STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365632	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majora Lane Ctr for Rehab & Nsg Care Inc	105 Majora Lane Millersburg, OH 44654

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility policy, the facility failed to notify the physician and/or responsible party of a change in condition. This affected three residents (#7, #35, and #46) of four residents reviewed for notification of change in condition. The facility census was 62.Findings include:1.Record review for Resident #35 revealed an admission date of 06/20/23. Diagnosis included vascular dementia unspecified severity, muscle weakness, age related physical mobility, lack of coordination, and need for assistance with personal care. Review of the Minimum Data Set (MDS) annual assessment dated [DATE] for Resident #35 revealed Resident #35 was moderately cognitively impaired. Resident #35 required extensive assistance with bed mobility, transfers, toilet use, and supervision with eating. Review of the care plan for Resident #35 dated 05/09/25 revealed Resident #35 had depression and anxiety. The goal included Resident #35 will maintain a daily routine that promotes maximum mental health and well being. Interventions included to report any increase or exacerbation of behaviors or conditions to physician, remove resident to a quiet area and allow time to re-focus. Notify the physician, encourage the resident to voice concerns, and identify factors that may cause exacerbation of behaviors such as overstimulation, time of day. Interview on 07/24/25 at 7:45 A.M. with Certified Nursing Assistant (CNA) #210 revealed she and CNA #277 came in one day in June 2025 to start their shift. Resident #35 rolled out of his room in his wheelchair crying. Resident #35 said a CNA and a nurse sat on top of him and trimmed his nails and cut him. CNA #210 recalled Resident #35 had a band aid on his thumb. Interview on 07/24/25 at 11:13 A.M. with CNA #277 revealed she and CNA #210 came into work one morning, this was sometime during the beginning of June 2025, and observed Resident #35 crying. Resident #35 was crying, complaining of his finger, and I asked what was wrong. Resident #35 stated staff the night prior cut his nail. Resident #35's thumb nails were always long, he stated he liked them long as it helped him open things, and staff left them long. CNA #277 revealed the night shift CNA the night prior had reported Resident #35 was being combative that night. Resident #35 had reported he was on the toilet the night prior and they (night shift staff) came in, cut his nails. Resident #35 reported staff were holding him down, cutting his nails, and cut his thumb. CNA #277 revealed she had observed Resident #35 with a band aid on his thumb and she reported this to Program Director #204 the same morning it occurred. Interview and record review on 07/24/25 at 3:24 P.M. with Program Director #204 of Resident #35's medical record from 01/01/25 to 07/24/25 confirmed there was no documentation of Resident #35's physician being notified of the incident when staff trimmed his nails on night shift. Interview on 07/24/25 at 4:13 P.M. with Resident #35's family member revealed she recalled the day when the night shift staff trimmed Resident #35's nails. When she came in to the facility that morning, she saw the band aid on his thumbnail. The family member stated, I got there, it was a month or two ago, he was upset, he did get teary eyed talking about it, he did have a band aid on it, they cut back too far, I guess it bled quite a bit so that's why. The family member additionally reported she now comes in and trims Resident #35's nails herself. Resident #35 had reported to her that one staff member held his arms down while another trimmed his nails, and he was upset. Program Director #204 had told her it was night shift who had trimmed the nails, that she was unsure what happened but was sorry and asked the family member to trim the nails from then on. The family member reported she had been trimming the resident's nails before that incident, but they must have gotten longer than she had thought. Interview on 07/24/25 at 4:24 P.M. with Resident #35 stated, I was in the bathroom, I don't know why they came in they were hurrying me, the one sat on my legs and the other held my arms, it was my left nail, I told her to stop she didn't she cut back to far it cut in and bled everywhere. Resident #35 reported after they let him go, the staff member cleaned up the blood. Resident #35 reported to his family member he was so upset. Resident #35 reported he liked his thumb nails long and stated he used to work construction and with wood, and would use the nail kind of like a putty knife and always kept his thumb nails long. Interview on 07/25/25 at 6:58 A.M. with CNA #202 confirmed she recalled the night when she assisted in trimming Resident #35's nails. CNA #202 stated Resident #35 did not want staff to cut his nails. CNA #202 was trying to change him and he was scratching, hitting, and kicking her. CNA #202 went to retrieve LPN #223. LPN #223 got her fingernail clippers, came into Resident #35's bathroom where he was seated on the toilet. She held his arm and trimmed his nails while CNA #202 held his other arm down. CNA #202 reported she had to hold the resident's other arm down so the nurse could trim the resident's nail as he was fighting so bad. CNA #202 stated LPN #223 clipped his finger and it did

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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 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. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**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 the residents' environment in the secured unit was clean and homelike. This had the potential to affect all 17 residents (#6, #9, #11, #19, #22, #24, #26, #27, #28, #33, #35, #38, #41, #44, #46, #51, and #57) residing in the secured unit. The facility census was 62. Findings include: 1.Record review for Resident #35 revealed an admission date of 06/20/23. Diagnosis included vascular dementia unspecified severity, muscle weakness, age related physical mobility, lack of coordination, and need for assistance with personal care. Review of the Minimum Data Set (MDS) annual assessment dated [DATE] for Resident #35 revealed Resident #35 was moderately cognitively impaired. Resident #35 required extensive assistance with bed mobility, transfers, and toilet use. Resident #35 used a raised toilet seat. Observation on 11/24/25 at 11:09 A.M. revealed the shared bathroom of Resident #35 and Resident #38 had a plastic toilet seat riser (used to elevate the height of the standard toilet bowl reducing the amount of effort needed to sit and stand). The toilet seat riser had areas of smeared stool. The rim under the seat, (used to hold the seat in place) was broken and dangling in the toilet bowl with black/grey discoloration and dried urine. The area had a foul odor. Resident #35 wheeled himself in the bathroom and began to transfer himself onto the raised toilet seat. CNA #210 entered and assisted Resident #35 onto the raised toilet seat to toilet. CNA #210 verified the broken raised toilet seat that had dried stool and urine. 2. Record review for Resident #38 revealed an admission date of 02/20/24. Diagnosis included unspecified dementia without behavioral disturbances, muscle weakness, and need for assistants with personal care.Review of the significant change in status MDS assessment dated [DATE] revealed Resident #38 was rarely or never understood, was frequently incontinent of bowel and bladder, required partial/moderate assistance with toileting hygiene, and supervision or touch assistance with chair/bed to chair transfer, and ambulation. Observation and Interview on 07/24/25 at 7:43 A.M. with Certified Nursing Assistant (CNA) #210 revealed the toilet in the shower room (located in the secured unit) was not flushing consistently, and it hadn't been for about two weeks. CNA #210 revealed they used the toilet in the shower room every day to assist residents with toileting after meals and revealed maintenance had been notified on several occasions. Observation of the toilet in the shower room with CNA #210 confirmed the toilet was not working properly and did not flush. Observation revealed the floor surrounding the toilet appeared dirty with a large amount of dirt/grime build up. Inside the shower, the caulking on the floor was grey/black. Observation revealed there was only one shower room on the secured unit.Observation and interview on 07/24/25 at 4:29 P.M. with CNA #308 confirmed she was the CNA for the second shift. First shift CNAs had left for the day. Observation of the raised toilet seat in Resident #35 and #38's shared bathroom revealed the raised toilet seat was still present, broken and uncleaned. The bathroom also still had a foul strong odor of urine. CNA #308 lifted the riser. The bottom of the riser had stained dried stool/urine along with a black/grey substance. CNA #308 confirmed the observation. Interview on 07/28/25 at 12:09 P.M. with Program Director #204 verified both residents, Residents #35 and #38 used the same raised toilet seat. Program Director #204 confirmed Resident #38 did not have an order or care plan for the raised toilet seat but again verified he does use it daily. Program Director #204 confirmed all residents residing in the secured unit use the shower. Observation and interview on 07/28/25 at 12:20 P.M. with Maintenance Coordinator #263 confirmed staff reported the toilet in the secured unit shower room was not working. Maintenance Coordinator #263 revealed when he checked it, it was working. Observation of the shower room in the secured unit revealed the toilet flushed. Maintenance Coordinator #263 confirmed surrounding the toilet and on the base was dirt/grime build up. There was also rust build up on the base of the toilet and on the floor surrounding the toilet. Maintenance Coordinator #263 revealed the rust was from water. Maintenance Coordinator #263 verified in the shower stall there was black/grey mold along the caulking on the floor and revealed he recently cleaned and repaired the wall in the shower stall where there was also a large amount of mold.Review of the facility policy titled, Environmental Services updated 07/01/25 revealed it is the facilities policy to maintain the resident's environment is a clean and sanitary condition.This deficiency represents non-compliance investigated under Complaint Number 1373625 (OH00167388).

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility policy, the facility failed to ensure Resident #35 was free from physical restraints. This affected one resident (#35) of one resident reviewed for physical restraints. The facility census was 62. Findings include: Record review for Resident #35 revealed an admission date of 06/20/23. Diagnosis included vascular dementia unspecified severity, muscle weakness, age related physical mobility, lack of coordination, and need for assistance with personal care. Review of Resident #35's care plan dated 09/21/23 revealed Resident #35 had impaired ability to perform or participate in activities of daily living (ADL) care. Interventions included to assist Resident #35 with toileting if needed, encourage the resident to participate with care as tolerated, and provide nail care and shampoo hair with showers per weekly schedule. Continued review of Resident #35's care plan dated 01/19/25 and 05/09/25 included Resident #35 will maintain daily routine that promotes maximum mental health and wellbeing; Report any increase or exacerbation of behaviors or conditions to physician, remove resident to a quiet area and allow time to re-focus. Encourage Resident #35 to voice concerns, identify factors that may cause exacerbation of behaviors such as overstimulation, and involve the resident in daily care and decision making as much as possible. Review of the Minimum Data Set (MDS) annual assessment dated [DATE] for Resident #35 revealed Resident #35 was moderately cognitively impaired. Resident #35 required extensive assistance with bed mobility, transfers, toilet use, and supervision with eating. Observation on 07/24/25 at 7:43 A.M. revealed Resident #35 was seated in his wheelchair. Resident #35 propelled himself without difficulty using his upper and lower extremities. Resident #35 was pleasant and was able to converse appropriately. Interview on 07/24/25 at 7:45 A.M. with Certified Nursing Assistant (CNA) #210 revealed she and CNA #277 came in one day in June 2025 to start their shift. Resident #35 rolled out of his room in his wheelchair crying. Resident #35 said a CNA and a nurse sat on top of him and trimmed his nails and cut him. CNA #210 recalled Resident #35 had a band aid on his thumb. Interview on 07/24/25 at 11:13 A.M. with CNA #277 revealed she and CNA #210 came into work one morning, this was sometime during the beginning of June 2025, and observed Resident #35 crying. Resident #35 was crying, complaining of his finger, and I asked what was wrong. Resident #35 stated staff the night prior cut his nail. Resident #35's thumb nails were always long, he stated he liked them long as it helped him open things, and staff left them long. CNA #277 revealed the night shift CNA the night prior had reported Resident #35 was being combative that night. Resident #35 had reported he was on the toilet the night prior and they (night shift staff) came in, cut his nails. Resident #35 reported staff were holding him down, cutting his nails, and cut his thumb. CNA #277 revealed she had observed Resident #35 with a band aid on his thumb and she reported this to Program Director #204 the same morning it occurred. Interview on 07/24/25 at 3:24 P.M. with Program Director #204 revealed she was the coordinator for the secured unit. Program Director #204 reported she was told the staff trimmed Resident #35's nails because he had been clawing at them. Staff had reported Resident #35 was soaked and they went in to change him when he started grabbing them and digging his nails into them. Program Director #204 questioned if he had actually allowed the staff to trim his nails as she knew how he was about his fingernails and he preferred long thumb nails. Staff reported the nurse trimmed one hand while the CAN held the other hand. Program Director #204 reported that was all she had been told. She was not sure if staff had applied a band aid, but a CNA from another shift may have said something about putting a band aid on but she could not remember for sure. Program Director #204 recalled the nurse involved was Licensed Practical Nurse (LPN) #223 and the aide involved was CNA involved was CNA #202. Review of Resident #35's medical record from 01/01/25 to 07/24/25 with Program Director #204 at the time of the interview confirmed there was no documentation including in the physician orders, progress notes, or evidence of skin assessments related to the occurrence or injury to Resident #35's thumb. Record review of the incident reports with Program Director #204 confirmed there was no report of the incident for Resident #35. Interview on 07/24/25 at 4:13 P.M. with Resident #35's family member revealed she recalled the day when the night shift staff trimmed Resident #35 ' s nails. When she came into the facility that morning, she saw the band aid on his thumbnail. The family member stated, I got there, it was a month or two ago, he was upset, he did get teary eyed talking about it, he did have a band aid on it, they cut back too far, I guess it bled quite a bit so that' s why. The family member additionally reported she now comes in and trims Resident #35's nails herself. Resident #35 had reported to her that one staff member held his arms down while

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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, and record review, the facility failed to ensure one resident, Resident #7, was provided with timely incontinence care. This affected one resident, (Resident #7) of three residents reviewed for incontinence care. The facility census was 62. Findings include: Record review for Resident #7 revealed an admission date of 04/30/24. Diagnosis included personal history of urinary tract infections, hemiplegia and hemiparesis following cerebral infarction, need for assistants with personal care, and muscle weakness. Review of the care plan dated 05/15/24 revealed Resident #7 was incontinent of bladder and was at risk for altered dignity, skin breakdown, and urinary tract infections (UTI). Interventions included to check and provide incontinence care as needed. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #7 was moderately cognitively impaired. Resident #7 was always incontinent of bowel and bladder, and was dependent for toileting hygiene, chair/bed to chair transfers, and toilet transfer. Interview on 07/25/25 between 7:12 A.M. and 9:48 A.M. with Assistant Director of Nursing (ADON) #207 and Registered Nurse (RN) Supervisor #316 revealed residents should be checked and changed if needed every two hours and as needed. Observation on 07/25/25 at 10:00 A.M., 12:10 P.M., and 3:07 P.M. revealed Resident #7 was up in her wheelchair. Interview on 07/25/25 at 3:12 P.M. with Certified Nursing Assistant (CNA) #239 confirmed she was Resident #7's primary CNA. CNA #239 revealed Resident #7 liked up in the morning between 9:00 A.M. and 10:00 A.M., and revealed she provided incontinence care for Resident #7 before she got her up that morning. CNA #239 confirmed she had not checked or changed Resident #7 since she got her up earlier that morning. Interview on 07/25/25 at 3:50 P.M. with Resident #7 revealed the staff got her up before 10:00 A.M. Resident #7 remembered the time because 10:00 A.M. was the scheduled smoking time. Resident #7 stated after the staff get her up into her chair in the morning, the staff do not check to see if she needs to be changed again until she goes to bed in the evening. Resident #7 stated, They never ask to check me, yes I am wet, I am incontinent, and they never check or change me during the day. Requested observation on 07/25/25 at 4:10 P.M. of incontinence care for Resident #7 with CNAs #239 and #281 revealed Resident #7 was transferred to bed via a mechanical lift. CNAs #239 and #281 reported Resident #7 usually goes to bed after the scheduled 7:00 P.M. smoke break. Resident #7 reported during the observation that her buttocks area felt sore. Observation revealed after removing Resident #7's pants, the brief underneath was bulging, saturated, and had a foul odor. Observation revealed after removing the brief, Resident #7's buttocks ware red. Resident #7 confirmed this was the first time she was changed since she got up that morning.

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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. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 timely assess and notify the physician when Resident #7 was noted to have blood in her urine. This affected one resident, Resident #7 of three resident reviewed for incontinence care. The facility census was 62. Findings include: Record review for Resident #7 revealed an admission date of 04/30/24. Diagnosis included type two diabetes mellitus with diabetic neuropathy, personal history of urinary tract infections, hemiplegia and hemiparesis following cerebral infarction, obstructive and reflux uropathy, presence of urogenital implants, need for assistance with personal care, and muscle weakness. Review of the care plan dated 05/01/24 for Resident #7 revealed Resident #7 had urinary obstruction, urinary retention, cystitis, unspecified hydronephrosis, right urinary stent placement, and overactive bladder, bloody urine at times. Interventions included to report UTI (acute confusion, urgency, frequency, bladder spasms, nocturia, burning pain, foul odor, concentrated urine, blood in urine). Review of the physician order for Resident #7 dated 06/26/24 revealed Resident #7 received Macrodantin (an antibiotic) 50 milligrams (mg) orally once a day for urinary tract infection (UTI) prophylactic (Intended to prevent UTI). Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #7 was moderately cognitively impaired. Resident #7 was always incontinent of bowel and bladder, was dependent for toileting hygiene, lower body dressing, bed mobility, chair/bed to chair transfers, and toilet transfer. Resident #7 had no pain marked in the past five days. Observation on 07/25/25 at 4:10 P.M. of incontinence care for Resident #7 with Certified Nursing Assistant (CNA) #239 and CNA #281 revealed Resident #7's brief was saturated with a mixture of foul-smelling blood and urine. Resident #7 stated I have a UTI. CNAs #239 and #281 confirmed the large amount of foul-smelling blood and urine in the brief and revealed the blood and urine has been in Resident #7's briefs when they change her for more than a month. CNA #281 revealed she remembered because that was when she started working at the facility; Resident #7 was bleeding then and has been ever since. Observation revealed as the CNAs wiped Resident #7's perineal area to clean her, the cloth had bright red smears of blood after each wipe. Interview and record review of Resident #7's medical record on 07/25/25 at 4:24 P.M. with the Director of Nursing (DON) and Administrator from 06/01/25 through 07/25/25 revealed Resident #7 had no documentation in the medical record of having blood in her urine. The DON revealed Resident #7 had a history of UTIs with blood in the urine, but none recently. The DON revealed she was unaware of Resident #7 currently having blood in the urine and confirmed if Resident #7 had blood in the urine, the nurses should have assessed Resident #7 when the bleeding started, notified the physician, and documented the assessment and notification. Phone interview on 07/25/25 at 4:47 P.M. with Resident #7's Primary Physician/Medical Director #320 with the DON and Administrator present revealed she was not aware Resident #7 had blood in her urine recently. Primary Physician/Medical Director #320 stated, She has had that in the past but not recently; I do need to be made aware when that happens so we can address that, no one made me aware. Interview on 07/28/25 at 11:14 A.M. with Registered Nurse (RN) 221 confirmed she was the charge nurse on day shift on 07/25/25. RN #221 revealed she was not told at any time during the previous month that Resident #7 had blood in her brief when being changed. RN #221 revealed CNAs do not always tell the nurses when something is going on, they know they are supposed to, but they just don't. Phone interview on 07/28/25 at 11:30 A.M. with Primary Physician/Medical Director #320 revealed a person could still have a UTI even if they were on a prophylactic antibiotic if the antibiotic was resistant. Primary Physician/Medical Director #320 revealed she ordered labs including a urinalysis and a complete blood count, a bladder/kidney ultrasound, and a gynecology consult for Resident #7 due to the blood in the urine reported on 07/25/25. Primary Physician/Medical Director #320 revealed she cannot be sure what is going on, until the culture and ultrasound results are back and the consultation with the gynecologist is completed. Interview on 07/28/25 at 12:40 P.M. with Certified Nurse Practitioner (CNP) #321 revealed she worked with Primary Physician/Medical Director #320 and Resident #7. CNP #321 confirmed she was not told about Resident #7's blood in the urine. CNP #321 revealed Resident #7 had a history of blood in the urine but none since her last UTI several months ago. CNP #321 revealed she would have wanted to be informed and was not. Review of the facility policy titled, Change in the Resident's Condition or Status updated 05/01/25 revealed the nurses will immediately notify the resident; consult with the resident's attending physician, on call physician, nurse practitioner, physician assistant, or clinical nurse specialist and notify the residents

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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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365632	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majora Lane Ctr for Rehab & Nsg Care Inc	105 Majora Lane Millersburg, OH 44654

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility policy, the facility failed to ensure injuries for two residents (#35 and #46) were recorded in each resident's medical record. This affected two (#35 and #46) of three residents reviewed for documentation. The facility census was 62.Findings include: 1. Record review for Resident #35 revealed an admission date of 06/20/23. Diagnosis included vascular dementia unspecified severity, muscle weakness, age related physical mobility, lack of coordination, and need for assistance with personal care. Review of the Minimum Data Set (MDS) annual assessment dated [DATE] for Resident #35 revealed Resident #35 was moderately cognitively impaired. Resident #35 required extensive assistance with bed mobility, transfers, toilet use, and supervision with eating. Interview on 07/24/25 at 7:45 A.M. with Certified Nursing Assistant (CNA) #210 revealed she and CNA #277 came in one day in June 2025 to start their shift. Resident #35 rolled out of his room in his wheelchair crying. Resident #35 said a CNA and a nurse sat on top of him and trimmed his nails and cut him. CNA #210 recalled Resident #35 had a band aid on his thumb. Interview on 07/24/25 at 11:13 A.M. with CNA #277 revealed she and CNA #210 came into work one morning, this was sometime during the beginning of June 2025, and observed Resident #35 crying. Resident #35 was crying, complaining of his finger, and I asked what was wrong. Resident #35 stated staff the night prior cut his nail. Resident #35's thumb nails were always long, he stated he liked them long as it helped him open things, and staff left them long. CNA #277 revealed the night shift CNA the night prior had reported Resident #35 was being combative that night. Resident #35 had reported he was on the toilet the night prior and they (night shift staff) came in, cut his nails. Resident #35 reported staff were holding him down, cutting his nails, and cut his thumb. CNA #277 revealed she had observed Resident #35 with a band aid on his thumb and she reported this to Program Director #204 the same morning it occurred. Interview and record review on 07/24/25 at 3:24 P.M. with Program Director #204 of Resident #35 ' s medical record from 01/01/25 to 07/24/25 confirmed there was no documentation of Resident #35 ' s physician being notified of the incident when staff trimmed his nails on night shift. 2. Record review for Resident #46 revealed an admission date of 06/12/24. Diagnosis included metabolic encephalopathy, Alzheimer ' s disease, history of falling, muscle weakness and need for assistance with personal care. Review of the care plan for Resident #46 dated 10/23/24 revealed Resident #46 frequently thinks he is working, tinkers with items, crawls on the floors and under furniture at times to work. Interventions included providing a fidget board. Review of the MDS quarterly assessment dated [DATE] revealed Resident #46 was rarely or never understood. Resident used a walker or wheelchair for mobility. Resident #46 required supervision or touching assistance with eating, bed mobility, substantial/maximal assistants with sit to stand, transfers, toileting, bathing, and personal hygiene and partial/moderate assistance with walking. Resident #46 had no falls since admission. Review of the progress note dated 06/18/25 at 10:11 A.M. completed by Program Director Licensed Practical Nurse (LPN) #204 revealed she spoke with Resident #46 ' s daughter who voiced understanding and acknowledged she was aware Resident #46 was transferred to the hospital. Review of the progress note dated 07/04/25 at 11:30 A.M. completed by Registered Nurse (RN) #316 revealed Resident #46 returned to the facility from a hospital stay. Resident #46 had no skin concerns except for a bruised left under eye area. Review of the medical record for Resident #46 for June 2025 revealed no documentation of Resident #46 having a bruised left eye prior to going to the hospital. Review of the wound summary report from 05/01/25 through 07/24/25 to include bruises revealed Resident #46 had no documentation related to the bruise left eye. Interview on 07/24/25 at 1:18 P.M. with Program Director #204 revealed Resident #46 went to the hospital on 6/17/25 due to unmanageable behaviors. Resident #46 ' s family lived out of state and rarely visited. Program Director #204 revealed Resident #46 had a bruised left eye before going to the hospital stating, It was swollen, mushy, we used ice packs on it. Program Director #204 confirmed there was no documentation in Resident #46 ' s medical record about the bruised and swollen left eye that was treated with ice packs and revealed she was unsure how the incident occurred. Program Director #204 confirmed Resident #46's physician nor Guardian was notified of Resident #46 ' s bruised and swollen left eye. Record review on 07/24/25 at 2:19 P.M. with Program Director #204 who presented a QAA document dated 06/12/25 naming Resident #46 as the person involved. The form was signed by the Director of Nursing (DON) and stated the resident purposefully attempted to get out of bed and down to the floor. Resident #46's head was near the handrail as he tried to lower himself. The documentation included the resident became