STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366472	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capri Gardens	6975 Graphics Way Lewis Center, OH 43035

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure pharmacy recommendations were completed accurately. This affected two (#3 and #17) out of five residents reviewed for pharmacy recommendations. The facility census was 78.Findings include: 1. Review of the medical record for Resident #7 revealed an admission date of 01/28/26 with diagnoses of metabolic encephalopathy, depression, cognitive communication deficit, anxiety and psychotic disorder with hallucinations due to a known physiological condition. Review of the care plan dated 02/09/26 revealed the resident has an alteration in sleep pattern and takes trazodone for insomnia. Interventions included administering medication as specified, monitoring for effectiveness, side effects, and adverse reactions and notifying the physician as appropriate. Review of a physician order dated 02/16/26 with a discontinue date of 03/12/26 revealed Trazodone HCl 100 milligram (mg) tablet. The order directed staff to give 1.5 tablets by mouth at bedtime for insomnia. Review of nursing/prescriber recommendations dated 02/20/26 revealed please adjust the trazodone order for this resident. Facility needs to ensure they are documenting exactly what is being administered. Reports supplier is sending both one x 50 mg tablet and one x 100 mg tablet for a total dose of 150 mg. Those pills will have to enter as two separate orders with the instructions total dose = 150 mg for both orders. Review of a physician order dated 03/13/26 with a discontinue date of 03/17/26 revealed Trazodone HCl 100 mg tablet with instructions to give 1.5 tablets by mouth at bedtime for insomnia. Review of nursing/prescriber recommendations dated 03/16/26 revealed please adjust the trazodone order for this resident. Facility needs to ensure they are documenting exactly what is being administered. Appears supplier is sending one x 150 mg tablet. Review of a physician order dated 03/17/26 with a discontinue date of 05/21/26 revealed Trazodone HCl 100 mg tablet. The order directed staff to give 1.5 tablets by mouth at bedtime for insomnia to equal 150 milligrams. Review of a single day physician order dated 05/25/26 revealed Trazodone HCl 100 mg tablet with instructions to give 1.5 tablets by mouth at bedtime for insomnia to equal 150 mg. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a physician order dated 05/27/26 revealed Trazodone HCl oral tablet 150 mg with instructions to give one tablet by mouth at bedtime for insomnia. Interview on 05/27/26 at 3:08 P.M. with the Director of Nursing revealed the resident always received a 150 mg tablet from the medication supplier. The Director of Nursing stated the initial recommendation from 02/20/26 was to separate the trazodone doses, both fiftyˆmilligram and oneˆhundredˆmilligram tablets, into separate orders but document they were both to be given at night. The Director of Nursing stated that on 03/16/26 the pharmacy again recommended the facility change the order to reflect what was actually being administered. The Director of Nursing confirmed the order should have been updated to reflect the medication being supplied as Trazodone HCl oral tablet 150 mg, one tablet by mouth at bedtime, when the pharmacy recommendation was first made on 02/20/26 and again on 03/16/26. The Director of Nursing stated the order was not accurately changed until 05/27/26 to reflect what was actually being administered. 2. Record review for Resident #3 revealed the resident was admitted to the facility on [DATE] with diagnoses including cerebral infarction, diabetes mellitus, hypertension, dementia, anxiety, major depressive disorder, and heart failure Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 had severely impaired cognition. Review of Resident #3's physician orders revealed the following orders: Latanoprost Solution 0.005 % Place one drop in both eyes every day at bedtime; Systane Ultra Ophthalmic Solution 0.4-0.3 % Instill 2 drop in both eyes two times a day for dry eyes; Timoptic Solution 0.5 % Instill 1 drop in both eyes two times a day; Trusopt Solution 2 % Instill 1 drop in both eyes two times a day. Review of Resident #3's pharmacist recommendation dated 03/17/26 revealed a recommendation to add the instruction allow 5 minutes between administration of different drops to all eye drop orders. Review of Resident #3's physician orders did not reveal the added instructions to allow five minutes between administration of different drops to any of the applicable orders. During an interview on 05/28/26 at 4:11 P.M. with the Director of Nursing, she confirmed the instructions had not been added to any of the eye drop orders. She explained that she did provide education to all of the nurses in March of 2026 concerning allowing five minutes between eye drop administrations.

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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 - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, the facility failed to ensure medications were stored securely. This had the potential to affect one (#60) of five residents reviewed for medications. The facility census was 78. Findings include: Record review for Resident #60 revealed an admission date of 05/22/26 with diagnoses including hemiplegia and hemiparesis, type 2 diabetes mellitus, diffuse traumatic brain injury, seizures, chronic kidney disease, chronic systolic heart failure and anxiety.Review of the Quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #60 was moderately cognitively impaired. Review of a physician order dated 07/25/25 revealed Tresiba FlexTouch Subcutaneous Solution Penˆ Injector 200 UNIT/ML (Insulin Degludec). The order directed to inject 54 units subcutaneously at bedtime for diabetes mellitus and to decrease the dose to 48 units if blood sugar was less than 80. Blood sugar was to be checked prior to administration.Observation on 05/26/26 at 11:40 A.M. of Resident #60's room revealed a Tresiba longˆacting insulin pen with an expiration date of 07/21/26 and no open date documented. The insulin was sitting out on a small dining room table in the resident's room. Resident #60 was unable to confirm if he had received the medication that morning or if it was left by night shift.Interview and observation on 05/26/26 at 11:44 A.M. with Licensed Practical Nurse (LPN) #227 confirmed the Tresiba insulin was sitting unattended in the resident's room on the dining table. LPN #227 stated she believed the insulin had been returned to the room by the resident's daughter after the resident left for a leave of absence on the night of 05/25/26.Interview on 05/26/26 at 11:57 A.M. with the Director of Nursing confirmed the facility did not have a medication storage policy and acknowledged that insulin should not be left out unsecured.

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure a urine specimen was collected, processed, and submitted to the laboratory in a timely manner. This affected one (#6) out of one residents reviewed for urinary tract infections. The facility census was 78.Findings include:Review of the medical record for Resident #6 revealed an admission date of 11/13/25, with diagnoses of type 2 diabetes mellitus, thrombocytopenia, retention of urine, transient ischemic attack and anxiety.Review of the Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 is cognitively intact, dependent on toileting hygiene and always incontinent of urine.Review of a physician order dated 05/21/26 at 4:15 P.M. revealed an order to complete a urine culture and urinalysis.Review of a progress note dated 05/21/26 at 4:17 P.M. revealed urine results were previously received, the laboratory did not perform a sensitivity and was unable to perform one on the current specimen. The nurse practitioner was notified and ordered recollection due to abnormal leukocytes in the urinalysis.Review of a progress note dated 05/21/26 at 6:17 P.M. revealed the resident refused urine sample collection multiple times.Review of a progress note dated 05/22/26 at 5:26 P.M. revealed the nurse attempted urine collection multiple times. The resident refused despite education.Review of a progress note dated 05/22/26 at 6:09 P.M. revealed urine was collected by Registered Nurse (RN) #201 and kept in the refrigerator. The laboratory was contacted, but there was no answer.Review of progress notes from 05/22/26 through 05/26/26 revealed no documentation lab was contacted for specimen pickup. Review of the urinalysis report received by laboratory 05/26/26 at 11:32 A.M., reported 05/28/26 at 12:57 P.M., revealed three or more isolates were present, suggesting contamination.Review of a progress note dated 05/27/26 at 3:22 P.M. revealed a urine specimen was collected, the specimen was contaminated and results could not be obtained. The resident was assessed and denied pain and dysuria. The nurse practitioner discontinued the order for urinalysis.Review of a progress note dated 05/27/26 at 4:14 P.M. revealed Resident #6's daughter expressed concern about resident confusion and requested that a urinalysis and culture and sensitivity be completed for a possible urinary tract infection. The nurse practitioner's order was reviewed.Interview on 05/28/26 at 11:21 A.M. with RN #201 confirmed she was able to collect Resident #6's urine on 05/22/26. She stated it was unusual for the resident to refuse collection. RN #201 reported RN #274 was notified the lab would need to be contacted for pickup.An attempted interview on 05/28/26 at 12:49 P.M. with RN #274, was unsuccessful.Interview on 05/28/26 at 12:53 P.M. with RN #249 confirmed he worked 05/23/26 during the day shift and denied night shift staff informed him the laboratory needed to be contacted to pick up Resident #6's urine.Interview on 05/28/26 at 2:30 P.M. with the Director of Nursing confirmed the facility was unable to determine whether the urine specimen was picked up by the laboratory in a timely manner, and no evidence was found in the medical record supporting additional attempts to contact laboratory services for pickup.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to maintain complete, accurate, and readily accessible medical records. This affected two (#7 and #8) out of two records reviewed for availability of records. The facility census was 78. Findings include:1. Review of the medical record for Resident #7 revealed an admission date of 01/28/26 with diagnoses of metabolic encephalopathy, type 2 diabetes mellitus, gastroesophageal reflux disease without esophagitis, anxiety, and psychotic disorder with hallucinations. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 was severely cognitively impaired, exhibited no rejection of care, had experienced a five percent or greater weight loss in the past month and was not on a physicianˆprescribed weightˆloss regimen. a. Review of physician orders dated 04/02/26 revealed weekly weights were ordered to be obtained every Thursday due to significant weight loss. Review of the shower sheet dated 04/09/26 received 05/28/26 to support refusal of weight revealed the resident refused the scheduled weekly weight. Review of the electronic medical record for 04/09/26 showed no documentation of the refusal or any reattempt to obtain the weight. Review of a physician order dated 05/06/26 revealed weekly weights were to be obtained every Wednesday. Review of the electronic medical record for 05/13/26 (Wednesday) revealed no documentation that the weekly weight was completed, refused or attempted. The medication administration record displayed N/A for the scheduled weight, and no supporting documentation existed in the medical record to explain the entry. Review of the dietician's significant weightˆchange report for the week of 05/07/26 through 05/13/26 received upon request on 05/28/26 revealed the dietician documented that Resident #7 refused the weekly weight. This refusal was not documented anywhere in the resident's medical record. Interview on 05/28/26 at 9:40 A.M. with the Director of Nursing and the Director of Clinical Services #351 revealed the resident was refusing multiple care tasks during the week of 04/09/26. They confirmed there was no documentation showing staff reattempted the weight, and staff could have attempted the weight on another day or used an alternative method. They stated the N/A entry on 05/13/26 was not supported by any documentation in the resident's medical record. Interview on 05/28/26 at 9:54 A.M. with the Director of Nursing confirmed the refusal on 04/09/26 was not captured in the electronic medical record and that no documentation existed to indicate staff attempted to obtain the weight again. Interview on 05/28/26 at 10:13 A.M. with the Director of Nursing confirmed refusals were not readily accessible in the medical record. She stated she had to provide the surveyor a bathing sheet and a (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dietary report because the medical record did not contain documentation of refusals or weight attempts. She confirmed staff did not document refusal of care under the required behavior task for the two days in question. Interview on 05/28/26 at 10:27 A.M. with Dietician #355 revealed she could provide evidence of refusals through the weekly dietician report. She confirmed that the resident's medical record did not contain documentation or evidence that the weekly weights were refused or reattempted. b. Review of a progress note dated 05/25/26 at 7:00 P.M. revealed the resident was readmitted to the facility from the hospital. Review of a physician order dated 05/26/26 at 6:00 A.M. revealed the resident was to receive Accuˆ Checks (a test to check blood sugar levels) two times daily. Review of the electronic medical record for 05/25/26 through 05/26/26 received 05/28/26 revealed only two blood glucose results were documented: on 05/25/26 at 7:16 P.M., measuring 163 milligrams per deciliter (mg/dL) and on 05/28/26 at 10:18 A.M., measuring 149 mg/dL. Review of nursing handwritten report sheets dated 05/26/26 revealed morning and evening blood glucose results of 186 and 167. Review of nursing handwritten report sheets dated 05/27/26 revealed morning and evening blood glucose results of 162 and 174. Interview on 05/28/26 at 8:18 A.M. with Nurse Practitioner #350 confirmed Resident #7 was ordered to receive twiceˆdaily blood sugar checks following readmission from the hospital. Interview on 05/28/26 at 8:20 A.M. with the Director of Nursing (DON) revealed she had been informed blood sugar records for 05/26/26 and 05/27/26 were not located in the medical record and requested that staff attempt to locate them. Interview on 05/28/26 at 8:41 A.M. with the DON reported the medication administration record did not generate a documentation field for glucose results. She confirmed nursing did not enter the values into the vitals tab, as required per physician order. Interview on 05/28/26 at 10:08 A.M. with the DON revealed she located some dayˆshift results on handwritten report sheets, but nightˆshift results had not been located. Interview on 05/28/26 at 12:22 P.M. with the DON revealed she located the nightˆshift results on handwritten report sheets. The DON confirmed that none of the blood glucose results from 05/26/26 or 05/27/26 were documented in or accessible through the resident's electronic medical record. 2. Review of a resident medical record revealed that Resident #8 was admitted to the facility on [DATE] and had diagnoses that included cerebral infarction, chronic back pain and fibromyalgia. Review of Resident #8's MDS assessment dated [DATE] revealed intact cognitive status. Resident #8 was assessed as using opioid medications. Review of Resident #8's physician orders dated 02/17/26 through 03/25/26 revealed that Resident #8 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was prescribed Hydromorphone HCl, an opioid pain reliever, 4 milligrams (mg) one tablet every eight hours as needed for pain. Review of Resident #8's physician orders starting 03/25/26 revealed that Resident #8 was prescribed Hydromorphone HCl, 4 mg, 1 tablet every eight hours as needed for moderate to severe pain. Review of Resident #8's care plan dated 01/20/26 revealed that Resident #8 was at risk for alteration in comfort related to fibromyalgia, generalized pain and spinal stenosis. An intervention listed was to administer medications as ordered. Review of Resident #8's March 2026 hydromorphone narcotic count sheet revealed that Hydromorphone HCl 4 mg one tablet was administered to Resident #8 on 03/03/26 at 10:00 A.M., 03/04/26 at 1:00 P.M., 03/07/26 at 7:30 A.M. and 3:00 P.M., 03/08/26 at 7:00 A.M. and 2:30 P.M., 03/11/26 at 5:31 P.M., 03/12/26 at 6:00 A.M. and 2:00 P.M., 03/13/26 at 6:00 A.M. and 1:30 P.M., 03/17/26 at 6:35 A.M., 03/18/26 at 2:15 P.M., 03/20/26 at 2:00 P.M., 03/21/26 at 1:00 P.M., 03/26/26 at 12:30 P.M., and on 03/27/26 at 12:00 P.M Review of Resident #8's March 2026 Medication Administration Record (MAR) revealed that on 03/03/26 at 10:00 A.M., 03/04/26 at 1:00 P.M., 03/07/26 at 7:30 A.M. and 3:00 P.M., 03/08/26 at 7:00 A.M. and 2:30 P.M., 03/11/26 at 5:31 P.M., 03/12/26 at 6:00 A.M. and 2:00 P.M., 03/13/26 at 6:00 A.M. and 1:30 P.M., 03/17/26 at 6:35 A.M., 03/18/26 at 2:15 P.M., 03/20/26 at 2:00 P.M., 03/21/26 at 1:00 P.M., 03/26/26 at 12:30 P.M., and on 03/27/26 at 12:00 P.M., the MAR did not reflect that Hydromorphone HCl 4 mg 1 tablet was administered to Resident #8. Review of Resident #8's April 2026 hydromorphone narcotic count sheet revealed that Hydromorphone HCl 4 mg 1 tablet was administered to Resident #8 on 04/01/26 at 1:00 P.M. and 9:00 P.M., 04/04/26 at 8:00 A.M. and 4:10 P.M., 04/05/26 at 8:00 A.M. and 4:00 P.M., 04/09/26 at 8:00 A.M. and 3:30 P.M., 04/10/26 at 8:00 A.M. and 4:00 P.M., 04/14/26 at 2:00 P.M., 04/18/26 at 8:00 A.M. and 4:00 P.M., 04/19/26 at 8:00 A.M. and 4:00 P.M., 04/20/26 at 12:00 A.M., 04/23/26 at 8:00 A.M. and 4:00 P.M., 04/24/26 at 8:00 A.M. and 4:00 P.M., 04/25/26 at 12:00 A.M., 04/27/26 at 11:00 A.M., 04/28/26 at 12:30 P.M., 04/29/26 at 2:00 P.M., and 04/30/26 at 3:00 P.M. Review of Resident #8's April 2026 MAR revealed that on 04/01/26 at 1:00 P.M. and 9:00 P.M., 04/04/26 at 8:00 A.M. and 4:10 P.M., 04/05/26 at 8:00 A.M. and 4:00 P.M., 04/09/26 at 8:00 A.M. and 3:30 P.M., 04/10/26 at 8:00 A.M. and 4:00 P.M., 04/14/26 at 2:00 P.M., 04/18/26 at 8:00 A.M. and 4:00 P.M., 04/19/26 at 8:00 A.M. and 4:00 P.M., 04/20/26 at 12:00 A.M., 04/23/26 at 8:00 A.M. and 4:00 P.M., 04/24/26 at 8:00 A.M. and 4:00 P.M., 04/25/26 at 12:00 A.M., 04/27/26 at 11:00 A.M., 04/28/26 at 12:30 P.M., 04/29/26 at 2:00 P.M., and 04/30/26 at 3:00 P.M., the MAR did not reflect that Hydromorphone HCl 4 mg 1 tablet was administered to Resident #8. Review of Resident #8's May 2026 hydromorphone narcotic count sheet revealed that Hydromorphone HCl 4 mg 1 tablet was administered to Resident #8 on 05/02/26 at 8:00 A.M. and 4:00 P.M., 05/03/26 at 8:00 A.M. and 3:00 P.M., 05/04/26 at 9:00 A.M., 05/06/26 at 11:00 P.M., 05/07/26 at 8:00 A.M. and 4:00 P.M., 05/08/26 at 8:00 A.M. and 3:30 P.M., 05/16/26 at 8:00 A.M. and 3:30 P.M., 05/17/26 at 8:00 A.M. and 4:00 P.M., 05/21/26 at 12:00 A.M., 8:00 A.M. and 4:00 P.M., 05/22/26 at 7:30 A.M. and 4:00 P.M., 05/23/26 at 9:30 A.M. and 5:11 P.M., and on 05/26/26 at 6:30 P.M. Review of Resident #8's May 2026 MAR revealed that on 05/02/26 at 8:00 A.M. and 4:00 P.M., 05/03/26 at 8:00 A.M. and 3:00 P.M., 05/04/26 at 9:00 A.M., 05/06/26 at 11:00 P.M., 05/07/26 at 8:00 A.M. and 4:00 P.M., 05/08/26 at 8:00 A.M. and 3:30 P.M., 05/16/26 at 8:00 A.M. and 3:30 P.M., (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/17/26 at 8:00 A.M. and 4:00 P.M., 05/21/26 at 12:00 A.M., 8:00 A.M. and 4:00 P.M., 05/22/26 at 7:30 A.M. and 4:00 P.M., 05/23/26 at 9:30 A.M. and 5:11 P.M., and on 05/26/26 at 6:30 P.M., the MAR did not reflect that Hydromorphone HCl 4 mg 1 tablet was administered to Resident #8. An interview with the Director of Nursing (DON) on 05/28/26 at 2:20 P.M. confirmed that the nurses were not accurately documenting hydromorphone administration on the MARs after medication administration. The DON confirmed that it is her expectation that medication administration would be immediately documented accurately on the MAR after administration.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, observation and staff interview, the facility failed to ensure that bedside table was in good repair to prevent a possible injury. This affected one (#59) out of two residents reviewed for environment. The facility census was 78 residents.Findings include:Review of a resident medical record revealed that Resident #59 was admitted to the facility on [DATE] and had diagnoses that included cerebral infarction, schizophrenia and acute embolism. Review of Resident #59's Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #59 was assessed as having moderate cognitive impairment. He was assessed as having no upper body impairment and being on an anticoagulant. Review of Resident #59's care plan dated 10/20/23 revealed that Resident #59 was at risk for bleeding related to use of anticoagulant medications. Observation on 05/26/26 at 9:43 A.M. revealed Resident #59's bedside table was within reach of the resident. The bedside table's edge was observed to be unfinished, broken, and had approximately three inches of exposed particle board with splinters and wood chips on the tabletop. Interview with Certified Nursing Aide (CNA) #205 on 05/26/26 at 10:02 A.M. confirmed Resident #59's bedside table was broken with rough, exposed particle board and wood chips, within reach of Resident #59.