STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366435	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand The	4500 John Shield Pkwy Dublin, OH 43017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on observations, staff interviews and policy review, the facility failed to ensure proper medication storage and handling practices. Five medication carts were observed out of ten total medication carts and four medication carts were observed of eight total medication rooms in the facility. This had the potential to affect all 121 residents residing in the facility who receive medications from the facility. Findings include:Observation and interview on 03/12/26 at 10:10 A.M. of the medication room on Unit C2 with Licensed Practical Nurse (LPN) #11 revealed multiple expired supplies, including a total of 47 Ultrasite needleless connectors (CMSˆ5000) with expiration dates of 09/30/25, 11/30/25, and 12/31/25. There were 23 heparin flush syringes (500 units (u)/5.0 milliliter (ml) expired 11/2025 and were found stored in an unlabeled container mixed with various medical supplies in the bottom drawer of a cabinet. The medication refrigerator in the medication room had one tuberculin vial with the dust cover cap removed, no open date documented, a needle puncture in the septum and had an expiration date of 09/2027. LPN #11 confirmed the needleless connectors and heparin flushes were expired. LPN #11 stated the heparin flushes were intended to be returned to the pharmacy; however the drawer where the expired heparin was stored contained no label or signage indicating it was designated for pharmacy return and therefore could be easily accessed for use.Observation on 03/12/26 at 10:30 A.M. of hallway C1 medication cart with LPN #20 revealed in the second drawer, there were three loose pills, identified as pantoprazole sodium delayed release 40 milligrams (mg), gabapentin 100 mg and fluoxetine hydrochloride 40 mg.Observation on 03/12/26 at 10:35 A.M. of the Unit C1 medication refrigerator revealed one tuberculin vial with the dust cover cap removed, no open date documented, a needle puncture in the septum and an expiration date of 06/2027.Interview on 03/12/26 at 10:48 A.M. with Unit Manager #91 confirmed expired medications should not be located in the medication room, tuberculin vials should be labeled with an open date, and the bottom drawer where the expired heparin was stored lacked signage indicating medications were to be returned to the pharmacy.Observation and interview on 03/12/26 at 11:01 A.M. of the medication cart on Unit B with LPN #8 revealed three loose pills in the second drawer, identified as citalopram hydrobromide 20 mg, diclofenac sodium delayed release 50 mg and furosemide 40 mg. LPN #9 confirmed the three looses pills in the second drawer.Observation and interview on 03/12/26 at 11:34 A.M. of the Unit A1 medication room with Unit Manager #92 revealed two intravenous start kits expiring 09/08/25, ten Ulticare TB syringes expiring 02/28/26 and three Safety Needle 23 Gauge by one unit expiring 01/20/25. Unit Manager #92 confirmed intravenous start kits, Ulticare TB syringes and Safety Needles were expired.Observation and interview on 03/12/26 at 11:50 A.M. of the Unit CL1 medication cart with LPN #6 revealed an EpiPen with an expiration date of 08/31/25 and a bisacodyl suppository 10 mg with an expiration date of 01/2025. LPN #6 verified the EpiPen and bisacodyl suppository were expired.Observation and interview on 03/12/26 at 12:00 P.M. of the Unit CL1 medication room with LPN #6 revealed one tuberculin vial with the dust cover cap removed, an open date of 04/03/25, a needle puncture in the septum, and an expiration date of 04/2026. LPN #6 confirmed the tuberculin vial should have been disposed of.Review of the medication and treatment (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	storage policy dated 02/03/26 revealed multiˆuse vials are to be dated when first accessed and discarded within 28 days unless otherwise specified by the manufacturer. The policy also stated expired, discontinued, or deteriorated drugs or biologicals are to be returned or destroyed per pharmacy return/destruction guidelines, and medication and treatment carts are to be kept clean of dirt, spillage, grime, and other foreign materials.Review of the Aplisol (tuberculin purified protein derivative) package insert revealed vials in use for more than 30 days should be discarded due to possible oxidation and degradation, which may affect potency.

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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 - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interview, and a review of facility policy, the facility failed to store food in a safe and sanitary manner. This had the potential to affect all 121 residents who received food from the kitchen. The facility census was 121 residents. Findings include:An observation of the kitchen walk in freezer on 03/09/26 at 6:22 A.M. revealed that a ten pound box of breakfast sausage, a twenty pound box of burger patties, and a ten pound box of cod were partially used and unsealed, open to the freezer air. An observation of the kitchen walk in freezer door on 03/09/26 at 6:30 A.M. revealed that the freezer door would not close fully due to ice build up around the perimeter of the frame of the door. Observation of the walk in freezer revealed ice build up on several containers of ice cream. An interview and observation with Dietary Aide #557 on 03/09/26 at 6:30 A.M. confirmed that the breakfast sausage, burger patties and cod were opened and unsealed, open to the freezer air, and there was ice build up on freezer content and the perimeter of the freezer door, causing it not to shut. Dietary Aide #557 was observed chipping the ice away from the freezer door frame with a kitchen scraper tool, allowing the door to close again. Review of the facility policy titled Food Storage Guidelines, dated 02/02/11, revealed food is stored by methods designed to prevent contamination. Foods should be covered, labeled and dated.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident, family and staff interviews, and policy review, the facility failed to provide a bed and mattress at an appropriate length for Resident #5, the facility failed to ensure Resident #64's hospital bed worked appropriately, and failed to ensure the call light was within reach for Resident #55. This affected three (Residents #5, #55, and #64) of 10 residents reviewed for activities of daily living. The facility census was 121. Findings include:1. Review of the medical record for Resident #64 revealed an admission date of 02/24/26. Diagnoses included fracture of the first and second lumbar vertebra, malignant neoplasm of liver and intrahepatic bile duct. The five-day Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed Resident #64 was cognitively intact, required moderate assistance for rolling left and right and sit to lying, and maximum assistance from lying to sitting. Resident #64 experienced frequent pain and shortness of breath when lying flat. Review of the plan of care for Resident #64, initiated 02/24/26, revealed a focus of risk for alteration in skin integrity related to decreased mobility and recent hospitalization following a fall with spinal fusion surgery and laminectomies. Interventions included the use of a pressure redistributing device on the bed, initiated 02/26/26, along with additional care including heel suspension or protection devices and a turning and repositioning program. Interview with Resident #64 on 03/09/26 at 9:28 A.M. stated his bed was too long for the bed frame and he continuously slid down in the bed. Observation and interview on 03/10/26 at 10:44 A.M. revealed the bed was positioned on the frame appropriately. The foot of the bed was angled downward. During this observation, Resident #64 stated the foot of the bed would not raise up. Interview with Resident #64's daughter on 03/10/26 at 10:44 A.M. revealed when the resident initially arrived at the facility, an aide lowered the bed to attempt to fix the angled foot issue of the bed. Resident #64 would sometimes hit the buttons on the bed to lower his feet and he was not sure when he was doing it, and confirmed the angled foot of the bed had been an ongoing concern since his admission. The daughter stated Registered Nurse (RN) #51 initially attempted to fix the bed by completely lowering it and raising it back up. Observation and interview on 03/10/26 at 11:11 A.M. with RN #51 confirmed the foot of Resident #64's bed was not raising to a flat position. During this observation, Resident #64's daughter confirmed with the nurse that this had been an initial concern when the resident first arrived at the facility. Resident #64 stated the bed was not going completely flat and he felt like he was sliding out of the bed and had to pull himself back up to prevent sliding downward. Observation on 03/12/26 at 11:19 A.M. revealed the foot portion of Resident #64's bed was still tilting downward. Maintenance staff had placed a foot board at the bottom of the bed to prevent the resident from sliding further down in the bed. Observation and interview on 03/12/26 at 11:32 A.M. revealed Maintenance Director #28, raised the foot of the bed and it appeared level. Maintenance Director #28 stated he was not aware of any issues with the bed other than the concern reported by Resident #64 today. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Equipment and Assistive Devices dated 10/18/23 revealed device conditions should be maintained according to manufacturers instructions. Defective or worn equipment or devices should be discarded or repaired. 2. Review of Resident #5's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included unilateral primary osteoarthritis right hip, type two diabetes mellitus with foot ulcer, pain in right hip, acute osteomyelitis right ankle and foot, peripheral vascular angioplasty status, peripheral vascular disease, pressure ulcer of right heel stage IV, and venous insufficiency (chronic). Resident #5 was 77 inches tall. Observation of Resident #5 on 03/09/26 at 6:50 A.M. revealed Resident #5's mattress was 8.5 inches shorter than the bed frame with the gap between the mattress and the bed frame filled with pillows. Resident #5's heels were resting on the pillows between the mattress and the bed frame. The bottom of Resident #5's feet were resting against a pillow placed against the foot board of the bed. Interview with Resident #5 on 03/9/26 at 6:50 A.M. reported the bed and mattress were too short for him, but a longer bed and mattress have not been provided. Resident #5 reported he was six feet five inches tall, but the bed was made for someone much shorter. Resident #5 revealed the bottom of his feet rest on the foot board so he places a pillow on the foot board to prevent pain from touching. Interview with Assistant Director of Nursing (ADON) #121 on 03/10/26 at 12:11 P.M. revealed Resident #5 has had his current bed frame and mattress since his most recent readmission to the facility on [DATE]. ADON #121 revealed maintenance staff extended the length of the bed and placed pillows in the gap because the mattress was too short to reach the end of the bed frame. ADON #121 confirmed the bed and mattress were too short to accommodate Resident #5's height. Interview with Maintenance #28 on 03/10/26 at 1:12 P.M. revealed Resident #5 requested a longer bed after being readmitted to the facility on [DATE]. Maintenance #28 revealed that a longer bed and mattress were not available from the Durable Medical Equipment (DME) provider. Maintenance #28 installed a bed extender and filled the gap between the foot board and the mattress with pillows. Interview with the Director of Nursing (DON) on 03/10/26 at 3:20 P.M. revealed Resident #5's mattress measured 72 inches and the bed measured 82 inches with the bed extender in place. Interview with the DME Provider #620 on 03/12/26 at 10:19 A.M. revealed longest bed frame was 84 inches and longest air mattress was 84 inches. Review of the policy titled Equipment and Assistive Devices issued 10/18/23 revealed the equipment or assistive device is used according to its intended purpose and to the resident's size and weight. 3. Review of the medical record for Resident #55 revealed an admission date of 03/12/25. Diagnoses included wedge compression fracture of first lumbar vertebra, fall, nondisplaced fracture of distal phalanx of right little finger, abnormalities of gait and mobility, and Parkinson's disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 had moderate cognitive impairment, and required moderate assistance from staff for toileting hygiene, showering, and upper and lower body dressing. Review of the care plan for Resident #55 revealed Resident #55 was at risk for falls related to (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	decreased mobility, use of assistive devices, assist of staff, status post recent hospital admit due to a fall and found with closed head trauma without acute intracranial abnormality, acute lumber one fracture non-operative management (NOM) and use of thoraco-lumbo-sacral orthosis (TLSO) (a brace that provides support from mid to the lower portion of the spine. This brace is most commonly used to provide support and stabilization of the spine after a back injury and/or surgery.) with an intervention dated 03/20/25 of call light within reach. Observation on 03/09/26 at 8:29 A.M. revealed in Resident #55's room, the call light was attached to his bed rail and Resident #55 was in the recliner which was one to two feet from the bed. Licensed Practical Nurse (LPN) #16 verified the call light was attached to Resident #55's bed and out of his reach at the time of the observation. Interview on 03/09/26 at 8:29 A.M. with LPN #16 stated Resident #55 knows how to use his call light and usually when Resident #55 needs something, he calls out and staff go and help him. Interview of 03/10/26 at 2:21 P.M. with Certified Nursing Assistant (CNA) #525 stated Resident #55 does use his call light sometimes. Review of the facility policy titled Call Light Accessibility and Timely Response dated 08/16/23 revealed the purpose of this policy is to ensure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. The guidance section of facility policy Call Light Accessibility and Timely Response dated 08/16/23 stated staff will ensure the call light is plugged in, functioning, within reach of residents, and secured, as needed.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on family interview, staff interview, record review, and facility policy review, the facility failed to ensure the resident's bathing preferences were honored. This affected one (Resident #93) of two residents reviewed for choices. The facility census was 121. Findings include:Review of the medical record for Resident #93 revealed an admission date of 12/19/25. Diagnoses included fracture of the upper and lower end of the right fibula, and morbid obesity due to excess calories.Review of the five-day Minimum Data Set (MDS) 3.0 assessment, dated 02/27/26, revealed the Brief Interview for Mental Status (BIMS) was not assessed. Resident #93 had no behaviors during the review period and was dependent on staff for showering or bathing.Review of the bathing task documentation from 12/20/25 to 03/10/26 revealed Resident #93 received two showers on 02/27/26 and 03/06/26. The resident of the documentation indicated he received multiple bed baths and a few dates the resident was not available. There was no documentation Resident #93 refused showers.Review of the Kardex for Resident #93 revealed bed baths were to be provided when a full bath was not tolerated.Review of progress notes for Resident #93 revealed no documentation indicating the resident refused showers that resulted in the resident receiving a bed bath.Interview with Resident #93's daughter on 03/09/26 at 3:25 P.M. revealed she was concerned the resident was not receiving her showers as scheduled and was only receiving bed baths.Interview on 03/10/26 at 2:08 P.M. with Certified Nursing Assistant (CNA) #184 stated the Kardex for Resident #93 indicated to provide bed baths only if a full shower was refused.Interview on 03/10/26 at 2:39 P.M. with Director of Nursing (DON) revealed she stated CNAs do not have the ability to write progress notes. The DON stated if there was a refusal of care, the CNAs would inform the nurse and the nurse should document the refusal in the electronic medical record. If there was a refusal of specific areas during bathing, it was best practice to inform nursing of any refusal of care. The DON confirmed there were no refusals documented in the electronic medical record regarding showers for Resident #93.Interview on 03/11/26 at 9:19 A.M. with CNA #153 stated Resident #93 preferred showers and the family also preferred showers. CNA #153 stated Resident #93 looked forward to showering but the resident was a Hoyer lift transfer and mainly received bed baths instead of showers due to the transfer with staff.Review of the facility policy titled Dignity (ADL), dated 09/21/23, revealed it was the policy of the facility that each resident would be cared for in a manner that promoted and enhanced his or her sense of well being, level of satisfaction with life, feeling of self worth, and self esteem. The residents would be treated with dignity and respect at all times. The facility culture supported dignity and respect for residents by honoring resident goals, choices, preferences, values, and beliefs beginning with the initial admission and continuing throughout the resident's stay at the facility. The individual needs and preferences of residents were to be identified through the assessment process and interactions and discussion with staff. Staff were expected to treat residents with dignity and respect while assisting with activities of daily living.Review of the facility policy titled Accommodation of Needs, dated 08/21/23, revealed the facility would treat each resident with respect and dignity and would evaluate and make reasonable accommodations for the individual needs and preferences of a resident, except when the health and safety of the individual or other residents would be endangered. The resident's individual needs and preferences would be accommodated to the extent possible and would be evaluated upon admission and reviewed on an ongoing basis. In order to accommodate individual needs and preferences, staff attitudes and behaviors must be directed toward assisting residents in maintaining independence, dignity, and well being to the extent possible and in accordance with the residents' wishes.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview with phlebotomist (specialized healthcare professional trained to draw blood for tests), and policy review, the facility failed to ensure the resident had privacy during a blood draw. This affected one (Resident #123) of 43 residents reviewed for privacy. The facility census was 121.Findings include:Medical record review revealed Resident #123 was admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease, chronic pain syndrome, and osteoporosis. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #123 had severe cognitive function and utilized a wheelchair for mobility,Observation on 03/09/26 at 9:00 A.M. and 11:00 A.M. revealed Resident #123 was sitting in the television room with three other residents. On 03/09/26 at 9:40 A.M., Phlebotomist #626 performed a blood draw (venipuncture) from the resident's right antecubital region (the anterior surface of the elbow) in the presence of other residents in the television room.Interview with Phlebotomist #626 on 03/09/26 at 9:42 A.M. confirmed she drew blood in Resident #123's antecubital area in the communal area. Phlebotomist #626 indicated the task was performed in the communal area because Resident #123 was initially refusing to participate in the blood draw. Phlebotomist #626 stated it was not typical to perform a blood draw in a public space. Review of the facility's Venipuncture Specimen Collection policy issued 08/07/23 revealed they were to provide privacy during a venipuncture sample collection.

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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 medical record review, staff and resident interviews, observations, and policy review, the facility failed to ensure residents who were dependent on staff for activities of daily living (ADL) received adequate and timely bathing and personal hygiene. This affected three (Residents #2, #12 and #151) of nine residents reviewed for ADLs. The facility census was 121.Findings include:1. Record review for Resident #2 revealed this resident was admitted to the facility on [DATE]. Diagnoses included hypotension, diabetes mellitus, pulmonary hypertension, muscle weakness, and chronic kidney disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had intact cognition and was dependent on staff for personal hygiene and bathing. Observation and interview with Resident #2 on 03/09/26 at 11:57 A.M. revealed the resident had multiple chin hairs present. Resident #2 stated staff have not offered to shave her chin hairs but said she would take advantage of the service if it was offered. During an interview on 03/10/26 at 11:31 A.M., Certified Nursing Assistant (CNA) #128 verified the presence of facial hair on Resident #2 and stated she would shave the resident that day, following the resident's shower. 2. Record review for Resident #151 revealed the resident was admitted to the facility on [DATE]. Diagnoses included diabetes mellitus, fracture of the left radius, muscle weakness, osteoarthritis, tremor, and macular degeneration. Review of the quarterly Minimum Data Set (MDS) assessment dated 07/1 6/24 revealed Resident #151 had intact cognition and was dependent on staff for bathing and personal hygiene. Interview and observation of Resident #151 on 03/10/26 at 8:55 A.M. revealed her fingernails exceeded the length of the finger by approximately one inch. Resident #151 said the facility refuses to cut her fingernails and has asked the facility to make her an appointment with a manicurist to have her nails cut. Review of the staff bath tasks, assigned to direct care staff, for Resident #151 revealed her nail length should be checked, and trimmed as appropriate. During an interview on 03/10/26 at 11:46 A.M., Unit Manager (UM) #76 stated nail care should be completed at minimum weekly by CNAs and as needed. She said CNAs can trim nails, provided the resident was not diabetic. If the resident was diabetic, it should be completed by a nurse. She did confirm Resident #151's nails were too long and could cause the resident injury to her skin. She also mentioned the resident's family prefers that they be kept much shorter. UM #76 then trimmed the resident's nails. Review of the facility's policy titled Dignity issued 09/21/23 revealed the facility staff will assist residents with groom, including hairstyles, nails and facial hair, per the resident's preferences. 3. Review of the clinical record revealed Resident #12 was admitted to the facility on [DATE]. Diagnoses included encounter for surgical aftercare following surgery on the digestive system, other (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	retroperitoneal abscess, other cirrhosis of liver, and hydronephrosis with ureteral stricture. Review of the five-Day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 was cognitively intact and required maximum assistance for showering/bathing, upper body dressing, lower body dressing, footwear, rolling left and right, and sitting to lying, and was dependent on staff for lying to sitting, sit to stand, chair to chair transfer, and toilet transfer. Under Preferences for Customary Routine and Activities, the resident indicated it was very important to be able to choose between a bed bath, shower, tub bath, or sponge bath. Review of the task documentation for bathing revealed Resident #12 received bed baths on 02/06/26, 02/10/26, 02/13/26, 02/17/26, 02/20/26, 02/24/26, 02/27/26, 03/03/26, and 03/06/26, with no showers indicated. There was no documentation Resident #12 refused showers. The care plan revealed there was focus of Resident #12 chooses not to agree with plan of care, may be resistive, refuse, or noncompliant with care or treatment as evidenced by refusing non-pharmacological interventions for pain at times, initiated 02/24/26. The intervention to leave and reapproach later if the resident resists or refuses care or treatment. Resident #12's clinical record and progress notes revealed no documentation of refusals related to bathing, hair care, or turning during bathing. During an interview and observation on 03/09/26 at 2:40 P.M., Resident #12 stated they were only giving her bed baths and preferred to have showers. Resident #12's hair appeared disheveled and Resident #12 stated they only use the shower cap and she has not had her hair thoroughly washed since admission. During an interview and observation on 03/10/26 at 2:08 P.M., Certified Nursing Assistant (CNA) #184 stated Resident #12 typically chooses a bed bath. She stated staff use a shampoo cap for hair care during bed baths. CNA #184 confirmed that the back of Resident #12's hair was very matted. CNA #184 stated Resident #12 refuses to turn for care to the back of the head and refuses trimming of the matted hair. CNA #184 stated a thorough wash would be needed to adequately clean the back of the resident's hair. She stated Resident #12 required a mechanical lift and the resident often refuses, but confirmed there was no documentation of refusals for hair care or turning during bathing. During an interview on 03/10/26 at 2:39 P.M., the Director of Nursing (DON) stated CNAs do not write progress notes; however if a resident refuses care, the CNA should notify the nurse and the nurse should document the refusal in the electronic medical record. The DON further stated if a resident refuses specific areas of care during bathing, it was best practice for CNAs to inform nursing so refusals can be documented, and that it was best practice to offer a full hair wash prior to using a shampoo cap. Review of the facility policy titled Dignity (ADL), dated 09/21/23, revealed it was the policy of the facility that each resident would be cared for in a manner that promoted and enhanced his or her sense of well being, level of satisfaction with life, feeling of self worth, and self esteem. The policy further revealed residents would be treated with dignity and respect at all times. The policy indicated the facility culture supported dignity and respect for residents by honoring resident goals, choices, preferences, values, and beliefs beginning with the initial admission and continuing throughout the resident's stay at the facility. The policy further indicated the individual needs and preferences of residents were to be identified through the assessment process and interactions and discussion with staff. The policy also indicated staff were expected to treat residents with dignity and respect while (continued on next page)

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	366435	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand The	4500 John Shield Pkwy Dublin, OH 43017

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assisting with activities of daily living. Review of the facility policy titled Accommodation of Needs, dated 08/21/23, revealed the facility would treat each resident with respect and dignity and would evaluate and make reasonable accommodations for the individual needs and preferences of a resident, except when the health and safety of the individual or other residents would be endangered. The policy further revealed the resident's individual needs and preferences would be accommodated to the extent possible and would be evaluated upon admission and reviewed on an ongoing basis. The policy indicated that in order to accommodate individual needs and preferences, staff attitudes and behaviors must be directed toward assisting residents in maintaining independence, dignity, and well being to the extent possible and in accordance with the residents' wishes.

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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 observations, medical record review, policy review, and resident and staff interviews, the facility failed to ensure a resident's orthotic (external wearable medical device) was in place according to physician orders. This affected one (Resident #55) of one resident reviewed for orthotics. The facility census was 121.Findings include:Review of the medical record for Resident #55 revealed an admission date of 03/12/25. Diagnoses included wedge compression fracture of first lumbar vertebra, concussion without loss of consciousness, disorder of bone density and structure, Parkinson's disease, and anxiety disorder.The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 had moderate cognitive impairment, required moderate assistance from staff for showering and upper body dressing. Resident #55 had no rejection of care during the review period.Review of the care plan revealed Resident #55 was at risk for falls related to decreased mobility, use of assistive devices, assist of staff, status post recent hospital admit due to a fall and found with closed head trauma without acute intracranial abnormality, acute lumber one fracture non-operative management (NOM) and use of thoraco-lumbo-sacral orthosis (TLSO) (a brace that provides support from mid to the lower portion of the spine. This brace is most commonly used to provide support and stabilization of the spine after a back injury and/or surgery.) with an intervention dated 01/08/26 splint wear: TLSO brace as needed for comfort.Review of the physician order dated 01/07/26 revealed the lumbar sacral brace to be worn at all times when sitting or standing. May only be removed while sleeping. Every shift do not remove to shower.Observation and interview on 03/09/26 at 8:29 A.M. revealed Resident #55 was sitting in a recliner with part of the back brace lying in his lap. Licensed Practical Nurse (LPN) #16 stated Resident #55's TLSO brace was not on correctly and she corrected it at the time of the observation.Interview on 03/10/26 at 2:21 P.M. with Certified Nursing Assistant (CNA) #525 stated when Resident #55 gets up in the morning, the CNA puts the TLSO brace on him.Review of the Treatment Administration Record (TAR) revealed the TLSO brace had been checked as being put on Resident #55 for 03/11/26 for the 7:00 A.M. shift.Observation on 03/11/26 at 10:36 A.M. revealed Resident #55 was in his room, sitting in a recliner with the footrest up and his legs on the footrest with no TLSO brace on. The TLSO brace was sitting on top of the trash can by his recliner. Interview on 03/11/26 at 10:36 A.M. with Resident #55 stated he did not take off the back brace and that no one had put it on him today.Interview on 03/11/2026 at 10:43 A.M. with Unit Manager #76 verified Resident #55's back brace was on top of his trash can. Unit Manager #76 stated it should be on Resident #55. Unit Manager #76 stated the Director of Therapy was just asking her who was going to put Resident #55's back brace on him. Review of the facility policy titled Activities of Daily Living (ADL) revised date of 12/07/23 revealed the residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs. Residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, personal, and oral hygiene. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals, and recognized standards of practice.

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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 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 observations, record review, policy review, and staff interviews, the facility failed to ensure a resident was seen routinely for podiatry services. This affected one (Resident #97) of one resident reviewed for foot care. The facility census was 121.Findings include:Review of the medical record for Resident #97 revealed an admission date of 04/10/23 with diagnoses including dementia and anxiety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #97 had severe cognitive impairment and required supervision with personal hygiene and showering. Review of the care plan revealed Resident #97 had an activities of daily living (ADL) self-care deficit related to dementia, cognition impairment, and communication deficit. Intervention dated 12/18/25 included bathing/showering, check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Additionally, Resident #97 had a care plan for ancillary services for resident's needs such as dental, podiatry, optometry, audiology, and psychological. An intervention dated 07/24/23 was to coordinate with social services for scheduling of resident need to see in house specialty physicians.Review of the podiatry notes for Resident #97 dated 07/16/25 revealed right and left foot toenails were elongated, discolored, mycotic (a fungal infection that affects your toenails), thick, yellow, subungual debris (crusty debris under the nail formed by the fungus on the toenail bed), and thickness of three millimeters (mm). Additionally, Resident #97's toenails on the right and left foot were debrided (the removal of damaged or infected tissue from the nail bed and surrounding areas) and reduced in length and thickness to one mm. The recommendation from the podiatry to be seen was indicated as medically necessary but no sooner than 60 days.Review of the podiatry list for residents to be seen on 08/29/25, 09/15/25, 0/16/25, 10/03/25, 11/25/25, 01/23/26, 01/26/26, and 01/27/26 revealed Resident #97 was not on the lists to be seen by the podiatrist any of the above dates.There were no podiatry notes for September 2025, October 2025, November 2025, December 2025, January 2026, or February 2026 for Resident #97 and no progress notes which indicated podiatry services were offered and declined.Review of the signed consent undated for Resident #97 revealed consent was signed for the facility to provide outside services for Resident #97 for podiatry.Review of the progress note created by Licensed Practical Nurse (LPN) # 16 dated 02/24/26 which was a late entry placed in Resident #97's chart on 03/10/26 revealed the right toenail fell off during the dressing change and all parties were notified.The progress note created by the Director of Nursing (DON) dated 02/24/26 as a late entry placed in Resident #97's chart on 03/10/26 revealed interdisciplinary team reviewed the incident dated 02/23/26. The facility staff noted the resident's right great toe was loose from her nailbed. Nursing notified. Resident assessed for further injury, no further new skin alterations noted. Resident denies pain to area, displays no non-verbal indication of pain. Area cleansed and dressed. Facility wound nurse notified for continuity of care throughout wound healing. Appropriate parties notified.The progress note dated 02/25/26 revealed there was a new skin concern to the right dorsum first digit (Hallux) and the toenail was partially off. There were signs and symptoms of infection which included erythema/edema and temperature was increased. The wound site was painful and aching. Medicate prior dressing change. The wound measured 0.9 centimeters (cm) in length and 1.4 cm in width and no depth. There was light exudate and was purulent. There was indication of pus, typically thick, yellow, green, tan or brown, and had a faint odor. Non-pitting edema extends less than four cm around wound. Cleanse with normal saline, apply triple antibiotic ointment (TAO) daily. Resident's toenail was partially removed from nailbed. Review of a physician order for Resident #97 dated 02/25/26 to 03/04/26 revealed to cleanse the right great toe's toenail with normal saline pat dry apply TAO and cover with dry dressing every day shift for monitoring.The provider note dated 03/01/26 revealed Resident #97 was started on Amoxicillin-potassium clavulanate (Augmentin) (antibiotic) 875-125 milligrams (mg) two times a day for seven days for the right great toe infection.The physician order for Resident #97 dated 3/05/26 to (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/12/26 revealed the wound treatment changed for right great toe to apply skin prep to right great toe every day shift for wound care.Interview on 03/10/26 at 2:33 P.M. with LPN #16 stated Resident #97's right toenail was very long. LPN #16 stated Resident #97's right toenail kept getting caught in the thromboembolic deterrent (TED) hose and then it was infected underneath. LPN #16 stated the toenail came off in the bandage when she was doing a treatment. LPN #16 stated the provider came and assessed the right toe when the toenail came off and changed the treatment to skin prep and open to air.Observation on 03/11/26 at 1:38 P.M. revealed Resident #97 was sitting in a recliner in her room. Resident #97's right foot toenails were yellow, thick and extended over skin, the second toenail was broken in half. Resident #97's left foot toenails were thick, yellow, and extended past skin. LPN #16 stated Resident #97's toenails were too long, yellow, and thick. LPN #16 verified the second toenail on Resident #97's right foot was broken in half. Resident #97's left big toenail had a slight redness to the inside of toe. When LPN #16 pushed Resident #97's left great toenail, Resident #97 flinched and said it hurt. There was a brown substance under the nail of Resident #97's left great toenail which LPN #16 verified at the time of the observation.Interview on 03/11/26 at 10:23 A.M. with Social Services #73 revealed the facility used an outside provider for specialty services such as podiatry. Social Services #73 stated the facility had consent for services signed from each resident in the building and when a new resident is admitted to the facility, then the new resident was offered the consents and services. Social Services #73 stated there was a running list for residents who were seen every three months, and the residents were automatically seen every two to three months. Social Services #73 stated if a resident was seen in July 2025, then they would be seen in October 2025. Social Services #73 stated unless a resident refuses on the day of service, then they will be seen every three months. Social Services #73 stated the podiatrist was in the facility usually every two months, because there were so many residents who need to be seen. Social Services #73 stated the podiatrist reports to social services (herself) and the DON on the day of the service and then podiatry reports were sent to the facility for each resident seen that day which was uploaded to the individua resident's electronic medical record. Social Services #73 could not provide a reason why Resident #97 was not seen by podiatry.Interview on 03/12/2026 at 12:58 P.M. with the DON stated all residents in the facility were seen by ancillary services every two to three months. The DON could not provide a reason why Resident #97 was seen by podiatry.Review of the facility policy titled Ancillary-Additional Services and Fees dated 02/14/13 revealed it is the center's policy to provide additional services where appropriate and upon request to our residents/patients that can be billed to their insurance policy or paid privately.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, staff interviews, and review of facility policy, the facility failed to ensure fall interventions were in place for a resident who was at risk for falling and had a history of falls. This affected one (Resident #17) of five residents reviewed for falls. The facility census was 121 residents. Findings include: Review of Resident #17's medical record revealed Resident #17 was admitted to the facility on [DATE]. Diagnoses included displaced fracture of base of next of right femur, a history of falling, vascular dementia, Parkinson's disease, and malignant neoplasm of bronchus or lung. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #17 had moderate cognitive impairment. Resident #17 was assessed as having lower extremity impairment on one side, being dependent on staff for toileting hygiene, mobility and transfers, and having two or more falls since admission without an injury. Review of the care plan dated 02/18/26 revealed Resident #17 was at risk for falls due to decreased mobility, needing assistance from staff, impaired decision making, dementia and Parkinson's disease. Interventions included a fall mat to bedside when in bed (dated 03/01/26), have the bed to the wall and to have bolsters to the bed when Resident #17 was in bed. The nursing progress note dated 03/03/26 revealed on 03/02/26, therapy notified nursing staff that Resident #17 reported that he had fallen over night and got himself back up. Upon assessment, resident's right lower extremity was noted to be rotated inward. The immediate intervention made was to have a fall mat to Resident #17's bedside. Secondary interventions made were to have his bed against the wall and bolsters added to the bed. Review of Resident #17's physician orders dated 03/09/26 revealed Resident #17 was to have his bed to the wall and to fall mat to beside when occupied, and bolsters to his bed, all with the effective date of 03/04/26. An observation of Resident #17 on 03/09/26 on 8:15 A.M. revealed Resident #17 was lying in bed, his bed was centered in the middle of the room and there was not a fall mat at the bedside. An observation of Resident #17 on 03/09/26 at 12:04 P.M. revealed Resident #17 was lying in bed, his bed was centered in the middle of the room and there was not a fall mat at the bedside.An observation of Resident #17 on 03/10/26 at 11:00 A.M. revealed Resident #17's bed was positioned against the wall and he had a fall mat in place next to his bedside. Resident #17 was in the bed and there were no bolsters present in Resident #17's bed. An interview with Licensed Practical Nurse (LPN) #15 on 03/10/26 at 11:02 A.M. revealed Resident #17's bed was newly against the wall and has a new fall mat at his bedside. LPN #15 confirmed the fall mat was not at his bedside and his bed was not against the wall on the morning of 03/09/26. LPLN #15 revealed that at some point on 03/09/26, management moved Resident #15's bed against the wall and placed a fall mat in his room. LPN #15 confirmed there were no bolsters present on Resident #17's bed. Review of the facility policy titled Fall Management Guidelines, revised on 02/03/26, revealed the interdisciplinary team will review the resident's care plan and interventions to ensure that the interventions are appropriate. The interventions will be reviewed and revised as indicated.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident, physician and staff interviews, observation, and review of facility policy, the facility failed to accurately assess and provide timely ongoing monitoring of a resident with significant weight loss. This affected one (Resident #39) of 11 residents reviewed for nutrition. The facility census was 121.Findings include: Review of the medical record for Resident #39 revealed he was admitted to the facility on [DATE]. Diagnoses included anxiety, depression, muscle weakness, chronic respiratory failure, congestive heart failure, chronic kidney disease stage III, and chronic obstructive pulmonary disorder. Review of Resident #39's initial nutrition assessment dated [DATE] revealed Resident #39 was at risk of malnutrition related to congestive heart failure and chronic kidney disease. The registered dietitian (RD) recommended house med pass (high caloric nutritional supplement) 120 ml twice per day. On 08/10/25, Resident #39 was 106 lbs. The nutritional recommendations were not implemented until 20 days later on 08/13/25, when the physician ordered the house med pass supplement 237 ml by mouth twice daily. The physician orders also revealed Resident #38 was on prednisone (steroid) 10 milligrams (mg) daily, starting on 08/13/25 and Lasix (diuretic) 40 mg one per day starting on 08/11/25. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 was cognitively intact, required supervision or touching assistance with eating, and did not exhibit any refusal of care during the review period. The nutrition care plan dated 01/18/26 revealed Resident #39 was at risk of malnutrition related to increased kilocalorie (kcals) and protein needs and he was at risk of dehydration related to diuretic use. Interventions included monitoring meal intakes, supplements as ordered, notifying the resident and/or responsible party and physician of severe weight changes and monitoring and recording weights per the facility policy. The goal was for Resident #39 to consume greater than 50% of her meals and her nutritional supplement drinks. On 02/01/26, Resident #39 was 110.0 lbs. From 02/01/26 to 02/09/26, there was no mention of Resident #39 having increased edema nor were there any physician orders to increase his diuretic use (Lasix). Resident #39 remained on Lasix 40 mg starting 08/11/25.Resident #39 was admitted to the hospital on [DATE] for a gastrointestinal bleed. Review of the hospital records dated 02/09/26 to 02/12/26 revealed Resident #39 weighed 100 lbs. at time of his hospital admission [DATE]). This was a 9.0 percent severe weight loss in nine days. Resident #39 appeared to be euvolemic (a state of normal body volume, where blood volume and total body water are balanced) and her chest computed tomography (CT) exam revealed no findings of fluid overload. Resident #39 elected palliative care services. Resident #39 was discharged from the hospital and returned to the facility on [DATE]. There was no weight obtained for Resident #39 upon readmission to the facility. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nutritional assessment dated [DATE] revealed it addressed Resident #39's weight of 100 lbs. on 02/09/26 at the hospital and the resident returned from the hospital with a significant weight loss but thought the weight loss was fluid related. (This is contradictory to the hospital and nursing assessments which indicated there was no additional fluid on Resident #39.) The RD recommendations included discontinuing the house liquid protein 60 ml once daily order. The RD did not initiate any additional monitoring or nutritional recommendations for Resident #39. There were no additional weights obtained from Resident #39 between 02/12/26 and 03/09/26. During an observation on 03/10/26 at 2:29 P.M., Certified Nursing Assistant (CNA) #142 obtained Resident #39's weight of 96.3 lbs. This was a weight loss of 3.7 lbs. since 02/09/26 Resident #39 agreed to obtain her weight. CNA #142 stated Resident #39 was normally very pleasant and agreeable to care and services. She denied Resident #39 refused to be weighed. During an interview on 03/10/26 at 5:11 P.M., RD #539 stated he attempted to get a re-weight from Resident #39 following the 02/12/26 weight change, but Resident #39 refused. (There was documentation of Resident #39 refusing to be weighed from 02/17/26 to 03/10/26.) RD #539 confirmed he did not request any additional attempts to reweigh Resident #39. RD #539 explained that he elected to not implement any nutritional interventions at this time because her caloric needs were being met. RD #539 said Resident #39's weight fluctuations were due to her physician ordering diuretics and steroids impacting her fluid balance. RD #539 explained with the calories and protein she was receiving between the ordered house med pass supplement 237 ml by mouth twice daily and her facility meals, she shouldn't have any nutritional deficits. RD #539 stated he reviews the nursing team's documentation of her meal and supplement consumption. RD #539 stated he has had issues obtaining resident weights due to inadequate staffing. RD #539 acknowledged it would have been optimal if he had obtained weekly weights for this resident. On 03/11/26, Resident #39's weight was 95.8 lbs. During an interview on 03/11/26 at 11:15 A.M., Resident #39 stated she was not aware of her weight loss and confirmed the facility staff had not discussed this with her. She confirmed she always refused the oral nutritional supplements because she was lactose intolerant. She also denied refusing to be weighed. She said no one had asked her to be weighed in a while.Review of the nutritional note dated 03/11/26 revealed Resident #39 was re-weighed. RD #539 conversed with the resident regarding possible dietary interventions and supplements. The resident was pleasant but declined all supplement options, noting that she likes Boost but it causes diarrhea. She expressed that she was not overly concerned about further weight loss and feels she has lived a good life. She requested discontinuation of her house med pass supplement but admitted she sometimes drinks it; RD #539 encouraged her to keep house med pass supplement available. She refused any additional supplements, including Magic Cup, but promised to keep eating as much as she can. During an interview on 03/11/26 at 10:50 A.M., Physician #215 denied Resident #39's weight fluctuations were attributed to excess fluid. Physician #215 confirmed the orders for prednisone and Lasix have not changed since her initial admission to the facility. Review of the facility's policy titled Weights dated 05/03/22 revealed reweights should be completed when the resident gains or loses five pounds, if they weigh 100 pounds or greater. The threshold for significant unplanned and undesired weight loss is based on the following criteria: a 5.0% weight loss over one month is significant. The RD or designee is responsible for the weight management program, (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including compliance with weight goals, tracking and trending, nutritional assessments, interventions, care plans, and follow-up.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and staff interview, the facility failed to ensure the resident's menu followed the nutritional needs of the resident. This affected one (Resident #45) of 11 residents reviewed for nutrition. The facility census was 121. Findings include:Review of the medical record revealed Resident #45 was admitted to the facility on [DATE] with diagnoses including acute on chronic diastolic (congestive) heart failure, type II diabetes mellitus with diabetic chronic kidney disease, type II diabetes mellitus with diabetic retinopathy without macular edema, and morbid (severe) obesity due to excess calorie.Review of the five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #45 was cognitively intact, received a therapeutic diet and required supervision with meals.Review of the physician orders dated 02/07/26 revealed an order for a renal/diabetic diet with regular texture and thin consistency.During an observation and interview on 03/11/26 at 9:56 A.M., Resident #45's breakfast tray contained an egg on a biscuit, hashbrowns, oatmeal with milk, apple juice, and eight ounces of milk. The renal diet menu on Resident #45's ticket indicated the resident should receive only four ounces of milk, and the biscuit and hashbrowns were not included on the renal diet menu. Resident #45 stated she consumed one bite of the hashbrowns but ate the biscuit. Certified Nursing Assistant (CNA) #149 confirmed Resident #45 did not receive the correct renal diet.During an observation and interview, on 03/11/26 at 12:22 P.M., Resident #45's lunch tray contained sweet potato fries instead of cauliflower, which was listed on the renal diet menu for that meal. During an interview at 12:26 P.M., CNA #149 confirmed the resident did not receive the correct renal diet when sweet potato fries were served instead of cauliflower.During an observation and interview on 03/12/26 at 8:23 A.M., Resident #45's breakfast tray contained eight ounces of milk, although the renal diet menu indicated the resident should receive only four ounces of milk. CNA #153 confirmed Resident #45 received eight ounces of milk instead of the four ounces listed on the renal diet menu.

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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 observations, record reviews, policy review, staff interviews and review of the Centers for Disease Control and Prevention (CDC) guidance, the facility failed to ensure proper hand hygiene and infection control procedures were followed during incontinence care and ensure staff were aware to follow enhanced barrier precautions (EBP) for a resident with an indwelling medical device. This affected two residents (#14 and #18). The facility census was 121.Findings include:1. Review of the medical record for Resident #14 revealed an admission date of 08/07/25. Diagnoses included dementia, anxiety, major depressive disorder, chronic respiratory failure with hypoxia, panic disorder, arthritis, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #14 had intact cognition and was dependent on staff for toileting hygiene. Review of the care plan dated 08/07/25 revealed Resident #14 required enhanced barrier precautions (EBP) related to history of multi-drug resistant organisms with interventions included EBP will be used for the duration of the residents' stay at the facility or until resolution of the wound pr discontinuation of the indwelling medical device that placed them at risk, and staff will wear gowns and gloves during high contact resident activities. Observation on 03/12/26 from 10:20 A.M. to 10:39 A.M. revealed Certified Nursing Assistant (CNA) #525 was going to provide bathing, and incontinence care for Resident #14. CNA #525 gathered items for a bed bath. CNA #525 obtained two washcloths, put one washcloth in the basin with soap and one washcloth in the basin with no soap. CNA #525 washed Resident #14's chest area and armpits, then she used the non-soapy water to rinse Resident #14 and then dried Resident #14 with a towel. Then using the same soapy washcloth, CNA #525 washed Resident #14's peri-area. CNA #525 opened the washcloth on her open palm and made several swipes with the open washcloth along Resident #14's abdominal area, and then washed downward in the vagina and then came back upwards in the vagina. CNA #525 then rolled Resident #14 over and CNA #525 used the same washcloth to wash Resident #14's backside. Resident #14 had a bowel movement and CNA #525 offered the bedpan and Resident #14 refused. Then CNA #525 used the non-soapy washcloth and wiped Resident #14's backside and stated she would have to get more washcloths. CNA #525 left the room and came back with more washcloths. CNA #525 did not cover Resident #14 when she went for more washcloths and left Resident #14 on her left side with her backside exposed while getting more washcloths. CNA #525 did offer the bedpan again and placed Resident #14 on the bedpan. Interview on 03/12/2026 at 10:21 A.M. with CNA #525 confirmed she only had two washcloths and acknowledged she should have had a different washcloth for pericare. CNA #525 confirmed she had open palm with the washcloth and wiped instead of using a clean section of the washcloth each time and confirmed she only had two washcloths for cleaning entire body. Interview on 03/12/26 at 10:21 A.M. with Unit Manager #76 verified Resident #14 had recently had a urinary tract infection and had been on antibiotics. Unit Manager #76 stated there were some educational opportunities here for CNA #525 for proper incontinence care. Review of the facility policy titled Incontinence Care-Urinary and Fecal dated 02/03/26 revealed the policy was to provide guidelines for cleansing the perineum and buttocks after an incontinent episode or with daily care. The guidelines stated if feces are present, remove with toilet paper or disposable (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wipe from the front of the perineum toward the rectum. Cleanse the peri-area and buttocks with disposable bathing wipe or washcloth and incontinent cleansing spray or soap and water, wiping from the front of the perineum toward the rectum. Use a separate area of the cloth or new disposable wipe for each stroke. Turn the resident side to side to cleanse the entire affected areas, as needed. Rinse with water, if needed, or per incontinent product instructions. For a female: gently separate the labia and wash the area using downward strokes from pubic area to the rectal area. Cleanse skinfolds. Use alternate sites of the cloth or new disposable wipe with each downstroke. Rinse using the same procedure with a clean washcloth as needed. Pat dry. 2. Review of Resident #78's medical record revealed he was re-admitted to the facility on [DATE]. Diagnoses included cholecystitis and chronic respiratory failure. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #79 had intact cognition. Review of the care plan dated 02/15/26 revealed Resident #78 required enhanced barrier precautions (EBP) related to indwelling medical device and peripherally inserted central catheter (PICC) line (a think tube inserted through a vein in the upper arm). Interventions included enhanced barrier precautions (EBP) will be used for the duration of the resident's stay. Review of the re-admission assessment on 02/27/26 revealed Resident #78 was admitted with a right upper quadrant Jackson Pratt (JP) drain (a soft, bulb-shaped surgical device used to remove fluids from a wound via gentle, active suction to promote healing and reduce infection risk) and a left upper quadrant JP drain. Review of Resident #78's physician orders dated 03/02/26 revealed the output on his right upper quadrant JP drain and left upper quadrant JP drain should be recorded each day on each shift. An order dated 03/02/26 revealed Resident #78 should have a PICC line assessment to right upper extremity each day on every shift. There were no physician orders for EBP. Observation of Resident #78 on 03/09/26 at 7:06 A.M. and 8:14 A.M. revealed Resident #78 had JP drains on his abdomen and his door did not have EBP signage. An interview with Licensed Practical Nurse (LPN) #15 on 03/09/26 at 8:24 A.M. confirmed there was no EBP signage outside of Resident #78's room and confirmed there should be EBP signage for a reminder for staff to wear PPE for high contact resident care activities. Review of CDC guidance titled Implementation of PPE (personal protective equipment) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) found at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html and dated 04/02/24 revealed MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. EBP is an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, pharmacy and staff interview, the facility failed to follow an antibiotic stewardship program and ensure antibiotics were not prescribed without adequate clinical indication. This affected two (#6 and #13) of four residents reviewed for antibiotic stewardship practices. The facility census was 121.Findings include: 1. Review of Resident # 13's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, intestinal obstruction unspecified as to partial versus complete obstruction, partial intestinal obstruction, acquired absence of the digestive tract, and malignant neoplasm of the endometrium. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 had moderate cognitive impairment and required partial/moderate assistance with toileting. The care plan dated 05/27/25 revealed Resident #13 was at risk for an alteration in gastro-intestinal status related to history of intestinal obstruction, bouts of nausea and vomiting at times, as well as effects of medications. Review of the physician orders revealed on 07/14/25, an order for Imodium A-D oral tablet two milligrams (mg) give one tablet by mouth every four hours as needed for loose stool. On 11/13/25, an order for Lomotil oral tablet 2.5-0.025 milligrams (mg) give one tablet by mouth three times a day for loose stools. Review of the eINTERACT SBAR (Situation, Background, Assessment, Recommendation) Summary for Providers dated 03/03/26 by Licensed Practical Nurse (LPN) #20 revealed Certified Nurse Practitioner (CNP) #625 was contacted for diarrhea and the nurse received an order for metronidazole (antibiotic). The physician order dated 03/03/26 revealed an order for metronidazole (Flagyl) oral capsule give 500 mg by mouth two times a day for diarrhea until 03/11/26. The progress note dated 03/03/26 by CNP #625 revealed Resident #13 has been on several medications to control diarrhea. Resident #13 was having several loose stools as reported by staff. Resident #13 had no abdominal pain or fevers. CNP #625 recommended a trial a course of Flagyl. The progress notes revealed antibiotic was monitored for Resident #13 on 03/04/26, 03/07/26, 03/08/26, and 03/10/26. The progress note dated 03/07/26 indicated the antibiotic was for Clostridioides difficile (C.Diff) infection. The medical record do not reflect that an antibiotic time out was conducted to determine the appropriateness of the antibiotic. Interview with Resident #13 on 03/09/26 at 10:35 A.M. revealed the resident had frequent diarrhea. Resident #13 reported recently starting a medication for the diarrhea. Resident #13 could not report if the medication was improving the diarrhea and the staff told her it would take a while for the diarrhea to improve. Interview with Certified Nursing Assistant (CNA) #145 on 03/09/26 at 12:34 P.M. reported Resident #13 had diarrhea daily, usually two to three times on day shift and two to three times on night shift. CNA #145 had not noticed any change in Resident #13's stools since the metronidazole was started. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Assistant Director of Nursing (ADON) #121 on 03/11/26 at 9:13 A.M. confirmed residents with suspected infectious diarrhea would have a stool culture sent and would be placed under contact precautions. Interview with Unit Manager #91 on 03/11/16 at 9:50 A.M. revealed Resident #13's stool was not sent for culture although this would normally be done. Unit Manager #91 further revealed a stool culture was not sent because the diarrhea was chronic in nature. Interview with the Director of Nursing (DON) on 03/11/26 at 10:00 A.M. revealed Resident #13 had chronic diarrhea and an infection was not suspected. The DON revealed the antibiotic was started by the CNP to reset the gut. The DON revealed that a stool culture was completed in the past. The DON provided a physician progress note dated 02/28/25 that revealed Resident #13 had a diagnosis of radiation enteritis (inflammation and damage to the intestines caused by radiation therapy). The DON revealed radiation enteritis was the suspected cause of Resident #13's chronic diarrhea. Interview with CNP #620 on 03/11/26 at 1:45 P.M. revealed the antibiotic was prescribed for Resident #13 with the goal of disrupting the flora of the gut and to re-bulk stools. Resident #13 may have undiagnosed Irritable Bowel Syndrome (IBS). CNP #620 confirmed the antibiotic was not prescribed for Resident #13 to treat an active infection. CNP #620 revealed she thought Resident #13 had a stool culture performed in the past. A copy of Resident #13's stool culture was requested from the facility on 03/11/26 at 10:00 A.M. and 1:45 P.M. but the facility did not provide a copy of the results. Telephone interview with LPN #20 on 03/11/26 at 4:05 P.M. revealed CNP #620 was contacted for orders on 03/03/26 because of the chronic nature of the diarrhea. LPN #20 reported Resident #13 was not experiencing an increase in the amount of diarrhea. LPN #20 reported Resident #13 was experiencing the usual amount of diarrhea. Review of the facility's McGeer Criteria Worksheet on 03/12/26 at 8:39 A.M. revealed the McGeer criteria serve as the basis for an antibiotic stewardship program, and Resident #13 needs to meet criteria for an infection before being started on antibiotic therapy. The resident did not have three or more liquid or watery stools above what is normal within a 24-hour period, two or more vomiting episodes in a 24-hour period, or stool sample testing. Interview with ADON #121 on 03/12/26 at 8:32 A.M. confirmed the use of metronidazole for Resident #13 does not meet McGeer criteria. ADON #121 revealed the facility prescribers will prescribe antibiotics for other infections as well, such as urinary tract infections, that do not meet McGeer criteria for infection. ADON #121 revealed education was provided to the prescribers regarding antibiotic stewardship. Interview with Consultant Pharmacist #610 on 03/12/26 at 9:49 A.M. revealed antibiotics, such as metronidazole, can cause gastrointestinal symptoms, such as nausea, vomiting, and diarrhea. Consultant Pharmacist #610 revealed metronidazole may help resolve diarrhea if used to treat infection. Consultant Pharmacist #610 confirmed that metronidazole is not used to disrupt the flora of the gut and re-bulk stools if infection is not present but noted that the medication can disrupt normal gut bacteria and cause loose stools. Review of the policy and procedure titled Antibiotic Stewardship dated 02/04/26 revealed the (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	program includes antibiotic use protocols and a system to monitor antibiotic use with protocols that included laboratory testing and the use of McGeer's Criteria to define infection and determine whether to treat an infection with antibiotics. 2. Review of Resident #6's medical record revealed she was admitted to the facility on [DATE] and diagnoses included end stage renal disease. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #6 had she had intact cognition and received an antibiotic within the lookback period. Review of the hospital records dated 02/21/26 revealed Resident #6 was seen on 02/21/26 in the hospital for a fall. Imaging showed the resident had acute cystitis. Resident #6 was prescribed Cephalexin (antibiotic). There was no evidence of a culture and sensitivity being completed in the hospital. Resident #6 was discharged from the hospital on [DATE]. Review of Resident #6's physician orders dated 02/22/26 revealed Resident #6 was prescribed Cephalexin 500 milligrams (mg) one capsule by mouth daily for five days. Review of the McGeer Criteria Worksheet dated 02/22/26 revealed Resident #6 was prescribed Cephalexin in the hospital for urinary symptoms due to cystitis and this did not meet McGeer's Criteria for infection. There was no evidence the facility completed a culture and sensitivity on Resident #6 to ensure the correct antibiotic was ordered to treat Resident #6's acute cystitis. An interview with Assistant Director of Nursing (ADON) #121 on 03/11/26 at 9:58 A.M. confirmed that the antibiotic course for Resident #6 was completed without a sensitivity to bacteria and without a confirmed infection. Review of the facility's McGeer Criteria Worksheet revealed the criteria serve as the basis for an antibiotic stewardship program. The patient needs to meet the criteria for an infection before starting on antibiotic therapy. Review of the facility policy titled Antibiotic Stewardship dated 06/03/25 revealed the facility uses McGeer's criteria to define infections. McGeer's criteria may be used to determine whether to treat an infection with antibiotics.