STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366491	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Strongsville Healthcare and Rehabilitation	18936 Pearl Road Strongsville, OH 44136

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, interviews, and review of facility policies, the facility failed to ensure proper implementation of required infection control practices. Specifically, the facility did not ensure staff consistently followed Enhanced Barrier Precautions (EBP) for residents with indwelling devices, did not properly don and doff required Personal Protective Equipment (PPE) when caring for a resident on droplet isolation for COVIDˆ19, did not use appropriate protective clothing during laundry handling, and did not maintain required procedures to prevent the growth of Legionella bacteria within the facility's water system. These deficient practices affected two residents (Residents #24 and #53) and had the potential to affect all residents in the facility. The facility census was 95.Findings include: 1. Record review for Resident #24 revealed an admission date of 04/02/24. Diagnoses included hemiplegia and hemiparesis following intracerebral hemorrhage affecting the left dominant side, neuromuscular dysfunction of bladder, and need for assistance with personal care. Review of the physician order for Resident #24 dated 12/15/25 revealed an order for an indwelling Foley urinary catheter due to obstructive uropathy. An additional order dated 01/06/26 included EBP: gloves and gown to be worn when providing dressing, bathing/showering, transferring, providing hygiene care, changing linens, changing briefs or assisting with toileting.Review of the Annual Minimum Data System (MDS) 3.0 assessment dated [DATE] revealed Resident #24 was cognitively intact. Resident #24 had an indwelling urinary catheter and required partial/moderate assistance with toileting hygiene, bed mobility, and substantial/maximal assistance with chair/bed to chair transfer.During an interview on 06/14/26 at 10:30 A.M., Resident #24 revealed, They never put a gown on when they do my catheter care or any care, are they supposed too?Observation on 06/14/26 at 10:41 A.M. of incontinence care for Resident #24 provided by Certified Nursing Assistant (CNA) #403 revealed CNA #403 never donned an isolation gown at any time during the care which included turning and repositioning in bed and incontinence of stool care. After incontinence care was completed, CNA #403 revealed she needed a second person to transfer Resident #403 from the bed to the chair. CNA #403 then exited the room to find additional staff.Observation on 06/14/26 at 10:47 A.M. revealed CNAs #403 and #478 returned to Resident #24's room and transferred Resident #24 from his bed to his chair using a slide board. Resident #24 was then transferred to the bathroom and CNAs #403 and #478 then transferred Resident #24 from his chair to the toilet. Observation revealed neither CNA donned an isolation gown while providing hands on care for Resident #24.During an interview on 06/14/26 at 10:54 A.M., CNA #478 stated staff were to donn an isolation gown only if they were providing catheter care. The isolation gown was not required for incontinence care or transfers. During an interview on 06/14/26 at 10:57 A.M., CNA #403 stated staff were only required to wear an isolation gown if the resident had COVID-19 or an infection. CNA #403 confirmed she never had donned an isolation gown while providing care for Resident #24.Observation on 06/14/26 at 10:59 A.M. of CNA #403 and Licensed Practical Nurse (LPN) #603 transfer Resident #24 from the toilet, provide incontinence care, place a brief on and transfer Resident #24 back to his chair revealed neither LPN #603 nor CNA #403 donned an isolation gown.During an interview on 06/14/26 at 11:04 A.M., LPN #603 confirmed she never donned an isolation gown (during the observation) while transferring and providing personal (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	care for Resident #24. LPN #603 confirmed Resident #24 had an EBP sign outside his doorway and confirmed she should have applied an isolation gown while providing hands on care for Resident #24.2. Record review for Resident #53 revealed a re-admission date of 06/09/26. Medical diagnosis included COVID-19.Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #53 was moderately cognitively impaired. Resident #53 required assistance with activities of daily living.Review of the physician orders for Resident #53 revealed an order dated 06/11/26 for droplet isolation precautions due to a diagnosis of COVID-19. All services and meals to be provided in resident's private room every shift for diagnosis of COVID-19. Observation on 06/15/26 at 9:26 A.M. revealed Resident #53 had a sign on his door for droplet precautions. A three-drawer container was sitting outside the doorway that had PPE inside. Inside were sufficient isolation gowns, N-95 masks, gloves and one pair of goggles. Observation revealed LPN #487 donned an isolation gown, N-95 mask and gloves. LPN #487stated Resident #53 had COVID-19, and she was going into his room to administer his medications. LPN #487 entered the room with a medication cup with medications inside but never donned goggles. During an interview on 06/15/26 at 12:16 P.M., LPN #487 confirmed she did not donn goggles when she went into Resident #53's room during medication administration at 9:26 A.M. LPN #487 confirmed there were only one pair of goggles in the isolation cart and revealed they should be thrown away after each use. LPN #487 then walked away and returned at 12:19 P.M. and revealed with those goggles you would clean them after each use with Sani wipes.During an observation and interview on 06/15/26 12:20 P.M., LPN #491 confirmed there were no Sani-wipes in or on Resident #53's isolation cart.Observation on 06/15/26 at 12:22 P.M. of CNA #411 donn an isolation gown and an N-95 mask revealed the lower strap of the mask was left dangling under his chin. CNA #411 stated he was going in Resident #53's room to provide his Foley catheter care, check his brief, and apply cream to buttocks. CNA #411 confirmed Resident #53 was in isolation for COVID-19. He then entered Resident #53 ?s room with the N-95 strap dangling under his chin, no goggles, and carrying one pair of gloves while entering the room. At 12:42 P.M., CNA #411 exited Resident #53's room, confirmed he drained Resident #53's indwelling catheter drainage bag, applied a fresh brief fresh brief, barrier cream and repositioned Resident #53. CNA #411 confirmed he did not secure the bottom strap of the N-95 mask stating it was too tight and confirmed that he did not wear goggles while providing care for Resident #53.Observation on 06/15/26 at 12:37 P.M. of CNA #460 donn PPE revealed Registered Nurse (RN) Infection Preventionist (IP) #604 stopped and reminded CNA #460 to also donn goggles when entering Resident #53's room. CNA #460 then donned all appropriate PPE including goggles and entered Resident #53's room. At 12:41 P.M., CNA #460 exited Resident #53's room, removed the goggles and tossed them in the top drawer of the isolation cart with clean PPE. CNA #460 confirmed she removed the goggles and placed them directly in the isolation cart without sanitizing them.During an interview on 06/15/26 12:46 P.M., RN IP #604 confirmed Resident #53 was on droplet isolation due to a diagnosis of COVID-19. RN IP #604 confirmed staff should donn an isolation gown, gloves, mask, and goggles before entering Resident #53's room and should make sure both N-95 straps were secured. Goggles were to be cleaned after each use with Sani wipes and left to air dry.3. Observation on 06/15/26 at 1:37 P.M. revealed the laundry area and process with the Director of Nursing (DON) revealed Housekeeping/Laundry Assistants #740 and #745 both revealed they did not know which clothes or linen were from which residents' rooms. When they received laundry to wash, the isolation rooms laundry was not separated from the other residents. Housekeeping/Laundry Assistants #740 and #745 both confirmed they never donned an isolation gown or apron when sorting or washing any of the residents' laundry. RN IP #604 revealed not all staff understand the infection control process.During an interview on 06/15/26 at 1:55 P.M., Regional Clinical Director #725 revealed when staff sort/wash laundry of residents who are on isolation precautions, they should wear gloves and an apron. 4. Record review and interview on 06/15/26 at 4:19 P.M. with Assistant Director of Property Management #750 and Maintenance Supervisor #408 confirmed there was no diagram or description to identify the areas in the water (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	system (needing routinely flushed) that could encourage the growth and spread of Legionella. Maintenance Supervisor #408 revealed there were four eye wash stations that he flushed once a month and confirmed he was unaware of any other areas in the building that needed flushed. Maintenance Supervisor #408 confirmed the facility had empty resident rooms, ice machines, hoses, etc. and revealed he did not know he was supposed to.Review of the undated facility policy titled, Enhanced Barrier Precautions revealed the purpose was to prevent the spread of novel or targeted multidrug-resistant organisms (MDROs). EBP expand the use of PPE beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high contact resident care activities that provide opportunities for MDROs to staff hands and clothing. High contact resident care activities include dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use or wound care. EBP apply to all residents with any of the following: Infection or colonization with a novel or targeted MDRO, wounds or an indwelling medical device (i.e.- central line, urinary catheter, feeding tube, trach or vent) regardless of MDRO colonization status.Review of the undated facility policy titled, Covid-19; SARS-CoV-2 revealed the COVID- 19 control plan set forth in this policy is based according to regulatory guidance for resident health and safety. Health care providers who enter the room of a resident with suspected or confirmed SARS-CoV-2 infection should donn an N-95 respirator, gown, gloves and eye protection (goggles or face shield that covers the front and sides of the face).Review of the undated facility policy titled, Laundry Procedures for the Avenue Buildings revealed each piece of equipment provided for the use by the laundry has many purposes such as infection control, operational efficiency as well as providing for a safe working environment for the laundry staff. The expectation is that the equipment provided and the procedures described below will be followed in each Avenue facility operated by Progressive Quality Care. The infection control policy will apply to this procedure, which at a minimum will require gloves and quite possibly a gown or apron to prevent the soiled material from touching or contaminating the clothing of the laundry person.Review of the facility policy titled, Legionella Water Management Program, revised September 2022, revealed the facility is committed to the prevention, detection, and control of water borne contaminants, including Legionella. The water management program includes a detailed description and diagram of the water system in the facility, including receiving, cold water distribution, heating, hot water distribution, and waste. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria including storage tanks, water heaters, filters, aerators, showerheads and hoses, misters, atomizers, air washers, humidifiers, hot tubs, fountains, and medical device equipment.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on staff interview, review of staff education, review of Centers for Medicare and Medicaid (CMS) Regulatory Update dated 05/31/23 titled Educate and Offer and review of the facility policy, the facility failed to educate/offer all eligible staff the COVIDˆ19 vaccination. This had the potential to affect all 95 residents residing at the facility.Findings include:During an interview on 06/15/26 at 9:04 A.M., Certified Nursing Assistant (CNA) #494 stated the fall of 2024 was the last time the facility educated/offered the staff the COVID-19 vaccine.During an interview on 06/15/26 at 10:10 A.M., Infection Preventionist (IP) Registered Nurse (RN) #604 confirmed facility staff were not educated/offered the COVID-19 vaccine in 2025 or 2026 and revealed she did not know she was supposed to. Review of staff education related to COVID-19 on 06/15/26 at 11:58 A.M. with IP RN #604 for 2025/2026 confirmed staff were not educated on COVID-19 vaccine benefits, risks and potential side effects.During an interview on 06/16/26 at 2:03 P.M. with Regional Director of Clinical Operations (RDCO) #725 confirmed staff were to be offered COVID-19 vaccines annually. Review of the CMS Regulatory Update, dated 05/31/23, revealed Federal staff vaccine mandate was rescinded. CMS finalized a rule that removed the COVIDˆ19 staff vaccination requirement originally imposed by the November 2021 interim final rule. CMS no longer enforces mandatory staff vaccination for COVIDˆ19 in nursing homes. Educate and offer requirement remains. CMS retained the Education and Offer provisions from the May 2021 interim final rule. Nursing homes must continue to: Educate staff about COVIDˆ19 vaccines (benefits, risks, and side effects) and offer vaccines actively, either onˆsite or by referring staff to offˆsite providers or pharmacies,Review of the facility policy titled, Employee Infection and Vaccination Status, dated January 2024, revealed employees are offered or provided with vaccinations per state or local agency policies/regulations. Employees are provided with educational materials to make informed decisions for non-mandated vaccines. If declined, a declination form is completed and placed in the employees' health record. The facility obtains and/or administers vaccinations required for pre- and post - exposure to infectious diseases in the workplace.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure accurate comprehensive assessments were completed as required. This finding affected three residents (Residents #107, #109 and #111) and had the potential to affect all six residents (Residents #103, #105, #107, #108, #109 and #111) who were transferred to the facility from a sister facility following a fire. The facility census was 95. Findings include: 1. Review of Resident #111's medical record revealed the resident was admitted to the facility 03/13/26 as a transfer from a sister facility with diagnoses including paraplegia, essential hypertension and legal blindness. Review of Resident #111's medical record revealed an admission Minimum Data Set (MDS) 3.0 Comprehensive assessment dated [DATE] with a description of Inactivation of Entry. The MDS did not have evidence that the home conducted a comprehensive, accurate, and standardized assessment of the resident's functional capacity. Telephone interview on 06/15/26 at 12:27 P.M. with Medicaid Representative #705 confirmed that their office did not instruct any facility to not complete MDS assessments as required. Interview on 06/15/26 at 12:40 P.M. with Regional Registered Nurse (RRN) #710 confirmed Resident #111's medical record did not have evidence of an admission MDS or any subsequent MDS assessments because the resident was a transfer from a sister facility who had a fire, and he was educated by the corporate office that the MDS assessments did not have to be completed for Resident #111 since she was a transfer. Email interview on 06/16/26 at 9:15 A.M. with the Administrator confirmed the facility followed the Resident Assessment Instrument (RAI) manual on completing assessments. The Administrator confirmed that six residents were transferred to the facility following a fire at a sister facility including Residents #103, #105, #107, #108, #109 and #111. 2. Review of the medical record for Resident #107 revealed an admission date of 03/13/26 with diagnoses including dementia, schizophrenia and atrial fibrillation. Review of the MDS 3.0 Comprehensive Assessment list revealed Resident #107 did not have any MDS assessments completed by the facility since admission. It was noted she had an entry MDS initiated on 03/13/26 but then it was inactivated. She also had an admission assessment dated [DATE] which was also inactivated. Review of emails provided by RRN #710 dated from 03/20/26 through 06/02/26 revealed direction given from Medicaid staff on 03/25/26 was for the originating facility to submit MDS's based on their routine schedule. Interview on 06/15/26 at 8:29 A.M. with Registered Nurse (RN) #715 revealed Resident #107 was a transfer from one of their sister facilities who had a fire and had to perform an evacuation. He stated Resident #107 had been at the facility for three months. He verified there were no MDS's completed per directive from his management team. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/15/26 at 9:16 A.M. with RRN #710 revealed MDS assessments for Resident #107 were not being completed by the facility or the sister facility (originating facility). He stated he had received directive from management that the assessments did not have to be completed until they returned to the originating facility by a Medicaid representative. Interview on 06/15/26 at 10:09 A.M. with RRN #710 where he presented documentation from Centers for Medicare and Medicaid Services (CMS) related to Frequently Asked Questions for Provider Survey and Certification for Declared Public Health Emergencies and All Hazards Health Standards and Quality Issues. He stated he had received this document from Medicaid Representative #705 on 03/27/26. Review of the document with him revealed when a resident returns to the evacuating facility within 30 days from the evacuation date, the facility would continue with the MDS cycle as though the resident was never transferred/discharged . However, if the evacuating facility determined the resident would not be able to return in the 30-day time frame, the evacuating facility should discharge the resident by completing a discharge assessment within the 30-day time frame. The receiving facility would then admit the resident if it was the resident's choice to stay there. RRN #710 verified the facility did not follow the documentation's guidance. Interview on 06/15/26 at 12:27 P.M. with Medicaid Representative #705 revealed she had spoken to the facility and its representatives. She verified she had not stated to the facility to not do the MDS assessments for the residents who had been evacuated. She stated they should have been doing the MDSs as directed by the guidance she had sent them on 03/27/26. Email interview on 06/16/26 at 9:15 A.M. with the Administrator confirmed the facility followed the RAI manual on completing assessments. The Administrator confirmed that six residents were transferred to the facility following a fire at a sister facility including Residents #103, #105, #107, #108, #109 and #111. 3. Review of the medical record for Resident #109 revealed an admission date of 03/13/26 with diagnoses including quadriplegia, depression and anxiety. Review of the MDS 3.0 assessment list revealed Resident #109 did not have any MDSs completed by the facility since admission. It was noted she had an entry MDS initiated on 03/13/26, but it was inactivated. Review of emails provided by RRN #710 dated from 03/20/26 through 06/02/26 revealed direction given from Medicaid staff on 03/25/26 was for the originating facility to submit MDSs based on their routine schedule. Interview on 06/15/26 at 8:29 A.M. with RN #715 revealed Resident #109 was a transfer from one of their sister facilities who had a fire and had to perform an evacuation. He stated Resident #109 had been at the facility for three months. He verified there were no MDSs completed per directive from his management team. Interview on 06/15/26 at 9:16 A.M. with RRN #710 revealed MDSs for Resident #109 were not being completed by the facility or the sister facility (originating facility). He stated he had received directive from management that the assessments did not have to be completed until they returned to the originating facility by a Medicaid representative. Interview on 06/15/26 at 10:09 A.M. with RRN #710 where he presented documentation from CMS (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	related to Frequently Asked Questions for Provider Survey and Certification for Declared Public Health Emergencies and All Hazards Health Standards and Quality Issues. He stated he had received this document from Medicaid Representative #705 on 03/27/26. Review of the document with him revealed when a resident returns to the evacuating facility within 30 days from the evacuation date, the facility would continue with the MDS cycle as though the resident was never transferred/discharged . However, if the evacuating facility determined the resident would not be able to return in the 30-day time frame, the evacuating facility should discharge the resident by completing a discharge assessment within the 30-day time frame. The receiving facility would then admit the resident if it was the resident's choice to stay there. RRN #710 verified the facility did not follow the documentation's guidance. Interview on 06/15/26 at 12:27 P.M. with Medicaid Representative #705 revealed she had spoken to the facility and its representatives. She verified she had not stated to the facility to not do the MDS assessments for the residents who had been evacuated. She stated they should have been doing the MDSs as directed by the guidance she had sent them on 03/27/26. Email interview on 06/16/26 at 9:15 A.M. with the Administrator confirmed the facility followed the RAI manual on completing assessments. The Administrator confirmed that six residents were transferred to the facility following a fire at a sister facility including Residents #103, #105, #107, #108, #109 and #111.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure comprehensive assessments were completed timely. This finding affected three (Residents #107, #109 and #111) and had the potential to affect all six residents (Residents #103, #105, #107, #108, #109 and #111) who were transferred to the facility from a sister facility following a fire. The facility census was 95. Findings include: 1. Review of Resident #111's medical record revealed the resident was admitted to the facility 03/13/26 as a transfer from a sister facility with diagnoses including paraplegia, essential hypertension and legal blindness. Review of Resident #111's medical record revealed the admission Minimum Data Set (MDS) 3.0 Comprehensive assessment dated [DATE] with a description of Inactivation of Entry. The MDS did not reflect the resident's medical, functional, and psychosocial conditions. This included identifying the resident's strengths and needs to maintain or improve the resident's overall status using the appropriate Resident Assessment Instrument (RAI), such as a comprehensive, quarterly, or significant change assessment. The facility did not ensure the accuracy and integrity of the resident's assessment including proper documentation, qualified professional involvement, and adherence to observation periods. Telephone interview on 06/15/26 at 12:27 P.M. with Medicaid Representative #705 confirmed that their office did not instruct any facility to not complete MDS assessments as required. Interview on 06/15/26 at 12:40 P.M. with Regional Registered Nurse (RRN) #710 confirmed Resident #111's medical record did not have evidence of an accurate MDS assessment because the resident was a transfer from a sister facility who had a fire, and he was educated by the corporate office that the MDS assessments did not have to be completed for Resident #111 since she was a transfer. Email interview on 06/16/26 at 9:15 A.M. with the Administrator confirmed the facility followed the Resident Assessment Instrument (RAI) manual on completing assessments. The Administrator confirmed that six residents were transferred to the facility following a fire at a sister facility including Residents #103, #105, #107, #108, #109 and #111. 2. Review of the medical record for Resident #107 revealed an admission date of 03/13/26 with diagnoses including dementia, schizophrenia and atrial fibrillation. Review of the MDS 3.0 assessment list revealed Resident #107 did not have any MDS's completed by the facility since admission. It was noted she had an entry MDS initiated on 03/13/26 but then it was inactivated. She also had an admission assessment dated [DATE] which was also inactivated. The MDS did not reflect the resident's medical, functional, and psychosocial conditions. This included identifying the resident's strengths and needs to maintain or improve the resident's overall status using the appropriate RAI, such as a comprehensive, quarterly, or significant change assessment. The facility did not ensure the accuracy and integrity of the resident's assessment including proper documentation, qualified professional involvement, and adherence to observation periods. Review of emails provided by RRN #710 dated from 03/20/26 through 06/02/26 revealed direction given from Medicaid staff on 03/25/26 was for the originating facility to submit MDS assessments based on their routine schedule. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/15/26 at 8:29 A.M. with Registered Nurse (RN) #715 revealed Resident #107 was a transfer from one of their sister facilities who had a fire and had to perform an evacuation. He stated Resident #107 had been at the facility for three months. He verified there were no MDS assessments completed per directive from his management team. Interview on 06/15/26 at 9:16 A.M. with RRN #710 revealed MDS's for Resident #107 were not being completed by the facility or the sister facility (originating facility). He stated he had received directive from management that the assessments did not have to be completed until they returned to the originating facility by a Medicaid representative. Interview on 06/15/26 at 10:09 A.M. with RRN #710 where he presented documentation from Centers for Medicare and Medicaid Services (CMS) related to Frequently Asked Questions for Provider Survey and Certification for Declared Public Health Emergencies and All Hazards Health Standards and Quality Issues. He stated he had received this document from Medicaid Representative #705 on 03/27/26. Review of the document with him revealed when a resident returns to the evacuating facility within 30 days from the evacuation date, the facility would continue with the MDS cycle as though the resident was never transferred/discharged . However, if the evacuating facility determined the resident would not be able to return in the 30-day time frame, the evacuating facility should discharge the resident by completing a discharge assessment within the 30-day time frame. The receiving facility would then admit the resident if it was the resident's choice to stay there. RRN #710 verified the facility did not follow the documentation's guidance. Interview on 06/15/26 at 12:27 P.M. with Medicaid Representative #705 revealed she had spoken to the facility and its representatives. She verified she had not stated to the facility to not do the MDS assessments for the residents who had been evacuated. She stated they should have been doing the MDS's as directed by the guidance she had sent them on 03/27/26. Email interview on 06/16/26 at 9:15 A.M. with the Administrator confirmed the facility followed the RAI manual on completing assessments. The Administrator confirmed that six residents were transferred to the facility following a fire at a sister facility including Residents #103, #105, #107, #108, #109 and #111. 3. Review of the medical record for Resident #109 revealed an admission date of 03/13/26 with diagnoses including quadriplegia, depression and anxiety. Review of the MDS 3.0 Comprehensive Assessment list revealed Resident #109 did not have any MDS assessments completed by the facility since admission. It was noted she had an entry MDS initiated on 03/13/26 but then it was inactivated. The MDS did not reflect the resident's medical, functional, and psychosocial conditions. This included identifying the resident's strengths and needs to maintain or improve the resident's overall status using the appropriate RAI, such as a comprehensive, quarterly, or significant change assessment. The facility did not ensure the accuracy and integrity of the resident's assessment including proper documentation, qualified professional involvement, and adherence to observation periods. Review of emails provided by RRN #710 dated from 03/20/26 through 06/02/26 revealed direction given from Medicaid staff on 03/25/26 was for the originating facility to submit MDS assessments based on their routine schedule. Interview on 06/15/26 at 8:29 A.M. with RRN #715 revealed Resident #109 was a transfer from one of (continued on next page)

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	366491	A. Building B. Wing	06/16/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	their sister facilities who had a fire and had to perform an evacuation. He stated Resident #109 had been at the facility for three months. He verified there were no MDS assessments completed per directive from his management team. Interview on 06/15/26 at 9:16 A.M. with RRN #710 revealed MDS assessments for Resident #109 were not being completed by the facility or the sister facility (originating facility). He stated he had received directive from management that the assessments did not have to be completed until they returned to the originating facility by a Medicaid representative. Interview on 06/15/26 at 10:09 A.M. with RRN #710 where he presented documentation from the Centers for Medicare and Medicaid Services (CMS) related to Frequently Asked Questions for Provider Survey and Certification for Declared Public Health Emergencies and All Hazards Health Standards and Quality Issues. He stated he had received this document from Medicaid Representative #705 on 03/27/26. Review of the document with him revealed when a resident returns to the evacuating facility within 30 days from the evacuation date, the facility would continue with the MDS cycle as though the resident was never transferred/discharged . However, if the evacuating facility determined the resident would not be able to return in the 30-day time frame, the evacuating facility should discharge the resident by completing a discharge assessment within the 30-day time frame. The receiving facility would then admit the resident if it was the resident's choice to stay there. RRN #710 verified the facility did not follow the documentation's guidance. Interview on 06/15/26 at 12:27 P.M. with Medicaid Representative #705 revealed she had spoken to the facility and its representatives. She verified she had not stated to the facility to not do the MDS assessments for the residents who had been evacuated. She stated they should have been doing the MDS's as directed by the guidance she had sent them on 03/27/26. Email interview on 06/16/26 at 9:15 A.M. with the Administrator confirmed the facility followed the RAI manual on completing assessments. The Administrator confirmed that six residents were transferred to the facility following a fire at a sister facility including Residents #103, #105, #107, #108, #109 and #111.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of the facility policy, the facility failed to ensure care planning conferences were completed at least quarterly. This affected two (Residents #10 and #111) of five residents reviewed for care planning. The facility census was 95. Findings include: 1. Review of Resident #10's medical record revealed the resident was admitted on [DATE] with diagnoses including dementia, bipolar disorder and essential hypertension.Review of Resident #10's medical record revealed a care conference was conducted on 09/30/25.Review of Resident #10's medical record revealed a care conference was conducted on 02/20/26.Review of Resident #10's Annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment.Telephone interview on 06/14/26 at 10:32 A.M. with Resident #10's family member revealed she had missed the care conference and tried to reschedule, but the facility had never returned her phone calls. Telephone interview on 06/15/26 at 12:12 P.M. with Prior Social Service Designee (SSD) #701 confirmed Resident #10's care conferences were not completed at least quarterly.2. Review of Resident #111's medical record revealed the resident was admitted to the facility 03/13/26 as a transfer from a sister facility with diagnoses including paraplegia, essential hypertension and legal blindness.Review of Resident #111's medical record revealed a MDS 3.0 assessment dated [DATE] with a description of Inactivation of Entry.Review of Resident #111's social service progress note dated 05/14/26 at 11:20 A.M. revealed the clinical and administrative team gathered for a care conference at the daughter's request. The team waited for up to 15 minutes and the daughter did not show. A call was made in an attempt to reach the daughter at this time to enquire if she would still arrive that day and no answer was obtained.Telephone interview on 06/14/26 at 12:09 P.M. with Resident #111's family member revealed a care conference was not completed since the resident's transfer to the facility from a sister facility. The family member indicated she was told a care conference would be completed and the staff did not contact her to conduct one.Telephone interview on 06/15/26 at 12:12 P.M. with Prior SSD #701 confirmed Resident #111 was transferred from a sister facility on 03/13/26 and the medical record did not have evidence a care conference was completed since admission.Review of the Advanced Care Planning policy, revised 12/2022, revealed the Interdisciplinary Team (IDT) will coordinate with the resident and/or their responsible party, an appropriate plan of care for the resident's needs or wishes specific to person centered care based on the assessment and reassessment process within the required time frames.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate care plans were initiated and updated for two residents (Resident #20 and #24) of 25 residents reviewed for care planning. The facility census was 95.Findings include:1. Record review for Resident #24 revealed an admission date of 04/02/24. Diagnoses included hemiplegia and hemiparesis following intracerebral hemorrhage affecting the left dominant side, neuromuscular dysfunction of bladder and need for assistance with personal care. Review of the physician order for Resident #24 dated 12/15/25 revealed an order for Foley (indwelling) urinary catheter due to obstructive uropathy. An additional order dated 01/06/26 included Enhanced Barrier Precautions (EBP): Gloves and gown to be worn when providing dressing, bathing/showering, transferring, providing hygiene care, changing linens, changing briefs or assisting with toileting.Review of the Annual Minimum Data System (MDS) 3.0 assessment dated [DATE] revealed Resident #24 was cognitively intact. Resident #24 had an indwelling catheter and required partial/moderate assistance with toileting hygiene, bed mobility, and substantial/maximal assistance with chair/bed to chair transfer.Review of the medical record for Resident #24 revealed there was no care plan initiated for the indwelling urinary catheter and for EBP.During an interview and medical record review on 06/16/26 at 1:03 P.M., the Director of Nursing (DON) confirmed Resident #24 had no care plan for the indwelling urinary catheter or EBP initiated until after the surveyor inquired about the care plan on 06/15/26.2. Record review for Resident #20 revealed an admission date of 05/04/23. Diagnoses included type II diabetes mellitus, chronic kidney disease, and lack of coordination.Review of the Annual MDS 3.0 assessment dated [DATE] revealed Resident #20 was moderately cognitively impaired. Resident #20's vision was adequate with corrective lenses. Review of the medical record for Resident #20 revealed no care plan was initiated for vision or corrective lenses.During an interview on 06/15/26 at 9:13 A.M., Resident #20 was sitting up in his chair in his room with glasses on. Resident #20 revealed he cannot see well even with the glasses, he can only see movement, he cannot even see letters to read. During a record review and interview 06/15/26 at 11:12 A.M., Registered Nurse (RN) Unit Manager (UM) #604 confirmed Resident #20 did not have a care plan for vision or corrective lenses.During an interview on 06/16/26 at 12:40 P.M., Resident #20's daughter confirmed he had seen the eye doctor, received new glasses but his vision had progressively continued to worsen, and he had expressed concerns several times that he cannot see well even with the new glasses. She confirmed that his vision was expected to continue to worsen due to his disease process.During an interview on 06/16/26 at 1:19 P.M, RN UM #425 confirmed Resident #20 expressed concerns with her regarding his poor vision even with glasses.

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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 review of medical records, hospital records, and staff interviews, the facility failed to ensure that appropriate immediate care was provided to Resident #84 following a fall. Staff moved the resident despite her complaints of pain and before notifying the physician or Certified Nurse Practitioner (CNP) for further direction. Resident #84 was later found to have sustained multiple fractures. This affected one resident (Resident #84) of four residents reviewed for accidents. The facility census was 95.Findings include:Record review for Resident #84 revealed an admission date of 10/24/24. Diagnoses included metabolic encephalopathy, dementia, and muscle weakness.Review of the Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #84 was rarely or never understood. Resident #84 used a wheelchair for mobility, required supervision or touch assistance for meals, substantial/maximal assistance for toileting hygiene, bathing, bed mobility, lying to sitting on the side of the bed, had not attempted sit to stand and was dependent on staff for chair/bed to chair transfer. Resident #84 had no falls since admission. Review of the fall risk assessment dated [DATE] for Resident #84 revealed a score of 15 indicating Resident #84 was at risk for falls.Review of the care plan initiated on 09/25/25 and revised 06/03/26 revealed Resident #84 had an actual fall and was at risk of further falls. Interventions included assessing the resident's footwear for safety, encouraging non-slip socks and appropriate footwear to promote safety, defined parameter air mattress, encouraging the use of the call light to call for staff assistance and to wait for staff to arrive, and a floor mat to the right side of the bed. Review of the progress note for Resident #84 dated 06/03/26 at 6:20 A.M. completed by Licensed Practical Nurse (LPN) #468 revealed, Aide notified this nurse that she found resident on the floor beside her bed. This nurse entered room and resident was lying on her back with her head at the foot of the bed, and legs towards head of bed. No visible injury. Resident does state my legs hurt. She was lifted via 2-person assistance into bed. Neuro checks started. LPN #468 indicated that the CNP was notified and ordered a STAT (immediate or at once) x-ray of the pelvis and bilateral femurs.Review of the Medication Administration Record (MAR) revealed Resident #84 received Tylenol 325 milligrams (mg) (analgesic) on 06/03/26 at 4:31 A.M. and 11:38 A.M. Review of the MAR and progress notes for May and June 2026 for the two weeks prior to the fall on 06/03/26 revealed no indication of Resident #84 having pain.Review of the progress note dated 06/03/26 at 11:57 A.M. revealed Resident #84's x-ray results included a left femur fracture. A new order was received to send her to the emergency department (ED) for evaluation and treatment.Review of the progress note dated 06/03/26 at 1:28 P.M. revealed Resident #84 was sent out to the ED at this time.Review of the Hospital Notes from Care Team/Discharge Summary for Resident #84 attestation signed 06/09/26 at 12:11 P.M. by Medical Doctor (MD) #730 revealed ED to hospital admission on [DATE]. Reasons for hospitalization included trauma, acute pain due to trauma, closed displaced supracondylar fractur with intracondylar extension of lower end of right femur, closed displaced supracondylar fractur without intracondylar extension of lower end of left femur. Hospital Course information included questionable right radial neck fracture, and subacute T5/T12 compression fracture. Resident #84 was admitted under trauma services. Single shot bilateral femoral nerve blocks with exparel were done. Medical decision making confirmed by MD #735 revealed during the hospital stay the patient (Resident #84) was found to have multiple traumatic injuries including bilateral distal femurs, and right proximal radial head. There were additional age indeterminate fractures appreciated on imaging. Resident #84 reports significant discomfort throughout her body. During the course of the ED evaluation, she was given intravenous (IV) fluids and a small dose of morphine. She ultimately underwent splinting with assistance of the orthopedic team. Given polytrauma and concern for possible neglect by the facility, Resident #84 was recommended for hospitalization for trauma tertiary assessment, pain management. The case was discussed with family who opted for non-operative management.Review of the progress note dated (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/05/26 at 1:03 A.M. revealed Resident #84 was hospitalized for multiple fractures.Review of the progress note dated 06/07/26 at 4:17 P.M. revealed Resident #84 returned to the facility.During a telephone interview on 06/16/26 at 7:55 A.M., Certified Nursing Assistant (CNA) #602 confirmed she was the CNA who found Resident #84 on the floor on 06/03/26 and reported it to the nurse. She recalled Resident #84's fall on 06/03/26 and stated that in the morning she was in the room next door providing care at approximately 4:15 A.M. She heard shouting from Resident #84, finished providing care, which took about 10 to 15 minutes, and then went to see why Resident #84 was yelling. She found her on the floor, went to get the nurse, and reported that the resident had fallen. The nurse and the CNA assisted in returning Resident #84 to bed. The resident said her knees were hurting and was yelling out in pain. They used a bath blanket, lifting the resident back into bed. The nurse informed her that the resident had also fallen out of bed the previous week.During a telephone interview on 06/16/26 at 8:10 A.M., Licensed Practical Nurse (LPN) #468 reported that shortly after 4:00 A.M., CNA #602 called out to her from down the hall. When she went to the room, she found Resident #84 lying directly beside the bed, with the resident's head positioned near the foot of the bed and her feet near the head of the bed. Resident #84 asked what she should do. LPN #468 stated she did not observe any bruising; the resident's knees were bent, and she complained of pain in her legs. LPN #468 explained that she checked Resident #84's vital signs and completed neurological checks while the resident was still on the floor. She then turned the resident and placed a sheet underneath her. CNA #602 held two corners of the sheet, and LPN #468 held the other two so they could lift the resident back into bed.LPN #468 reported that she then contacted the Nurse Practitioner because she believed the resident would need an Xˆray due to the leg pain. She added that the resident continued to complain of discomfort, so she administered Tylenol and noted that it was unusual for Resident #84 to report pain.During a telephone interview on 06/16/26 at 9:33 A.M., MD #720 explained that when a resident experiences a fall, the decision to move them depends on whether the clinical setting is safe. If there is any medical concern, emergency medical services (EMS) should be called.During an interview on 06/16/26 at 1:33 P.M., the Regional Director of Clinical Operations #725 and the Director of Nursing (DON) confirmed that when a resident falls and reports pain, staff should not move the resident until the physician or CNP has been notified and provides direction on how to proceed with the transfer.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and review of the facility policy, the facility failed to ensure expired medications were discarded and insulin vials were appropriately dated and discarded as appropriate. This finding affected two (Residents #4 and #19) of two residents identified during the audit of three medication administration carts. The facility census was 95.Findings include:1. Review of Resident #4's medical record revealed the resident was admitted on [DATE] with diagnoses including Parkinson's disease with dyskinesia, essential hypertension and type II diabetes mellitus without complications.Review of Resident #4's physician orders revealed an order dated 03/09/26 (discontinued 03/10/26) for Lantus long-acting insulin inject 10 units subcutaneously at bedtime for diabetes; an order dated 03/10/26 (discontinued 04/20/26) for Lantus long acting insulin inject 10 units subcutaneously at bedtime for diabetes; and an order dated 5/07/26 for Glargine Solostar (Lantus) long acting insulin inject 10 units subcutaneously at bedtime for diabetes. Notify the physician for a blood sugar less than 70 or greater than 400.Review of Resident #4's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.During observation on 06/14/26 from 1:30 P.M. to 1:36 P.M. of three medication administration carts and medication storage rooms with the Director of Nursing (DON) revealed the East Hall Long Term Medication Cart B, Resident #4's Lantus KwikPen long-acting insulin was opened and used with no open date and no expiration date.During an interview on 06/15/26 at 1:30 P.M., the DON also confirmed Resident #4 received the Lantus KwikPen long-acting insulin from the East Hall Medication Cart B which was not dated, and she was unable to determine if the insulin was expired. 2. Review of Resident #19's medical record revealed the resident was admitted on [DATE] with diagnoses including rheumatoid arthritis, essential hypertension and muscle weakness.Review of Resident #19's physician orders revealed an order dated 03/10/25 for COQ10 capsule 100 milligrams (mg) give 100 mg by mouth in the morning for supplement.Review of Resident #19's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment.During observation 06/14/26 from 1:30 P.M. to 1:36 P.M. of the South Hall Medication Cart, an over-the-counter bottle of CQ10 100 mg expired on 04/2026.During an interview on 06/14/26 at 1:36 P.M., the DON confirmed Resident #19 was the only resident who received CQ10 100 mg from the South Hall Medication Cart. Review of the Medication Storage policy, revised 08/2014, revealed medications and biologicals were stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply was accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.