STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365287	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare of Cuyahoga Falls Ctr for Rehab & Nursin	2728 Bailey Rd Cuyahoga Falls, OH 44221

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility policy the facility failed to ensure Resident #9 was treated with respect and dignity. This affected one resident (Resident #9) out of three residents reviewed for abuse prevention. The facility census was 76. Findings include: Review of Resident #9's medical record revealed an admission date of 07/26/24 and diagnoses including dementia, unspecified severity with dementia, major depressive disorder, unspecified psychosis not due to a substance or known physiological condition. Review of Resident #9's care plan dated 11/05/24 revealed Resident #9 exhibited verbal aggression, and paranoid delusions at times. Resident #9 reported everyone was talking about her and laughing at her, reported that she was being singled out and lied to, and believed people were taking her things and hiding them in her room. Resident #9 forgot where she put her things. Resident #9 would not harm self or others with daily care and activity routine through the target date of 06/25/25. Interventions included to avoid overstimulation if not tolerated by Resident #9; maintain a calm environment and consistent approach with Resident #9 as able; notify physician of new or escalated behaviors and safety concern for Resident #9 or staff; staff to observe for any activity or events that triggered Resident #9's behavior and redirect, divert attention to prevent escalation. Review of Resident #9's Quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #9 was cognitively intact. Resident #9 required supervision or touching assistance for toileting and personal hygiene. Resident #9 reported feeling down, depressed and hopeless, had a poor appetite and trouble concentrating. Review of Certified Nursing Assistant (CNA) #439's Personnel Action Form dated 02/27/25 included on 02/25/25 CNA #439 stated to a resident that a person she was afraid of was going to come and get her in the night. Trump (the president of the United States/POTUS) is going to come get you tonight. The violation was on employee code of conduct #6 for intimidating other employees, residents or families. Review of a witness statement dated 02/27/25 included Nurse #433 notified the Administrator that CNA #439 was saying things to Resident #9 causing anxiety. Resident #9 confirmed this occurred. Resident #9 stated she was afraid of the POTUS and CNA #439 kept saying the POTUS was going to get her at night. Resident #9 voiced her anxiety and fear. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #9's witness statement included when CNA #439 was caring for Resident #9 she kept making jokes about Trump coming to get me at night. CNA #439 knew Resident #9 was afraid of the POTUS, and thought it was funny. That night she could not sleep, was anxious and stayed in the common area with other aides for company and to calm her anxiety. Resident #9 did not want CNA #439 to take care of her because CNA #439 upset her on purpose and thought it was funny. Review of CNA #439's witness statement included I said Trumps coming for us, you. CNA #439 wrote it was a joke and they were laughing. Review of Nurse #433's witness statement dated 02/27/25 included on 02/25/25 CNA #439 told Resident #9 the POTUS was going to come into her room tonight and attack her. CNA #439 knew Resident #9 did not like the POTUS. The night nurse told Nurse #433 that Resident #9 sat in the common area for seven hours because she was believed the POTUS was going to come into her room to attack her. Review of Resident #9's progress notes dated 02/01/25 through 06/05/25 did not reveal evidence Resident #9 was afraid to sleep in her room during the night of 02/27/25 and stayed in the common area during the night because she was afraid the POTUS was going to come in her room and attack her. There was no documentation stating why Resident #9 was afraid to sleep in her room. Observation on 06/03/25 at 8:11 A.M. of Resident #9 revealed she was sitting on her bed in her room. Resident #9 was pleasant, alert, oriented and in no distress. Resident #9 stated she was outspoken against policies promoted by the POTUS Trump and some of the staff and residents won't talk to her because she was outspoken and she felt they were not nice to her. Resident #9 stated she did not know the names of the staff or residents who were not nice to her. Resident #9 stated she was mocked because she did not like the POTUS. Resident #9 did not indicate she felt abused and was not currently fearful at the time of the interview. Interview on 06/04/25 at 7:17 A.M. of Nurse #433 and CNA #420 revealed Resident #9 thought everyone was against her because she was against the POTUS and there was an aide who was disciplined because she said something to Resident #9 about the POTUS sneaking into her window to attack her. The night nurse told them Resident #9 stayed up all night, and sat in the common area because she was scared and would not sleep in her room. CNA #420 stated another aide heard CNA #439 tell Resident #9 that the POTUS was going to attack her, and CNA #439 admitted to him she said it. Nurse #433 stated she reported the situation because Resident #9 stayed up all night, and if it was causing her this much anxiety then it should be reported. Interview on 06/05/25 at 8:56 A.M. of the Director of Nursing (DON) revealed she had some personal issues she was dealing with and did not know a lot about the situation where CNA #439 told Resident #9 that the POTUS was going to come in her room and attack her. The DON stated she signed CNA #439's discipline form and the Administrator handled everything else, but she was on maternity leave right now and could not be contacted. The DON stated Resident #9 was anti president, had delusions about other residents trying to get her, and gets in a tizzy when the POTUS name and politics were brought up. This had been going on since before the election in 11/2024. The DON stated staff or residents bringing up politics or the POTUS triggered Resident #9, and when Resident #9 got worked up it took about a half hour to calm her down. The DON indicated the nurses and aides knew not to talk about politics, especially politics regarding the POTUS around Resident #9 because it would set her off. The DON verified the actions of CNA #439 were not respectful nor dignified treatment of Resident #9 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Resident Rights, updated 05/01/25, revealed the facility would make every effort to ensure residents were always treated with respect, kindness, and dignity. This deficiency represents non-compliance investigated under Complaint Number OH00164353 and OH00165488

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of the medical record for Resident #61 revealed a date of admission of 05/07/24 with diagnoses including chronic kidney disease, anxiety disorder, and unspecified abnormalities of gait and mobility. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment, dated 02/11/25, revealed the resident had intact cognition. The resident required supervision for activities of daily living. Observations on 06/02/25 at 9:35 A.M. noted Resident #61 lying in bed on a clearly visible fitted sheet that had multiple dry stains of various colors covering 50 percent of the sheet. Resident #61 stated staff don't change the sheets that often. A interview on 06/02/25 at 9:42 A.M. with Activity Coordinator (AC) #377 in Resident #61's room revealed AC #377 observed the stained sheets and stated the sheets were unacceptable and needed to be changed immediately. This deficiency represents non-compliance investigated under Complaint Numbers OH00165064, OH00165843, OH00164353 and OH00165488. Based on observation, interview and record review, the facility did not ensure carpeting throughout the facility was maintained in a manner to promote a clean, comfortable and homelike environment, and did not ensure Resident #61 had clean bed linens. This affected 27 residents (#1, #4, #6, #12, #14, #15, #21, #24, #26, #29, #34, #42, #49, #52, #57, #58, #59, #61, #67, #75, #136, #137, #234, #237 #238, #284, and #287) out of 76 residents reviewed for environment. The facility census was 76. Findings include: 1. Review of an email document, dated 04/18/25, provided by the Administrator revealed Procurement Specialist #601 placed an order for a [NAME] Clipper 12 Carpet Extractor machine on 04/18/25 and shipping was expected two weeks after the order had been placed. Review of invoices from a professional carpet cleaning company between the time frame between 06/02/24 and 06/02/25 revealed on 08/05/24 the facility carpets in the hallways, dining room and living room common areas had been professionally cleaned, on 09/03/24 the carpet in a currently empty resident room on the B unit had been professionally cleaned, and on 04/30/25 the carpet in Resident #70's room had been professionally cleaned to help remove the urine smell. Review of an email document, dated 08/29/24, provided by the Administrator revealed Regional Plant Maintenance Director (RPMD) #602 indicated the facility carpet was installed in the facility to allow moisture to escape from the concrete underneath the carpet, and RPMD #602 indicated a company could come to the facility to do the moisture testing in the dining areas over a six-month period to capture any moisture changes per season. If the moisture testing would come back okay, then any new flooring could be installed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation was conducted on 06/02/25 between 10:28 A.M. and 3:00 P.M. with Environmental Service Coordinator (ESC) #345 of the carpeting throughout the facility in resident common areas. The carpeting had multiple areas that would cause shoes to stick to the carpet while walking throughout the facility. ESC #345 confirmed the findings at the time of the observation. An interview on 06/02/25 at 3:14 PM with the Administrator revealed she was aware of the carpet concerns, and the facility had ordered a new carpet cleaner on 04/18/25, and it has since arrived. Prior to the new carpet cleaner arriving, the facility had a spot cleaner machine. She indicated the facility did have a couple resident rooms cleaned by a professional carpet cleaning company. The Administrator verified there was a moisture issue identified related to facility flooring by RPMD #602. Observation on 06/03/25 at 9:29 A.M. revealed Maintenance Assistant (MA) #358 was using a carpet cleaning machine to clean Residents #26 and #29's room. Interview at the time of the observation revealed MA #358 stated the carpets in the facility were disgusting and hadn't been cleaned in three and a half years. He stated the facility had recently purchased a carpet cleaner, and he was the only one who knew how to operate the machine. He stated since the carpet cleaning machine had arrived, he had been able to clean common areas and some of the residents' rooms with more serious carpet concerns. He stated there was no schedule for the cleaning of the carpets in the facility and many resident rooms and common areas still needed to be cleaned. Interview on 06/03/25 at 9:55 A.M. with Ombudsman #600 revealed there had been concerns voiced by residents and/or resident family members regarding the carpets not being clean and having a urine smell in some of the rooms. Interview on 06/04/25 at 9:55 A.M. with Housekeeper #326 revealed the carpet was always sticky and she could hear her feet sticking to the carpet as she walked on it. She stated the facility recently had purchased a new carpet cleaning machine, and there was no schedule for carpet cleaning. She stated some rooms had a urine smell since the urine smell was hard to get out of the carpet. She stated prior to the facility purchasing the new carpet cleaner, the facility had a small carpet spot cleaner which she had used a couple times if the carpet was really bad, but she didn't have the time to use the small carpet spot cleaner to routinely clean carpets in the residents' rooms. Interview on 06/04/25 at 1:33 PM ESC #345 revealed when the facility was renovated three to four years ago, the flooring provider had recommended the facility needed to be carpeted due to the moisture content coming from the foundation slab of the building. ESC #345 indicated the restrooms and the community shower rooms were the only resident areas in the facility without carpet. She stated some of the resident rooms didn't have a restroom, and the residents who resided in those rooms could either use a bedside commode sitting on the carpet or could use a community restroom. ESC #345 indicated the bedside commodes sitting on the carpet would cause the carpet to smell from spills from the bedside commode collection basin or if the residents missed the collection basin. ESC #345 stated prior to receiving the new carpet cleaner, the facility had a carpet cleaner which would put cleaning solution down but there was no way to remove the solution from the carpet so the carpets were not being adequately cleaned. ESC #345 stated the facility had a smaller spot cleaner machine, and the carpet in the resident rooms were just being spot cleaned. ESC #345 indicated there was no master schedule for when carpets were to be cleaned, and everyday housekeeping staff were spraying a deodorizing solution throughout the facility, and it was a no win situation. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation was conducted on 06/04/25 between 1:45 P.M. and 2:45 P.M. with ESC #345 of all resident rooms and common areas, and the following concerns were identified which were confirmed by ESC #345 at the time of the observations. • the carpet in front of the recliner in Resident #1's room was very sticky. • the carpet in front of the bathroom door was very sticky in the rooms of Resident #12, #67, #75, and #284. • there were sticky areas to the carpet throughout the resident rooms for Resident #6, #15, #21, #24 #26 #34, #42, #52, #57, #59 #136, and #137. • the hallway carpeting in front of the supply room on Unit A was sticky. • there was a urine odor coming from the carpet in Resident #234's room. There was a bedside commode sitting on the carpet. Interview at the time of observation with Resident #234 revealed she had seen the bedside commode drip urine on the carpet, and she had also leaked urine on the carpet and the carpet smelled like urine. • the carpet in Residents #237 and #238's room had a sticky feel throughout the room. Interview at the time of observation with Resident #237 revealed she had spilled pop and dropped sandwiches on the carpet. She said the carpet was dirty and she had never seen her carpets cleaned. • there was a strong urine smell in Resident #49's room. At the time of observation, ESC #345 stated Resident #49's urine catheter sometimes leaked onto the carpeted floor. • there was a strong urine smell coming from Resident #29's side of the room. Interview with ESC #345 stated Resident #29 will spill his urinal or urinate or defecate on the floor of his room. • (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there was a strong urine smell coming from Resident #4's room. At the time of observation ESC #345 stated Resident #4's catheter leaked. She indicated the facility had cleaned her carpet three times in the past month, and the facility was supposed to have a professional carpet cleaner come and clean her room carpet to try to rid the odor of urine. • the carpet in Residents #287 and #14's room had sticky areas throughout the room. Interview with family of Resident #287 revealed the carpets were very sticky and her shoes would stick to the carpet. • on the left side of Resident #58's bed was white spots on the carpet. At the time of observation, a family member of Resident #58 confirmed the carpet was dirty and needed to be cleaned. He indicated Resident #58 tended to drop items on the floor. An interview on 06/09/25 at 8:49 A.M. with Maintenance Coordinator (MC) 322 revealed about four years ago when the facility was being renovated, it was recommended by the flooring provider the luxury vinyl in the facility be replaced with a breathable carpet due to the concrete foundation having too much moisture. After the carpet had been placed, the facility had purchased a cleaning machine for cleaning the carpet, at the recommendation of the flooring company, which consisted of a brush that went round and round but picked up little to nothing. He stated the facility had been using the wrong cleaning machine for the carpet and had recently purchased a new carpet cleaning machine. He stated he was not aware a moisture test had ever been completed to see if different flooring could be installed. Interview on 06/12/25 at 1:45 P.M. with Regional Nurse Consultant #431 revealed she was unaware a moisture test had ever been done since the carpet had been put down and would assume if MC #322 was unaware, it hadn't been done. Review of the website for the Ohio Department of Aging located at https://aging.ohio.gov/care-and-living/ombudsman/residents-rights/nursing-home-assisted-living-rights revealed long term care residents have a right to a dignified existence which included a homelike environment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of medical record, interviews, and review of facility policy, the facility failed to ensure a member from food and nutrition services was participating in the care conferences as required. This affected one resident (#284) out of one resident reviewed for care planning. The facility census was 76. Findings include: Review of medical record for Resident #284 revealed an admission date of 03/29/25. Diagnoses included displaced fracture of shaft of ulna, displaced intertrochanteric fracture of right femur, fracture of lower end of right radius, Alzheimer's disease, and depression. Review of Resident #284 admission Minimum Data Set (MDS) 3.0 assessment, dated 04/04/25, revealed the resident was severely impaired cognitively, exhibited inattention and disorganized thinking which was present and fluctuated, required supervision for eating and oral hygiene, substantial assistance from staff for shower/bathe self, and was dependent on staff for toileting hygiene, lower body dressing, and personal hygiene. The resident required substantial assistance from staff to roll left and right was dependent on staff to transfer resident from bed/chair to chair. Walking had not been attempted and had not used a wheelchair during the assessment reference period. Further review of Resident #284's medical record revealed a facility document Initial Resident Care Conference 081519, dated 04/07/25, which indicated a care conference meeting was held on 04/07/25 at 2:15 P.M. in the resident's room with Resident #284 and her husband, Assitant Director of Nursing #410, and Former Social Service Coordinator #502. There had been no one at the meeting representing the dietary department. Interview on 06/05/25 at 3:52 P.M. with Dietitian #501 revealed she was in the facility four days a week and wasn't attending care conferences. She stated the dietary coordinator was new to the position and the prior dietary coordinator hadn't attended care conferences. She indicated she didn't fill out any information for the care conferences and was not sure how the nutrition information was being relayed to the attendees of the care conference meetings. Interviews on 06/10/25 between 08:42 AM and 11:52 AM with Social Services Coordinator #414 confirmed no one from dietary attended the conference meetings. She stated she was the person who filled out the different sections of the document Initial Resident Care Conference 081519, and would obtain the information from the resident's medical record. Interview on 06/10/25 at 10:44 A.M. with Dietary Coordinator (DC) #378 revealed she had not attended a care conference since she started. DC #378 stated she thought the dietitian was to attend care conferences, and if the dietitian couldn't attend, she would attend. Review of facility policy Care Plan Meeting, updated 05/01/25, revealed all disciplines needed to be prepared and punctual to the meeting time and place, and during each meeting, each team member would give insight into the resident assessments, achievements, goals, and needs.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility policy the facility failed to ensure all residents who are unable to carry out activity of daily living (ADL) received the necessary services by staff. This affected four residents (Resident's #4, #16 #20, and #65) out of five residents reviewed for ADLs. The facility census was 76. Findings include: 1. Review of Resident #20's medical record revealed Resident #20 was discharged from the facility on 05/15/25 and readmitted to the facility on [DATE]. Resident #20's diagnoses included chronic obstructive pulmonary disease, muscle weakness, major depressive disorder and chronic respiratory failure with hypoxia. Review of Resident #20's medical record including progress notes dated 05/23/25 through 06/12/25 did not reveal evidence Resident #20 refused showers. Review of Resident #20's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #20 was cognitively intact. Resident #20 did not reject care during the seven-day assessment look-back period. Resident #20 used a walker and a wheelchair. Resident #20 required substantial to maximal assistance for toileting hygiene and upper and lower body dressing. Resident #20 required partial to moderate assistance for the ability to get on and off a toilet or commode and bathing. Resident #20 was occasionally incontinent of urine and frequently incontinent of bowel. A bowel toileting program was not currently being used to manage Resident #20's bowel continence. Review of Resident #20's care plan dated 06/03/25 included Resident #20 had an impaired ability to perform or participate in daily ADL related to diagnoses. Resident #20 would participate with ADL's as much as possible and would remain clean, dry, comfortable and neat in appearance daily by the target date of 09/03/25. Interventions included to provide every day and as needed, or per resident preference to provide nail care, shampoo hair with showers per weekly schedule, to groom hair daily and encourage resident to participate as able. Review of the resident shower schedule for C unit revealed Resident #20 should receive showers on Wednesday and Saturday during second shift. Showers were scheduled for 05/28/25, 05/31/25, 06/04/25, 06/07/25 and 06/11/25. Review of Resident #20's shower sheets did not reveal showers were completed on 05/28/25, 05/31/25, 06/04/25, 06/07/25 and 06/11/25. Observation on 06/02/25 at 3:14 P.M. of Resident #20 revealed he was laying in bed in his room with the head of the bed elevated and was using oxygen via nasal cannula Resident #20's hair was oily and not combed. Interview on 06/09/25 at 5:45 A.M. of CNA #394 revealed Resident #20 had not received a shower since he was admitted to the facility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/09/25 at 1:57 P.M. of Resident #20 revealed they ask if I want a shower, I say yes, they say okay and then they do not come back. I have not had a shower since i was admitted . Resident #20's hair was not oily and not combed. Interview on 06/10/25 at 12:32 P.M. of CNA #420 revealed he was walking hurriedly through the hall to assist a resident. CNA #420 stated he typically worked second shift, often he was the only aide on the unit and he had not given Resident #20 a shower since he was admitted . CNA #420 stated it was hard to get to the showers when there was only one aide on the unit. CNA #420 stated the aide documentation looked like he gave showers, but he charted incorrectly, and confirmed again he did not give Resident #20 a shower. Interview on 06/12/25 at 11:24 A.M. of the DON revealed the DON stated she had been in the role of DON, Human Resources Director and Scheduler since 03/2025. The DON stated typically residents who did not receive showers would be identified during morning clinical meetings, and she would follow up with the staff that day to ensure they were completed. The DON indicated she was so busy being the DON, Human Resource Director and Scheduler she didn't have time to follow up to ensure showers were being completed as scheduled. Interview on 06/12/25 at 10:10 A.M. of Regional Nurse Consultant (RNC) confirmed the missing shower sheets and confirmed there was no proof Resident #20 was offered showers on other days. Review of the facility policy titled Shower Tub Bath updated 05/01/25 included it was the facility policy to promote resident hygiene by offering and assisting residents with bathing per their plan of care. Document completion of services in the clinical record. Document refusals of care in the clinical record. 2. Review of Resident #4's medical record revealed an admission date of 04/18/24 and diagnoses included flaccid hemiplegia affecting the left dominant side, vascular dementia, unspecified severity without behavioral disturbance, psychotic disturbance, or mood disturbance, bipolar disorder and obstructive and reflux uropathy and urine retention. Review of Resident #4's Annual MDS 3.0 assessment dated [DATE] revealed Resident #4 had moderate cognitive impairment. Resident #4 was dependent for toileting hygiene, lower body dressing and putting on and taking off footwear. Resident #4 required partial to moderate assistance for the ability roll from lying on the back to left and right side and return to lying on back on bed. Review of Resident #4's care plan dated 01/22/25 included Resident #4 had an impaired ability to perform or participate in daily ADL (Activity of Daily Living) care related to diagnoses. Resident #20 would participate with ADL's as much as possible and would remain clean, dry, comfortable and neat in appearance daily by the target date of 09/03/25. Interventions included to assist with toileting if needed, provide incontinence care as needed and apply moisture barrier cream after each incontinent episode. Review of Resident #4's progress notes dated 05/08/25 through 06/09/25 did not reveal evidence Resident #4 refused incontinence care. (continued on next page)

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Altercare of Cuyahoga Falls Ctr for Rehab & Nursin	2728 Bailey Rd Cuyahoga Falls, OH 44221

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #4's aide charting revealed Resident #4 was incontinent of bowel on 06/08/25 at 8:03 P. M. There was no additional documentation of bowel incontinence until CNA #367 documented on 06/09/25 at 3:14 A.M. that Resident #4 was incontinent of bowel. Interview on 06/02/25 at 2:41 P.M. with Resident #4 revealed Resident #4 stated the residents at the facility were not taken care of, and the aides laughing among themselves and do not pay attention to us. Observation on 06/09/25 at 5:10 A.M. with Certified Nursing Assistant (CNA) #394 of Resident #4's incontinence care revealed a large amount of black tarry feces on her bed linens and incontinence brief. CNA #394 stated Resident #4 was not cleaned properly from her last bowel movement, it went everywhere and now Resident #4 needed an entire bed change. CNA #394 stated this was the first time she changed Resident #4 since she arrived for work at 10:30 P.M., she checked her every two hours but this was the first time she needed changed. Resident #4 stated she was last changed around 9:00 P.M. on 06/08/25, and was waiting since 3:00 A.M. to be changed. Interview on 06/09/25 at 6:00 A.M. with CNA #367 revealed when asked if Resident #4 was incontinent of bowl on 06/09/25 at 3:14 A.M. CNA #367 responded with a yes, but did not verify he changed her incontinence brief at that time. Interview on 06/09/25 at 10:00 A.M. of the DON confirmed incontinent residents should be checked and changed every two hours or as needed. Review of the facility policy titled Perineal Care updated 05/01/25 included it was the facility policy to provide perineal care to residents in order to promote cleanliness, comfort, and reduce the risk of infections and promote skin integrity. 3. Review of Resident #65's medical record revealed an admission date of 10/19/24 and diagnoses included cerebral infarction, dysphagia following cerebral infarction, unspecified dementia with other behavioral disturbance, and anxiety disorder. Review of Resident #65's care plan dated 03/18/25 revealed Resident #65 had impaired ability to perform ADLs due to dementia and stroke. Interventions included to provide assistance with all ADLs. The care plan also indicated a date of 01/23/25 to include Resident #65 had the potential for swallowing problems related to dysphagia. Resident #65 would not choke or aspirate food, liquids. Interventions included to observe resident closely for signs of difficulty swallowing and, or aspiration, and aid in maintenance of proper body alignment and posture. Review of Resident #65's Quarterly MDS 3.0 assessment dated [DATE] revealed Resident #65 had moderate cognitive impairment. Resident #65 required supervision or touching assistance when eating. Resident #65 was dependent for toileting hygiene, bathing and lower body dressing. Resident #65 required substantial to maximal assistance for the ability to roll left and right. The ability to move from lying on the back to sitting on the side of the bed and with no back support was not attempted and Resident #65 did not perform this activity prior to the current illness, exacerbation or injury. Resident #65 was always incontinent of urine and bowel. Resident #65 did not reject care during the seven-day assessment look-back period. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #65's Occupational Therapy Treatment Encounter Notes, dated 06/04/25, revealed Resident #65 was observed at bed level and was leaning heavily to the right side with concerns for safety. Resident #65 required maximum assistance to reposition to center of bed. A positioning wedge was provided to Resident #65's right side, under her shoulder and the bed sheet to assist in maintaining safe positioning for self feeding and overall safety while at bed level. Resident #65 had increased confusion and decreased judgement requiring encouragement and education in importance of safe positioning. Review of Resident #65's Occupational Therapy Treatment Encounter Notes dated 06/05/25 included Resident #65 was observed at bed level with her bedside table pushed back to the wall out of her reach. Resident #65 remained at midline with foam wedge in place on her right side and Resident #65 displayed improved positioning with the use of the wedge. Nursing education provided on the importance of positioning for safety with use of the wedge. Resident #65 expressed comfort with positioning. Observation on 06/03/25 at 7:57 A.M. of Resident #65 revealed she was in bed and there were no staff members in the room. Resident #65's head of the bed was raised about 30 degrees, she was laying back and slumped to the right side and was leaning against the bed rails. Her bare arm was directly against the bed rails and no pillows or foam wedge were positioned to help her stay upright in the bed. Resident #65's breakfast tray was on a bedside table positioned over the bed and was about twelve inches above what would be a comfortable height for her to eat. Resident #65 had to raise her arm while slumped to the right to reach her food. Resident #65 stated she was not really comfortable and her right arm kept hitting the railing. Resident #65 indicated she could barely use her left arm due to her stroke and observation revealed she was struggling to open packets of condiments. There was dried food on her hospital type gown and dried pieces of food was seen on the floor. The floor was carpeted and very sticky. Resident #65 stated she dropped her dinner meal on the floor yesterday and that was why so much food could be seen on the floor. Resident #65 stated no one brought her a new dinner tray or cleaned up from the tray that spilled and she did not have a dinner to eat. Social Services Designee (SSD) #414 walked in the room pushing a sweeper and confirmed Resident #65's floor was covered in pieces of food and the floor was sticky. SSD #414 stated she was also a Certified Nursing Assistant, but she did not assist Resident #65 to sit up and position her properly for her meal. SSD #414 stated she already positioned her when she brought her tray, and she slid right back to the right side and it would not do any good to put her upright because she would just slide right again. SSD #414 swept the room and left without helping Resident #65 to properly position while she ate. Resident #65 stated if staff helped position her in a sitting position and upright as soon as they left she slid right back to the right side of the bed against the bed rail and that was how she would have to try to eat her meal. Resident #65 stated staff did not use pillows or foam to help her sit up in an upright position and keep her from sliding to the right side of the bed next to the railing. Interview on 06/03/25 at 8:09 A.M. of Nurse #320 confirmed Resident #65 was in bed, was almost laying down and slumped to the right side of the bed and her arm was hitting the bed rail. Nurse #320 stated that is what she does. When asked by the surveyor if a slumped position was appropriate for Resident #65, Nurse #320 found an aide and Resident #65 was placed in an upright position and not slumped to the right side of the bed. Observation on 06/09/25 at 8:25 A.M. of Resident #65 revealed she was in bed, the head of the bed was elevated, and Resident #65 was sitting upright and positioned with a foam wedge to keep her from sliding to the right side of the bed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/09/25 at 8:53 A.M. of Nurse #320 revealed when asked about Resident #65's foam wedge Nurse #320 stated she did not know Resident #65 had a foam wedge to help with positioning but she was glad someone put it there. Nurse #320 stated after she talked to the surveyor on 06/03/25 the nursing management staff asked her what was brought up and what the surveyor wanted. Nurse #320 stated she told them what was talked about and Assistant Director of Nursing (ADON) #410 might have gotten an order for the foam wedge. Interview on 06/09/25 at 10:13 A.M. of Director of Rehab (DOR) #726 and Occupational Therapist (OT) #548 revealed therapy recently received a referral from Regional Nurse Consultant's (RNC) #431 and #547 for Resident #65's positioning. DOR #726 stated she put a foam wedge under her right side and it was keeping Resident #65 from sliding to the right. DOR #726 stated she was waiting to make sure it was going to work before she got a physician order. OT #548 stated Resident #65 was afraid of falling off the bed because she had no control. Interview on 06/09/25 at 2:45 P.M. of DOR #726 revealed Resident #65 was sitting at midline using the foam wedge and it was working really well. DOR #726 stated she asked Nurse #320 to get an order for the wedge. Resident #65 told her she was comfortable and not afraid of falling anymore. , 4. Review of the medical record for Resident #16 revealed an admission date of 03/15/19. Pertinent diagnoses included hemiplegia and hemiparesis following a cerebral infarction (stroke), anxiety, major depression, contracture left hand, and difficulty in walking. Review of care plan, dated 10/08/21, revealed Resident #16 had impaired ability to perform or participate in daily activity of daily living care related to history of cerebral infarction with left hand side hemiplegia, left hand contracture, weakness, debility, anemia, and osteoarthritis. Interventions included staff to provide nail care and shampoo hair with showers weekly schedule, groom hair daily and encourage resident to participate as able, provide/assist with morning and evening care, encourage resident to participate with hygiene as tolerated; and assist with and/or shave facial hair daily or per resident preference. Interview on 06/02/25 at 11:10 A.M. with Resident #16 revealed the resident wasn't receiving showers. She indicated when it is her shower day, the staff would tell her they didn't have the staff to give her a shower. Review of shower schedule for Resident #16 revealed the resident was to receive a shower Wednesday and Saturdays during day shift. Interview on 06/05/25 at 9:17 A.M. with Resident #16 revealed she should have had a shower the day before but hadn't received a shower. She stated she couldn't remember the last time she had a shower. She stated the day before she had pressed her call light to remind the staff it was her shower day, and when the staff member answered the call light, the resident reminded the staff member it was her shower day, the staff member said nothing and left. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/05/25 at 10:27 A.M. with Aide in Training #330 revealed she had worked on 06/04/25 and confirmed Resident #16 should have had a shower on day shift. She stated Resident #16 had told her she wanted a shower on 06/04/25 , however, Aide In Training #330 indicated she was unable give Resident #16 her shower since she was on the floor by herself most of the shift. She indicated when there was only one aide on the floor, she couldn't get showers completed, and if she was able to bath a resident, it was a bed bath. Review of shower sheets for Resident #16 between 05/05/25 and 06/12/25 revealed there were four completed shower sheets dated 05/17/25, 05/21/25, 05/24/25, and 06/11/25. There was no proof showers had been offered/given on 05/07/25, 05/10/25, 05/14/25, 05/28/25, 05/31/25, 06/04/25, and 06/07/25. Interview on 06/12/25 at 10:10 A.M. with Regional Nurse Consultant #431 confirmed the missing shower sheets and confirmed there was no proof Resident #16 had been offered to be bathed or had been bathed on those days with the missing shower sheets. Interview on 06/12/25 at 11:24 A.M. with the Director of Nursing (DON) revealed she had been filling in as Human Resources/Scheduler in addition to being a DON since March of 2025. She stated normally she would follow up with residents who missed their showers during clinical meetings to ensure they were completed the next day, but she indicated with her being so busy completing tasks for Human Resource/Scheduler/DON she hadn't had time to follow up to ensure showers were being completed as scheduled. Review of facility policy and procedure Shower-Tub Bath, updated 05/01/25, revealed it was the facility's policy to promote resident hygiene by offering and assisting residents with bathing per their plan of care, and the procedure was to document completion of shower/bath along with refusals in the clinical record. This deficiency represents non-compliance investigated under Complaint Number OH00165843, OH00165648, OH00165488, OH00165497, OH00164353, and OH00166251.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4.Review of the medical record for Resident #284 revealed an admission date of 08/06/23. Resident #284 was discharged on 05/22/25. Diagnoses included peripheral vascular disease, hypertension, type two diabetes, obstructive pulmonary disease, anxiety, and acute osteomyelitis. Review of the comprehensive MDS 3.0 assessment, dated 02/21/25, revealed the resident had intact cognition. The resident was dependent for activities of daily living. Review of the Medication Administration Records (MAR) for Resident #284 revealed Resident #284 was ordered fluticasone propion-salmeterol inhaler dated 08/06/23 twice a day. Further review noted the inhaler was not available on 04/18/25, 04/20/25, 04/21/25 and 04/22/25. Interview on 06/09/25 at 1:40 P.M., the Regional Nurse Consultant (RNC) #431 provided pharmacy documentation indicating facility staff called in a refill on 04/21/25. The inhaler was delivered to the facility on the evening of 04/21/25 but was not administered until 04/23/25. RNC #431 stated I have no good answer as to why it took staff so long to reorder the inhaler or administer the medication after it was delivered. This deficiency represents non-compliance investigated under Complaint Number OH00164001, OH00165488, OH00165648 Based on observation, interview, record review and review of the facility policy the facility failed to ensure lab results were timely reported to the physician for Resident #20, Resident #82 had a comprehensive assessment upon admission to the facility, Resident #234's appointment was scheduled timely, and Resident #284's medications were available for administration. This affected one resident(Resident #284) of seven residents reviewed for medications, one resident (Resident #20) out of three reviewed for reporting lab results, one resident (Resident #82) out of three residents reviewed for comprehensive admission assessments, and one resident (Resident #234) of one resident for scheduling appointments timely. The facility census was 76. Findings include: 1. Review of Resident #20's medical record revealed Resident #20 was discharged from the facility on 05/15/25 and readmitted to the facility on [DATE]. Resident #20's diagnoses included chronic obstructive pulmonary disease, muscle weakness, major depressive disorder and chronic respiratory failure with hypoxia. Review of Resident #20's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was cognitively intact. Resident #20 did not reject care during the seven-day assessment look-back period. Resident #20 used a walker and a wheelchair. Resident #20 required substantial to maximal assistance for toileting hygiene and upper and lower body dressing. Resident #20 required partial to moderate assistance for the ability to get on and off a toilet or commode. Resident #20 was occasionally incontinent of urine and frequently incontinent of bowel. A bowel toileting program was not currently being used to manage Resident #20's bowel continence. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #20's care plan dated 06/02/25 included Resident #20 was at risk for bruising, bleeding related to the use of anticoagulant medication. Resident #20 would have no signs and symptoms of bruising, bleeding daily by the target date of 09/02/25. Interventions included to administer medication per physician order and to report any adverse side effects; obtain and report lab work per physician order. Review of Resident #20's physician orders dated 05/28/25 revealed Protime and INR every week on Tuesday. Review of Resident #20's medical record including progress notes dated 06/02/25 through 06/11/25 did not reveal evidence Resident #20's INR result of 3.9 was reported to the physician. Review of Resident #20's INR results dated 06/03/25 included the specimen was collected on 06/03/25 at 6:52 A.M. and reported on 06/03/25 at 3:41 P.M. Resident #20's INR was 3.9 (normal range was 0.9 to1.2) and his Protime was 38.5 (normal range was 9.8 to 12.2 sec). Standard anticoagulant was 2.0 to 3.0 INR and aggressive anticoagulant was 2.5 to 3.5 INR. There was no evidence in Resident #20's medical record these results were reported to Resident #20's physician. Review of Resident #20's physician progress notes dated 06/09/25 included on 06/03/25 a finalized INR of 3. 9 was not reported to the team. Resident #20 was currently on warfarin 1 mg on Monday and 2 mg for the remainder of the week for history of DVT (deep vein thrombosis). Interview on 06/11/25 at 10:22 A.M. of Physician #437 and Licensed Practical Nurse (LPN) #438 confirmed they were not notified on 06/03/25 of Resident #20's INR of 3.9. LPN #438 and Physician #437 indicated there was no on-call note or day shift note on 06/02/25 or 06/03/25 about Resident #20's INR of 3.9. Physician #437 stated if he was notified he would have held Resident #20's warfarin for 48 hours then recheck his INR. Interview on 06/13/25 at 4:00 P.M. of the Director of Nursing (DON) revealed she thought Resident #20's INR of 3.9 which was collected and reported on 06/03/25 was reported to Physician #437 and she would check with him. No additional information was received from the DON. Review of the facility policy titled Anticoagulation Clinical Protocol undated included Coumadin usage possessed the highest risk for adverse reaction to residents, therefore strict monitoring of the medication and side effects was required. Report associated lab work promptly to physician. 2. Review of Resident #82's closed medical record revealed an admission date of 03/14/25 and diagnoses included metabolic encephalopathy, acute respiratory failure, cerebral infarction due to embolism of the right anterior cerebral artery and osteomyelitis of vertebra. Resident #82 was discharged from the facility on 03/15/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #82's Clinical admission assessment dated [DATE] at 5:07 P.M. included Resident #82 was admitted for osteomyelitis of vertebra. Resident #82 was admitted from a hospital. Resident #82's short and long term memory were impaired and Resident #82 was alert and oriented to self. Resident #82 was disoriented times two. Resident #82 was incontinent of bowel and bladder. Administer and monitor enteral feedings as per order, report concerns with placement, tolerance, site complications to physician and, or Nurse Practitioner. Tube feeding as per order. Monitor, check, validate placement before any formula or fluids. Report residuals per order. There were no vital signs documented. There were no notes pertaining to Resident #82's feeding (PEG) tube, what the insertion site looked like, and if it was patent. Review of Resident #82's medical record dated 03/14/25 through 03/15/25 including vitals, progress notes, Medication Administration Record and Treatment Administration Record did not reveal evidence vital signs were checked and recorded. Further review did not reveal evidence Resident #82's feeding (PEG (percutaneous endoscopic gastrostomy tube) was checked for patency until 03/15/25 at 12:33 A.M. when it was determined the PEG tube was unable to be accessed and Resident #82 was sent to the emergency room for evaluation and treatment. Review of Resident #82's progress notes dated 03/15/25 at 12:33 A.M. included the nurse was unable to access Resident #82's PEG tube. Call placed to the on call Nurse Practitioner and notified her of being unable to access Resident #82's PEG tube. A new order was received to send Resident #82 to the emergency room for evaluation and treatment. Review of Resident #82's Hospital Observation assessment dated [DATE] at 2:03 A.M. revealed it was not recorded until 03/17/25 at 1:52 P.M. or completed until 03/18/25 at 8:26 P.M. which was over three days after Resident #82 was transported to the hospital. The form stated Resident #82 was sent to the hospital for a PEG tube replacement. Interview on 06/10/25 at 2:22 P.M. with the Director of Nursing (DON) confirmed there were no vital signs documented from the time of Resident #82's admission until he was transported to the hospital on [DATE] at 2:03 A.M. Interview on 06/10/25 at 4:03 P.M. with Physician #553 revealed she was not familiar with Resident #82 but it would be expected as part of Resident #82's Clinical admission assessment that his PEG tube would be checked for patency and if it was unable to be flushed or there were other issues then either the Nurse Practitioner or Physician #553 should be called. Interview on 06/11/25 at 11:31 A.M. with Nurse #554 revealed she did not arrive for work on 03/14/25 until 6:30 P.M. Nurse #554 stated when she received report on Resident #82 she did not remember the day shift nurse telling her anything about Resident #82's PEG tube. Nurse #554 indicated Resident #82 had alot going on and was really sick. Nurse #554 stated she did not try to access Resident #82's PEG tube until later in the evening and when she checked it she realized the facility did not have to correct supplies to access the PEG tube and that was when she called the on call Nurse Practitioner. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/11/25 at 11:54 A.M. with the Director of Nursing revealed when Resident #82 was admitted his PEG tube site should have been evaluated for things like excoriation, drainage and should be documented on the Clinical admission assessment. Resident #84's PEG tube should have been evaluated for patency within three hours. The DON confirmed Resident #82's Clinical admission assessment did not reveal evidence Resident #82's PEG tube site was checked for excoriation, drainage or Resident #82's PEG tube was checked for patency and flushed within three hours. Interview on 06/12/25 at 11:29 A.M. with the DON confirmed Resident #82 was transported to the hospital on [DATE] at 2:03 A.M. but his Hospital Observation assessment was not completed until 03/18/25 at 8:26 P.M. The DON stated Nurse #554 did not complete Resident #82's Hospital Observation assesssment on 03/15/25 when he was transported to the hospital and it should have been completed at that time. The DON stated it was brought to her attention the form needed completed and that was why it was not finished until 03/18/25. The DON stated she called Nurse #554 regarding the vital signs and Nurse #554 still had the paper she wrote Resident #82's vital signs on when she sent him to the hospital. Review of the facility policy titled Resident Rights updated 05/01/25 included it was the facility policy that employees should treat all residents with kindness, respect, dignity and health equity. Health equity referred to the attainment of the highest level of health for all people. 3. Review of Resident #234's medical record revealed an admission date of 05/08/25 and diagnoses included candidiasis of skin and nail, erythema intertrigo, and type two diabetes mellitus with diabetic polyneuropathy. Review of Resident #234's admission MDS assessment dated [DATE] included Resident #234 was cognitively intact. Resident #234 did not reject care during the seven-day assessment look-back period. Resident #234 required partial to moderate assistance with bathing, toileting hygiene and personal hygiene. Resident #234 was occasionally incontinent of urine and frequently incontinent of bowel. Review of Resident #234's care plan dated 05/21/25 included Resident #234 had the potential for alteration in comfort related to chronic pain, skin candidiasis, erythema intertigo and decreased mobility. Resident #234 would show evidence of relief from episodes of pain as evidenced by no episodes of breakthrough pain, voiced feelings of comfort with care and routine, would have normal sleep patterns and pain would not interfere with daily routine. Interventions included to assist Resident #234 to maintain the most comfortable conditions, educate and work with direct care staff to promote resident comfort during care, to assess pain for possible cause, location, duration. Review of Resident #234's physician orders dated 05/29/25 revealed refer to [NAME] dermatology. Discontinue when appointment was made. Review of Resident #234's medical record including physician orders, progress notes dated 05/29/25 through 06/11/25 did not reveal evidence an attempt was made to schedule Resident #234's dermatology appointment. Observation on 06/02/25 at 1:45 P.M. of Resident #234 revealed she had a bad yeast infection. Observation of Resident #234 revealed she had large areas of red and raw looking areas under her breasts, abdominal folds in the bilateral groin area, buttock area, under her arms and perineal area. Resident #234 stated the yeast infection was on her body for a long time. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare of Cuyahoga Falls Ctr for Rehab & Nursin	2728 Bailey Rd Cuyahoga Falls, OH 44221

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/10/25 at 4:14 P.M. with Assistant Director of Nursing (ADON) #410 revealed she was the wound nurse for the facility. ADON #410 stated Resident #234 was admitted with a widespread fungal infection on her body. ADON #410 stated Resident #234 had an order for a dermatology appointment, the appointment had not been scheduled yet and she would have Nurse #391 call to schedule the appointment. Observation on 06/10/25 at 4:19 P.M. of Resident #234's with ADON #410 revealed ADON #410 stated it still looks very red and irritated, but it was better than when she was admitted to the facility. Interview on 06/11/25 at 2:13 P.M. with ADON #555 revealed she just made Resident #234's appointment. ADON #555 stated she reached out today and was able to make the appointment. Review of Resident #234's physician orders dated 06/11/25 revealed a dermatology appointment was scheduled for 09/10/25 at 9:00 A.M. The order was written to schedule the appointment on 05/29/25 which was 13 days ago.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility policy the facility failed to ensure Resident #32's care planned interventions were implemented and physician orders were followed for passive range of motion exercises. This affected one resident (Resident #32) out of three residents reviewed for restorative services. The facility census was 76. Findings include: Review of Resident #32's medical record revealed an admission date of 02/25/19 and a readmission date of 12/19/24. Diagnoses included quadriplegia, muscle weakness, major depressive disorder and contractures of right and left hands. Review of Resident #32's Annual Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #32 was cognitively intact. Resident #32 was dependent for all Activity of Daily Living (ADL) and mobility. Resident #32 used a motorized wheelchair. Review of Resident #32's care plan dated 07/11/19 included Resident #32 needed a restorative passive range of motion program related to paraplegia and muscle weakness. Resident #32 would show no further decline in range of motion to his bilateral upper extremities (BUE) by the target date of 08/01/25. Interventions included at least 15 minutes per day of a restorative PROM (passive range of motion) program; encourage Resident #32 to do 20 sets of repetitions; if Resident #32 refused to participate approach at a later time and report to the nurse. Review of Resident #32's physician orders dated 04/01/25 revealed restorative, encourage and assist with PROM to BUE and BLE (bilateral lower), 15 reps times two sets for 15 minutes, four to seven times per week as tolerated, twice a day. Review of Resident #32's progress notes dated 05/01/25 through 06/09/25 did not reveal evidence Resident #32 refused to have PROM completed as ordered. Review of Resident #32's aide charting for passive range of motion dated 05/01/25 through 06/09/25 revealed there was no evidence passive range of motion was done two times a day as ordered on 05/01/25, 05/02/25, 05/04/25, 05/09/25, 05/13/25, 05/15/25, 05/16/25, 05/24/25, 05/26/25, 05/29/25, 05/30/25, 06/05/25, 06/07/25, 06/08/25. Review of Resident #32's aide charting for passive range of motion revealed on 05/05/25, 05/06/25, 05/07/25, 05/08/25, 05/10/25, 05/11/25, 05/12/25, 05/14/25, 05/17/25, 05/18/25, 05/19/25, 05/21/25, 05/22/25, 05/23/25, 05/27/25, 05/28/25, 05/31/25, 06/01/25, 06/02/25, 06/03/25, 06/04/25, 06/06/25, 06/09/25 one session was completed but there was no evidence passive range of motion was completed one additional time a day as ordered. Review of Resident #32's aide charting revealed only two days (05/20/25 and 05/25/25) where Resident #32's PROM was completed two times a day per physician orders. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #32's aide charting dated 05/01/25 through 06/09/25 revealed on the days Resident #32 refused his passive range of motion there was no evidence a follow up attempt was made to complete it as ordered (except on 05/04/25 two attempts were made and refused). Observation on 06/09/25 at 10:29 A.M. of Resident #32 revealed he was lying in bed and Certified Nursing Assistant (CNA) #435 was completing his morning care. Resident #32 stated the nursing staff spent too much time socializing and not enough time taking care of the residents. Resident #32 stated often his range of motion to his hands was not completed and he did not refuse to have it done. Resident #32 stated to check what the aide charting had documented about his range of motion and the surveyor would be able to tell it was not done as often as was ordered. CNA #435 stated she could tell Resident #32's range of motion was not being done because he was limited in how much she was able to do. CNA #435 showed the surveyor how Resident #32 did not have the range of motion he should have due to it was not being done as ordered. Observation on 06/10/25 at 2:03 P.M. of CNA #420 revealed CNA #420 was walking very fast in the hall, breathing fast and with a harried look on his face. CNA #420 said he was really busy today, did not have time for a break or lunch, and was running around like a chicken. CNA #420 stated he was able to complete Resident #32's range of motion to his upper extremities today, but there were definitely days he was not able to complete it because he was too busy and there was not enough staff. CNA #420 stated if there were days it was not documented it was most likely not done. CNA #420 stated one reason he was so busy was because for two to three hours he was the only aide on the nursing unit because the second aide assigned went with a resident to an appointment and did not get back until 12:15 P.M. or so. Interview on 06/13/25 at 4:00 P.M. of the Director of Nursing revealed when told Resident #32 did not have PROM for his BUE and BLE per physician orders the DON stated Resident #32 refused his care at times and was care planned for it. Review of the facility policy titled Restorative Nursing Care undated included Restorative programs were nursing programs and did not include procedures or techniques carried out by or under the direction of qualified therapists. A Registered Nurse would complete an assessment of the resident and determine if the resident would benefit from a Restorative program. Findings would be documented in the clinical record. Restorative programs included assisting residents with their range of motion exercises. The Restorative program would typically be delivered up to seven days per week by nursing staff and documented in the clinical record.

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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 record review, interview and review of facility policy, the facility did not ensure post-fall investigations were accurate and complete to mitigate risk of future accidents for Resident #3. This affected one resident (#3) of six residents reviewed for accidents. The facility census was 76. Findings include: Review of the medical record revealed Resident #3 was admitted [DATE] with diagnoses including multiple sclerosis, muscle weakness, and type II diabetes. Review of the Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #3 had a moderate cognitive impairment and required supervision with dressing, sit to lying, and sit to standing and independent with chair/bed-to-chair transfers. Review of the care plan revealed Resident #3 was at risk for falls or injury due to a diagnosis of multiple sclerosis. Interventions included bilateral assist bars to aid bed mobility and promote independence and encouraging Resident #3 to use call light for transfers and ambulation. Resident #3 was also care planned for non-adherence to care and services. Review of the progress notes revealed a note recorded as a late entry on 05/30/25 at 1:50 P.M. which stated Resident #3 suffered a fall on 05/27/25 that was witnessed by Registered Nurse (RN) #417. RN #417 noted Resident #3 lost her balance and slid to the floor. Resident #3 denied any pain or injury and RN #417 notified the on-call nurse practitioner (NP). Review of the incident log confirmed the fall occurred on 05/27/25 and that Resident #3 had not suffered any other falls since admission. Review of the fall investigation report revealed it was created on 05/30/25 at 1:52 P.M. with the event date as 05/27/25 at 7:30 A.M. The fall occurred in Resident #3's room and Resident #3 had been lying in bed prior to falling. The fall was witnessed, and adaptive equipment was not in use at the time of the fall. The response included completing a post fall assessment and implementing call don't fall for safety. Further review of the fall investigation revealed there was one witness statement dated 05/27/25 at 7:30 A.M. provided by RN #417. The witness statement indicated Resident #3 was observed transferring from the bed to wheelchair, lost her balance, and slid to the floor. Resident #3 sat on the floor with her legs extended and upon assessment, Resident #3 denied any pain and no injuries were noted. RN #417 assisted Resident #3 back to bed and educated Resident #3 on using call button to ask for help prior to transferring from bed to chair. No additional witnesses to the fall identified. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/04/25 at 2:13 PM with Resident #3 revealed she remembered falling, her door was closed at the time of the fall and no staff were present at the time of the fall. Resident #3 reported she did not use her call button and opted to wait on the floor for staff to find her which took about 10 minutes. Resident #3 reported she was found by the Certified Nursing Assistant (CNA) assigned to the unit. Resident #3 was assisted back in bed by two or three staff members. Resident #3 denied any pain or injuries following the fall. Interview on 06/04/25 at 3:33 P.M. with RN #417 revealed Resident #3's door was open, and RN #417 witnessed the fall out of his peripheral vision while standing in the hallway near the medication room. RN #417 sought out the assistance of a CNA to assist with getting Resident #3 off the floor and back in bed but was unable to recall which CNA assisted. Interview on 06/05/24 at 8:43 A.M. with CNA #347 revealed she was present on the unit when Resident #3 fell on [DATE]. CNA #347 reported she went to Resident #3's room to check on her and found the resident sitting on the floor with her legs extended. CNA #347 left Resident #3's room to get RN #417 to assist. CNA #347 reported Resident #3's door was closed prior to entering per resident preference and that the fall was unwitnessed. CNA #347 confirmed she did not provide a witness statement for the fall investigation. Review of the Fall Risk Management Policy updated 05/01/25 revealed the facility was to obtain statements from staff members, other residents, and visitors who witnessed or were in the area of the incident. This deficiency represents non-compliance investigated under Complaint Number OH00163696 and OH00166268.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility policy the facility failed to provide scheduled toileting to promote continence for Resident #20 and failed to ensure Resident #4's received the appropriate care and services to prevent and treat a urinary tract infection (UTI). This affected two resident's (Resident's #4 and #20) out of three reviewed for bowel and bladder. The facility census was 76. Findings include: 1. Review of Resident #20's medical record revealed Resident #20 was discharged from the facility on 05/15/25 and readmitted to the facility on [DATE]. Resident #20's diagnoses included chronic obstructive pulmonary disease, muscle weakness, major depressive disorder and chronic respiratory failure with hypoxia. Review of progress notes for Resident #20 dated 05/23/25 through 06/11/25 did not reveal evidence Resident #20 refused to be assisted to the bathroom for toileting. Review of Resident #20's medical record dated 05/23/25 through 06/13/25 did not reveal evidence a Clinical admission assessment was completed to identify bowel and bladder needs. Review of Resident #20's physician orders dated 05/28/25 revealed prompted toileting: offer and encourage the resident to toilet upon rising, before meals and at bedtime. Review of Resident #20's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #20 was cognitively intact. Resident #20 did not reject care during the seven-day assessment look-back period. Resident #20 used a walker and a wheelchair. Resident #20 required substantial to maximal assistance for toileting hygiene and upper and lower body dressing. Resident #20 required partial to moderate assistance for the ability to get on and off a toilet or commode. Resident #20 was occasionally incontinent of urine and frequently incontinent of bowel. A bowel toileting program was not currently being used to manage Resident #20's bowel continence. Review of Resident #20's care plan dated 05/30/25 included Resident #20 was incontinent of bowel per tracking, assessment and was a candidate for a prompted bowel program. Resident #20 would reduce incontinent episodes to zero to one episode weekly by the next review date of 08/30/25. Interventions included to document restorative participation on restorative delivery record per program; encourage Resident #20 to ask staff for help or make staff aware of the need to toilet between identified times; explain program to Resident #20 as able before beginning and give positive feedback and praise Resident #20 for participating in the program; if unable to use the bathroom use a bedside commode to promote bowel movements per program safely; provide physical support, assistance for toileting safety as indicated for resident. Observation on 06/02/25 at 3:14 P.M. of Resident #20 revealed he was alert, oriented and was laying in bed in his room with the head of the bed elevated and was using oxygen via nasal cannula A wheelchair was placed by the side of his bed, there was no bedside commode in the room and Resident #20's room did not have a bathroom. A bedpan was noted under the bed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/02/25 at 3:14 P.M. with Resident #20 revealed he had to wait an hour or two to get changed when he had a bowel movement. Resident #20 stated he put his light on for help and would loudly scream when the call light was not answered to get a staff person in the room to help him. Resident #20 stated there was no bathroom in his room, no bedside commode and they put a brief on me because the bathroom was way down hall, and they don't want to mess with taking me to the bathroom. If I went home today I could use the bathroom and I know when I have to go. Observation on 06/05/25 at 1:15 P.M. of Certified Nursing Assistant (CNA) #342 revealed she was walking very quickly down the hall and was carrying one wet washcloth which was folded and laying on top of one towel and one incontinence brief. CNA #342 had a harried, flustered look on her face. When asked where she was going she said she was going to provide Resident #20's incontinence care. CNA #342 entered Resident #20's room and a urinal with about 200 cc of urine was noted sitting on his bedside table. CNA #342 proceeded to provide Resident #20's incontinence care and when his incontinence brief was removed a large brown, formed bowel movement was in the brief. When asked if Resident #20 was assisted to the community bathroom CNA #342 stated she never assisted Resident #20 to the community bathroom, because he was a check and change and had always been a check and change. CNA #342 stated she had not encouraged Resident #20 to use the community bathroom or asked Resident #20 if he wanted to use the bathroom down the hall. CNA #342 stated Resident #20 was not on a schedule to use the bathroom and verified there was no bedside commode or bathroom in his room. CNA #342 finished Resident #20's incontinence care and left the room without emptying the urinal. Interview on 06/05/25 at 1:59 P.M. of Director of Rehab (DOR) #726 and Physical Therapist (PT) #540 revealed Resident #20 had been admitted to the facility three or four different times and required alot of encouragement to get out of bed. DOR #726 stated going home was very important to Resident #20 and this time around was more motivated to participate in therapy. DOR #726 indicated therapy was focusing on toileting, dressing, bathing, tub transfers, ambulation, bed mobility, functional transfers and medication management. DOR #726 stated Resident #20 was a stand-by-assist for toileting, clothing managment and hygiene. Resident #20 did not have a bathroom in his room and the community shower room and the therapy bathroom was used during his therapy sessions. DOR #726 indicated Resident #20 was supervision for toileting and therapy was there to add assistance if it was needed. DOR #726 stated Resident #20 would use the bathroom if staff would help him and she definitely would not want him to be incontinent. PT #540 stated Resident #20 could go to the bathroom with assistance even if the bathroom was down the hall, it was absolutely within the realm, and he did not need alot of help. Interview on 06/05/25 at 2:31 P.M. of Certified Occupational Therapy Assistant (COTA) #541 revealed I definitely think Resident #20 could go to the bathroom with stand-by-assistance of a nurse or aide. Resident #20 was able to pull his pants up and could provide his hygiene. COTA #541 stated when she went to Resident #20's room at around 7:45 A.M. to get him for his therapy sessions there was never a nurse or aide around. COTA #541 indicated she talked to the nursing staff if a resident expressed difficulty going to the bathroom, but if a resident was able to activate his call light and was a stand-by-assist that would not prompt her to talk to nursing staff. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/10/25 at 7:36 A.M. of the Director of Nursing (DON) confirmed Resident #20's Clinical admission assessment was not completed when he was readmitted to the facility on [DATE]. The DON stated the expectation was that the Clinical admission assessment was completed when a resident was admitted to the facility. The DON stated she could not say how the information for Resident #20's care plan was obtained because the admission assessment was not completed. The DON indicated the nurses probably used a previous assessment. Interview on 06/11/25 at 11:15 A.M. of CNA #420 revealed Resident #20 was not assisted to the bathroom. CNA #420 stated Resident #20 was not encouraged to use the community bathroom and was not on a schedule to ask if he wanted to use the community bathroom. CNA #420 stated Resident #20 started asking to use the bathroom on 06/07/25, but he usually poops in his brief. Interview on 06/11/25 at 12:10 P.M. of the DON revealed the nursing staff communicated with therapy and therapy talked to the nurses and aides about any changes such as if a resident was using a bedside commode or bedpan. The DON stated therapy was responsible to communicate with the nursing staff about a resident and what they were working on and what the resident could do. If there was a change in a resident's status therapy should communicate with the staff and put a memo out. The DON stated there was no therapy memo for Resident #20 communicated to staff including the use of the bathroom. The DON stated Resident #20 was very vocal about what he wanted. Interview on 06/11/25 at 12:38 P.M. of COTA #541 revealed she had no idea staff were checking and changing Resident #20, and she thought staff were taking Resident #20 to the bathroom. COTA #541 stated it was not up to the therapy staff to tell the aides to take Resident #20 to the bathroom. COTA #541 stated Resident #20 did really well in the bathroom and it was just awkward trying to position the oxygen and wheelchair. Review of the facility policy titled Restorative Nursing Care, undated, included Restorative programs were nursing programs and did not included procedures or techniques carried out by or under the direction of qualified therapists. A Registered Nurse would complete an assessment of the resident and determine if the resident would benefit from a Restorative program. Findings would be documented in the clinical record. Restorative programs included improving bowel and bladder continence. The Restorative program would typically be delivered up to seven days per week by nursing staff and documented in the clinical record. 2. Review of Resident #4's medical record revealed an admission date of 04/18/24 and diagnoses included flaccid hemiplegia affecting the left dominant side, vascular dementia, unspecified severity without behavioral disturbance, psychotic disturbance, or mood disturbance, bipolar disorder and obstructive and reflux uropathy and urine retention. Resident #4 discharged to the hospital on [DATE] and returned to the facility on [DATE] with a hospital diagnosis of urinary tract infection (UTI). Review of Resident #4's Annual Minimum Data Set assessment dated [DATE] revealed Resident #4 had moderate cognitive impairment. Resident #4 was dependent for toileting hygiene, lower body dressing and putting on and taking off footwear. Resident #4 required partial to moderate assistance for the ability roll from lying on the back to left and right side and return to lying on back on bed. Resident #4 had an indwelling catheter and was always incontinent of bowel. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #4's care plan dated 01/22/25 included Resident #4 had an impaired ability to perform or participate in daily ADL (Activity of Daily Living) care related to diagnoses. Resident #20 would participate with ADL's as much as possible and would remain clean, dry, comfortable and neat in appearance daily by the target date of 09/03/25. Interventions included to assist with toileting if needed, provide incontinence care as needed and apply moisture barrier cream after each incontinent episode. Further review of Resident #4's medical record including progress notes, physician orders and laboratory testing for date range of 04/10/25 to 05/02/25 revealed no evidence Resident #4 had a urinalysis and there was no documentation regarding urinary symptoms and/or cloudy, foul smelling urine from the facility. Review of the police Case Report dated 05/02/25 and timed 10:49 P.M. revealed Resident #4 had called the police because she was bedridden and had not been changed or cleaned and her urinary cathetar bag had not been emptied since 05/02/25 at 5:30 A.M. causing her to lay in her own waste for an extended period of time. Emergency Medical Services transported Resident #4 to the hospital for a medical assessment and Adult Protective Services were notified. Review of Resident #4's progress notes dated 05/02/25 through 05/05/25 did not reveal evidence as to why Resident #4 called the police or why she was transported to the hospital. Review of Resident #4's hospital admission records dated 05/02/25 through 05/06/25 revealed Resident #4 reported she was in soiled diapers at the facility for a long period of time and her indwelling catheter bag was not emptied. Resident #4's problem list included UTI (urinary tract infection). Resident #4's urinalysis showed brown urine with turbid clarity (cloudy, murky, appearing thick and opaque rather than clear), leukocyte esterase (strong indicator for urinary tract infection), white blood cells (WBC) and a few bacteria. A urine culture was sent. Resident #4 was treated with an antibiodic to treat the UTI. Review of Resident #4's physician progress notes dated 05/08/25 at 2:15 P.M. included Resident #4 was readmitted to the facility. Resident #4 had a urinary tract infection without hematuria and the plan was to monitor her closely. Resident #4 was treated with ceftriaxone antibiodic while she was admitted to the hospital. An interview on 06/02/25 at 2:41 P.M. with Resident #4 revealed the facility aides were too busy laughing among themselves and do not pay attention to resident needs. Resident #4 stated about a month ago she had been in the hospital due to a urinary infection. Resident #4 stated the aids did not empty her urinary cathetar bag and instead it would be completely full of urine and no one would come empty it. Resident #4 also stated she would be left to sit in her incontinence brief full of stool for long periods of time before anyone would change her. Interview on 06/05/25 at 11:36 A.M. with Nurse Practitioner (NP) #543 revealed Resident #4 was a long term resident in the facility. NP #543 stated Resident #4 had a chronic indwelling catheter and had been treated for multiple urinary tract infections. Two to three weeks ago Resident #4 called the police and it was unusual she had called the police because she never complained. NP #543 stated she was not in the facility the day the police were called but something happened and there was only one aide working on the unit Resident #4 resided on. Resident #4 was transported to the hospital and was admitted for a few days. (continued on next page)

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Altercare of Cuyahoga Falls Ctr for Rehab & Nursin	2728 Bailey Rd Cuyahoga Falls, OH 44221

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/12/25 at 8:54 A.M. of Assistant Director of Nursing (ADON) #410 revealed she stayed late on 05/02/25 to finish up some work she had not been able to complete. The police dispatch operator called and told her a resident had called the police. ADON #410 stated she started making rounds to figure out what resident called and finally she talked to Resident #4 and Resident #4 confirmed she called the police because she needed her incontinence brief changed. ADON #410 stated she talked to Agency Certified Nursing Assistant (CNA) #544, and she said she would change Resident #4. ADON #410 indicated she did not stay to ensure Resident #4 was changed, went back to her office and when the police arrived ADON #314 handled everything from there. Interview on 06/12/25 at 8:10 A.M. of CNA #394 revealed when she arrived for work at 10:30 P.M. on 05/02/25 Nurse #387 was the nurse on the unit, and there was also an agency aide who she did not know. ADON #410 was walking out of Resident #4's room and ten minutes later the police arrived. CNA #394 stated here were more than two police cars in the parking lot and we did not know what happened. CNA #394 indicated Resident #4 stated she activated her call light and was not attended to for three to four hours. CNA #394 stated she did not know if that was true because she just got to work. The police took pictures of Resident #4's room. CNA #394 stated a couple days before the police came to the facility Resident #4's catheter bag was so full of urine that the bag leaked in the hall and made the whole hall smell very bad, the bag was leaking and smelly. CNA #394 stated she could not remember the color, but it was a very heavy smell. CNA #394 indicated the nurse was aware of the bad smell, but she could not remember which nurse it was. Interview on 06/12/25 at 9:38 A.M. of Licensed Practical Nurse (LPN) #320 revealed she was not working on 05/02/25 when Resident #4 called the police, but she heard about it. LPN #320 stated Resident #4's urine was cloudy before she was transported to the hospital, and it often looked cloudy. LPN #320 stated she noticed Resident #4's urine had an odor, but she thought it was a typical catheter smell. LPN #320 verified she did not document anything regarding Resident #4's urine having odor and being cloudy. Interview on 06/12/25 at 11:04 A.M. with Nurse #387 revealed on 05/02/25 he arrived for work around the time Resident #4 called the police. Resident #4 reported she had not been changed for a long time. Nurse #387 stated he was told Resident #4's soiled incontinence brief was changed before the police arrived to the facility. Nurse #387 indicated he did not think Resident #4 was accurate in how long it took for her to be changed because she was confused when the police were called to the facility. Nurse #387 stated Resident #4 was usually not confused. The police arranged for Resident #4 to be transported to the hospital. Review of the facility policy titled Catheter Care, Urinary updated 05/01/25 included it was the facility policy to provide catheter care to reduce the risk of infection to the resident's urinary tract and to promote good hygiene. Monitor the urine in the drainage bag for abnormal appearance (for example presence of blood, cloudy, abnormal color etcetera) and report abnormal findings to the nurse.

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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. Based on record review, interview and review of facility policy, the facility did not ensure a significant weight loss was assessed by the dietitian for Resident #285 . This affected one resident (#285) of two residents reviewed for nutrition. The facility census was 76. Findings include: Review of closed medical record for Resident #285 revealed an admission date of 03/14/25 and a discharge date of 04/11/25. Diagnoses included fracture of coccyx, dysphagia (difficulty swallowing), cognitive communication deficit, type two diabetes, chronic diastolic (congestive) heart failure, chronic kidney disease stage four, vascular dementia, and depression. Review of the admission Minimum Data Set (MDS) 3.0 assessment, dated 03/20/25, revealed Resident #285 was cognitively intact, exhibited no behaviors, was dependent on staff for eating; had no significant weight loss, and was on a mechanical soft and therapeutic diet. Review of the care plan dated 03/21/25 for Resident #258 revealed the resident was at risk for altered nutritional status related to therapeutic diet, mechanically altered diet due to dysphagia, varied meal intakes, dependant for meal intakes and advanced age. Interventions included notifying the dietitian and physician if there was a significant weight change. Review of physician orders revealed a diet order dated 03/21/25 for LCS (low concentrated sweets) nectar liquids, special instruction small bites 1800 calories/day dysphagia two diet and a no sugar added house supplement four ounces daily. On 03/26/25 the order was updated for the diet to be LCS mechanical soft thin liquids special instruction 1800 kcal/day. Review of the initial nutrition assessment for Resident #258, dated 03/21/25 and authored by Dietitian #501, revealed Resident #285 was on a low carb puree diet with nectar liquids with special instructions for small bites, 1800 calories/day, dysphagia two. Food intake varied from 26-100% of meals being consumed. The resident was not on any supplements and the area for the resident's usual body weight to be listed had not been filled out. Estimated needs were between 2060 and 2470 for calories, 82 to 103 grams for protein and 2060 milliliters (ml) for fluid. Dietitian #501 noted meal intakes were varied, the resident was dependent on staff for meal intakes, the resident was working with the speech therapist for dysphagia, and the dietitian was going to recommend a four ounce no sugar added house supplement daily, which was appropriate for nectar thick liquids. Further review of medical record revealed a progress note dated 03/27/25 which indicated a modified barium swallow study (a video study to evaluate the swallow function) had been completed on 03/26/25 and indicated Resident #285 had moderate oral dysphagia and moderate to severe pharyngeal dysphagia with the resident aspirating (items enter airway or lungs) on all consistencies except the soft solids. Recommendations included discussing options of continued oral intake with mechanical soft diet consistency with thin liquids verses receiving nothing by mouth with alternate method of feeding/hydration with family. Family wanted to continue to feed the resident an oral diet despite the risks of aspiration. Review of Resident #285 recorded meal intakes between 03/15/25 and 04/10/25 revealed meal intakes remained varied with 1 to 100% of meals being recorded. (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 Resident #285's weights revealed on 03/20/25 the resident weighed 226.2 pounds, on 04/02/25 the resident weighed 226 pounds, on 04/04/25 the resident weighed 175.2 pounds (50.8 pound weight loss in two days), and on 04/07/25 the resident weighed 177 pounds. Further review of Resident #285's medical record revealed other than the initial nutrition assessment on 03/21/25, there had been no additional documentation by the dietitian to address the resident's weight loss and assess nutritional status. Interview on 06/09/25 at 2:59 P.M. with Dietitian #501 revealed she was questioning the accuracy of the 175. 2 pound weight for Resident #285, which was why she had requested a reweigh which had been obtained and was 177 pounds. She confirmed the weight loss was not assessed to determine etiology of the weight loss including whether or not the weights were accurate before the resident was discharged on 04/11/25. Dietitian #501 had no explanation why she had not addressed the significant weight change and verified the physician had not been notified of the weight loss. Dietitian #501 stated normally when there was weight loss, she would document the weight loss, try and determine the reason behind the weight loss, and make a recommendation to the physician. Review of the facility policy Weight/Reweigh Policy, dated 05/01/25, revealed there was nothing in the policy indicating when a significant weight loss should be documented in the medical record. This deficiency represents non-compliance investigated under Complaint Number OH00165488,

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of facility policy the facility did not ensure Resident #20 was treated for pain in accordance with physician orders and care planned interventions. Also, the facility did not ensure pain assessments were completed as ordered by the physician for Resident #3. This affected two residents (Resident #20 and #3) out of three residents reviewed for pain. The facility census was 76. Findings include: 1. Observation on 06/05/25 at 1:15 P.M. with Certified Nursing Assistant (CNA) #342 of Resident #20 revealed Resident #20 was laying in bed, had facial grimacing, dark circles under his eyes and his skin was kind of grayish looking. Resident #20 stated he did not feel well, his foot hurt and his Percocet (pain medication) was decreased to twice a day. Observation of Resident #20's right foot and heel revealed the bottom of the heel was very red and when CNA #342 pressed on the reddened area on the heel Resident #20 cried out in pain. Observation on 06/09/25 at 1:57 P.M. of Resident #20 revealed the bottom of his heel was still very red and swollen. Resident #20 stated he could not sleep because the pain woke him up. Review of Resident #20's medical record revealed Resident #20 was discharged from the facility on 05/15/25 and readmitted to the facility on [DATE]. Resident #20's diagnoses included chronic obstructive pulmonary disease, muscle weakness, major depressive disorder and chronic respiratory failure with hypoxia. Physician orders dated 05/29/25 revealed oxycodone-acetaminophen tablet (Percocet) 5-325 mg, administer twice a day as needed. Only administer BID (twice a day), for moderate pain (4-6) or severe pain (7-10). Offer non pharmacological interventions prior to administration. A physician order for Tylenol (non-narcotic pain medication) was noted on 06/10/25. Review of Resident #20's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #20 was cognitively intact. Resident #20 did not reject care during the seven-day assessment look-back period. Resident #20 required substantial to maximal assistance for toileting hygiene and upper and lower body dressing. Resident #20 required partial to moderate assistance for the ability to get on and off a toilet or commode. Resident #20 almost constantly had pain or hurting in the last five days and almost constantly the pain made it hard for him to sleep at night. Resident #20 frequently limited participation in rehabilitation therapy sessions due to pain. Over the last five days Resident #20 rated his pain at a seven out of 10 on a pain scale of zero being not pain and ten the worst pain he could imagine. Review of Resident #20's care plan dated 06/03/25 revealed Resident #20 had actual pain related to chronic pain syndrome and thoracic thoracolumbar and lumbosacral intervertebral disc disorder. Resident #20 would maintain daily routine and would verbalize he was comfortable daily by the target date of 09/03/25. Interventions included to administer pain medications as ordered and observe for effectiveness, observe and report to physician any adverse side effects; observe for episodes of breakthrough pain and medicate as ordered or contact physician as needed; offer non-pharmacological interventions such as dim lights, soft music, position changes, TV and conversation/distraction; remind Resident #20 reporting pain early might improve effectiveness of pain medication. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes dated 06/05/25 revealed no evidence of nursing be alert by CNA #342 that Resident #20 was complaining of pain at 1:15 P.M. Review of Resident #20's Medication Administration Record (MAR) dated 06/05/25 revealed oxycodone-acetaminophen tablet (Percocet) 5-325 mg tablet was administered at 7:37 P.M. for complaints of pain, but the pain level was not rated on a scale of zero to ten to determine severity of the pain. The Percocet follow-up was documented as effective. Review of Resident #20's MAR dated 06/09/25 revealed Percocet was administered at 11:45 A.M. for complaints of pain but the pain level was not rated on a scale of zero to 10 to determine severity of the pain. The follow up administration of the Percocet stated effective. Resident #20 was not given another Percocet until 10:25 P.M. for complaints of pain, but the pain level was again not rated. Review of Resident #20's progress notes and MAR dated 06/05/25 and 06/09/25 revealed no evidence of non-pharmacological interventions being attempted. Review of Resident #20's MAR dated 06/10/25 revealed the resident was administered no Percocet. On 06/10/25 at 5:36 P.M. the pain level was noted to be six out of 10 and Tylenol 650 mg was administered instead of the Percocet as ordered to be given for moderate (pain level four to six) or severe (pain level seven to 10) pain. Review of Resident #20's physician progress notes dated 06/11/25 revealed Resident #20 was evaluated to assess his right foot pain. Resident #20 continued to have ongoing complaints of right heel pain and had three xrays completed with no fractures seen. Resident #20 had oxycodone-acetaminophen 5-325 mg (Percocet) tablet ordered two times a day and as needed. Review of administration showed he was consistently using the Percocet and tolerated it without reported side effects. Resident #20 endorsed continued pain, and edema was noted to the bilateral lower extremities. The plan was to start lasix 20 mg every day, increase oxycodone (Percocet) to TID (three times a day) and order and ECHO (echocardiogram). Interview on 06/10/25 at 3:27 P.M. of Nurse #433 revealed Resident #20 had an xray of his right heel about a week ago because he was complaining of pain. The xray did not show a fracture. Nurse #433 stated Resident #20's heel was not red and swollen the last time she looked at it, but she did not say when that was. Nurse #433 stated Resident #20 had a marijuana vape a few days ago, he was high, she took the weed vape away and called the physician because she was not comfortable giving Percocet when he was in that state. Nurse #433 stated she had Physician #437 change the Percocet from every six hours to two times a day. Nurse #433 stated Resident #20 also had Tylenol ordered for pain. Observation on 06/10/25 at 3:58 P.M. with Nurse #433 of Resident #20 confirmed his right foot was very reddened on bottom of heel and swollen. Resident #20 said his pain level was a nine out of a 10. Nurse #433 pushed on the heel and Resident #20 cried out in pain. Nurse #433 stated Resident #20 had medical issues and was non compliant with care and I do not know what more we can do, this is his baseline. Nurse #433 did not ask Resident #20 if he wanted pain medication during the observation. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/11/25 at 8:43 A.M. with the Director of Nursing (DON) confirmed Resident #20's pain level just said pain and the pain was not rated with a number on the MAR in order to determine if the Percocet was being given according to the physician orders. The DON stated she checked with the corporate office because she believed the nurses were unable to physically enter/document a pain scale number but the corporate office was working to fix it. Interview on 06/11/25 at 9:28 A.M. with Resident #20 revealed Nurse #433 did not administer pain medication on 06/10/25 when he said his pain was a nine out of a 10. Resident #20 stated he had to ask and she gave him Tylenol, and the Tylenol helped a little but his pain was still a seven out of 10 after the Tylenol. Resident #20 stated Nurse #433 did not ask him what his pain level was after she gave him the Tylenol. Resident #20 said he was having right foot pain at an eight. Interview on 06/11/25 at 9:32 A.M. with Nurse #433 revealed she gave Resident #20 Tylenol on 06/10/25 because he was out of Percocet. Nurse #433 stated she called the pharmacy and ordered Resident #20's Percocet. Nurse #433 confirmed the facility had Percocet on hand, but she did not check to see if there was any in the starter box and she did not call the pharmacy for an authorization number. Nurse #433 confirmed if Resident #20's pain level was moderate to severe his physician orders were to administer Percocet. Observation on 06/11/25 at 10:56 A.M. with Physician #437 and Licensed Practical Nurse (LPN) #438 of Resident #20 revealed Resident #20 stated his foot hurt. Physician #437 evaluated Resident #20's right foot and the bottom of his heel and confirmed it was red and boggy. Physician #437 stated the pain was probably due to the swelling, and he was trying to figure out why the foot was red and swollen. Physician #437 stated Resident #20 recently had three xrays of his right foot for complaints of pain. Physician #437 stated the right foot needed padded and protected and he was going to order an echo of the right foot. Physician #437 stated he was also going to increase Resident #20's Percocet to three times a day. Interview on 06/11/25 at 11:26 A.M. with Pharmacist #542 revealed Resident #20's Percocet was filled on 06/10/25 and was delivered to the facility at 11:37 P.M. Pharmacist #542 stated Resident #20's refill order was received on 06/09/25 directly from Physician #437, and there was no call from the facility requesting an authorization code for the starter box to pull Resident #20's Percocet and administer it. Review of the facility policy titled Pain Assessment and Management updated 05/01/25 included it was the facility policy to assess, monitor, treat, and evaluate pain to ensure effective pain management was provided. A resident's experience of pain was highly individual and subjective. As a general rule, pain was whatever the resident said it was. Residents who have been identified to have acute or chronic pain were to be assessed for pain in accordance with their plan of care. Residents who have been identified as experiencing pain would be treated in accordance with their plan of care. Non pharmacological interventions should be attempted first, if appropriate. 2. Record review revealed Resident #3 was admitted [DATE] with diagnoses including multiple sclerosis, muscle weakness, and type II diabetes. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 had moderate cognitive impairment and required supervision with dressing, sit to lying, and sit to standing and was independent with chair/bed-to-chair transfers. Review of the physician orders revealed Resident #3 had an order to assess pain every shift using a scale of zero to10 with a start date of 12/19/24. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes revealed a note recorded as a late entry on 05/30/25 at 1:50 P.M. and stated Resident #3 suffered a fall on 05/27/25 that was witnessed by Registered Nurse (RN) #417. RN #417 noted Resident #3 lost her balance and slid to the floor. Resident #3 denied any pain or injury and RN #417 notified the on-call nurse practioner (NP). Review of progress note dated 05/29/25 at 1:23 P.M. revealed Resident #3 complained of pain to her bilateral lower extremities and had swollen legs that were red and painful to touch. The NP was contacted and ordered x-rays. A progress note dated 05/30/25 at 9:53 A.M. revealed the results of the x-rays noted left and right 3rd, 4th, and 5th metatarsal fractures and Resident #3 was referred to an orthopedist. Review of the May 2025 MAR revealed Resident #3 was not assessed for pain on the night shift on 05/27/25. Further review of the MAR revealed pain was also not assessed at night on 05/07/25, 05/22/25, and 05/23/25. Interview on 06/10/25 at 2:02 P.M. with the DON revealed Certified Medical Assistant (CMA) #416 worked the night of 05/27/25. Due to the limitations of the certification, CMA #416 only passed medications and was unable to complete the pain assessment. The DON further reported the supervising nurse, Licensed Practical Nurse (LPN) #349, was responsible for assessing and documenting Resident #3's pain. Interview on 06/11/25 at 8:23 A.M. with LPN #349 confirmed a CMA passed medications the night of 05/27/25 and did not assess Resident #3's pain however LPN #349 stated she spoke with the resident and she wasn't in any pain.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and review of facility policy, the facility failed to provide nursing staff in sufficient numbers to attain or maintain the highest practical physical, mental and psychosocial well-being of each resident. This affected eight residents (#4, #6, #12, #16, #20, #32, #70, and #241) out of 37 residents reviewed for staffing with potential to affect all residents in the facility. The facility census was 76. Findings include: 1. Review of Resident #20's medical record revealed Resident #20 was discharged from the facility on 05/15/25 and readmitted to the facility on [DATE]. Resident #20's diagnoses included chronic obstructive pulmonary disease, muscle weakness, major depressive disorder and chronic respiratory failure with hypoxia. Review of Resident #20's medical record including progress notes dated 05/23/25 through 06/12/25 did not reveal evidence Resident #20 refused showers. Review of the resident shower schedule for C unit revealed Resident #20 should receive showers on Wednesday and Saturday during second shift. Showers were scheduled for 05/28/25, 05/31/25, 06/04/25, 06/07/25 and 06/11/25. Review of Resident #20's shower sheets did not reveal showers were completed on 05/28/25, 05/31/25, 06/04/25, 06/07/25 and 06/11/25. Review of Resident #20's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was cognitively intact. Resident #20 did not reject care during the seven-day assessment look-back period. Resident #20 used a walker and a wheelchair. Resident #20 required substantial to maximal assistance for toileting hygiene and upper and lower body dressing. Resident #20 required partial to moderate assistance for the ability to get on and off a toilet or commode and bathing. Resident #20 was occasionally incontinent of urine and frequently incontinent of bowel. A bowel toileting program was not currently being used to manage Resident #20's bowel continence. Review of Resident #20's care plan dated 06/03/25 included Resident #20 had an impaired ability to perform or participate in daily ADL (Activity of Daily Living) related to diagnoses. Resident #20 would participate with ADL's as much as possible and would remain clean, dry, comfortable and neat in appearance daily by the target date of 09/03/25. Interventions included to provide every day and as needed, or per resident preference to provide nail care, shampoo hair with showers per weekly schedule, to groom hair daily and encourage resident to participate as able. Interview on 06/02/25 at 3:39 P.M. of Certified Nursing Assistant (CNA) #544 revealed she was often the only aide scheduled to work on second shift on Nursing Unit C and that was not enough to watch the residents on C hall, they were needy and the facility downplayed how much care the residents needed to make it seem like it was okay to only have one aide scheduled to work on C hall. CNA #544 stated when she was the only aide scheduled she was unable to give showers including Resident #20's shower. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare of Cuyahoga Falls Ctr for Rehab & Nursin	2728 Bailey Rd Cuyahoga Falls, OH 44221

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/02/25 at 3:14 P.M. of Resident #20 revealed he was laying in bed in his room with the head of the bed elevated and was using oxygen via nasal cannula A wheelchair was placed by the side of his bed, there was no bedside commode in the room and Resident #20's room did not include a bathroom. If Resident #20 needed to use the bathroom or to shower he had to use a walker or wheelchair and had to travel down the hall and around the corner to use the community bathroom, shower. Resident #20's hair was oily and uncombed. Interview on 06/09/25 at 5:45 A.M. of CNA #394 revealed Resident #20 had not received a shower since he was admitted to the facility. Interview on 06/09/25 at 1:57 P.M. of Resident #20 revealed they ask if I want a shower, I say yes, they say okay and then they do not come back. I have not had a shower since I was admitted on [DATE]. Resident #20's hair was oily and uncombed. Interview on 06/10/25 at 12:32 P.M. of CNA #420 revealed he was walking hurriedly through the hall with a rushed look on his face to assist a resident. CNA #420 stated he typically worked second shift, often he was the only aide on the unit and he had not given Resident #20 a shower since he was admitted . CNA #420 stated it was hard to get to the showers when there was only one aide on the unit. CNA #420 stated the aide documentation looked like he gave showers, but he charted incorrectly, and confirmed again he did not give Resident #20 a shower. CNA #420 stated when he was the only aide on the unit showers were not completed including Resident #20. Interview on 06/12/25 at 11:24 A.M. with the Director of Nursing (DON) revealed the DON stated she had been in the role of DON, Human Resources Director and Scheduler since 03/2025. The DON stated typically residents who did not receive showers would be identified during morning clinical meetings, and she would follow up with the staff that day to ensure they were completed. The DON indicated she was so busy being the DON, Human Resource Director and Scheduler she didn't have time to follow up to ensure showers were being completed as scheduled. Interview on 06/12/25 at 10:10 A.M. of Regional Nurse Consultant (RNC) confirmed the missing shower sheets and confirmed there was no proof Resident #20 was offered showers on other days. Review of the facility policy titled Shower Tub Bath updated 05/01/25 included it was the facility policy to promote resident hygiene by offering and assisting residents with bathing per their plan of care. Document completion of services in the clinical record. Document refusals of care in the clinical record. 2. Review of Resident #241's medical record revealed an admission date of 05/15/25 and diagnoses included acute appendicitis with localized peritonitis, without perforation or gangrene, atrial fibrillation, acute and chronic respiratory failure, congestive heart failure and anxiety disorder. Review of Resident #241's admission MDS assessment dated [DATE] revealed Resident #241 was cognitively intact. Resident #241 required substantial to maximal assistance for toileting hygiene. Resident #241 was frequently incontinent of urine and bowel. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #241's care plan dated 05/28/25 included Resident #241 was incontinent of bowel and was at risk for altered dignity, skin breakdown, diarrhea and constipation. Resident #241 would have soft bowel movements at least every three days without complications by the target date of 08/27/25. Interventions included to check and provide incontinence care as needed and apply moisture barrier cream after each incontinent episode; maintain resident dignity when checking and providing incontinence care for Resident #241. Review of Resident #241's aide charting dated 05/18/25 revealed at 4:47 A.M. Resident #241 was incontinent of bowel. There was no further evidence Resident #241 was incontinent of bowel until 6:12 P.M. Review of Resident #241's progress notes dated 05/18/25 revealed Resident #241 was incontinent of bowel at 7:47 A.M., 9:30 A.M. and 12:05 P.M. There was no further evidence Resident #241 was incontinent of bowel until 6:12 P.M. Review of the facility Daily Roster dated 05/18/25 revealed from 6:30 A.M. to 2:30 P.M. CNA's #379 and #549 were assigned to care for the residents residing on Nursing Unit C. Nurse #320 was assigned to Nursing Unit C. Review of the facility time punch details revealed CNA #379 did not work on 05/18/25 and was on a leave of absence. CNA #549 was the only aide working with Nurse #320 on 05/18/25. Review of Resident #241's police Incident Supplement Report dated 05/18/25 at 1:52 P.M. included Friends #545 and #546 contacted the police to report concerns regarding the treatment of Resident #241. Friends #545 and #546 stated Resident #241 was left lying in feces for an extended period and expressed serious concerns about the overall quality of care Resident #241 was receiving at the facility. The police officers spoke with Nurse #320 along with several other nurses and aides. Staff reported Resident #241 was cleaned and changed four times throughout the day. Staff acknowledged that the facility was currently experiencing significant staffing shortages, which required them to triage residents and prioritize care based on urgency. The police mediated the discussion between the nursing staff and Friends #545 and #546 and at the time appeared to be a complaint regarding facility conditions and staffing levels. Adult Protective Services were notified. Review of Resident #241's late entry progress notes dated 05/19/25 at 12:22 P.M. included on 05/18/25 at 4:45 P.M. the Director of nursing spoke with Resident #241's family. Resident #241 received incontinence care at least three times during the day shift related to diarrhea. Resident #241 received Immodium for diarrhea. Resident #241's family expressed concerns with his care, stating he had not been changed. The DON explained the care Resident #241 received during the day. Further review of the progress notes included Resident #241's light was answered and Nurse #320 asked Resident #241 to give her a few minutes because she was about to change two other residents. Resident #241 said okay. Nurse #320 changed a resident across the hall and when she came out of the room a police officer was standing in the doorway of Resident #241. The police officer told her Friend #545 called the police. Friend #546 began making accusations about Resident #241 not being changed all day and saying Nurse #320 did not know what she was doing. ADON #410 was notified of the situation and a nurse from another nursing unit changed Resident #241's incontinence brief. Observation on 06/02/25 at 3:21 P.M. of Resident #241 revealed he was sitting on his bed in his room. Resident #241 was pleasant and willing to answer questions. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/02/25 at 3:21 P.M. of Resident #241 revealed he wanted to go home and was working hard to get stronger. Resident #241 stated when he was admitted he could not stand up because he was so weak. Resident #241 indicated when he was admitted the facility staff did not take good care of me. The police were called and found me in feces. Resident #241 stated things changed after the police were called and now he was taken care of. Interview on 06/03/25 at 9:20 A.M. of Friend #545 revealed she felt like Resident #241 was receiving poor care at the facility and both she and her husband filed a police report. Friend #545 stated Resident #241 was sitting in feces for at least 30 minutes. A nurse said she would be in the room soon because she had other things to do first, they waited but no one came in to provide incontinence care and she called the police and Adult Protective Services. Friend #545 stated Resident #241 did not want to be in the facility but he has anxiety and he was afraid to go to a new place. Friend #545 stated when the police arrived at the facility a staff member she thought was the Director of Nursing was yelling at her and asking her why she was stirring things up among other things. The police let her go on like that. Interview on 06/09/25 at 5:45 A.M. of Nurse #320 revealed she was working the day the police were called for Resident #241. Nurse #320 stated there was only one aide assigned to Nursing Unit C where she was also assigned to work. There were only two staff for 25 residents and Nurse #320 stated I was doing nurse and aide work. Nurse #320 indicated Resident #241 had diarrhea at least three times before noon and was changed each time. Nurse #320 stated she administered Immodium for Resident #241's diarrhea. Nurse #320 indicated she was assisting a resident with care who resided across the hall from Resident #241, exited the resident's room carrying soiled linen and trash in bags and saw a police officer. The police officer stated Resident #241's visitor called the police and Resident #241 told the police officer he needed his incontinence brief changed. Nurse #320 stated she told the police officer she was going to dispose of the soiled items she was carrying and then talk to him. Nurse #320 stated she was doing the best she could, it was a nightmare of a weekend, she started crying and the police officer told Resident #241's visitors they were being inappropriate and needed to calm down. Assistant Director of Nursing (ADON) #410 was called. Nurse #320 stated there were call offs and she was so busy she had not taken a break or gone to the bathroom all morning. Nurse #320 stated she was not sure how long Resident #241 was laying in feces, but she thought it was about 15 minutes. Interview on 06/12/25 at 4:00 P.M. with the DON confirmed CNA #379 was on a leave of absence and did not work on 05/18/25. The DON stated she forgot to take her off the schedule. Review of the facility policy titled Perineal Care updated 05/01/25 included it was the facility policy to provide perineal care to residents in order to promote cleanliness, comfort, and reduce the risk of infections and promote skin integrity. 3. Review of Resident #32's medical record revealed an admission date of 02/25/19 and a readmission date of 12/19/24. Diagnoses included quadriplegia, muscle weakness, major depressive disorder and contractures of right and left hands. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #32's care plan dated 07/11/19 included Resident #32 needed a restorative passive range of motion program related to paraplegia and muscle weakness. Resident #32 would show no further decline in range of motion to his bilateral upper extremities by the target date of 08/01/25. Interventions included at least 15 minutes per day of a restorative PROM (passive range of motion) program; encourage Resident #32 to do 20 sets of repetitions; if Resident #32 refused to participate approach at a later time and report to the nurse. Review of Resident #32's Annual MDS assessment dated [DATE] revealed Resident #32 was cognitively intact. Resident #32 was dependent for all Activity of Daily Living's and mobility. Resident #32 used a motorized wheelchair. Review of Resident #32's physician orders dated 04/01/25 revealed restorative, encourage and assist with PROM to BUE and BLE, 15 reps times two sets for 15 minutes, four to seven times per week as tolerated, twice a day. Review of Resident #32's progress notes dated 05/01/25 through 06/09/25 did not reveal evidence Resident #32 refused to have PROM completed as ordered. Review of Resident #32's aide charting for passive range of motion dated 05/01/25 through 06/09/25 revealed there was no evidence passive range of motion was done two times a day on 05/01/25, 05/02/25, 05/04/25, 05/09/25, 05/13/25, 05/15/25, 05/16/25, 05/24/25, 05/26/25, 05/29/25, 05/30/25, 06/05/25, 06/07/25, 06/08/25 as ordered. Review of Resident #32's aide charting for passive range of motion revealed on 05/05/25, 05/06/25, 05/07/25, 05/08/25, 05/10/25, 05/11/25, 05/12/25, 05/14/25, 05/17/25, 05/18/25, 05/19/25, 05/21/25, 05/22/25, 05/23/25, 05/27/25, 05/28/25, 05/31/25, 06/01/25, 06/02/25, 06/03/25, 06/04/25, 06/06/25, 06/09/25 one session was completed but there was no evidence passive range of motion was completed one additional time a day as ordered. Review of Resident #32's aide charting revealed only two days (05/20/25 and 05/25/25) where Resident #32's PROM was completed two times a day per physician orders. Review of Resident #32's aide charting dated 05/01/25 through 06/09/25 revealed on the days Resident #32 refused his passive range of motion there was no evidence a follow up attempt was made to complete it as ordered (except on 05/04/25 two attempts were made and refused). Review of the facility Daily Roster dated 06/10/25 from 6:30 A.M. through 2:30 P.M. revealed all four Nursing Units (A, B, C, and D) only had one aide assigned to work on the unit. There were other aides scheduled but it was unclear what their assignments were or if they were actually working on 06/10/25. CNA #335 did not have an assignment identified but was scheduled as working. There was nothing on the Daily Roster about CNA #335 accompanying Resident #6 to an appointment. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/09/25 at 10:29 A.M. of Resident #32 revealed he was lying in bed and CNA #435 was completing his morning care. Resident #32 stated the nursing staff spent too much time socializing and not enough time taking care of the residents. Resident #32 stated often his range of motion to his hands was not completed and he did not refuse to have it done. Resident #32 stated to check what the aide charting had documented about his range of motion and the surveyor would be able to tell it was not done as often as was ordered. CNA #435 stated she could tell Resident #32's range of motion was not being done because he was limited in how much she was able to do. CNA #435 showed the surveyor how Resident #32 did not have the range of motion he should have due to it was not being done as ordered. Interview on 06/10/25 at 8:50 A.M. of CNA's #335 and #420 revealed today there was only one aide assigned to work on each of the nursing units. CNA #335 stated her assignment was split between Nursing Unit C and D and CNA #420 was the only aide scheduled on Nursing Unit C. CNA #335 stated she had a split assignment which meant she could not be on either Nursing Unit C or D all day and she was also assigned to accompany Resident #6 to an appointment and the transportation was arriving at 9:50 A.M. to pick Resident #6 up and take to her appointment. CNA #335 stated she would most likely be gone two to three hours. Observation on 06/10/25 at 2:03 P.M. of CNA #420 revealed CNA #420 was walking very fast in the hall, breathing fast and with a harried look on his face. CNA #420 said he was really busy today, did not have time for a break or lunch, and was running around like a chicken. CNA #420 stated he was able to complete Resident #32's range of motion to his upper extremities today, but there were definitely days he was not able to complete it because he was too busy and there was not enough staff. CNA #420 stated he chose to complete Resident #32's range of motion rather than take a break because it was important to do it. CNA #420 stated if there were days it was not documented it was most likely not done. CNA #420 stated one reason he was so busy was because for two to three hours he was the only aide on the nursing unit because CNA #335 went with Resident #6 to an appointment and did not get back until 12:15 P.M. or so. Interview on 06/13/25 at 4:00 P.M. of the DON revealed when told Resident #32 did not have PROM for his BUE and BLE per physician orders the DON stated Resident #32 refused his care at times and was care planned for it. The DON verified the findings in the aide charting when the PROM was not documented as provided to Resident #32. Review of the facility policy titled Restorative Nursing Care undated included Restorative programs were nursing programs and did not included procedures or techniques carried out by or under the direction of qualified therapists. A Registered Nurse would complete an assessment of the resident and determine if the resident would benefit from a Restorative program. Findings would be documented in the clinical record. Restorative programs included assisting residents with their range of motion exercises. The Restorative program would typically be delivered up to seven days per week by nursing staff and documented in the clinical record. 4. Review of Resident #4's medical record revealed an admission date of 04/18/24 and diagnoses included flaccid hemiplegia affecting the left dominant side, vascular dementia, unspecified severity without behavioral disturbance, psychotic disturbance, or mood disturbance, bipolar disorder and obstructive and reflux uropathy and urine retention. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #4's care plan dated 01/22/25 included Resident #4 had an impaired ability to perform or participate in daily ADL (Activity of Daily Living) care related to diagnoses. Resident #20 would participate with ADL's as much as possible and would remain clean, dry, comfortable and neat in appearance daily by the target date of 09/03/25. Interventions included to assist with toileting if needed, provide incontinence care as needed and apply moisture barrier cream after each incontinent episode. Review of Resident #4's Annual MDS assessment dated [DATE] revealed Resident #4 had moderate cognitive impairment. Resident #4 was dependent for toileting hygiene, lower body dressing and putting on and taking off footwear. Resident #4 required partial to moderate assistance for the ability roll from lying on the back to left and right side and return to lying on back on bed. Resident #4 had an indwelling catheter and was always incontinent of bowel. Review of Resident #4's progress notes, physician orders and lab results dated 04/10/25 through 05/02/25 did not reveal evidence Resident #4's urine was cloudy, had an odor or a urine was sent for urinalysis and culture and sensitivity. Review of the facility Daily Roster and time punch detail dated 05/02/25 revealed CNA #379 called off work on 05/02/25, leaving CNA #335 as the only aide scheduled to work on Unit C. It was unclear from reviewing the Daily Roster if an additional aide was assigned to Nursing Unit C. Review of the facility Daily Roster dated 05/02/25 revealed Licensed Practical Nurse (LPN) #320 was scheduled to work on Nursing Unit C from 6:30 A.M. until 3:00 P.M. However, review of LPN #320's time punch detail dated 05/02/25 revealed she clocked in for work at 6:15 A.M. and clocked out at 6:57 A.M. It was unclear from reviewing the Daily Roster if Nursing Unit C had a nurse assigned after LPN #320 clocked out. There was no nurse assigned to work on Nursing Unit C from 6:30 A.M. until 7:00 P.M. Review of Resident #4's aide charting dated 05/02/25 included Resident #4 was incontinent of bowel at 8:13 P.M. Review of Resident #4's police Case Report dated 05/02/25 at 10:49 P.M. included Resident #4 reported she was neglected by the facility. Resident #4 stated she was bed ridden and had not been changed or cleaned and her catheter had not been emptied since 05/02/25 at 5:30 A.M. causing her to lay in her own waste for an extended period of time. Emergency Medical Services transported Resident #4 to the hospital for a medical assessment and Adult Protective Services were notified. Review of Resident #4's hospital admission dated 05/02/25 through 05/06/25 included Resident #4 reportedly called 911 for the local police due to concerns of neglect. Resident #4 reported she was in soiled diapers for a long period of time and her indwelling catheter bag was not emptied. Resident #4's problem list included UTI (urinary tract infection). Resident #4's urinalysis showed brown urine with turbid clarity (cloudy, murky, appearing thick and opaque rather than clear), leukocyte esterase (strong indicator for urinary tract infection), [NAME] Blood Cells and a few bacteria. A urine culture was sent. Review of Resident #4's progress notes dated 05/02/25 through 05/05/25 did not reveal evidence on 05/02/25 that Resident #4 called the police or why she was transported to the hospital. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #4's physician progress notes dated 05/08/25 at 2:15 P.M. included Resident #4 was readmitted to the facility. Resident #4 had a urinary tract infection without hematuria and the plan was to monitor her closely. Resident #4 was treated with ceftriaxone antibiotic while she was admitted to the hospital. An interview on 06/02/25 at 2:41 P.M. with Resident #4 revealed the facility aides were too busy laughing among themselves and do not pay attention to resident needs. Resident #4 stated about a month ago she had been in the hospital due to a urinary infection. Resident #4 stated the aids did not empty her urinary catheter bag and instead it would be completely full of urine and no one would come empty it. Resident #4 also stated she would be left to sit in her incontinence brief full of stool for long periods of time before anyone would change her. Interview on 06/05/25 at 11:36 A.M. of Nurse Practitioner (NP) #543 revealed Resident #4 was a long term resident in the facility. NP #543 stated Resident #4 had a chronic indwelling catheter and had been treated for multiple urinary tract infections. Two to three weeks ago Resident #4 called the police. NP #543 stated she was not in the facility the day the police were called but something happened and there was only one aide working on the unit Resident #4 resided on. NP #543 indicated Resident #4 never complained and it was unusual that she would call the police. Resident #4 was transported to the hospital and was admitted for a few days. Interview on 06/12/25 at 8:54 A.M. of Assistant Director of Nursing (ADON) #410 revealed she stayed late on 05/02/25 to finish up some work she had not been able to complete. The police dispatch operator called and told her a resident had called the police. ADON #410 stated she started making rounds to figure out what resident called and finally she talked to Resident #4 and Resident #4 confirmed she called the police because she needed her incontinence brief changed. ADON #410 stated she talked to Agency CNA #544, and she said she would change Resident #4. ADON #410 indicated she did not stay to ensure Resident #4 was changed, went back to her office and when the police arrived ADON #314 handled everything from there. Interview on 06/12/25 at 8:10 A.M. of CNA #394 revealed when she arrived for work at 10:30 P.M. Nurse #387 was the nurse on the unit, and there was also an agency aide who she did not know. ADON #410 was walking out of Resident #4's room and ten minutes later the police arrived. There were more than two police cars in the parking lot and we did not know what happened. CNA #394 indicated Resident #4 stated she activated her call light and was not attended to for three to four hours. CNA #394 stated she did not know if that was true because she just got to work. The police took pictures of Resident #4's room. CNA #394 stated a couple days before the police came to the facility Resident #4's catheter bag with urine was so full it leaked in the hall and made the whole hall smell very bad, the bag was leaking and smelly. CNA #394 stated she could not remember the color, but it was a very heavy smell. CNA #394 indicated the nurse was aware of the bad smell, but she could not remember which nurse it was. Interview on 06/12/25 at 8:58 A.M. of Regional Nurse Consultant (RNC) #431 confirmed CNA #379 called off work on 05/02/25. (continued on next page)

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	365287	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare of Cuyahoga Falls Ctr for Rehab & Nursin	2728 Bailey Rd Cuyahoga Falls, OH 44221

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/12/25 at 9:38 A.M. of LPN #320 revealed she was not working on 05/02/25 when Resident #4 called the police, but she heard about it. LPN #320 stated Resident #4's urine was cloudy before she was transported to the hospital, but it often looked cloudy. LPN #320 stated she noticed Resident #4's urine had an odor, but she thought it was a typical catheter smell. LPN #320 indicated she did not remember Resident #4 having restlessness or confusion. Interview on 06/12/25 at 11:04 A.M. of Nurse #387 revealed on 05/02/25 he arrived for work around the time Resident #4 called the police. Resident #4 reported she had not been changed for a long time. Nurse #387 stated he was told Resident #4's soiled incontinence brief was changed before the police arrived to the facility. Nurse #387 indicated he did not think Resident #4 was accurate in how long it took for her to be changed because she was confused when the police were called to the facility. Nurse #387 stated Resident #4 was usually not confused. The police arranged for Resident #4 to be transported to the hospital. Review of the facility policy titled Catheter Care, Urinary updated 05/01/25 included it was the facility policy to provide catheter care to reduce the risk of infection to the resident's urinary tract and to promote good hygiene. Monitor the urine in the drainage bag for abnormal appearance (for example presence of blood, cloudy, abnormal color etcetera) and report abnormal findings to the nurse. 5.Review of the medical record for Resident #16 revealed an admission date of 03/15/19 with diagnoses including hemiplegia and hemiparesis following a cerebral infarction (stroke), anxiety, major depression, contracture left hand, and difficulty in walking. Review of the care plan, dated 10/08/21, revealed Resident #16 had impaired ability to perform or participate in daily activity of daily living care related to history of cerebral infarction with left hand side hemiplegia, left hand contracture, weakness, debility, anemia, and osteoarthritis. Interventions included staff to provide nail care and shampoo hair with showers weekly schedule, groom hair daily and encourage resident to participate as able, provide/assist with morning and evening care, encourage resident to participate with hygiene as tolerated; and assist with and/or shave facial hair daily or per resident preference. Interview on 06/02/25 at 11:10 A.M. with Resident #16 revealed the resident wasn't receiving showers. She indicated when it is her shower day, the staff tells her her they don't have the staff to give her a shower. Review of the shower schedule for Resident #16 revealed the resident was to receive a shower Wednesday and Saturdays during day shift. Review of shower sheets for Resident #16 between 05/05/25 and 06/12/25 revealed there were four completed shower sheets dated 05/17/25, 05/21/25, 05/24/25, and 06/11/25. There was no proof showers had been offered/given on 05/07/25, 05/10/25, 05/14/25, 05/28/25, 05/31/25, 06/04/25, and 06/07/25. Interview on 06/05/25 at 9:17 A.M. with Resident #16 revealed she should have had a shower the day before but hadn't received a shower. She stated she couldn't remember the last time she had a shower. She stated the day before she had pressed her call light to remind the staff it was her shower day, and when the staff member answered the call light and the resident reminded the staff member it was her shower day, the staff member said nothing and left. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/05/25 at 10:27 A.M. with Aide in Training #330 revealed she had worked on 06/04/25 and confirmed Resident #16 should have had a shower on day shift. She stated Resident #16 had told her she wanted a shower on 06/04/25, however, Aide In Training #330 indicated she was unable give Resident #16 her shower since she was on the floor by herself most of the shift. She indicated when there was only one aide on the floor, she couldn't get showers completed and if she was able to bath a resident, it was a bed bath. Interview on 06/12/25 at 10:10 A.M. with Regional Nurse confirmed the missing shower sheets and confirmed there was no proof Resident #16 had been offered to be bathed or had been bathed on those days with the missing shower sheets. Interview on 06/12/25 at 11:24 A.M. with the DON revealed she had been filling in as Human Resources/Scheduler in addition to being a DON since March of 2025. She stated normally she would follow up with residents who missed their showers during clinical meetings to ensure they were completed the next day, but she indicated with her being so busy completing tasks for H[TRUNCATED]

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on record review, observation, and interview the facility failed to administer medications as ordered. This affected one (Resident #135) of five residents reviewed for medication administration. The facility census was 76. Findings include: Review of the medical record for Resident #135 revealed an admission date of 05/29/25. Diagnoses included wedge compression fracture of the lumbar vertebra, malignant neoplasm of the prostate, history of transient ischemic attack and cerebral infarction. Review of the plan of care dated 06/02/25 revealed Resident #135 was at risk for bruising/bleeding related to use of anticoagulant medication. Review of the medication admiration record for June 2025 noted Resident #135 was ordered enoxaparin (lovenox) 0.7 milliliters (ml). The syringes were filled with 0.8 ml, staff were to administer only 0.7 ml. Review of the facilities laboratory results for Resident #135's International Normalized Ratio (INR), a blood test to measure the time it takes for blood to clot noted normal values (0.9-1.2) on 06/02/25, 06/03/25. The INR level on 06/04/25 was 1.4 which was flagged as high. Observations on 06/04/25 at approximately 2:00 P.M. revealed the wife of Resident #135 was telling staff that Resident #135 was receiving too much enoxaparin. The wife left the facility angry. An observation was conducted on 06/05/25 at 7:42 A.M., with Registered Nurse (RN) #436 who was observed administering medications to Resident #135. RN #436 was observed injecting 0.8 ml of enoxaparin into Resident #135's stomach. Interview immediately after RN #436 had completed administering the medications, RN#436 reviewed the order and verified she administered too much enoxaparin. Interview on 06/10/25 at 10:58 A.M., the wife stated on 06/04/25 around 2:00 P.M. she observed RN #432 who was in training administer 0.8 ml of enoxaparin. The wife voiced concerns about the dosage to RN #432 who stated, it really doesn't matter. The wife also stated she voiced concerns about changing the location injection, the nurse stated, it really doesn't matter. Review of the facility policy titled Medication Administration, dated 2018 noted the five rights of administration: right resident, right drug, right dose, right route and right time. The medication administration record (MAR) is always employed during medication administration. Prior to administration the medication and dosage schedule on the MAR are compared with the medication label. This deficiency represents non-compliance investigated under Complaint Number OH00164001, OH00164353,OH00165488 and OH00165648.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, review of diet spreadsheets, and review of the facility document Mechanical Soft Diet, the facility failed to ensure residents on a mechanical soft diet received the appropriate diet consistency. This affected three residents (#14, #286, and #292) of three residents observed for mechanical soft diets. The facility identified eight residents (#14, #22, #29, #42, #55, #59, #286, and #292) as being on a mechanically altered diet. The facility census was 76. Findings include: 1.Review of the medical record for Resident #292 revealed an admission date of 06/05/25. Pertinent diagnoses included dysphagia (difficulty swallowing), severe protein-calorie malnutrition, and disorder of teeth and supporting structures. Resident #292 had a physician order, dated 06/06/25, for a regular mechanical soft diet with thin liquids and was cognitively intact. Further review of Resident #292's medical record revealed an initial nutrition assessment, dated 06/09/25, which indicated a mechanical soft diet was in place and the resident was agreeable to the diet. Review of the nutritional care plan, dated 06/09/25, revealed the resident was at nutritional risk related to being on a mechanical soft diet related to dysphagia and poor dentition. Interventions included: provide diet per physician order; supplements per physician order; offer menu alternatives PRN; honor food preferences as available and reasonable; monitor weekly weights x 4 then monthly if stable; notify dietitian/physician of significant weight changes greater than five percent; observe resident labs as available; and review resident's skin status. 2.Review of the medical record for Resident #14 revealed and admission date of 12/19/24. Pertinent diagnoses included moderate protein-calorie malnutrition, dysphagia, and chronic obstructive pulmonary disease (COPD). Resident #14 had a physician order, dated 01/09/25, for a regular mechanical soft diet with thin liquids. Review of Resident #14's quarterly Minimum Data Set (MDS) assessment, dated 04/01/25, revealed the resident was cognitively intact, required supervision or touch assistance for eating, and was on a mechanically altered diet. Further review of Resident #14's medical record revealed a quarterly nutrition assessment, dated 04/07/25, which indicated the resident was on a mechanical soft diet with thin liquids. Review of Resident #14's nutrition care plan, dated 06/08/24, revealed the resident was at risk for altered nutrition since the resident had a history of significant weight loss and was on a mechanically altered diet. Interventions included: provide diet per physician order; supplements per physician order; offer menu alternatives as needed; honor food preferences as available and reasonable; monitor weekly weights x 4 then monthly if stable; notify dietitian/physician of significant weight changes greater than five percent; observe resident labs as available; and review resident's skin status. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.Review of the medical record for Resident #286 revealed an admission date of 05/14/25. Pertinent diagnoses included mild protein calorie malnutrition, malignant neoplasm (cancerous tumors) of colon and lymph nodes, anxiety disorder, and feeding difficulties. The resident had a physician order, dated 05/1/5/25, for a regular mechanical soft diet with thin liquids. Review of Resident #286's admission Minimum Data Set (MDS) assessment, dated 05/20/25, revealed the resident was moderately impaired cognitively, required supervision for eating, and was on a mechanical soft diet. Further review of Resident #14's medical record revealed an initial nutrition assessment, dated 05/15/25, which indicated the resident was on a mechanical soft diet with thin liquids. Review of Resident #14's nutrition care plan, dated 05/20/25, revealed the resident was at risk for altered nutrition related to being on a mechanical soft to facilitate ease of chewing due to recent teeth extraction and to offer reduced fiber due to recent bowel surgery with an Ileostomy present and the resident reported a history of significant weight loss. Interventions included: provide diet per physician order; supplements per physician order; offer menu alternatives as needed; honor food preferences as available and reasonable; monitor weekly weights x 4 then monthly if stable; notify dietitian/physician of significant weight changes greater than five percent; observe resident labs as available; and review resident's skin status. Review of the facility's spring and summer menu 2025 spread sheet for lunch on 06/09/25 revealed residents on regular consistency diets were to receive three ounces of citrus glazed roasted turkey, four ounces of scalloped potatoes, four ounces of Prince [NAME] blend vegetables and four ounces of mixed fruit. The residents on a mechanical soft diet were to receive one number ten scoop (3.25 ounces) ground citrus glazed roast with gravy, four ounces scalloped potatoes, four ounces Prince [NAME] blend vegetables, and four ounces canned fruit. Review of facility document Mechanical Soft Diet, revised 09/2024, revealed a person on a mechanical soft diet would be allowed all canned fruit except pineapple tidbits and all meat would be ground with gravy or sauce. Observation of tray line on 06/09/25 from 11:36 A.M. to 12:19 P.M. revealed during the tray line Resident #292, whose dietary ticket on the meal tray indicated the resident was on a mechanical soft diet, was served three ounces of glazed turkey (not ground), four ounces of scalloped potatoes, four ounces of Prince [NAME] vegetables, and four ounces canned mixed fruit (which had pineapple tidbits). Resident #14, whose dietary ticket on the meal tray indicated the resident was on a mechanical soft diet, was served one number ten scoop of ground turkey with gravy, four ounces scalloped potatoes, four ounces of Prince [NAME] vegetables, and four ounces of canned mixed fruit which contained pineapple tidbits. At 11:57 A.M. after all the residents' meal trays had been placed on the meal cart and the meal cart was ready to be delivered to the unit, the state surveyor intervened and asked to see Residents #292 and #14 meal trays. At the time of observation, [NAME] #384 and Dietary Coordinator #378 confirmed Resident #292 had been served a regular slice of turkey and should have been served ground turkey and Residents #292 and #14 had been served canned mixed fruit which included pineapple tidbits which should have been served canned pears and Resident #292 received a new meal tray which included ground turkey, scalloped potatoes, and Prince [NAME] blend vegetables and the canned mixed fruit with pineapple tidbits on Residents #292 and #14 meal tray had been replaced with canned pears. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further observation of the facility's tray line revealed Resident #286, whose dietary ticket on the meal tray indicated the resident was on a mechanical soft diet, received an alternate menu item choice of a mechanical soft hamburger and canned mixed fruit which included pineapple tidbits. At 12:11 PM as the resident's meal tray was about to be taken to the unit by a dietary employee, the state surveyor intervened and asked to see the meal tray. [NAME] #384 and Dietary Coordinator #378 confirmed Resident #286 had been served canned mixed fruit which included pineapple tidbits and should have been served canned pears and immediately replaced the mixed fruit with canned pears prior to the meal tray being taken to the unit. Interview on 06/09/25 at 4:13 P.M. with Speech Therapist #500 revealed a resident on a mechanical soft diet would receive ground meat and soft canned fruit which was not difficult to chew. She stated from time to time she has seen residents at the facility receive the wrong diet consistency. This deficiency represents non-compliance investigated under Complaint Number OH00165488.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. Review of the medical record for resident #284 revealed an admission date of 03/29/25. Diagnoses included encounter for orthopedic aftercare related to the displaced fracture of the ulna (one of two bones in the forearm) and right femur (thigh bone) and fracture of lower end of right radius (one of two bones in the forearm), Alzheimer's disease, depression, age related osteoporosis, and other abnormalities of gait and mobility. Review of Resident #284's admission MDS assessment, dated 04/04/25, revealed the resident was severely impaired cognitively; exhibited inattention and disorganized thinking which was present but fluctuated; had functional limitation in range of motion on one side of the upper and lower extremity; was dependent on staff for toileting hygiene, lower body dressing, and personal hygiene; was dependent on staff to transfer the resident from chair/bed to chair and walking ten feet had not been attempted; and was frequent incontinent of bowel and bladder. Further review of Resident #284's medical record revealed the assessment Social Services Social History Assessment 11.15, dated 04/02/25 and authored by Former Social Services Coordinator (SSC) #351, revealed the assessment hadn't had any questions answered and was marked in progress. Review of the blank assessment revealed there were questions regarding the primary language of the resident and if the resident needed an interpreter; if the resident was a veteran; what was the highest level of education completed; previous life experience/occupation; living arrangements prior to admission including home set up; what was the resident's marital status; who was the primary support system; if the resident had a durable power of attorney for healthcare or finance or was the resident their own responsible party; if the resident had an advanced directive; what the cognitive status was of the resident; if the resident wanted a referral for any ancillary services which included dental, vision, podiatry, or audiology; what the current mood state was of the resident and if the resident was exhibiting any behaviors; if the resident needed any psychological services; did the resident have any concerns with social determinants of health which included transportation, health literacy, or social isolation; what was the resident's current discharge plan; were there any barriers to the discharge plan and was there an alternate discharge plan; what durable medical equipment (DME) did the resident use or own at home; what DME and community services may be needed at the time of discharge; was a referral needed to be made to a local contact/government agency; and who was the resident's primary care physician and what pharmacy did they use in the community. Interview on 06/10/25 at 8:49 A.M. with SSC #414, revealed within the first week of admission, the Social Services History Assessment needed to be completed to determine what the resident's discharge plans were going to be, what medical equipment the resident had, if the resident was going to need medical equipment, who was the resident's primary care physician, and if the facility will need to set up a transitional care appointment. She confirmed, after reviewing Resident #284's social service history assessment, the assessment was blank and had not been completed. She stated she had not been in her current position at that time, and the Former SSC #351 had been the one who had initiated the assessment. She could not give a reason why the assessment had not been completed. Based on record review, interview and review of facility policy the facility did not ensure medical records were complete and accurate for Resident #12, #142, and #284. This affected three residents (#12, #142, and #284) out of 43 reviewed for resident records. The facility census was 76. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings include: 1. Record review revealed Resident #12 was admitted [DATE] with diagnoses of bipolar disorder, generalized muscle weakness, spinal stenosis, and cervical disc disorder with myelopathy. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 was cognitively intact, required moderate assistance with toileting hygiene, and maximal assistance with showers and transfers. Review of section Showers/Bathe Self in the electronic record point of care (POC) history revealed Resident #12 received assistance with showers on night shift at 05/19/25 at 4:39 A.M., 05/22/25 at 4:31 A.M., 05/25/25 at 3:14 A.M., and 05/27/25 at 3:31 A.M. Review of the shower schedule revealed Resident received showers twice a week on second shift which was from 2:30 P.M. to 10:30 P.M. Interview on 06/05/25 at 3:19 P.M. with certified nursing assistant (CNA) #350 confirmed she worked third shift on 05/19/25, 05/22/25, and 05/27/25 and that she did not provide any showers to Resident #12 and that she documented under the wrong area. Interview on 06/05/25 at 3:51 P.M. with CNA #305 confirmed Resident #12 only received showers on second shift and that the shower she documented on 05/25/25 at 3:14 A.M. was actually given earlier that day on second shift but was documented late. 2. Record review revealed Resident #142 was admitted [DATE] with diagnoses of unspecified sequelae of cerebral infarction, intercranial space-occupying lesion found on diagnostic imaging of central nervous system, and paralytic gait. Review of the Discharge MDS dated [DATE] revealed Resident #142 was cognitively intact and required moderate assistance with toileting, showers, dressing, and bed mobility. Review of the shower sheets revealed Resident #142 received showers on 02/28/25, 03/10/25, 03/26/25, 04/02/25, 04/03/25, and 04/10/25. Review of section Showers/Bathe Self in the electronic record point of care (POC) history with a run date of 06/11/25 at 1:58 P.M. provided by the DON revealed Resident #142 received two showers on 03/24/25, 03/25/25, 03/26/25, 03/27/25, 04/02/25, 04/03/25, and 04/11/25. Further review revealed documentation reflected three showers were given on 03/04/25, 03/11/25, 03/31/25, and 04/01/25. The documentation also reflected Resident #142 was both independent and dependent, and also required moderate assist, maximal assist, and supervision. Interview on 06/11/25 at 2:58 P.M. with Licensed Practical Nurse (LPN) #320 and CNA #305 revealed staff were to document showers in POC for each shift however, staff should have documented did not occur as the outcome if a shower did not occur on their shift. CNA #305 further explained that showers were also to be documented on shower sheets and should correspond with the dates in POC which did not always occur. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/11/25 at 3:40 P.M. with CNA's #316 and #412 revealed showers were to have been documented in both POC and on shower sheets and confirmed residents were not receiving two to three showers on any given day so the documentation in Resident #142's record was not accurate. Interview on 06/11/25 at 3:50 P.M. with the DON revealed the facility had recently hired a lot of new CNA's who were learning as they go whereas the nurses were sent to training for POC and that shower sheets were recently introduced the beginning of March. Review of the Shower-Tub Bath Policy updated 05/01/25 revealed staff were to document completion of services in the clinical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of facility policy the facility failed to ensure infection control measures were consistently implemented during care of Resident #20, Resident #235, Resident #241, Resident #32 and Resident #139. This affected five residents out of seven residents reviewed for infection control. The facility identified 18 residents (#4, #6, #7, #16, #25, #32, #33, #49, #52, #53 #57, #60, #67, #80, #238, #240, #286, #295) who were on Enhanced Barrier Precautions (EBP) and two resident's (Resident's #70 and #139) who were on Contact precautions. The facility census was 76. Findings include: 1a. Review of Resident #235's medical record revealed an admission date of 05/23/25 and diagnoses including acute kidney failure, open wound lower leg, cognitive communication deficit, muscle weakness, and type two diabetes mellitus. Review of Resident #235's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #235 had moderate cognitive impairment. Resident #235 was dependent for toileting hygiene and required substantial to maximal assistance for bathing. Sit to stand, chair-to-bed-to-chair transfer, toilet transfer and shower transfer were not attempted due to medical condition or safety concerns. Resident #235 was frequently incontinent of urine and bowel. 1b. Review of Resident #20's medical record revealed Resident #20 was discharged from the facility on 05/15/25 and readmitted to the facility on [DATE]. Resident #20's diagnoses included chronic obstructive pulmonary disease, muscle weakness, major depressive disorder and chronic respiratory failure with hypoxia. Review of Resident #20's admission MDS assessment dated [DATE] revealed Resident #20 was cognitively intact. Resident #20 did not reject care during the seven-day assessment look-back period. Resident #20 used a walker and a wheelchair. Resident #20 required substantial to maximal assistance for toileting hygiene and upper and lower body dressing. Resident #20 required partial to moderate assistance for the ability to get on and off a toilet or commode. Resident #20 was occasionally incontinent of urine and frequently incontinent of bowel. A bowel toileting program was not currently being used to manage Resident #20's bowel continence. Review of Resident #20's care plan dated 05/30/25 included Resident #20 was incontinent of bowel per tracking/assessment and was a candidate for a prompted bowel program. Resident #20 would reduce incontinent episodes to zero to one episode weekly by the next review date of 08/30/25. Interventions included to document restorative participation on restorative delivery record per program; encourage Resident #20 to ask staff for help or make staff aware of the need to toilet between identified times; explain program to Resident #20 as able before beginning and give positive feedback and praise Resident #20 for participating in the program; if unable to use the bathroom use a bedside commode to promote bowel movements per program safely; provide physical support, assistance for toileting safety as indicated for resident. (continued on next page)

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Altercare of Cuyahoga Falls Ctr for Rehab & Nursin	2728 Bailey Rd Cuyahoga Falls, OH 44221

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/02/25 at 11:01 A.M. of Resident #235 revealed he was laying in bed and answered questions appropriately. A bedpan could be seen under Resident #235's bed. The bedpan was laying directly on the floor and was not in a plastic bag or a container. Further observation revealed Resident #235's room did not include a bathroom or sink, and the community shower and bathroom was down the hall by the nurses station. Resident #235 confirmed he did use the bed pan when needed. Interview on 06/02/25 at 11:48 A.M. of Assistant Director of Nursing (ADON) #555 confirmed Resident #235 had a bedpan under his bed, the bedpan was placed directly on the floor and was not in a plastic bag or container. ADON #555 stated the bedpan should not be placed directly on the floor. Observation on 06/02/25 at 3:14 P.M. of Resident #20 revealed he was laying in bed watching television. Further observation revealed a bedpan was placed directly on the floor under Resident #20's bed and was not put in a bag or other container. Resident #20's room did not have a bathroom or sink and the community shower, bathroom was down the hall by the nurse's station. Interview on 06/02/25 at 3:39 P.M. of Certified Nursing Assistant (CNA) #556 confirmed Resident #20 had a bedpan placed under his bed and the bedpan was not in a plastic bag or other container. CNA #556 stated many resident rooms did not have bathrooms and it was common practice at the facility to place bedpans directly under resident beds without using plastic bags or other containers including Resident #20 and #235. Interview on 06/10/25 at 7:53 A.M. of the Director of Nursing (DON) revealed she was not aware staff were placing resident bedpans including Resident #20 and #235's under their beds on the floor without using a plastic bag or other container. The DON stated the rooms had no place to hang the bedpans and the bedpans should be placed in bags and kept on top of the Resident's #20 and #235's wardrobe. The DON indicated some of the rooms including Resident's #20 and #235 did not have bathrooms or sinks and the residents had to use the community shower and bathroom. 2. Review of Resident #32's medical record revealed an admission date of 02/25/19 and a readmission date of 12/19/24. Diagnoses included quadriplegia, muscle weakness, major depressive disorder and contractures of right and left hands. Review of Resident #32's care plan dated 04/10/24 included Resident #32 required enhanced barrier precautions (EBP) related to an indwelling medical device. Resident #32 would have EBP maintained to reduce the risk of transmission of MDRO's by facility process by the review date of 08/01/25. Interventions included to post sign to alert caregivers of the need for EBP; utilize the use of PPE (personal protective equipment) gown and gloves during high contact resident care activities when in resident room, shower room or therapy; EBP supplies to be placed in Resident #32's room. Review of Resident #32's Annual Minimum Data Set assessment dated [DATE] revealed Resident #32 was cognitively intact. Resident #32 was dependent for all Activity of Daily Living's and mobility. Resident #32 had an indwelling catheter (suprapubic). Resident #32 used a motorized wheelchair. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/09/25 at 9:03 A.M. of Resident #32's room revealed a sign posted on his door. The sign stated Enhanced Barrier Precautions, everyone must clean hands before entering and when leaving room. Providers and staff must also wear gloves and a gown for the following high contact resident care activities: dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, and device care use including urinary catheters and wound care. PPE supplies including isolation gowns were observed in a plastic cart outside Resident 32's room. Observation on 06/09/25 at 9:03 A.M. of Certified Nursing Assistant (CNA) #435 revealed she entered Resident #32's room to assist with his morning care and bed bath. CNA #435 donned non sterile gloves but did not don an isolation gown before entering Resident #32's room. Observation on 06/09/25 at 9:41 A.M. of CNA #435 revealed she exited Resident #32's room carrying urine in a plastic container. CNA #435 did not have an isolation gown on and carried the urine to the community bathroom, shower room by the nurses station to discard the urine. Resident #32's room did not have a bathroom or sink. Interview on 06/09/25 at 9:41 A.M. of CNA #435 confirmed she did not don an isolation gown before providing Resident #32's bed bath and morning care including draining and discarding the urine from his catheter bag. CNA #435 confirmed the sign on the door stated she should wear PPE including an isolation gown and gloves when providing Resident #32's care. CNA #435 stated the last time she was here an unidentified nurse told her she did not need an isolation gown, and only needed gloves when she provided care for residents who were on Enhanced Barrier Precautions. CNA #435 stated she could not remember what nurse told her. Observation on 06/10/25 at 8:28 A.M. of CNA #420 revealed he entered Resident #32's room to provide incontinence care. CNA #420 donned gloves, but did not don an isolation gown before entering Resident #32's room. Observation on 06/10/25 at 8:36 A.M. of CNA #420 providing Resident #32's incontinence care without donning an isolation gown. CNA #420 threw Resident #32's incontinence brief which was soiled with feces directly on the floor with other soiled sheets and bed linens. CNA #420 did not use a plastic bag or other container for the soiled incontinence brief and bed linens. Interview on 06/10/25 at 8:40 A.M. of CNA #420 confirmed he did not don and isolation gown prior to providing Resident #32's incontinence care and confirmed he threw Resident #32's soiled incontinence brief and bed linens directly on the floor without using a plastic bag or other container. Review of the facility policy titled Perineal Care updated 05/01/25 included it was the facility policy to provide perineal care to residents in order to promote cleanliness, comfort, and reduce the risk of infections and promote skin integrity. Discard disposable items into designated containers and place soiled linen into designated container. 3. Review of Resident #241's medical record revealed an admission date of 05/15/25 and diagnoses included acute appendicitis with localized peritonitis, without perforation or gangrene, atrial fibrillation, acute and chronic respiratory failure, congestive heart failure and anxiety disorder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #241's admission MDS assessment dated [DATE] revealed Resident #241 was cognitively intact. Resident #241 required substantial to maximal assistance for toileting hygiene. Resident #241 was frequently incontinent of urine and bowel. Review of Resident #241's care plan dated 05/28/25 included Resident #241 was incontinent of bowel and was at risk for altered dignity, skin breakdown, diarrhea and constipation. Resident #241 would have soft bowel movements at least every three days without complications by the target date of 08/27/25. Interventions included to check and provide incontinence care as needed and apply moisture barrier cream after each incontinent episode; maintain resident dignity when checking and providing incontinence care for Resident #241. Interview on 06/04/25 at 1:38 P.M. of Environmental Service Coordinator (ESC) #345 revealed the facility and all resident rooms had carpet in them. ESC #345 stated bedside commodes were used in resident rooms without bathrooms and the commodes sit on the carpet which meant the carpet frequently needed cleaned. ESC #345 stated the carpet smells due to bedside commodes leaking. ESC #345 stated a floor technician was just hired to clean the carpets and she has all resident rooms on a cleaning schedule. ESC #345 indicated residents sometimes missed the bedside commode when going to the bathroom and the room needed spot cleaned when that happened. Observation on 06/09/25 at 5:45 A.M. with CNA #394 of Resident #241's room revealed a bedside commode sitting on the carpeted floor. There was a plastic bag covering the bucket in the bedside commode and a moderate amount of yellow urine was in the bucket. The seat of the bedside commode had some brown clumps of bowel movement on it. CNA #394 confirmed the clumps of bowel movement on the seat of the bedside commode and stated alot of times the urine and feces miss the bedside commode and gets on the floor. Looking at the carpet in front of the bedside commoded showed an area with bowel movement on it. CNA #394 confirmed there was bowel movement on the floor. Further observation revealed the privacy curtain separating Resident #241 from his roommate had an area of bowel movement on it. CNA #394 confirmed bowel movement was on the privacy curtain also. CNA #394 stated Resident #241's roommate complained because of the smell from the bedside commode. CNA #394 took the plastic bag out of the bucket, tied the bag and took the bag with urine to the community bathroom and shower room to dispose of it. CNA #394 stated the linen and trash bins were usually kept outside the bathroom in the hall but for some reason today someone put the bins in the shower room. Observation on 06/09/25 at 6:00 A.M. with the Director of Nursing (DON) of Resident #241's room confirmed the presence of bowel movement on the privacy curtain, carpeted floor and seat of bedside commode. The DON stated she would have someone take care of it. 4. Review of Resident #139's hospital Infectious Disease progress note dated 05/19/25 included an aerobic bottle was positive for coagulase negative staphylococcus and Resident #139's urine culture showed greater than 100,000 CFU (colony forming unit) per milliliter proteus mirabilis MDRO (multi-drug resistant organisim) and greater than 100,000 CFU per milliliter pseudomonas aeruginosa. Review of Resident #139 medical record revealed an admission date of 05/21/25 and diagnoses included urinary tract infection, staphylococcus as the cause of diseases classified elsewhere, coagulase negative staph infection and Parkinson's Disease. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #139's physician orders dated 05/22/25 revealed contact transmission based precautions, Resident #139 to remain in room and all services brought to the room. Special instructions: related to signs and symptoms of highly transmissible disease or epidemiologically significant pathogen and, or positive test. Observation on 06/12/25 at 9:06 A.M. of CNA #402 revealed she was standing in Resident #139's room near the foot of his bed. Resident #139 was on contact precautions and CNA #402 was observed not wearing any PPE (personal protective equipment). Upon noticing the surveyor, CNA #402 exited Resident #139's room, pointed to contact precautions sign on Resident #139's door, and asked is this every time? to which the surveyor responded yes. Interview on 06/12/25 at 12:16 P.M. of the Director of Nursing revealed Resident #139 was on contact precautions and PPE including an isolation gown and gloves should be worn when his room was entered. The DON stated Resident #139 was on contact precautions due to proteus mirabalis and pseudomonas aeruginosa in his urine. Review of the facility policy titled Isolation Initiating Transmission Based Precautions updated 11/2020 included it was the facility policy that Transmission Based Precautions would be initiated when there was a reason to believe a resident had a communicable disease. Transmission Based Precaution included contact precautions, droplet precautions or airborne precautions. If a resident was suspected of, or identified as having a communicable infectious disease the CDC guidelines for appropriate transmission based precautions would be followed. Review of Centers for Disease Control and Prevention (CDC) guidance titled Transmission-Based Precautions, Infection Control dated 04/03/2024 included Contact precautions were implemented to prevent the spread of infections that could be transmitted through direct or indirect contact with a patient or their environment. Healthcare personnel must wear gloves and gowns when entering the patient's room and interacting with the patient or their environment. PPE should be donned (put on) before entering the room and doffed (removed) before exiting This deficiency represents non-compliance investigated under Complaint Number OH00165648 OH00165488 and OH00164001.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review, interview, and review of Centers for Disease Control and Prevention (CDC) guidance the facility failed to ensure residents were offered, screened, educated and received pnuemococcal vaccinations as required. This affected five residents (Resident's #4, #6, #32 #49, #139) of five reviewed for vaccinations with the potential to affect all residents in the facility excluding five residents (Resident's #43, #60, #285, #293 and #294) the facility identified as not eligible for the vaccine. The facility census was 76. Findings include: 1. Review of Resident #6's medical records revealed an admission date of 11/01/23. Diagnoses included displaced fracture of the shaft of left femur, subsequent encounter for closed fracture with routine healing. Review of Resident #6's immunization records revealed no documentation related to pnuemococcal vaccinations, consent/declination of the vaccination or education provided on the vaccines. 2. Review of Resident #4's medical record revealed an admission date of 04/18/24 and diagnoses included flaccid hemiplegia affecting the left dominant side, vascular dementia, unspecified severity without behavioral disturbance, psychotic disturbance, or mood disturbance, bipolar disorder and obstructive and reflux uropathy and urine retention. Review of Resident #4's immunization records revealed no documentation related to pnuemococcal vaccinations, consent/declination of the vaccination or education provided on the vaccines. 3. Review of Resident #49's medical record revealed an admission date of 07/12/23 and diagnoses included obstructive and reflux uropathy, type two diabetes mellitus with diabetic neuropathy, anemia, and cognitive communication deficit. Review of Resident #49's immunization records revealed no documentation related to pnuemococcal vaccinations, consent/declination of the vaccination or education provided on the vaccines. 4. Review of Resident #32's medical record revealed an admission date of 02/25/19 and a readmission date of 12/19/24. Diagnoses included quadriplegia, muscle weakness, major depressive disorder and contractures of right and left hands. Review of Resident #32's immunization records revealed no documentation related to pnuemococcal vaccinations, consent/declination of the vaccination or education provided on the vaccines. 5. Review of Resident #139 medical record revealed an admission date of 05/21/25 and diagnoses included urinary tract infection, staphylococcus as the cause of diseases classified elsewhere, coagulase negative staph infection and Parkinson's Disease. Review of Resident #139's immunization records revealed no documentation related to pnuemococcal vaccinations, consent/declination of the vaccination or education provided on the vaccines. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/11/25 at 4:52 P.M. of the Director of Nursing (DON) and Regional Nurse Consultant (RNC) #431 revealed the DON and ADON #410 started working at the facility in the fall around the time influenza vaccines and COVID-19 vaccines were offered. The DON stated they concentrated on making sure influenza and COVID-19 vaccines were offered to the residents, and would offer pneumococcal vaccines later. The DON and RNC #431 stated pneumococcal vaccines were not offered to the residents and they knew it needed to be done and would be a priority going forward. Review of the Centers for Disease Control and Prevention (CDC) information/guidance for pneumococcal vaccination dated 10/26/24 revealed the following: CDC recommends pneumococcal vaccination for children younger than 5 years and adults 50 years or older. CDC also recommends pneumococcal vaccination for children and adults at increased risk for pneumococcal disease. Follow the recommended immunization schedule to ensure that your patients get the pneumococcal vaccines that they need. The CDC guidance provides additional information for the types of risk associated with pneumococcal disease for vaccination of those individuals between the ages of 5 and 49 and also provides guidance on the type of pneumococcal vaccination/schedule for administration based on an assessment of the resident. This deficiency represents non-compliance investigated under Complaint Number OH00165648.