/11/26 at 11:31 A.M., the Administrator confirmed the orientation training on allergies was a single slide and the training information did not suggest when in the process of preparing or serving the food that the food allergies should be reviewed. She confirmed the Convivium Family Style Dining document also did not mention checking for allergies. During a telephone interview on 05/11/26 at 2:10 P.M., CNA #144 stated she remembered there was an incident with an resident who had a reaction to a strawberry drink. She said it was either herself or her partner who served the resident. CNA #144 stated she did not know the resident was allergic to strawberry. She stated it was always in the binder, but maybe she did not check. She stated after it happened the manager spoke to everyone. During an interview on 05/11/26 at 5:26 P.M. CNA #188 stated he had heard about Resident #64's strawberry allergy but did not know the details. He stated they had the resources to check allergies but he was not sure if everyone cared enough to check the binders. During a telephone interview on 05/12/26 at 12:51 P.M. Resident #64's daughter stated the first time her mom just took a sip of the juice in July 2025, the resident felt a tingling in her tongue and asked about it and they had confirmed it was strawberry flavor. She stated maybe they did not update the information but she knew she and Resident #64 had told the facility that the resident was allergic to anything strawberry flavored. She stated on 07/06/26, her mom was eating dinner in the room and was served the drink. She stated Resident #64 should have asked if the drink had strawberry but she could not fault her mom for trusting those who were caring for her. During an interview on 05/12/26 at 2:44 P.M., Licensed Practical Nurse (LPN) #311 said she still remembered Resident #64's face was red when she saw her after the resident had eaten the Neapolitan ice cream in March 2025. She stated Resident #64 did not know that she would have a reaction to the ice cream because it said artificial on the front but when they looked at the fine print of the ingredients they discovered it had real strawberries. LPN #311 stated she called the doctor and got an EpiPen and Benadryl order and was monitoring the resident every five minutes because she was worried about her. She stated she gathered the staff and let them know they needed to look at the ingredients to things. LPN #311 stated she was surprised even after she spoke with the staff about the severity of the allergy, she still caught staff walking to Resident #64's room the next day with a bowl of strawberries. She was grateful that she caught them before they gave it to her. 2. Review of the electronic medical record for Resident #23 revealed an admission date of 07/05/22 with diagnoses including senile degradation of the brain, severe protein-calorie malnutrition, dysphagia, and diverticulosis of the intestine. On 07/06/22, Resident #23 was identified as having moderate lactose intolerance which results in nausea. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the annual MDS assessment completed on 02/12/26 revealed Resident #23 had mild cognitive impairment and was independent with eating tasks. Review of Resident #23's physician orders revealed dietary orders for a regular diet, regular texture, and thin liquids. Further review revealed no other dietary alerts regarding lactose intolerance. Further review revealed no orders for anti-allergy medications (Benadryl, etc.), lactase enzyme supplements (Lactaid, etc.), or epinephrine to treat potential lactose intolerance. Review of Resident #23's care plan revealed the resident was at risk for changes to nutrition and hydration for reasons including lactose allergy with exceptions. There were no goals or interventions relating to the lactose allergy, severity, or offering non-dairy alternatives. Review of the lunch menu on 05/04/26 revealed the main entrée was pepperoni pizza casserole, a side salad, and garlic bread. Review of the dinner menu of the same day revealed the main entrée was a cheesesteak sandwich, onion rings, and mixed fruit. The dessert option was an ice cream bar. Observation on 05/04/26 at 1:02 P.M. revealed Resident #23 was served a portion of pepperoni pizza casserole for lunch. Observation on 05/04/26 at 4:33 P.M. revealed Resident #23 was served a cheesesteak for dinner. Interview on 05/04/26 at 4:45 P.M. with CNA #137 confirmed dinner was a cheesesteak and no alternates were served to residents in the house. Review of the lunch menu on 05/07/26 revealed the main entrée was lasagna, California blend vegetables, and garlic bread. Observation on 05/07/26 at 12:59 P.M. revealed Resident #23 was served a portion of lasagna, vegetables, and garlic bread. Interview on 05/07/26 at 1:02 P.M. with CNA #180 confirmed Resident #23 has a lactose allergy. CNA #180 stated the lasagna had no cheese in it. Review of the recipe for pepperoni pizza casserole revealed the entrée was made with eight cups of mozzarella cheese. Review of the recipe for lasagna revealed the entrée was made with 32 ounces of cottage cheese, three cups of mozzarella cheese, and 0.5 cups of parmesan cheese. Interview on 05/11/26 at 9:00 A.M. with the Administrator confirmed pepperoni pizza casserole, cheesesteak, and lasagna all contained cheese. This deficiency represents non-compliance investigated under Complaint Number 2562223.

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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 medical record review, resident and staff interview, review of the incident and accident log, and policy review, the facility failed to ensure weekly skin assessments were accurately documented in the medical record and failed to ensure the medical record was complete related to resident incident documentation. This affected one (Resident #1) of one residents reviewed for assessment accuracy. The facility census was 52.Findings include:1. Record review revealed Resident #1 was admitted on [DATE] with diagnoses including endˆstage renal disease, type II diabetes mellitus, morbid obesity, and acquired absence of the right leg below the knee. Review of Resident #1's physician order dated 11/04/25 revealed the resident was ordered weekly skin assessments to be completed by a licensed nurse. Review of Resident #1's care plan dated 11/05/26 identified the resident had potential impairment of skin integrity with interventions including completing weekly skin screens. Review of an assessment used to predict development of pressure ulcers dated 01/27/26 revealed Resident #1 had a moderate risk for pressure sore development.Review of a physician order dated 02/02/26 revealed Resident #1 was to attend dialysis on Monday, Wednesday, and Friday, with a scheduled pickˆup time of 11:10 A.M. and treatment starting at 12:00 P.M. Review of the Minimum Data Set (MDS) assessment completed 03/31/26 indicated Resident #1 was severely cognitively impaired, was dependent on staff for all activities of daily living (ADLs) care needs, was at risk for pressure injuries, and utilized a pressureˆreducing mattress with ongoing wound care.Review of a dialysis treatment record dated 04/22/26 revealed Resident #1 was at dialysis from 12:14 P.M. until 4:19 P.M.Review of a progress note dated 04/22/26 at 12:33 P.M. documented the wound physician intended to observe Resident #1's current skin alterations; however, the wound could not be assessed because the resident was at dialysis.Review of the weekly skin observation tool dated 04/22/26 at 12:40 P.M. revealed Resident #1's assessment was documented as completed, indicating no skin irregularities or new areas were present and current skin areas were being treated per physician orders.Interview with the Director of Nursing (DON) on 05/11/26 at 5:43 P.M. revealed the facility attempted to contact the nurse who documented Resident #1's skin assessment on 04/22/26; however, the nurse could not be reached. The DON confirmed the nurse could not have completed the assessment at the documented time because Resident #1 was not in the facility. The DON also confirmed the assessment omitted skin areas that were documented both the previous week (04/16/26) and the following week (04/27/26), and therefore the 04/22/26 assessment lacked legitimacy. Review of the facility's skin care management procedure, dated 12/09/22, revealed weekly skin assessments are to be completed and documented in the forms tab to identify new or potential areas of concern.2. Further review of Resident #1's medical record revealed progress notes from 04/22/26 through 04/25/26 with no documentation of a foot scan, swelling, injury, or assessment related to Resident #1's reported accident.Review of Resident #1's assessments from 04/22/26 through 04/25/26 revealed no skin check recorded.Review of Resident #1's physician order dated 04/23/26 revealed a diagnostic foot scan was ordered for a swollen foot and toes. Review of the radiology report dated 04/23/26 revealed no acute fracture was identified.Review of Resident #1's physician order dated 05/01/26 revealed instructions to monitor the left foot bruising and assess for pain, and to notify the nurse practitioner if the bruising did not heal.Review of Resident #1's progress note dated 05/01/26 at 1:59 P.M. revealed the results were sent to the nurse practitioner, and the foot issue appeared to be due to a chronic condition.Review of Resident #1's psychiatric note dated 05/01/26 revealed the resident reported a significantly swollen foot after striking it against a vehicle while facility staff were attempting to transport her to dialysis. The note documented that an xˆray had been completed but results were not yet finalized, and the resident reported her foot was extremely swollen and she was unable to use it.Review of the incident and accident log from (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/20/26 through 04/25/26 revealed no documentation of an incident involving Resident #1.Interview with Resident #1 on 05/05/25 at 9:45 A.M. revealed the resident reported an accident occurred a couple of weeks prior. The resident stated she was waiting for staff to assist her out of the van and became impatient, then began moving her power wheelchair. She stated she misjudged the distance between her foot pedal and the back of one of the seats and struck her foot. The resident stated an xˆray was completed to ensure her foot was not broken. She reported her foot was feeling better but still had some bruising.Interview on 05/11/26 at 2:05 P.M. with the Administrator, Director of Nursing, and Social Worker #183 confirmed Resident #1 had an order for an xˆray of her foot due to swelling and bruising on 04/23/26. They confirmed the medical record contained no documentation pertaining to the incident, including skin assessments, physician notes, an accident report, interviews, or any investigation. The Administrator confirmed the medical record should contain detailed information regarding this event.This deficiency represents non-compliance investigated under Complaint Number 1397524 (OH00167475).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and review of a Centers for Disease Control and Prevention sign, the facility failed to ensure infection control measures were utilized for residents on enhanced barrier precautions. This affected one (#13) of eight residents reviewed for infection control. The facility census was 52.Findings include: Review of the medical record for Resident #13 revealed an admission date of 12/16/25 with diagnoses including encephalopathy, osteomyelitis of the left ankle and foot, type one diabetes mellitus, sepsis due to Escherichia coli, peripheral vascular disease, and a nonˆpressure chronic ulcer of the left foot with necrosis of bone. Review of the care plan dated 04/26/26 revealed Resident #13 had impaired skin integrity related to a chronic vascular would of the left great toe, with interventions to utilize enhanced barrier precautions. Further review revealed staff will follow proper hand hygiene, don gloves and gown to minimize microorganism transmission, and remove personal protective equipment (PPE) prior to exiting when preforming high contact resident care activities. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 was cognitively impaired, dependent on staff for toileting, required substantial to maximal assistance for sitˆtoˆstand transfers, was frequently incontinent of bowel and bladder, and had one venous/arterial ulcer. Review of Resident #13's physician order dated 04/28/26 directed staff to follow enhanced barrier precautions and to wear gloves and a gown when providing treatment or care related to the nonˆpressure ulcer on the left foot. Observation on 05/04/26 at 2:55 P.M., revealed Certified Nurse Aide (CNA) #165 and CNA #140 entering Resident #13's room revealed both staff entered without applying PPE. A contact isolation sign was posted outside the resident's room instructing staff to put on PPE before entering. Observation and interview on 05/04/26 at 3:02 P.M. revealed CNA #165 and CNA #140 inside Resident #13's room without PPE. Both CNAs stated they had just removed Resident #13 from the toilet and were preparing to complete a pivot transfer into the bed. CNA #165 and CNA #140 completed the handsˆon transfer without wearing PPE, with their hands and lift belt in direct contact with the resident's clothing. Interview on 05/04/26 at 3:06 P.M. with CNA #165 and CNA #140 confirmed the signage was posted outside the room and that staff were required to apply PPE, including gloves and a gown, before providing care. Interview on 05/04/26 at 3:08 P.M. with Social Worker (SW) #183 confirmed PPE should be applied before entering Resident #13's room. SW #183 confirmed the signage was posted at the door. Interview on 05/07/26 at 5:02 P.M. with the Director of Nursing (DON) and SW #183 revealed Resident #13's isolation status of contact isolation was incorrect and was intended only for hypervigilance to prevent infection; however, staff were still required to follow enhanced barrier precaution guidance, which included wearing PPE during direct resident care due to the resident's wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of undated enhanced barrier precautions signage from the Centers for Disease Control and Prevention (CDC) revealed staff are required to wear gloves and a gown for high^contact resident care activities, including changing briefs, assisting with toileting, and transferring. This deficiency represents non-compliance investigated under Complaint Number 2581715.