STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366433	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mapleview Country Villa	775 South Street Chardon, OH 44024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, record review and facility policy review, the facility failed to treat Resident #51 with dignity and respect. This affected one (Resident #51) of three residents reviewed for resident rights and had the potential to affect all 88 residents who resided in the facility. Findings include: Review of the medical record for Resident #51 revealed an admission date of 09/12/22. Diagnoses included diabetes mellitus type two, congestive heart failure, dementia and peripheral vascular disease. Observation on 06/09/25 at 6:54 A.M. of 200-hall back unit revealed Certified Nursing Assistant (CNA) #631 entered the unit and stood in the center of the hallway in front of Resident #51's room. Interview with CNA #631 reported arriving for day shift and was training and looking for the right area to be in. During the interview, Resident #51 was heard yelling out repeatedly from the room Help. Please come help me. CNA #631 then left the unit and did not make any attempt to inquire with Resident #51 to see what was needed. Observation on 06/09/25 at 6:56 A.M. on 200-hall back unit revealed Resident #51 quieted and ceased from repeated yelling out for assistance. Observation on 06/09/25 at 6:57 A.M. on 200-hall back unit revealed Licensed Practical Nurse (LPN) #513 entered the unit. Interview at the time of the observation confirmed LPN #513 revealed she was working day shift as a nursing assistant for the unit and was the only one. LPN #513 then passed in front of Resident #51's room, who was hollering out for help and inquired with the resident, who was in bed, asking for some tea. There was also no cup of water in the room. LPN #513 responded to Resident #51 of needing to get report first and then would get the tea. Observation on 06/09/25 at 7:06 A.M. on 200-hall back unit revealed Resident #51 was still waiting for the requested cup of tea. Observation on 06/09/25 at 7:17 A.M. on 200-hall back unit revealed Resident #51 was still waiting for the requested cup of tea. Observation on 06/09/25 at 7:43 A.M. of 200-hall back unit revealed Resident #51 was still waiting for the requested cup of tea. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/09/25 at 7:53 A.M. of 200-hall back unit revealed Resident #51 remained in bed with no bedside table in reach, no requested tea and no water at the bedside. Interview on 06/09/25 at 7:56 A.M. with LPN #513 confirmed not having yet obtained Resident #51's requested tea, but stated the resident would get it on her breakfast tray anyway. Interview on 06/09/25 at 8:19 A.M. with Resident #51 complained about wanting the previously requested tea. The resident indicated probably getting it with breakfast but preferred to have it already. Observation on 06/09/25 at 8:25 A.M. of 200-hall back unit revealed a cart of four breakfast trays were brought onto the unit by LPN #513 who proceeded to pass them out; however, there was no tray on the cart for Resident #51 who was waiting for tea. Observation on 06/09/25 at 8:31 A.M. of 200-hall back unit revealed LPN #513 entered Resident #51's room and indicated going to get the resident dressed and up to have breakfast in the dining room. Observation on 06/09/25 at 8:39 A.M. of 200-hall back unit revealed LPN #513 left Resident #51's room with the resident dressed and still lying in bed with no bedside table in reach, water or tea. Interview at the time of the observation with LPN #513 indicated having to wait to get Resident #51 transferred out of bed because of needing a second staff member for the transfer. Observation on 06/09/25 at 8:47 A.M. of 200-hall back unit revealed Resident #51 remained in bed awaiting staff assistance to get up for breakfast in the dining room. Interview at the time of the observation with Resident #51 confirmed wanting to eat breakfast in the dining room, not the resident's room. Resident #51 complained of still not having a drink of tea. Interview with LPN #513 after speaking with Resident #51 verified having to wait for another staff member, but indicated the nurse aide who could help was busy, so LPN #513 was waiting for someone to become available. LPN #513 made no attempt to get Resident #51 some tea. Observation on 06/09/25 at 8:49 A.M. of Rosewood's main dining room revealed breakfast service had started and on 200-hall back unit, Resident #51 remained in bed. Interview on 06/09/25 at 8:54 A.M. with LPN #513 confirmed Resident #51 was still waiting to get out of bed for the dining room but indicated it was too late now because dining room service had finished so a tray would be ordered for Resident #51 to eat breakfast in the resident's room. Interview on 06/09/25 at 8:59 A.M. with Resident #51 on 200-back hall unit complained about having to eat breakfast in the resident's room instead of the dining room and further complained about being made to wait so long for tea. Interview on 06/09/25 at 9:06 A.M. with LPN #513 verified Resident #51's was made to eat breakfast in the resident's room because of not getting the resident out of bed quickly enough. LPN #513 made no attempt to get Resident #51 some tea. Observation on 06/09/25 at 9:13 A.M. on 200-back hall unit revealed LPN #513 with CNA #621 entered Resident #51's room and transferred the resident into a wheelchair. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/09/25 at 9:18 A.M. on 200-back hall unit revealed Resident #51 who was sitting up in a wheelchair received a breakfast tray in the resident's room. Interview at the time of the observation with Resident #51 who expressed disappointment in having to remain in the room to eat but was glad to at least be out of bed. Observation and interview on 06/09/25 at 9:44 A.M. with Resident #51 on 200-hall back unit revealed there was no tea on the resident's breakfast tray as requested but instead received coffee. Resident #51 complained about receiving coffee instead of tea and did not want the coffee but wanted the tea now. Interview on 06/09/25 at 9:45 A.M. with LPN #513 on 200-hall back unit confirmed not checking to make sure Resident #51 received the requested tea but stated she would get the tea from the kitchen now and then left the unit. Observation on 06/09/25 at 9:49 A.M. of 200-hall back unit revealed LPN #513 returned to the unit and delivered a cup of hot tea to Resident #51, nearly three hours after the original request. This deficiency represents non-compliance investigated under Complaint Numbers OH00164344 and OH00165145.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on record review, observation, interview and facility policy review, the facility failed to maintain call lights within reach of Residents #24 and #50. This affected two (Residents #24 and #50) of 88 residents reviewed for call light accessibility. The facility census was 88. Findings include: 1. Review of the medical record for Resident #24 revealed an admission date of 04/29/25. Diagnoses included Parkinson's disease, diabetes mellitus type two, dementia and overactive bladder. Observation on 06/09/25 at 5:06 A.M. of 200-hall middle unit revealed Resident #24 was hollering out for help. Upon room entrance, the resident was lying diagonally in bed with no sheet or blanket. A sheet appeared to be bunched up underneath both legs. There was no call light within reach as it was seen on the floor behind Resident #24's headboard of the bed. Interview with Resident #24 complained of needing changed because of feeling wet but could not find the call light. The resident accused staff of hiding the call light away because of using it too much and complained the staff made him get out of bed into a chair if he urinated too much in the bed, but he could not help it. Interview at the time of the observation with Registered Nurse (RN) #542 verified the observation and stated remembering leaving the resident's call light in reach but was uncertain how it ended up behind the headboard. Interview on 06/09/25 at 5:13 A.M. with Certified Nursing Assistant (CNA) #629 on 200-hall middle unit verified being the only nurse aide assigned to the unit and denied placing Resident #24's call light out of reach to prevent frequent calling, stating being unaware of how the resident's call light was placed behind the headboard. 2. Review of the medical record for Resident #50 revealed an admission date of 09/22/23. Diagnoses included chronic atrial fibrillation, sick sinus syndrome and cognitive communication deficit. Observation on 06/09/25 at 5:00 A.M. of 200-hall back unit revealed no staff on the unit. Resident #50's call light was on. Observation on 06/09/25 at 5:15 A.M. of 200-back hall unit revealed there continued to be no staff on the unit, and Resident #50's call light was still sounding. Observation on 06/09/25 at 5:18 A.M. of 200-back hall unit revealed there continued to be no staff on the unit, and Resident #50's call light remained on. Upon entering the resident's room, there was a strong odor of urine. Resident #50 was in a recliner chair located to the left of the bed. The resident's call light was not in reach and was seen on the floor located to the right of the bed. Resident #50 was holding her head and had a furrowed brow. Interview with the resident revealed a complaint of a terrible headache. When Resident #50 was asked how she was able to put the call light on since it was not in reach, she described having to get up from the recliner, walk around the bed, and pick up the call light from the floor to turn it on. Resident #50 complained about wishing the call light was next to her but could not figure out how to pull it over around the bed to where she was sitting, so she had no choice but to keep getting up to go use it. The resident then requested assistance to find staff to help. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/09/25 at 5:20 A.M. of 200-hall back unit revealed there continued to be no staff on the unit, and Resident #50's call light remained sounding. Observation on 06/09/25 at 5:23 A.M. of 200-hall back unit revealed RN #542 enter the unit and answer Resident #50's call light. Interview at the time of the observation with RN #542 verified the strong odor of urine in the resident's room and the call light out of reach. Review of the facility policy, Use of Call Light, reviewed 01/06/25, revealed staff were to never make the resident feel you are too busy to give assistance, and be sure call lights were placed within reach of the resident. This deficiency represents non-compliance investigated under Complaint Numbers OH00164344 and OH00165145.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility policy, the facility did not ensure Resident #52 was assisted with eating and drinking. This affected one (Resident #52) out of two residents reviewed that required feeding assistance. This had the potential to affect four (Residents #4, #36, #52, and #67) identified by the facility requiring assistance with feeding on the secured unit. Findings include: Review of the medical record for Resident #52 revealed an admission date of 03/26/24 with diagnoses including Alzheimer's disease, diabetes, hypertension, right hip fracture, and anxiety disorder. Review of the weight record revealed Resident #52's weight recorded on 08/08/24 was 99.8 pounds and on 06/10/25 her weight was 89.6 pounds. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 had impaired cognition as she was rarely or never understood. She required partial to moderate assistance with eating and substantial to maximum assistance with transfers. She was dependent on staff for toileting hygiene, lower dressing, showering and personal hygiene. Her weight was 92 pounds. Review of the June 2025 physician orders revealed Resident #52 was on a regular diet, received hospice services due to Alzheimer's disorder, and resided on the secure dementia unit. Review of the task bar in the electronic medical record (EMR) for meal intake percentage from 06/03/25 to 06/10/25 revealed Resident #52 had a varied appetite as either refusing to eat or ate up to 75 percent. On 06/06/25, Resident #52 ate less than 75 percent of breakfast and refused lunch and dinner. On 06/07/25 there was only one entry at 7:00 P.M. for one meal and that she ate less than 25 percent. There was no other documentation for 06/07/25. On 06/08/25 Resident #52 refused breakfast and only one other meal was documented as eating less than 25 percent. There was no documentation for 06/09/25 of any meal intakes and/or refusals. On 06/10/25, Resident #52 ate 50 percent at breakfast and 75 percent at lunch. Review of the task bar in the EMR for eating assistance from 06/03/25 to 06/10/25 revealed Resident #52 required substantial to maximum assistance and or was dependent on staff for eating. There was nothing documented for 06/09/25. Review of the care plan last revised 06/05/25 revealed Resident #52 had altered nutritional status evidenced by cognitive impairment related to Alzheimer's disease and diabetes. She was admitted to hospice. Interventions included alert dietician if consumption was poor for more than 72 hours, encourage adequate fluid and oral intake, supplements as ordered, and monitor and record the resident's intake after each meal. Review of the Nutritional assessment dated [DATE] and completed by Dietitian Tech #500 revealed Resident #52 was on a regular diet and was unable to make her needs known. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/09/25 at 8:32 A.M. revealed trays came to the secured dementia care unit and Licensed Practical Nurse (LPN) #626 (working as an aide on the secured unit) and Certified Nursing Assistant (CNA) #554 began passing the trays. Resident #52 was sitting in the lounge/dining area in a Broda chair (a specialized recliner on wheels that was able to recline) that was reclined back with her eyes open sitting at a table. Staff placed the tray in front of her with the lid covering the plate, and silverware in the cloth napkin. Staff opened her milk but did not pour it in a cup or place a straw, and Resident #52 remained in a reclined position unable to reach her tray. Observation on 06/09/25 at 9:08 A.M. revealed LPN #626 and CNA #554 completed passing all the trays on the unit in the dining room and on the hall and proceeded to pick up the trays from residents that were finished. Resident #52 continued to be positioned in a reclined position in her Broda chair with her plate covered with a plastic lid, silverware continued to be wrapped in the cloth napkin, milk container open without a straw, all food and drink were out of reach of Resident #52 and no assistance and/or encouragement was offered. CNA #554 walked up to Resident #52's table and said, you not going to eat and Resident #52 mumbled what appeared nonsensical but this surveyor (approximately five feet away) was unable to hear what Resident #52 stated. CNA #554 proceeded to pick up her tray and placed it back on the cart without attempting to position Resident #52 from a reclined position, uncover her food, unwrap her silverware, and/or provide assistance with eating or drinking. Interview on 06/09/25 at 9:08 A.M. with CNA #554 revealed she had only worked at the facility three days, and she was told that Resident #52 does not eat breakfast and stated, so, no I do not try to get to eat. She then replied she did ask her, and she stated she did not want her food. She verified that she did not attempt to position Resident #52 properly to eat from a reclined position, uncover her food, unwrap her silverware, place a straw in her milk and/or pour her milk into a cup, provide food and/or drink within reach, attempt to encourage and/or assist Resident #52 to drink and/or eat. CNA #554 stated again, I was told she does not eat breakfast. Interview on 06/09/25 at 9:10 A.M. with LPN #624 (nurse assigned to the secured unit) who was passing medications on the hallway and in the area was asked about Resident #52 and not being assisted and encouraged with her breakfast and if there was anything regarding Resident #52 not eating breakfast. LPN #624 revealed, I really am not sure as she looked down and continued to prepare medications. Interview on 06/09/25 at 10:13 A.M. and 10:41 A.M. with Dietitian #589 and Registered Nurse (RN)/Unit Manager/Infection Control #531 verified per the nutritional assessment completed per Dietary Technician #500, Resident #52 was unable to make her needs known, her cognitive status per the MDS was impaired as she was rarely or never able to make needs known, and she required partial to moderate assistance with eating. RN/ Unit Manager/ Infection Control #531 revealed that since she had been back from the hospital, she was dependent on staff for eating and drinking. They verified staff should have positioned her in the Broda chair from a reclined position to upright, uncovered her food, unwrapped her silverware, applied a straw to her milk and assisted with encouraging and feeding her breakfast. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/10/25 at 8:23 A.M. revealed the dietary cart came to the secured unit with trays on it. Observation revealed Resident #52 who was already sitting in an upright position in the lounge/dining room received her tray from CNA #622. CNA #622 proceeded to sit in a chair next to Resident #52 and apply butter and syrup to the waffle and cut into bite size pieces. She then prompted Resident #52 to open her mouth as she fed her breakfast. She proceeded in between bites to offer her a drink of water through a straw. CNA #52 had to encourage Resident #52 to open her mouth with each bite and drink. Resident #52 ate 50 percent of her breakfast after total assistance from staff. Interview on 06/10/25 at 8:33 A.M. with CNA #622 revealed Resident #52 was always dependent on staff to assist her with eating and drinking. She revealed somedays she did better with breakfast and others she did better with lunch and dinner. Review of the facility policy labeled, Dining and Meal Service, dated 06/08/22, revealed the dining experience would be person centered with the purpose of enhancing each individual resident's quality of life. Residents would be positioned comfortably for the meal and in a way that would assist with eating and drinking. The policy revealed staff would offer to open containers, remove lids, and cut food, as needed. The policy revealed appropriate staff would assist as needed to ensure adequate intake of food and fluids at the meal. This deficiency represents non-compliance investigated under Complaint Numbers OH00165146 and OH00164464.

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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. Based on observation, interview, record review and review of facility policy, the facility did not ensure residents had proper signage upon entry to their room indicating oxygen was in use and/or there was a physician order for the use of oxygen. This affected two (Residents #24 and #33) out of three residents reviewed for oxygen use. This had the potential to affect 14 (Residents #3, #7, #14, #24, #27, #28, #33, #35, #41, #44, #49, #51, #65, and #71) identified by the facility on oxygen. Findings include: 1. Review of the medical record for Resident #33 revealed an admission date of 06/06/25 with diagnoses including emphysema, chronic obstructive pulmonary disease (COPD) with acute exacerbation, and acute and chronic respiratory failure. Review of the undated care plan revealed Resident #33 had ineffective breathing patterns as evidenced by shortness of breath, labored respirations due to COPD, emphysema and respiratory failure. Interventions included adjusting the head of bed and body positioning to assist with the ease of respirations, administering oxygen as ordered, administering respiratory treatments as ordered, monitoring and documenting signs of shortness of breath and reporting abnormal findings to the physician. Review of the June 2025 Physician Orders revealed Resident #33 had an order for oxygen at two liters per minute per nasal cannula as needed for COPD. Observation on 06/09/25 at 5:43 A.M. revealed Resident #33 was lying in his bed wearing oxygen per nasal cannula at two liters per minute. There was no sign indicating oxygen was in use upon the entry to Resident #33's room. Interview on 06/09/25 at 5:46 A.M. with Licensed Practical Nurse (LPN) #627 verified Resident #33 was utilizing oxygen in his room and there was no signage on the outside of the door indicating oxygen was in use. Review of the facility policy labeled, Oxygen Administration, dated 01/06/25, revealed the nurse was to check the physician order for liter flow and method of administration of the oxygen, and an oxygen in use sign was to be placed. 2. Observation on 06/09/25 at 5:06 A.M. of Resident #24 in bed with oxygen being administered via nasal cannula by a concentrator. Observation on 06/09/25 at 6:05 A.M. of Resident #24 in bed with oxygen being administered via nasal cannula by a concentrator. There was no oxygen safety sign displayed within the room or on the doorway. Interview at the time of the observation with Registered Nurse (RN) #542 verified there was no oxygen safety sign in place as required. Review of the medical record for Resident #24 revealed an admission date of 04/29/25. Diagnoses included Parkinson's disease, diabetes mellitus type two, dementia and overactive bladder. Review of Resident #24's physician orders effective June 2025 revealed no oxygen administration orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/11/25 with LPN #632 verified Resident #24 received oxygen administration without active physician orders within the resident's medical record. Review of the facility policy Oxygen Administration, reviewed 01/06/25, revealed to check the physician's order for liter flow and method of administration, and place an oxygen in use sign. This deficiency represents non-compliance investigated under Complaint Number OH00164344.

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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 record review, interview, review of a self-reported incident (SRI), observation, and review of the facility policy, the facility did not ensure Resident #36 received trauma-informed care in accordance with professional standards of practice. This affected one (Resident #36) out of one resident reviewed for trauma informed care. This had the potential to affect four (Residents #36, #64, #84, and #87) identified by the facility with post-traumatic stress disorder (PTSD) and/or trauma. Findings include: Review of the medical record for Resident #36 revealed an admission date of 08/11/23 with diagnoses including dementia, chronic obstructive pulmonary disease (COPD), anxiety disorder, mood disorder, and depression. There was not a diagnosis of PTSD listed. Review of the Social Service admission assessment dated [DATE] and completed by Social Service Designee (SSD) #533 revealed he asked Resident #36 if she experienced any trauma or witnessed a traumatic event, and she stated no. Review of Social Service Quarterly Assessments completed by SSD #533 revealed he assessed Resident #36 on 11/08/24, 02/04/24, and 04/28/24. There was nothing on the assessments regarding assessing for trauma. Review of care plan dated 03/26/25 revealed Resident #36 demonstrated paranoia, hallucinations and unrealistic fears due to mood disorder, anxiety disorder, and dementia with agitation. Interventions included administering medications as ordered, referring to psych services as needed, encouraging the resident to participate in activities, and educating the resident on changes prior to making changes. There was nothing in the care plan regarding Resident #36 reporting she was sexually abused by a family member, any triggers identified (including soft mattresses) and/or any interventions to eliminate or mitigate triggers that may cause re-traumatization of the resident. Review of the SRI with tracking number 258656 dated 03/26/25 revealed the Administrator filed an allegation of abuse as Resident #36 alleged Certified Nursing Assistant (CNA) #682 was rough during care as she laid her down abruptly. During the investigation, Resident #36 recanted her statement stating she was confused and continued to have flashbacks from her childhood trauma. The SRI revealed Resident #36 had delusions from when she was assaulted by a family member when she was younger. The SRI revealed Nurse Practitioner (NP) #643 and social service assessed the resident and psych services followed the resident. The SRI revealed the police department was notified. Review of the witness statement dated 03/26/25 and completed by Licensed Practical Nurse (LPN)/Unit Manager #632 revealed Resident #36 reported that CNA #682 threw her into the bed, a travel trailer with a hammock that folded into three pieces. Resident #36 then stated she was having flashbacks from when a family member raped her at the age of 13. The statement revealed Resident #36 stated soft mattresses scare her due to the rape. Resident #36 revealed the family member almost pulled her into the trailer and raped her again, but her dog had saved her. Resident #36 revealed she thinks her flashbacks were causing hallucinations and delusions. The statement revealed Resident #36 would like therapy for her flashbacks. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the police report dated 03/26/25 and completed by Police Officer #683 revealed Resident #36 stated a CNA #682 threw her on the bed. The report revealed Resident #36 was diagnosed with PTSD, hallucinations and other medical conditions. The report revealed the facility was investigating and would update the police on their findings. Review of the progress note dated 03/26/25 at 1:42 P.M. stated NP #643 revealed Resident #36 was making delusional statements as Resident #36 stated she was placed in a box with high sides and felt claustrophobic. Resident #36 also complained of insomnia as she was tossing and turning at night due to pain and thinking about things from the past. The note revealed she was talking about past sexual trauma when she was 13. NP #643 increased the trazodone (anti-depressant) to 150 milligrams at night and Resident #36 would benefit from psychiatric services. Review of Psych NP #645 progress note dated 04/15/25 revealed she collaborated with the floor nurse who revealed Resident #36 was at baseline but continued to experience hallucinations almost daily. Psych NP #645 evaluated and there was no documentation regarding the incident that was reported on 03/25/25 related to flashbacks of a family member sexually abusing her. Review of the Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 had intact cognition with hallucinations and delusions. Review of the Social Service Quarterly assessment dated [DATE] and completed by SSD #533 revealed there were no psychosocial changes that may affect mood and there was no documentation that trauma was assessed. There was also no other documentation from 03/25/25 to 04/28/25 by SSD #533. Review of the progress note dated 05/13/25 revealed Psych NP #645 evaluated Resident #36, and there was no documentation regarding the incident that was reported on 03/25/25 related to flashbacks of a family member sexually abusing her. Review of the Kardex (guidelines provided to the staff regarding a resident's care) dated 06/11/25 revealed Resident #36 did not have anything regarding her history of potential trauma, triggers and/or interventions. Interview on 06/11/25 at 9:26 A.M., 9:50 A.M. and 1:28 P.M. with the Administrator verified the SRI dated 03/26/25 stated SSD #533 assessed Resident #36 after she stated she had been sexually abused as a child. She verified SSD #533 was never told about the incident as she just asked SSD #533 to do a routine psychosocial assessment as she did not want SSD #533 to have a biased opinion when he assessed her. When asked how SSD #533 could have assessed Resident #36 for trauma if he routinely does not assess for trauma during a routine psychosocial assessment unless there was a need, she did not reply. She verified Resident #36 stated she was sexually abused as a child, but the facility felt it was one of her delusions as Resident #36 had a history of delusions and hallucinations. She verified she did not have any documentation that SSD #533 assessed Resident #36 for trauma after the incident on 03/25/25. She also had no documentation stating psych services (a psychologist, counseling, and/or Psych NP #645) was consulted regarding Resident #36's statements of sexual trauma as a child. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/11/25 at 9:45 A.M. with SSD #533 revealed he assessed Resident 36 on admission, 11/24/23, and she denied trauma. He revealed he does not assess any further for trauma unless there is a need. He revealed he was not aware of the SRI dated 03/26/25 regarding Resident #36 stating she was sexually abused in the past by a family member. The SRI dated 03/26/25 revealed SSD #553 assessed her after the incident; he verified he did not assess her for trauma as he did not know about her reporting she was sexually abused in the past. Interview on 06/11/25 at 10:18 A.M. with CNA #607 revealed she worked on the secured unit and revealed she was not aware of any past trauma events for Resident #36 including sexual abuse, any triggers and/or any interventions. She revealed if there was it would show up on the Kardex. She reviewed Resident #36's Kardex with this surveyor and stated there was nothing on the Kardex related to history of sexual abuse, any triggers and/or any interventions Interview on 06/11/25 at 10:38 A.M. with Resident #36 she appeared happy and smiling as she talked about how she trained dogs and how she loved animals. When asked if she ever had any trauma in her life, Resident #36 stated lots of things and many things that she cared not to remember. She revealed a family member that she specifically identified was a bad man as when her mother worked night shift, the man would come into her room when she was young, and she stated molested her. During the interview, Resident #36's mood changed as she looked down, avoided eye contact and seemed upset. She then proceeded to state that she would rather not talk about it as nobody can do anything now as he no longer was on earth. Interview on 06/11/25 at 10:42 A.M. with Psych NP #645 revealed she comes into the facility once a week, and she sees each resident in need of services approximately every one to two months or as needed. She revealed she does not recall the facility notifying her regarding Resident #36 talking about a past trauma that included sexual abuse. This surveyor reviewed the SRI dated 03/26/25 and witness statement by LPN/ Unit Manager #632 and she again revealed she did not recall being notified. She stated she would have documented that in her notes if she was notified. Review of the facility policy labeled, Trauma- Informed Care and Post- Traumatic Stress Disorder (PTSD), dated 01/06/25, revealed PTSD was a trauma- related disorder caused by an individual's exposure to actual or threatened death, serious injury, or sexual violence in one or more ways including directly experiencing the traumatic event or witnessing the event in person. The policy revealed residents would be referred to psych services. The policy did not include anything regarding assessing residents for trauma and ensuring triggers were identified in a resident's plan of care. This deficiency is an incidental finding identified during the complaint investigation.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, review of the PBJ (Payroll-Based Journal) Staffing Data Report, and review of facility assessment, schedules, incidents logs, resident care lists, policies and the staffing tool, the facility failed to provide adequate staffing to meet resident needs in the Rosewood residential area which contained three units, 200-hall front (a secured memory care unit), 200-hall middle, and 200-hall back. This affected 47 residents (#2, #3, #4, #5, #7, #8, #9, #10, #12, #14, #19, #20, #22, #24, #25, #27, #28, #30, #35, #36, #38, #40, #42, #45, #47, #49, #50, #51, #52, #55, #57, #58, #59, #60, #61, #62, #67, #68, #70, #71, #72, #75, #76, #79, #83, #84 and #85) who resided in the Rosewood residential area. The facility census was 88. Findings include: Review of the facility census effective 06/08/25 revealed the Rosewood residential area, 200-hall front unit had 17 residents residing there, 200-hall middle unit had 16 residents, and 200-hall back unit had 14 residents. Observation on 06/09/25 at 4:58 A.M. of the night shift in the Rosewood residential area revealed upon entering through the double doors leading to all three units was a strong odor of urine which lingered. There was one nurse for all three units, one nursing assistant for 200-hall front (secured) unit, one nursing assistant for 200-hall middle unit, and no nursing assistant assigned to 200-hall back unit. Interview at the time of the observation with Registered Nurse (RN) #542 verified the staffing assignments and indicated not only being the nurse for all three units, but also having to work as the nursing assistant for 200-hall back unit. Observation on 06/09/25 at 5:00 A.M. of 200-hall back unit revealed no staff on the unit. Resident #50's call light was on, and Resident #27 was lying in bed with the light on leaning to the left in a fetal-like position. Observation on 06/09/25 at 5:06 A.M. of 200-hall middle unit revealed Resident #24 was hollering out for help. Upon entering the room, the resident was lying diagonally in bed with no sheet or blanket. A sheet appeared to be bunched up underneath both legs. There was no call light within reach as it was seen on the floor behind Resident #24's headboard of the bed. Interview with Resident #24 complained of needing changed because of feeling wet but could not find the call light. The resident accused staff of hiding the call light away because he used it too much and complained the staff made him get out of bed into a chair if he urinated too much in the bed, but he could not help it. Visible on the left knee was a small red discolored area which appeared to be an abrasion. Resident #24 indicated falling but could not remember when. Interview at the time of the observation with RN #542, who had pharmacy packaged medications in hand, verified the observation and stated remembering leaving the resident's call light in reach but was uncertain how it ended up behind the headboard. RN #542 indicated needing to handle the pharmacy medication delivery and then would return to provide incontinence care. Observation on 06/09/25 at 5:12 A.M. of 200-back hall unit revealed no staff on the unit, and Resident #50's call light was still on. RN #542 completed the pharmacy delivery at the nurse's station area and then went onto 200-hall middle unit, obtained clean linens, and entered Resident #24's room. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/09/25 at 5:13 A.M. with Certified Nursing Assistant (CNA) #629 on 200-hall middle unit verified being the only nurse aide assigned to the unit, and residents who needed two staff assistance for care or mechanical lifts would wait until the nurse or nurse aide from the secured unit (200-hall front) came over to help. CNA #629 insisted on only working on 200-hall middle unit and denied knowing who was attending the 200-hall back unit because she was not going over there. CNA #629 complained about how difficult it was to complete care because of being alone and newly hired but would leave the unit to find help when needed. The nurse aide denied placing Resident #24's call light out of reach to prevent frequent calling and reported being unaware of how the resident's call light was placed behind the headboard. Observation on 06/09/25 at 5:15 A.M. of 200-back hall unit revealed there continued to be no staff on the unit, and Resident #50's call light which was initially seen on at 5:00 A.M. was still sounding. Observation on 06/09/25 at 5:18 A.M. of 200-back hall unit revealed there continued to be no staff on the unit, and Resident #50's call light remained on. Upon entering the resident's room, there was a strong odor of urine. Resident #50 was in a recliner chair located to the left of the bed. The resident's call light was not in reach and was seen on the floor located to the right of the bed. Resident #50 was holding her head and had a furrowed brow. Interview with the resident revealed a complaint of a terrible headache. When Resident #50 was asked how she was able to put the call light on since it was not in reach, she described having to get up from the recliner, walk around the bed, and pick up the call light from the floor to turn it on. Resident #50 complained about wishing the call light was next to her but could not figure out how to pull it over around the bed to where she was sitting, so she had no choice but to keep getting up to go use it. The resident then requested assistance to find staff to help. Observation on 06/09/25 at 5:20 A.M. of 200-hall back unit revealed there continued to be no staff on the unit, and Resident #50's call light remained sounding. Peering through the 200-hall front (secured) unit entrance door window, no staff was seen. On 200-hall middle unit, there was no staff seen in the hallway. Observation on 06/09/25 at 5:23 A.M. of 200-hall back unit revealed RN #542 enter the unit and answer Resident #50's call light. Interview at the time of the observation with RN #542 verified the strong odor of urine in the resident's room and the call light out of reach. RN #542 did not check for incontinence care need but put the call light in the resident's reach and assessed the pain level. After exiting Resident #50's room, RN #542 reported the resident was known to change her own briefs at times and had a tendency to put used briefs in the bathroom but continued down the unit's hallway without investigating the resident's need for incontinence care and left the unit. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/09/25 at 5:25 A.M. of 200-hall front (secured) unit revealed one nurse aide present, CNA #517. Interview at the time of the observation with CNA #517 verified being the only staff member on the secured unit and not permitted to leave it unless it was covered by another staff member but admitted to having no choice but leave long enough to find another staff member for assistance or find the nurse when needed. CNA #517 described the unit as having several residents who required two staff assistance with care or mechanical lifts, and one resident (#8) who had behaviors at times requiring up to three staff members to complete care, so it was difficult to get enough help together for that resident. CNA #517 stated being unable to adequately monitor wanderers for safety or be present to redirect behaviors like wandering in and out of or rummaging in other resident rooms because of being alone on the unit. CNA #517 expressed a belief that falls had increased lately because the unit was full of 17 residents and there once was always two nurse aides on the unit but now there was only one nurse aide, and since the nurse covers all three units, the nurse was not able to be on the unit helping with resident behaviors or watching for safety. CNA #517 reluctantly acknowledged, in general, there were times when a second staff member could not be found so mechanical lifts or care would be completed with one staff member because there were no other options. At the time of the interview, CNA #517 looked across the hallway into Resident #79's room and saw the resident had self-transferred from the bed for toileting. The nurse aide entered the room and encouraged the resident to call for assistance to prevent falls then proceeded to address Resident #79's needs. Interview at 06/09/25 at 5:33 A.M. with RN #542 on 200-hall middle confirmed being responsible for completing nurse aide responsibilities on 200-hall back as well as the nurse but was not able to make it back on the unit yet. RN #542 verified being the only one available to provide incontinence care or rounds to check and change but stated there were not too many incontinent residents there. RN #542 was unable to report the last time 200-hall back received any rounds or assistance with incontinence care but confirmed it was at some time prior to 5:00 A.M. RN #542 acknowledged it was difficult to perform nurse aide tasks for an entire unit in addition to doing all the nursing responsibilities for all three units and still be able to keep up timely with resident needs as some tasks may be late or not get done. Observation on 06/09/25 at 5:35 A.M. of 200-hall back revealed no staff on the unit. Observation on 06/09/25 at 5:40 A.M. of 200-hall back revealed RN #542 returned to the unit with a medication cart and administered pain medication to Resident #50 in fulfillment of the request made at 5:23 A.M. Observation on 06/09/25 at 5:44 A.M. revealed RN #542 exited Resident #50's room, left the 200-hall back unit and entered the 200-hall front (secured) unit, leaving no staff on the 200-hall back unit. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/09/25 at 5:48 A.M. of 200-hall middle unit revealed at the center of the unit was a small common area with chairs and an adjacent hallway table between the rooms for Residents #30 and #68. Setting on the chair next to the hallway table was an opened package of barbeque potato chips, and a wadded-up blanket. Setting on the hallway table was a portable space heater plugged in and blowing warm air toward the chair with the wadded-up blanket and opened bag of potato chips. Setting next to the space heater on the table was a cellphone with ear buds attached, and an ear bud case was located on the chair seat near the potato chips. Underneath the chair with the opened bag of potato chips there were multiple pieces of food debris on the floor. Nearby were some personal items including a bag with reading books. Interview at the time of the observation with CNA #629 confirmed the personal belongings, food items, cellphone and running space heater belonged to her, as she was using the spot to watch the unit because of not being able to take breaks away from the unit. Observation on 06/09/25 at 5:51 A.M. of 200-hall middle unit revealed a lingering faint smell of urine within the hallway. Interview at the time of the observation with CNA #629 verified the observation. Observation on 06/09/25 at 5:55 A.M. at the front of 200-hall back unit revealed a strong urine odor. RN #542 was seen administering medications, and no other staff were on the unit to address incontinence care needs. Observation on 06/09/25 at 6:04 A.M. of 200-hall middle unit revealed CNA #629 entered Resident #28's room with the mechanical lift and transferred the resident from the bed to Geri chair with the assistance of Resident #28's private aide, CNA #646 who was present in the room, in lieu of obtaining assistance from a facility staff member. Observation on 06/09/25 at 6:13 A.M. of 200-hall back unit revealed no staff were present on the unit. Interview with Resident #51 complained of feeling wet and not being changed during the night. There was no water at the bedside. Observation on 06/09/25 at 6:15 A.M. of 200-hall back unit revealed Resident #71 self-transferring to the bathroom for toileting and no call light on. Interview at the time of the observation with Resident #71 complained the facility was short on staff and many residents who cannot help themselves wait a long time for help. Observation on 06/09/25 at 6:21 A.M. of 200-hall back unit revealed no staff on the unit. CNA #517 left 200-hall front (secured) unit unattended to find RN #542 who was on 200-hall middle unit and discussed an unknown resident on the secured unit who was in pain and needed medication. CNA #517 then returned to the secured unit within three minutes. Observation on 06/09/25 at 6:25 A.M. of 200-hall middle unit revealed CNA #629 in the middle of the hallway at the common area sitting in the chair with a blanket and space heater blowing heat toward her and manipulating the screen of the cellphone with the attached earbuds. RN #542 approached CNA #629 and spoke unknown words to the nurse aide who shortly thereafter stood up and returned to working within the unit. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/09/25 at 6:29 A.M. with Resident #28's private aide, CNA #646, on 200-hall middle unit who complained there was usually only one nurse aide assigned to the hallway especially at night so it was a typical scenario of not enough help for those who need more than one staff member for assistance, which was why CNA #646 assisted the facility nurse aide with the resident's mechanical lift transfer. CNA #646 stated it was likely why Resident #28's family hired private aides to make certain care was received. Observation on 06/09/25 at 6:31 A.M. of 200-hall back unit revealed no staff on the unit and no rounds to check for incontinence yet seen. RN #542 was observed to be on 200-hall front (secured) unit through the unit's window. Observation on 06/09/25 at 6:35 A.M. of 200-hall back unit revealed no staff remained on the unit. Interview on 06/09/25 at 6:38 A.M. with Resident #71 on 200-hall back unit, who complained about not having enough staff and no one in the hallway for help and described call lights being on for long periods or not being able to find any staff when needed. Interview on 06/09/25 at 6:40 A.M. with Resident #47 on 200-hall back who requested help to put a sweater on and complained about not being able to find any staff on the unit to help, then turned on the call light. Observation on 06/09/25 at 6:42 A.M. of 200-hall back unit revealed RN #542 entered the unit and assisted Resident #47 then left the unit and returned to 200-hall front (secured unit) when Resident #55's call light turned on who resided on 200-hall back unit. Observation on 06/09/25 at 6:48 A.M. of 200-hall back unit revealed Resident #55's call light remained on and there were no staff on the unit. Observation on 06/09/25 at 6:54 A.M. of 200-hall back unit revealed Resident #55's call light remained on, and there were no staff on the unit. CNA #631 entered the unit and stood in the center of the hallway in front of Resident #51's room. An interview with CNA #631 reported arriving for day shift and was training and looking for the right area to be in. During the interview, Resident #51 was heard yelling out repeatedly from the room Help. Please come help me. CNA #631 then left the unit and did not make any attempt to answer Resident #55's call light or inquire with Resident #51 to see what was needed. Observation on 06/09/25 at 6:56 A.M. on 200-hall back unit revealed Resident #51 quieted and ceased from repeated yelling out for assistance. There were no staff on the unit, and Resident #55's call light remained on. Observation on 06/09/25 at 6:57 A.M. on 200-hall back unit revealed Licensed Practical Nurse (LPN) #513 entered the unit. Interview at the time of the observation confirmed LPN #513 was the day shift nurse assigned to work as a nursing assistant for the unit and would be the only one. LPN #513 then passed in front of Resident #51's room, who was hollering out for help and inquired with the resident, who was in bed, and asked for some tea. There was no cup of water in the room. LPN #513 responded to Resident #51 of needing to get report first and then would get the tea then left the room and the unit. Resident #55's call light remained on. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/09/25 at 6:59 A.M. on 200-hall back unit revealed Resident #55's call light remained on. Interview with Resident #55 at the time of the observation complained of wanting to get out of bed and was waiting a long time for help. Observation on 06/09/25 at 7:00 A.M. on 200-hall back unit revealed LPN #513 returned to the unit and entered Resident #55's room to provide assistance. Day shift staff were now observed in the Rosewood area. There were two nurses for all three units, and one nurse aide for each of the three units with an additional trainee on 200-hall front (secured) unit. Observation on 06/09/25 at 7:06 A.M. on 200-hall back unit revealed Resident #50's call light went on, and Resident #51 was still waiting for the requested cup of tea. Observation on 06/09/25 at 7:07 A.M. on 200-hall back unit revealed LPN #513 exited Resident #55's room, left the unit and returned with another staff member to Resident #55's room. Observation on 06/09/25 at 7:13 A.M. on 200-hall back unit revealed LPN #513, and the unknown staff member exited Resident #55's room who was now up in a wheelchair and both staff left the unit. Resident #50's call light was still on and no rounds to check for or provide incontinent care or repositioning had been completed since prior to 5:00 A.M. as stated by RN #542. Observation on 06/09/25 at 7:17 A.M. on 200-hall back unit revealed LPN #513 returned to the unit and answered Resident #50's call light. Resident #27 was still lying in bed, leaning to the left in a fetal-like position as originally observed at 5:00 A.M, and Resident #51 was still waiting for the requested cup of tea. Observation on 06/09/25 at 7:23 A.M. of 200-hall back unit revealed LPN #513 entered Resident #27's room and asked if the resident desired to get up, which Resident #27 responded affirmatively and then LPN #513 left the room stating the resident required a mechanical lift for transferring so she would have to find help from another staff member. LPN #513 then left the unit. Interview on 06/09/25 at 7:24 A.M. with Resident #27 complained about being wet and needing changed stating it had been a long since being helped last. Observation on 06/09/25 at 7:26 A.M. of 200-hall back unit revealed Resident #45 yelling out from the room repeatedly, get me up. There were no staff seen on the unit. Interview at the time of the observation with Resident #45 complained of needing changed and stated it had been a long time. The resident also requested breakfast. Observation on 06/09/25 at 7:30 A.M. of 200-hall back unit revealed no staff on the unit. Observation on 06/09/25 at 7:35 A.M. of 200-hall back unit revealed LPN #513 returned to the unit and went into Resident #45's room who was yelling out, exited the room at 7:38 A.M., and then left the unit. Observation on 06/09/25 at 7:43 A.M. of 200-hall back unit revealed no staff on the unit. Rounds to check for or provide incontinent care or repositioning had not yet been completed since prior to 5:00 A.M. as stated by RN #542. Residents #27, #45 and #51 continued to wait for assistance. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/09/25 at 7:46 A.M. of 200-hall back unit revealed LPN #624 entered the unit with a medication cart and began administering medications. LPN #513 then re-entered the unit, spoke with LPN #624 and started having to go find stuff indicating having not been a nurse aide for about 12 years. LPN #513 then left the unit. Observation on 06/09/25 at 7:53 A.M. of 200-hall back unit revealed Resident #51 remained in bed with no bedside table in reach, no requested tea and no water at the bedside. Observation on 06/09/25 at 7:56 A.M. of 200-hall back unit revealed LPN #513 returned to the unit and entered Resident #27's room for incontinent care. LPN #513 reported never having been a nurse aide on the floor before and was not warned ahead of time to prepare for the day. LPN #513 removed Resident #27's heavily soiled brief with urine and stool. The outermost portion of the stool appeared dried, and upon cleansing the buttocks area it appeared reddened. LPN #513 verified the area was reddened and appeared to be irritated from the stool being on the skin. Barrier cream was applied to the area followed by a clean brief and repositioning. At the time, Resident #27 expressed concern to LPN #513 of never wanting another pressure ulcer and asked if she was okay. In response, LPN #513 provided encouragement and answered affirmatively. Continued interview with LPN #513 confirmed there was not enough staff for incontinent rounds stating no knowledge of when the residents last received incontinent checks or care since she had not received any report from the off going night shift staff. LPN #513 additionally stated being uncertain when any rounds could be performed because she had to concentrate on getting residents ready for breakfast. Resident #27 was repositioned to the right side and upon LPN #513 leaving the room confirmed not having yet obtained Resident #51's requested tea, but stated the resident would get it on her breakfast tray. Observation on 06/09/25 at 8:08 A.M. of 200-hall back unit revealed LPN #513 entered Resident #45's room, transferred the resident into a shower chair and went to the shower room. Interview on 06/09/25 at 8:19 A.M. with Resident #51 complained about wanting the previously requested tea. The resident indicated probably getting it with breakfast but preferred to have it already. Observation on 06/09/25 at 8:23 A.M. of 200-hall back unit revealed LPN #513 returned from the shower room with Resident #45 and then transported her to the dining room for breakfast. Observation on 06/09/25 at 8:25 A.M. of 200-hall back unit revealed a cart of four breakfast trays were brought onto the unit by LPN #513 who proceeded to pass them out; however, there was no tray on the cart for Resident #51 who was waiting for tea. Observation on 06/09/25 at 8:31 A.M. of 200-hall back unit revealed LPN #513 entered Resident #51's room and indicated going to get the resident dressed and up to have breakfast in the dining room. Observation on 06/09/25 at 8:38 A.M. of 200-hall front (secured) unit revealed Resident #4's call light was on. Observation on 06/09/25 at 8:39 A.M. of 200-hall back unit revealed LPN #513 left Resident #51's room with the resident dressed and still lying in bed with no bedside table in reach and no water or tea. Interview at the time of the observation with LPN #513 indicated having to wait to get Resident #51 transferred out of bed because of needing a second staff member for the transfer. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/09/25 at 8:45 A.M. of 200-hall front (secured) unit revealed Resident #4's call light remained on. Observation on 06/09/25 at 8:47 A.M. of 200-hall back unit revealed Resident #51 remained in bed awaiting staff assistance to get up for breakfast in the dining room. Interview at the time of the observation with Resident #51 confirmed wanting to eat breakfast in the dining room, not the resident's room. Resident #51 complained of still not having a drink of tea. Interview with LPN #513 after speaking with Resident #51 verified having to wait for another staff member to help transfer the resident because of requiring two staff assistance, but the nurse aide who was to help was busy on the secured unit assisting to feed residents, so LPN #513 was waiting for someone to become available. Observation on 06/09/25 at 8:49 A.M. of Rosewood's main dining room revealed breakfast service had started and on 200-hall back unit, Resident #51 remained in bed with no staff visible on the unit. On the 200-hall front (secured) unit, Resident #4's call light was answered. Observation on 06/09/25 at 8:53 A.M. on the 200-back hall unit revealed Resident #75 emerged from the resident's room. Interview at the time of the observation with Resident #75 loudly complained about not yet receiving any breakfast which was supposed to be served around 8:00 A.M. Interview on 06/09/25 at 8:54 A.M. with LPN #513 who returned to the 200-back hall unit stated the unit had not received enough breakfast trays and was trying to figure out why and who still needed breakfast. LPN #513 confirmed Resident #51 was still waiting to get out of bed for the dining room but indicated it was too late now because dining room service had finished so a tray would be ordered for Resident #51 to eat breakfast in the resident's room. LPN #513 proceeded to round through the unit and make note of which residents still needed breakfast which were Residents #19, #50, #51, #58 and #75 and then left the unit. No staff remained on the unit. Rounds to check for or provide incontinent care or repositioning had not yet been completed since prior to 5:00 A.M. as stated by RN #542. Interview on 06/09/25 at 8:59 A.M. with Resident #51 on the 200-back hall unit complained about having to eat breakfast in the resident's room instead of the dining room and further complained about being made to wait so long for tea. Observation on 06/09/25 at 9:01 A.M. on the 200-back hall unit revealed Resident #58 emerged from the resident's room. Interview at the time of the observation with Resident #58 complained about not yet receiving any breakfast. There were no staff visible on the unit. Observation on 06/09/25 at 9:06 A.M. on 200-back hall unit revealed LPN #513 returned to the unit. Interview at the time of the observation with LPN #513 verified Resident #51 was made to eat breakfast in the resident's room because of missing dining room service. There was not enough staff to get Resident #51 out of bed quickly enough. The resident was on the list for night shift to get her up for breakfast, but night shift did not do it because there was no nurse aide on the unit. LPN #513 further stated there was not enough staff to get morning rounds done either because of being the only nurse aide, and it appeared the unit's breakfast trays were ordered incorrectly because it was done by a staff member not assigned to the unit. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/09/25 at 9:10 A.M. with Resident #19 on the 200-back hall unit complained about staffing being routinely short and sometimes no staff on the unit in the late evenings or during the night. The resident also complained about water not being passed out every shift and only getting it after asking. Resident #19 expressed feeling fortunate to have the ability to request help because there were many residents on the unit who could not and did not get assistance. Observation on 06/09/25 at 9:13 A.M. on 200-back hall unit revealed LPN #513 with CNA #621 entered Resident #51's room and transferred the resident into a wheelchair. Concurrently, the missing resident breakfast trays were delivered to the unit and various staff from other areas passed out the trays. Observation on 06/09/25 at 9:18 A.M. on 200-back hall unit revealed Resident #51 who was sitting up in a wheelchair received a breakfast tray in the resident's room. Interview at the time of the observation with Resident #51 who expressed disappointment in having to remain in the room to eat but was glad to at least be out of bed. Interview on 06/09/25 at 9:20 A.M. with CNA #621 who was the only nurse aide assigned to the 200-hall middle unit reported Residents #30 and #61 were not taken to the dining room for breakfast because night shift could not get them up. CNA #621 confirmed there was not enough staff to manage the amount of care needed in the different units, with the middle unit having the most residents who required two staff assistance, especially for mechanical lifts and incontinent care. CNA #621 indicated staff reported staffing needs to administration but were told the census was too low so the staff would have to make do with what they had. Observation and interview on 06/09/25 at 9:44 A.M. with Resident #51 on the 200-hall back unit revealed there was no tea on the resident's breakfast tray as requested but instead received coffee. Resident #51 complained about receiving coffee instead of tea and did not want the coffee but wanted the tea now. Interview on 06/09/25 at 9:45 A.M. with LPN #513 on 200-hall back unit confirmed not checking to make sure Resident #51 received the requested tea but stated she would get the tea from the kitchen now and then left the unit. Observation on 06/09/25 at 9:49 A.M. of 200-hall back unit revealed LPN #513 returned to the unit and delivered a cup of hot tea to Resident #51. Review of the facility get up list for Rosewood provided 06/09/25 revealed on 200-hall front (secured) unit there were four residents (#25, #52, #57 and #67) scheduled for night shift to get up each morning. On 200-hall middle unit, there were three residents (#28, #30 and #61) on the list, and 200-hall back unit had one resident (#51) on the list. Review of the list of residents who required moderate staff assistance or were dependent on staff with activities of daily living, provided 06/11/25, revealed 200-hall front (secured) unit had 17 residents (#4, #5, #8, #9, #10, #20, #22, #25, #36, #38, #52, #57, #67, #70, #72, #76 and #79) out of 17 residents who had those care needs. On 200-hall middle unit, 13 residents (#3, #12, #14, #24, #28, #30, #35, #40, #42, #60, #61, #62 and #68) out of 16 residents who had those care needs, and on 200-hall back unit, 11 residents (#2, #19, #27, #45, #49, #50, #51, #55, #58, #71 and #84) out of 14 residents who had those care needs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the list of residents who were incontinent, provided 06/09/25, revealed 200-hall front (secured) unit had nine residents (#4, #5, #20, #25, #52, #67, #70, #76 and #86) out of 17 residents who required incontinence care. On 200-hall middle unit, 12 residents (#3, #12, #24, #28, #35, #40, #42, #59, #60, #61, #62 and #68) out of 16 residents who required incontinence care, and on 200-hall back unit, eight residents (#19, #27, #45, #47, #50, #51, #55 and #85) out of 14 residents who required incontinence care. Review of the list of residents who required mechanical lifts for transfers, provided 06/09/25, revealed 200-hall front (secured) unit had four residents (#4, #25, #52 and #67) out of 17 residents who required mechanical lifts. On 200-hall middle unit, eight residents (#12, #28, #42, #59, #60, #61, #62 and #68) out of 16 residents who required mechanical lifts, and on 200-hall back unit, two residents (#19 and #27) out of 14 residents who required mechanical lifts. Review of the facility incident logs from 12/09/24 to 06/09/25 revealed there was an increasing trend in falls from seven in March, to 17 in April, and 32 in May. From 06/01/25 to 06/09/25, 14 falls had already occurred. Review of the facility PBJ Staffing Data Report from 01/01/25 to 03/31/25 revealed the facility triggered for one star staffing rating and excessively low weekend staffing. Review of the staffing tool from 06/03/25 to 06/09/25 revealed the facility exceeded the daily direct care requirement of 2.50 hours per resident; however, the lowest hours were on Saturday 06/07/25 at 2.93, and on Sunday 06/08/25 at 2.51 being just above the minimum requirement. Interview on 06/10/25 at 1:02 P.M. with the Administrator verified the staffing tool results. Review of facility schedules from 05/12/25 to 06/09/25 revealed three eight-hour shifts, days, evenings and nights. Rosewood's three units (front, middle and back) typically had two nurses for days and evenings and one nurse for nights covering all three units, and one nurse aide for each unit on each shift. Review of the facility assessment dated [DATE] revealed the facility considered staffing needs for each resident unit for each shift and adjusted as necessary based upon resident population. For unplanned staffing need, the facility utilized on-call management to either fill the shift or find appropriate replacements. In the event no facility staff were available, staff from sister facilities were utilized. Review of the facility policy, Incontinence Care, reviewed 01/06/25, revealed the purpose was to keep the skin clean, dry and free of irritation and odor, and to prevent skin breakdown. Review of the facility policy, Use of Call Light, reviewed

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on medical record review, review of the incident log, review of Quality Assurance and Performance Improvement (QAPI) data, review of hospital records, review of facility policy, and interviews with staff, the facility failed to prevent a significant medication error for Resident #51 when the resident's insulin medication with insulin hold parameters, was not administered with meals as ordered beginning on 02/02/25 and then on 05/08/25 was administered outside of the set parameters. Actual Harm occurred on 05/08/25 when Resident #51, who had severe cognitive impairment and required diabetes management with insulin, was admitted to the hospital with hypoglycemia (when blood glucose dropped below the normal range of relatively 80 to 130 milligrams per deciliter [mg/dL]). The facility found Resident #51 unresponsive, flushed, drooling, sweating and moaning with a blood glucose (BG) level of 37 mg/dL approximately two hours after being administered ten units of a short acting insulin (Novolog), despite the resident having a BG level of 97 mg/dL at the time, and the physician's order instructed the insulin held if the BG level was less than 110 mg/dL. This affected one (Resident #51) of three residents reviewed for medication administration. The facility identified a total of 13 additional residents (#12, #20, #23, #30, #31, #42, #44, #48, #49, #52, #66, #71 and #85) who received insulin. The facility census was 88. Findings include: Review of the medical record for Resident #51 revealed an admission date of 09/12/22 with diagnoses including diabetes mellitus type two with hypoglycemia, diabetic chronic kidney disease, diabetic peripheral angiopathy, congestive heart failure and dementia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/27/25, revealed Resident #51 had severe cognitive impairment. Review of Resident #51's physician orders revealed an order dated 02/02/25 to administer ten units of Novolog insulin with meals and hold for BG level of less than 110 mg/dL. Review of Resident #51's care plan initiated 09/20/22 revealed the resident was at risk for hyper/hypoglycemic (BG levels above or below the normal range) reactions and abnormal laboratory (lab) values related to diabetes and use of diabetic medications. Interventions included giving medications per physician order and monitoring for signs and symptoms of hypo/hyperglycemia, for example change in mental status, fatigue, change in vital signs, and increased urination, hunger or thirst. Review of the incident logs from 12/09/24 to 06/09/25 specified a medication error which involved Resident #51 on 05/08/25. Review of the incident report for Resident #51 dated 05/08/25 revealed at 4:15 P.M. an unspecified Licensed Practical Nurse (LPN) did not follow an insulin order, and Resident #51 was unable to provide a description of the incident. Intramuscular (injection into the muscle) glucagon (primarily used for emergency treatment for very low blood sugar) was administered and the physician was notified. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #51's Medication Administration Record (MAR) for May 2025 revealed the Novolog insulin order with meals was administered on 05/08/25 by LPN #647 at the 5:00 P.M. scheduled dose for dinner. Resident #51's BG level was monitored prior to the dose with a reading of 97 mg/dL. Despite the ordered parameters of holding the insulin dose for a BG of less than 110 mg/dL, LPN #647 administered the insulin to Resident #51. Review of the nursing progress note dated 05/08/25 at 6:47 P.M. indicated Resident #51 was found by an aide flushed, drooling, sweating and moaning. A BG check resulted in a reading of 37 mg/dL. Emergency Medical Services (EMS) was contacted, and the resident was taken to the hospital for treatment. Review of the hospital records printed 05/09/25 revealed Resident #51 was admitted for hypoglycemia after presenting to the emergency room (ER) on 05/08/25 with BG levels between 30 and 40 mg/dL and not responsive. Per EMS, the resident's BG was found to be 37 mg/dL after being given ten units of a short acting insulin and was found lying in bed. The facility gave one mg of IM (intramuscular) glucagon; however, Resident #51 remained unresponsive. A recheck of the BG was 48 mg/dL which then improved to 112 mg/dL after EMS gave 50 grams of dextrose and transported the resident to the ER. The facility was contacted and reported Resident #51 received ten units of insulin with a BG of 97 mg/dL for the scheduled dinner dose despite the order reading to hold for a BG of less than 110 mg/dL. The resident was admitted for further management. On 05/09/25, Resident #51 was discharged back to the facility with a medication order to continue Novolog ten units with meals three times daily. Review of the nursing progress note dated 05/09/25 at 7:13 P.M. indicated Resident #51 returned from the hospital without complaint. Interview on 06/10/25 at 3:49 P.M. with the Administrator verified Resident #51 was admitted to the hospital with hypoglycemia on 05/08/25 after LPN #647 did not follow the physician's order and administered ten units of Novolog insulin outside of the hold parameters. LPN #647 reported misreading the order and thought the order was to give the ten units without holding it with a BG of 97 mg/dL. The Administrator described LPN #647 as new to the facility but not a newly licensed nurse, and a QAPI plan was completed which included resident assessments, nurse training, audits and continued QAPI meetings. Review of the personnel file for LPN #647 revealed a hire date of 01/23/25 as an LPN charge nurse with an active unencumbered license and no findings of abuse or neglect in the state nurse aide registry (NAR). The Notice of Corrective Action dated 05/09/25 indicated LPN #647 was terminated for poor work performance due to not following physician orders and medication administration. Review of the QAPI plan dated 05/09/25 revealed the facility performed the following actions: Resident #51 was assessed on 05/09/25 with no negative findings; Resident #51's Power of Attorney (POA) was notified on 05/09/25; the medical director was notified on 05/09/25; like residents with insulin orders were assessed and insulin parameters were reviewed and deemed accurate on 05/09/25; medication administration education was provided to all licensed nurses on 05/09/25; one-on-one education was provided to LPN #647 on following physician orders and medication administration on 05/09/25; Director of Nursing (DON) or designee audited insulin parameters on 05/09/25 to continue three times weekly for four weeks; and the interdisciplinary team (IDT) met to review the QAPI plan on 05/09/25 to continue weekly for four weeks. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of the MARs from February to June 2025 for the 02/02/25 Novolog insulin order for ten units with meals which was administered in error revealed Resident #51 was administered daily at 12:00 P.M. for lunch and 5:00 P.M. for dinner; however, there was no administration of the Novolog insulin from 02/02/25 to 06/11/25 with the breakfast meal. This error was not found during the QAPI insulin order audit completed on 05/09/25 or weekly thereafter and was not found or changed on 05/09/25 when Resident #51 returned from the hospital with a discharge order for Novolog ten units with meals three times daily. Interview on 06/11/25 at 12:34 P.M. with Registered Nurse (RN) #600 confirmed Resident #51 received the Novolog insulin order for ten units with meals for only lunch and dinner daily from 02/02/25 to 06/11/25. Interview on 06/11/25 at 12:45 P.M. with the Administrator verified there was a discrepancy between Resident #51's hospital discharge order for Novolog insulin ten units with meals three times daily, the facility order for Novolog insulin ten units with meals, and the scheduled times the insulin was to be administered which was only at lunch and dinner. Review of the facility policy, Medication Administration - General Guidelines, dated November 2021, revealed medications were administered in accordance with written orders of the prescriber. This deficiency represents non-compliance investigated under Complaint Numbers OH00164344 and OH00165145.

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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. Based on review of medical record, observation, interview, review of Center for Disease Control and Prevention (CDC) guidelines and review of facility policy, the facility did not ensure proper signage was utilized to identify Resident #78 was on transmission-based precautions (TBP) and did not ensure medical equipment was cleaned properly between resident use. This affected one (Resident #78) out of one resident identified by the facility on TBP and two (Residents #31 and #80) of three residents observed for proper infection control during the use of medical equipment. The facility census was 88. Findings include: 1. Review of the medical record for Resident #78 revealed an admission date of 06/07/25, and she had no diagnoses listed. On 06/09/25, diagnoses were added that included malignant neoplasm of the bone, adult failure to thrive, malignant neoplasm of the breast, hypertension, and depression. Review of lab report completed at the hospital prior to admission for Resident #78 revealed a specimen was collected on 06/04/25 and resulted on 06/06/25 indicating Resident #78's parvovirus (a seasonal respiratory virus that was transmitted through respiratory droplets by people with symptomatic and asymptomatic infection. Isolation precautions were recommended in healthcare settings) B19 immunoglobulin G (igG) was 1.82 (a level 1.10 or greater indicated it was positive which may indicate a current or past infection). Review of the care plan dated 06/07/25 revealed Resident #78 was on strict droplet isolation due to parvovirus. Interventions included all services to be in her room, droplet TBP, post sign on door to see the nurse before entering, resident to reside in private room, and monitor for sign and symptoms of depression due to isolation status. Review of the physician order dated 06/07/25 revealed Resident #78 was on droplet TBP and to post a sign on entry door to see the nurse before entering and wear gloves, mask, and gown as needed. The order also included to provide personal blood pressure cuff, stethoscope, and thermometer. The order revealed to wash hands when touching environment and with direct patient care and all care activities and therapies were to be provided in her room. Observation on 06/09/25 at 5:35 A.M. revealed Resident #78's door was closed, and a yellow bag was on the outside of the door that contained personal protective equipment (PPE) that included gloves, gown, and masks. There was no signage on the outside of the door indicating Resident #78 was on TBP or what type of TBP. Interview on 06/09/25 at 5:28 A.M. with Certified Nursing Assistant (CNA) revealed she was the CNA assigned to Resident #78 and stated she thought Resident #78 was on isolation but was unsure of what type. She verified there was no signage on the entrance of the room indicating type of TBP. Interview on 06/09/25 at 5:40 A.M. with Licensed Practical Nurse (LPN) #627 revealed he had gotten in report that Resident #78 was on TBP due to breast cancer but was unsure. He checked through her electronic medical record and stated he did not find anything regarding why she was on TBP including what type. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366433	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mapleview Country Villa	775 South Street Chardon, OH 44024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/09/25 at 5:43 A.M. with LPN #627 revealed he had found out that Resident #78 was on droplet TBP due to parvovirus. He verified that there was no signage on the entry of Resident #78's room, just the yellow bag with PPE. Interview on 06/09/25 at 12:08 P.M. with Registered Nurse (RN)/Unit Manager/Infection Control Designee #531 verified Resident #78 had no diagnoses listed in her electronic medical record indicating type of infection. She revealed medical records usually inputted the diagnoses after a resident was admitted . She revealed the admitting nurse should have placed proper signage on the entrance of the doorframe to her room indicating the type of TBP. She revealed in the report the nurse should have communicated with the oncoming nurse the type of TBP and reason of. She verified Resident #78 was on droplet TBP due to parvovirus. Review of the facility policy labeled, Isolation Precautions, dated 01/06/25, revealed TBP would be used for known or suspected infections for which the route of transmission/prevention was known. TBP categories were airborne, droplet, or contact. The policy had nothing in the policy regarding proper signage upon entry to the room or regarding ensuring staff/visitors were aware of type of TBP to be utilized. Review of the facility policy labeled, Antibiotic Stewardship Program, dated 01/06/25, revealed nursing staff would notify the infection preventionist or designee when an infection was suspected as this would allow early detection and management of a potential infection as well as implementation of appropriate TBP. The policy did not include anything regarding proper signage upon entry to the room or regarding ensuring staff/visitors were aware of type of TBP to be utilized. Review of the CDC guidelines labeled Appendix A: Type and Duration of Precautions Recommended for Selected Infections and Condition, dated 02/07/25, revealed droplet TBP per recommended for parvovirus. The guidelines recommended maintaining precautions for the duration of the stay when chronic disease occurs in an immunocompromised patient. 2. Observation on 06/10/25 at 7:55 A.M. of medication administration revealed LPN #630 entered Resident #80's room with eight prepared medications for administration while pulling the vital signs monitor on wheels retrieved from the hallway. LPN #630 removed the blood pressure cuff from the monitor's storage basket and without sanitizing it prior to use, applied it to Resident #80's left arm and obtained a blood pressure reading. LPN #630 then placed the cuff back into the monitor's storage basket, administered the resident's medications and left the room pulling the vital signs monitor back into the hallway without sanitizing it after use. LPN #630 then entered Resident #31's room while pulling the same uncleaned vital signs monitor from the hallway, removed the soiled blood pressure cuff from the monitor's storage basket, and obtained the resident's blood pressure reading without sanitizing it prior to use. LPN #630 then returned it to the same storage basket, left the room without sanitizing the equipment and stored the monitor back in the hallway before proceeding on with medication administration to Resident #31. Interview on 06/10/25 at 8:24 A.M. with LPN #630 confirmed the vital signs monitor was not sanitized appropriately prior to or after use between Residents #80 and #31 but indicated there were sanitizing wipes usually available on the medication cart for that purpose. (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 the medical record for Resident #80 revealed an admission date of 06/03/25. Hospital discharged records dated 06/03/25 indicated the resident had B-cell lymphoma with bone involvement, was status post chemotherapy, and was immunocompromised. Review of the medical record for Resident #31 revealed an admission date of 04/20/25 with diagnoses including diabetes mellitus type two, malignant neoplasm of the pancreas and heart failure. This deficiency represents non-compliance investigated under Complaint Number OH00164974.