In the Court of Common Pleas for Stark County, Ohio

BRUCE VANDERHOFF, DIRECTOR OHIO DEPARTMENT OF HEALTH 246 North High Street Columbus, Ohio 43215	:	Case No. ____ 2026CV00066 Judge _____
Plaintiff,	:	
v.	:	
HARI GROUP, LLC dba HOUSE OF LORETO 2812 Harvard Ave. NW Canton, OH 44709	:	
and	:	
c/o Statutory Agent, Bharat Thakkar 3922 Wood Road Madison, OH 44057	:	
Defendant.	:	

COMPLAINT FOR INJUNCTIVE RELIEF UNDER R.C. 3721.08

INTRODUCTION

1. Plaintiff Bruce Vanderhoff ("The Director") is the Director of the Ohio Department of Health ("ODH"). The Director has authority under R.C. Chapter 3721 to grant and monitor licensed nursing homes.

2. This action is brought under R.C. 3721.08(B) which authorizes the Director to "petition the court of common pleas of the county in which the home is located for such injunctive relief as is necessary to close the home, transfer one or more occupants to other homes or other appropriate care settings, or otherwise eliminate the real and present danger. The court shall have the jurisdiction to grant such injunctive relief upon a showing that there is real and present danger."

3. Defendant Hari Group, LLC owns and operates the House of Loreto ("HL") -- a nursing home licensed by ODH. It is located at 3812 Harvard Ave, NW, Canton, Ohio 44709.

4. Ownership of HL transferred in March 2025 to Hari Group, LLC.

5. ODH Surveyors have repeatedly inspected HL and seen a rapid deterioration of care to its residents. On or about December 15, 2025, ODH notified HL that twelve of its residents had been in "Real and Present Danger" since November 12, 2025, due to shockingly poor care. There were only twenty-nine residents present at HL, so over a third of the residents are in Real and Present Danger. (As of January 10, 2026, there were twenty-seven residents present.)

6. The primary underlying issue is that HL does not have a full-time registered nurse acting as the Director of Nursing. The previous DON went on medical leave at the end of October (with no known return-to-work date). A third-shift, part-time nurse agreed to be DON. But during the entire month of December 2025, she

worked between one and three eight-hour shifts per week -- all during the night shift. Ohio law requires that a DON work at least five eight-hour shifts "predominantly" during the day. Adm.Code 3701-17-08(B).

7. There is a licensed nursing home administrator at HL. But she is hands-off to an extreme degree, delegating almost all work to the "executive director" -- an individual with no health care license.

8. With no one at the wheel, it is hardly surprising that HL is spinning out of control.

9. It is a basic role of nursing homes to try to prevent falls, and when one occurs, to conduct a root cause analysis to try to prevent further falls. HL simply is not doing that. One resident fell eight times between November 26 and December 30, 2025. The resident suffered significant injuries including intercranial bleeding and a fractured clavicle. Yet even though that resident suffered serious injuries, HL has not conducted root cause analysis to figure out why the resident fell in the first place.

10. Another key role of nursing homes is to assure that residents receiving blood thinners (such as Coumadin/warfarin) receive proper blood testing to assure that they will not spontaneously bleed to death. HL has repeatedly failed to notify prescribers of adverse test results and, for one patient, continued to administer warfarin even after a physician ordered the warfarin to be discontinued.

11. One of the most common reasons that individuals enter nursing facilities is because they have wounds that need skilled care. The wound care by HL has been haphazard at best. For one resident, HL's staff thought that wound care was being done by a private duty nurse -- it wasn't. The resident ended up with much more serious injuries in his legs, while complaining that he was in a lot of pain. Not surprising because HL failed to administer pain medication to the resident for eleven days.

12. On January 10, 2026, ODH surveyors did a monitoring inspection. HL had failed to take its residents out of real and present danger. The only nurse on staff was an LPN from an agency (it was her second time she had ever worked at the facility) The only manager on site was the laundry manager. There continued to be resident falls without any follow-up investigation, staff could not find the results of a warfarin blood test for a resident, and a hospice patient was denied pain medication.

13. The Director does not seek this injunction lightly. HL is so dysfunctional that the Director lacks any confidence that the current leadership at HL will be able to right the ship.

PARTIES

14. The Ohio Department of Health ("ODH") is a cabinet agency created under R.C. 121.02(G) and is administered by Director Bruce Vanderhoff ("the Director") consistent with R.C. Chapter 3701.

15. Defendant Hari Group, LLC owns and holds the license to operate the House of Loreto nursing home located in Canton, Ohio.

JURISDICTION AND VENUE

16. This Court has jurisdiction over this matter pursuant to R.C. 3721.08, R.C. 2307.382(A)(1), and Civ. R. 65.

17. Venue is proper because House of Loreto operates in Stark County, Ohio.

LAW

18. "'Real and present danger' means immediate danger of serious physical or life-threatening harm to one or more occupants of a home." R.C. 3721.01(A)(14).

19. "'Home' means an institution, residence, or facility that provides, for a period of more than twenty-four hours, whether for a consideration or not, accommodations to three or more unrelated individuals who are dependent upon the services of others, including a nursing home, residential care facility, home for the aging, and a veterans' home[.]" R.C. 3721.01(A)(1)(a).

20. "Unless the department of medicaid or contracting agency has taken action under section 5165.77 of the Revised Code to appoint a temporary manager or seek injunctive relief, if, in the judgment of the director of health, real and present

danger exists at any home, the director may petition the court of common pleas of the county in which the home is located for such injunctive relief as is necessary to close the home, transfer one or more occupants to other homes or other appropriate care settings, or otherwise eliminate the real and present danger. The court shall have the jurisdiction to grant such injunctive relief upon a showing that there is real and present danger." R.C. 3721.08(B).

21. "Each nursing home will:

    (1) employ a registered nurse to serve as director of nursing:

        (a) This standard may be met by two registered nurses who share the position as co-directors of nursing.

        (b) The director of nursing or co-directors of nursing will be on duty five days per week, eight hours per day predominantly between the hours of six a.m. and six p.m. to direct the provision of nursing services.

        (c) The nursing home will post the name of the director of nursing in a place easily accessible to residents, resident's families or sponsors, and staff.

    (2) Designate another registered nurse in its employ to serve as acting director of nursing in the event the director of nursing or co-directors of nursing are absent from the nursing home due to illness, vacation or an emergency situation. The nursing home will post the name of the acting director of nursing in a place easily accessible to residents, residents' families or sponsors, and staff."

    Adm.Code 3701-17-08(B).

22. "Each operator will appoint an administrator. The administrator is responsible for:

    (1) Daily operation of the nursing home in accordance with rules 3701-17-01 to 3701-17-26 of the Administrative Code;

(2) Implementation of the provisions of section 3721.12 of the Revised Code, including the development of policies and procedure that ensure the rights of residents are not violated;

(3) Ensuring that individuals used by the home are competent to perform their job responsibilities and that services are provided in accordance with acceptable standards of practice;

(4) Notifying the department of any of the following:

(a) Interruption of essential services or a notice of potential interruption of essential services, due to lack of payment. Essential services include, but are not limited to, therapy, phone, internet service provider, a utility, food delivery, fire alarm monitoring, and maintenance contracts;

(b) Inadequate staffing, meaning the nursing home does not have enough staff available to meet the needs of residents based on the acuity and/or number residents as per the facility's assessment; and

(c) A known change in the control, ownership or operator of the facility or a change in the company to which the administrator reports.

(5) If the nursing home is physically part of a hospital, inform a prospective resident, prior to admission, that the home is licensed as a nursing home and is not part of the acute care service of the hospital." Adm.Code 3701-17-06(B).

FACTUAL BACKGROUND

23. HL has operated as a nursing home in Ohio since approximately 1963.

24. In March 2025, ODH authorized Hari Group, LLC to purchase HL.

HL Has No Qualified Leadership.

25. The current executive director for HL told an ODH surveyor on or about December 18, 2025, that Hari Group, LLC purchased HL sight unseen and that Hari Group,

LLC did not have any experience running a healthcare business. Exhibit A, Survey at 13.

26. When HL purchased House of Loreto, a very experienced nursing home administrator was in place. However, HL acknowledged to a surveyor that the administrator did not have operational control or decision-making authority. Exhibit A, Survey at 15. The nursing home administrator resigned in August 2025. Exhibit A, Survey at 14.

27. Although HL does have a licensed nursing home administrator, the *de facto* administrator is the executive director. She does not have a license to be a nursing home administrator. Exhibit A, Survey at 16. When she was hired, she was hired to perform "sales/marketing" with no job description. *Id.* In an interview on or about December 3, 2025, she told an ODH surveyor that she had no clinical background and had nothing to do with the nursing department. *Id.* at 17.

28. The owner of Hari Group, LLC told surveyors in December 2025 that his son Parth Thakker primarily oversees operations within the facility, but that the son was currently on an extended vacation in India. Mr. Thakker does not have a nursing license, nor is he a licensed nursing home administrator.

29. The facility lacks a director of nursing ("DON"). An individual was working as the "interim" DON but has been on an extended leave of absence since the end of October 2025 with an unknown return to work date. Exhibit A, Survey at 18.

30. HL has installed a part-time night-shift nurse as the DON. She reported to ODH surveyors that she was "thrusted" into the acting DON position. Exhibit A, Survey at 18.

31. A DON must be "on duty five days per week, eight hours per day predominately between the hours of six a.m. and six p.m. to direct the provision of nursing services." Adm.Code 3701-17-08(B)(1)(b).

32. The DON is a part-time employee who only works at night. During the week of November 30, she worked two eight hours shifts. During the week of December 7, she again worked two eight-hour shifts. The week of December 14, the DON worked three eight-hour shifts. The week of December 21, the DON worked only one eight-hour shift. Exhibit A, Survey at 19. The DON has not worked any daytime hours since the prior DON went on medical leave. Exhibit A, Survey at 18.

33. HL failed to post anything to identify the acting DON to staff, residents or visitors a requirement of Adm.Code 3701-17-08(B)(2).

34. On December 29, 2025, HL reported that it did not have any interviews scheduled to hire a new DON. Exhibit A, Survey at 20.

35. On December 30, 2025, the executive director told surveyors that she was not participating in any day-to-day activities of the facility or participating in any corrective action efforts. Exhibit A, Survey at 20.

36. When confronted with various failings, the administrator repeatedly cited the lack of a full-time DON as a primary reason. Exhibit A, Survey at 22.

37. On December 31, 2025, HL supplied an "Abatement Plan." HL claims that it had recently engaged a job search for a director of nursing. It states, in total:

> Qualified DON -- Leaderstat and Tobin & Assoc -- contracts are pending for interim DON assignment. Both companies are both actively looking for candidates.

Exhibit B, Plan of Correction, p.1

38. Not coincidentally, HL's own policies require it to have to have its residential care overseen by a board. All agree that it does not have such a governing board. 42 CFR 483.70(d) requires nursing homes to comply with their own governing policies.

39. ODH conducted an unannounced monitoring visit on January 10, 2026. The faculty administrator was not present during the inspection. Exhibit C, 1/10/26 Monitoring Visit Report. HL had still not arranged for a full-time RN to act as the DON.

40. When ODH surveyors arrived, the manager in charge of HL was the laundry supervisor. The Executive Director (who does not have a health care license), after receiving a phone call, did drive in. She was unable to provide key documents explaining repeatedly that she was "limited" because she does not have a nursing background. Exhibit C, 1/10/26 Monitoring Visit Report.

41. Only one nurse was on site when surveyors arrived, an LPN that was hired through an agency. It was her second day at the facility and her training apparently only consisted of having a list of phone numbers to call. Exhibit C, 1/10/26 Monitoring Visit Report.

42. The LPN reported that there was a problem with a medication order for a resident and she was unable to get guidance from any individual employed by HL. Exhibit C, 1/10/26 Monitoring Visit Report.

43. The second-shift LPN arrived during the monitoring visit. She reported that this was her first time at the facility. She was given a report from the daytime nurse (working her second shift ever at the facility), but not given a tour, or provided information about the locations of supplies, fresh water, applesauce for medication administration, overflow or a contact list for administration. Exhibit C, 1/10/26 Monitoring Visit Report.

HL Is Failing To Prevent Falls After Residents Have Serious Injuries

44. One of the most basic jobs for a nursing home is to try to minimize the risk that residents will fall. Adm.Code 3701-17-10(E)(10). And if there is a fall, nursing homes must figure out why the fall happened and try to take any necessary steps to prevent repeat falls. Adm.Code 3701-17-14(B) ("Each nursing home will provide adequate supervision of residents who are assessed for risk of falls[.]")

45. HL does not have a log or system to track incidents and accidents. Exhibit A, Survey at 21.

46. When asked to list all falls and accidents, the administrator had to go through each resident's progress notes to determine who had fallen in the facility since November 2025. Exhibit A, Survey at 21-22.

47. The administrator reported that HL did not have any nurses who knew how to update care plans after a resident fell. Exhibit A, Survey at 22.

48. The most egregious example is with Resident #5. Resident #5 was admitted with both cognitive impairment and a high risk of falls because she: (1) used assisted devices, (2) had a weak gait, (3) had a history of falls, and (4) "forgot or overestimated" her physical abilities. Exhibit A, Survey at 79. Her fall risk was listed as 80 (45 and above is high risk). Exhibit A, Survey at 79.

49. Between November 26 and December 30, Resident #5 fell ***eight*** times. She had actual harm from those falls. On December 3, 2025, Resident #5 received sutures on her head after a fall. On December 6, 2025, Resident #5 broke her clavicle and suffered an intercranial bleed. Exhibit A, Survey at 77. On December 13, 2025, Resident #5 was hospitalized again after another fall. Exhibit A, Survey at 78. She had further documented falls on December 21, 24, and 30. Exhibit A, Survey at 77.

50. The intercranial brain bleed had serious implications for Resident #5. During hospitalization on December 13th, doctors discovered a deep vein thrombosis in

her left leg. Doctors could *not* treat with anti-coagulants because of her brain bleed. This was the impetus for the family to shift Resident #5 to hospice treatment at HL. Exhibit A, Survey at 78.

51. After each fall, HL should have documented that it (1) had conducted an investigation with root cause analysis to figure out why Resident #5 was falling, and (2) to implement additional steps to address her safety needs and to prevent further falls. Exhibit A, Survey at 77. "On 12/09/25 at 5:40 p.m. interview with the administrator revealed there was little, if any documentation regarding incidents such as falls for any resident, including Resident #5. The administrator revealed she had located some incident reports and some documentation in the medical records but again, there was no system in place to determine a root cause and ensure appropriate follow-up was completed. The Administrator stated she had no nurses who knew how to update care plans and she did not know why." Exhibit A, Survey at 87-88.

52. A certified nurse assistant told surveyors that there was "no list of residents who were at risk for falls. The CNA revealed she had not received any nurse guided direction/education related to individualized fall prevention interventions for any of the residents (including Resident #5) who reside in the facility." Exhibit A, Survey at 90.

53. At the January 10th monitoring visit, ODH surveyors learned that there had been two additional falls since the previous survey on January 2nd.

54. On January 4, 2026, Resident #18 slid out of bed. There was no root cause analysis, nor were any new interventions put into place other than to "remind" staff to keep bed in lowest, position, keep a mat on the floor, keep call light in reach, and to check resident "more frequently." Exhibit C, 1/10/26 Monitoring Visit Report.

55. On January 6, 2026, Resident #26 was found on the floor, sitting in her own excrement. The resident has dementia. The resident does not have a fall risk plan of care that was individualized to her. The post fall assessment included the question, "Based on the above information, draw conclusion as to possible cause of this fall event." The answer: "incontinence." Exhibit C, 1/10/26 Monitoring Visit Report.

56. HL again failed to conduct a thorough after-fall investigation and root cause analysis. Notably, ODH issued a survey on January 2nd directing HL to do so. HL has still not implemented a comprehensive fall management system. Exhibit C, 1/10/26 Monitoring Visit Report.

HL Is Not Properly Monitoring Patients on Blood Thinners

57. Warfarin is a powerful blood thinner that is notoriously dangerous if over-administered. (The most common brand name is Coumadin.) The FDA requires

that patients receiving warfarin to have regular blood tests to assure that the patient won't die of spontaneous bleeding.[1]

58. The Home was not notifying practitioners when they received test results for patients on warfarin. Three residents (#4, #12 and #27) had orders for warfarin. But there were "no specific orders for the frequency of laboratory testing, inconsistent documentation of when testing was completed and communicated to the provider, and the resident records did not consistently contain evidence of the laboratory testing being completed when it should have been." Exhibit A, Survey at 22-23. "These residents experienced side effects including bleeding due to critically elevated INR results, hematuria and required transport to the emergency room and hospital admission due to elevated INR results." Exhibit A, Survey at 23.

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[1] The FDA requires this "Black Box warning" for warfarin:

> Warfarin sodium can cause major or fatal bleeding. Bleeding is more likely to occur during the starting period and with a higher dose (resulting in a higher INR). Risk factors for bleeding include high intensity of anticoagulation (INR >4.0), age ≥65, highly variable INRs, history of gastrointestinal bleeding, hypertension, cerebrovascular disease, serious heart disease, anemia, malignancy, trauma, renal insufficiency, concomitant drugs (see PRECAUTIONS), and long duration of warfarin therapy. Regular monitoring of INR should be performed on all treated patients. Those at high risk of bleeding may benefit from more frequent INR monitoring, careful dose adjustment to desired INR, and a shorter duration of therapy. Patients should be instructed about prevention measures to minimize risk of bleeding and to report immediately to physicians signs and symptoms of bleeding (see PRECAUTIONS: Information for Patients).

https://www.accessdata.fda.gov/drugsatfda_docs/label/2010/009218s108lbl.pdf

59. The administrator admitted on December 8, 2025, that the Home "did not have a process for generating a list of residents who were to have laboratory testing completed, and no clinical staff within the facility to monitor the laboratory testing orders had been completed/drawn." Exhibit A, Survey at 24. The administrator stated that not having a DON lead to a lack of oversight regarding warfarin.

60. A nurse practitioner who had ordered warfarin for patients stated that HL was not placing her orders *or* the test results into the electronic medical records for residents. Exhibit A, Survey at 23. There were multiple instances when she had not been notified of laboratory results. Exhibit A, Survey at 24. She could not easily raise her concerns because there was no full-time DON. Exhibit A, Survey at 23.

61. A physician who acted as medical director for a short period of time reported that testing was not being conducted. Exhibit A, Survey at 25. They physician also reported that "coumadin was still being administered to Resident #12 after it was discontinued[.]" Exhibit A, Survey at 25.

62. At the January 10th monitoring visit, ODH surveyors saw that there was an order for PT/INR testing to be completed on January 5, 2026, for Resident #12. (This is the test to assure that patients taking warfarin do not spontaneously bleed to death.) During the monitoring visit, staff was unable to find the testing results. Exhibit C, 1/10/26 Monitoring Visit Report.

HL Is Not Providing Basic Infection Control

63. Infection control is another base-line requirement for nursing homes. HL does not have a licensed healthcare professional overseeing the infection prevention and control -- a requirement of Adm.Code 3701-17-11(A). Exhibit A, Survey at 61-62.

64. The administrator told surveyors that there was no one with the ability to provide medical input to oversee the program. Exhibit A, Survey at 62. She was aware that there were multiple issues with not having effective systems in place and that there was no oversight with the nurses. Exhibit A, Survey at 62.

65. Staff at HL complained that they did not have basic infection-control supplies such as hand-sanitizer and germicidal wipes. Exhibit A, Survey at 65. The administrator admitted that there were no germicidal wipes. Exhibit A, Survey at 66.

HL Is Not Providing Appropriate Wound Care

66. The Home failed to take basic steps with patients with existing wounds. *See* Adm.Code 3701-17-01(JJ)(1) (skilled nursing care includes "irrigations" and "application of dressings"). The most egregious case involved Resident #6. Between November 1 and December 20, there are twenty-two days where the Home did not document providing the daily-required treatments for a leg wound. Exhibit A, Survey at 33. When asked, an LPN incorrectly explained that all wound care was completed by a private duty nurse -- something which was simply wrong.

Exhibit A, Survey at 33. After being notified that there was no private duty nurse, the LPN attempted to perform wound care but admitted that she did not know how to measure wounds. Exhibit A, Survey at 33. The LPN did not use required infection-control protection (including wearing a gown). When asked, she was unsure if the facility had gowns available. Exhibit A, Survey at 35.

67. Resident #4 had wounds in both of his legs. There was a physician order requiring dressing changes on Monday, Wednesday and Friday. Exhibit A, Survey at 30. HL did not document that these dressing changes occurred on eight occasions in October and November 2025. Exhibit A, Survey at 30.

68. On November 20, the dressing change order for Resident #4 was changed from day shift to night shift. But the RN (acting as DON) said that "she did not do the dressing when she worked because she did not want to wake Resident #4 up, medicate the resident for pain, then do a dressing change in the middle of the night." Exhibit A, Survey at 31. Resident #4's son showed photos to the surveyor of "open wounds expositing the fat layers. The wounds were red and appeared to have been bleeding. The bilateral leg ulcers were extensive and covered the anterior surface from approximately two inches below the knee to just above the resident's ankle. The resident's son shared these wound were very painful for Resident #4." Exhibit A, Survey at 31-32. No wonder. The facility did not document that it had given Patient #4 any oxycodone (ordered for twice a day) at

all between November 14 and 24. Exhibit A, Survey at 41. Making matters worse, Resident #4 is one of the individuals taking warfarin, so the appearance of bleeding is that much more serious.

Not Documenting Administration of Medications

69. The facility repeatedly failed to document that it had administered medications to Residents #4, #12 and #27. Adm.Code 3701-17-17(B)("medicines and drugs are to ... be recorded on the resident's medication administration record.")

70. Among her many problems, Patient #4 was in congestive heart failure. In addition to the oxycodone mentioned above, the Home failed to document that it had properly administered Lasix (a diuretic), Metropolol (blood pressure medication), and Clorazepate (an anti-anxiety medication.)

71. Resident #12's records also showed lack of evidence of administered medications. This included atorvastatin (a cholesterol medication), Dilitazem (for atrial fibrillation) and Levothyroxine (for thyroid problems).

72. Resident #27 did not receive Allopurinol (for uric acid build-up), and Gabapentin.

73. The records did not show that the pharmacy was notified why the medications were not administered as ordered. An LPN reported that medicines for residents were frequently not available. The administrator admitted that there was no proactive plan to prevent missed medications.

74. At the January 10th monitoring visit, ODH surveyors learned that Resident #16 returned from the hospital after being treated for abdominal abscesses. The resident returned on January 3, 2026, with orders to be treated as a hospice patient. This included as-needed orders for pain medicine (hydrocodone) and anti-anxiety medications (Ativan). The Resident reported pain and was very agitated on January 4, 2026 -- but HL had not arranged for the hydrocodone or Ativan to be delivered. Resident #16 did not receive the medications until 5:30 p.m. the next day. Exhibit C, 1/10/26 Monitoring Visit Report.

Other Deficiencies

75. Among these many horrors, the facility's controlled substance reconciliation was deeply problematic with numerous discrepancies. Adm.Code 3701-17-17(H). An LPN reported that the facility had "the most confusing and unusual" narcotic logging system she had encountered. Exhibit A, Survey at 45.

76. There were no "contingency" medications on hand. Adm.Code 3701-17-17(E)(3). That is, there was not a store of commonly used medications that could be used if a Resident needed a medication that had not been previously prescribed.

77. There was no one on the staff identified as a facility infection preventionist. Adm.Code 3701-17-08(E)(5); Adm.Code 3701-17-11(A).

78. There were no facility control logs to track and trend infections in the facility. Adm.Code 3701-17-11(B).

COUNT I:
STATUTORY INJUNCTIVE RELIEF UNDER R.C. 3921.08(B)

79. The Director repeats and incorporates by reference all allegations set forth in the preceding paragraphs as if fully set forth herein.

80. The Director has made the determination that there are multiple "real and present dangers" ongoing at HL. Under R.C. 3921.08(B), this gives the Director authority to "petition the court of common pleas of the county in which the home is located for such injunctive relief as is necessary to close the home, transfer one or more occupants to other homes or other appropriate care settings, or otherwise eliminate the real and present danger. The court shall have the jurisdiction to grant such injunctive relief upon a showing that there is real and present danger."

81. There is a real and present danger at HL because there is an "immediate danger of serious physical or life-threatening harm to one or more occupants of a home." R.C. 3721.01(A)(14).

82. In a statutory injunction action under R.C. 3721.08, courts should grant the injunction if the statutory prerequisites for injunctive relief are met. *Ackerman v. Tri-City Geriatric & Health Care, Inc.*, 55 Ohio St.2d 51 (1978). The Director "need not aver and show, as under ordinary rules in equity, that great or irreparable injury is about to be done for which he has no adequate remedy at law * * *." *Id.* at 56 quoting *Stephan v. Daniels*, 27 Ohio St. 527, 536 (1875).

83. This Court should issue an injunction consistent with R.C. 3721.08(B) ordering the immediate closure of HL and the transfer of all residents to other nursing homes.

COUNT II
INJUNCTIVE RELIEF UNDER CIV. R. 65

84. The Director repeats and incorporates by reference all allegations set forth in the preceding paragraphs as if fully set forth herein.

85. The Director is entitled to preliminary and permanent injunctive relief under Civ. R. 65 to prevent HL from operating a nursing home that places its residents in real and present danger.

86. There is a real danger of irreparable harm because HL is failing to comply with even the most basic requirements for a nursing home. Residents are already suffering harm. Resident #4 suffered ongoing pain after HL failed to do required dressing changes or give the resident his prescribed oxycodone. Resident #5 had multiple falls leading to a broken clavicle and intercranial bleeding. The resident's health condition was so dire that the resident's family chose to transition the resident to hospice care only.

87. An injunction will not harm third parties and will protect the public, specifically the residents of HL and potential residents of HL. The Director has determined that there are adequate nursing home beds in the immediate area. The Director has contacted the ombudsman from the Department of Aging. A transition team is presenting gearing up for the removal of residents from HL.

88. An injunction will serve the public interest by forcing a dangerous nursing home to stop risking the health and safety of its residents.

89. The Director has no adequate remedy at law.

PRAYER FOR RELIEF

WHEREFORE, the Director asks this Court for:

A) A temporary restraining order, preliminary injunction, and permanent injunction ordering Hari Group, LLC to close the home, transferring all residents to other homes or other appropriate care settings, or otherwise eliminate the real and present danger.

B) All such further relief, legal or equitable, as the Court may deem just and proper.

VERIFICATION

I, Stacy Pickenpaugh, having been duly sworn verify that the information in this complaint is based upon my own knowledge, information and belief and I believe the information to be true.

Stacy L. Pickenpaugh

Sworn to and subscribed in my presence this 12th Day of January, 2026.

Cynthia L. Whitacre
Notary Public

Feb. 27, 2030
Expiration Date

Respectfully submitted,

DAVE YOST (0056290)
Attorney General of Ohio

/s/ Henry G. Appel
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Counsel for Plaintiff
Bruce Vanderhoff, Director of the Ohio Department of Health

CERTIFICATE OF SERVICE

I certify that in addition to requesting the Clerk of Courts to issue summons on the Defendants named in this lawsuit, on January __, 2026, I also served a copy of the foregoing upon the following by personal service:

HARI GROUP, LLC
dba HOUSE OF LORETO
2812 Harvard Ave. NW
Canton, OH 44709

and

c/o Statutory Agent,
Bharat Thakkar
3922 Wood Road
Madison, OH 44057

/s/ Henry G. Appel
HENRY G. APPEL (0068479)
Principal Assistant Attorney General

Exhibit A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0651N	A. BUILDING: _____ B. WING _____	C 01/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF LORETO	2812 HARVARD AVENUE, NW CANTON, OH 44709

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments Total Capacity: 50 Total Census: 29 County: Stark Administrator: Rebecca Samblanet, #6675 Survey Type: Master Complaint Number OH00169143, Complaint Number OH00168644 and Complaint Number OH00168548. The following violations are based on the complaint survey completed on 01/02/2026. The facility also remains out of compliance from the surveys dated 07/17/25 and 10/07/25.	N 000		
N 080	O.A.C. 3701-17-06 (A) Responsibility of Operator O.A.C. 3701-17-06 (A) - The operator is responsible for: (1) Operation of the nursing home; (2) Payment of the annual license renewal fee to the director; (3) Submission of such reports as may be required, using an electronic system prescribed by the director, including the immediate reporting of real, alleged, or suspected abuse, neglect, or misappropriation; and (4) Compliance with Chapter 3721. of the Revised Code, Chapters 3701-13 and 3701-61, and rules 3701-17-01 to 3701-17-26 of the Administrative Code, and all federal, state, and local laws applicable to the operation of a nursing home.	N 080		

EXHIBIT A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0651N	A. BUILDING: _____ B. WING _____	C 01/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF LORETO	2812 HARVARD AVENUE, NW CANTON, OH 44709

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N 080	Continued From page 1 This Rule is not met as evidenced by: Based on record review, interview, and policy and procedure review, the operator of the facility failed to ensure agreed-upon conditions for operation were maintained and the facility was operated in a manner to ensure the care needs of all residents were met. Additionally, the facility failed to ensure a report of alleged staff-to-resident abuse was reported to the State Agency and thoroughly investigated as required. This had the potential to affect all residents residing within the facility. The facility census was 29. Findings include: 1. Review of the facility's change of ownership records dated 11/14/24 included an entering operator's statement referencing Ohio Revised Code (ORC) 3721.026 that an "entering operator or a person ... who will have operational control of the nursing home" must have "at least five years of experience as ... An administrator of a nursing home located in" Ohio. The statement continued that to comply with the requirement, Former Administrator #800 (who was the current operator at the time the statement was written) would continue as the licensed administrator after the closing of the transaction. The statement noted Former Administrator #800 had well over the requisite five years of experience and the licensed administrator would be offered a seat on the Board of Directors to comply with the ORC requirement. Review of correspondence between the Ohio Department of Health (ODH) and the incoming	N 080		

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N 080	Continued From page 2 operator revealed outstanding items needed for the change of ownership included information on who the Board of Directors are for the incoming operator and the date Former Administrator #800 joined the Board of Directors. Review of a document authored by Former Administrator #800 dated 12/27/24, and submitted to ODH, referenced her understanding that it was a requirement for her to serve on the Board of Directors and as the Licensed Nursing Home Administrator for at least one year after the closing date (of the change of ownership). Upon assurances of adequate funding, staffing, and operational control, Former Administrator #800 agreed to do so. The notice referenced she had first been licensed in 1993, was the current Licensed Nursing Home Administrator of record for the facility where she had served continuously as co-administrator or administrator since 2005. The notice concluded that again, the plan was for her to stay [as Administrator] on for at least another year. Review of a document titled Appointment Notice - Board of Managers ..." dated 01/08/25 revealed per the agreement of the parties, the facility had appointed Former Administrator #800 to the Board of Managers for 2025. The position was noted to begin as of closing and continue until 12/31/25. The board will contact you to provide further details about the position, including the first scheduled board meeting. The board will be responsible for overseeing the day-to-day operations at the facility. While the board will delegate most of the management of the facility and its staff to the management team (including yourself as the licensed administrator), the board will exercise operational control over the company, including but not limited to finances,	N 080		

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N 080	Continued From page 3	N 080		

strategic planning, resident care, operations, and medical. The notice was sent by an attorney's office and signed as approved by Owner #820.

Review of a letter dated 06/03/25 from Former Administrator #800 to Owner #820 revealed ODH had approved her continued service as Administrator under the new ownership, with a contingency that she remain a participating manager of the Board of Managers. Former Administrator #800 referenced according to the letter dated 01/08/25, the board was to contact her to provide further details about the position, including the first board meeting. It also clearly stated the operational control of the board, including the Administrator, would involve "finances, strategic planning, resident care, operations, and medical". This detail was to satisfy the terms ODH imposed in order to approve the sale (of the facility to new ownership). The letter continued to state there had been no contact, even though she had attempted through Chief Executive Officer (CEO) #500 to make contact. As the Administrator, whose obligations by law included operational control, Former Administrator #800 stated she had no say in any of the above functions other than trying to manage the outcomes after the decisions are made. Former Administrator #800 wrote that the facility was in a crisis regarding medical care and the Board needed to meet to resolve it. The letter concluded by referencing there were other details too detailed to be mentioned in a letter but as the Administrator she was formally requesting a meeting of the Board of Managers to address her concerns.

An interview on 12/17/25 at 4:33 P.M. with the Administrator stated there was no Board of Directors for the facility that she was aware of.

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N 080	Continued From page 4 An interview on 12/18/25 at 9:56 A.M. with Executive Director (ED) #501 revealed there was no Board of Directors for the facility, "or anything like that". When asked about the ownership of the facility, she stated she had worked at the facility since June 2025, she was one of the first ones the new owners hired, and they "trusted her". She stated the owners bought the facility sight unseen and did not have the knowledge of running a healthcare facility. She stated they run other businesses, but not healthcare. ED #501 again reiterated there was no Board of Directors or Board of Managers for the facility. When asked about Former Administrator #800, ED #501 confirmed she was former Administrator but has had no involvement whatsoever since she resigned effective August 2025. An interview on 12/18/25 at 1:20 P.M. with Former Administrator #800 revealed she had a lot of concerns regarding the facility. When the new owners took over in March 2025, many things changed. Former Administrator #800 stated vendors were changed to save money and she was no longer involved in any day-to-day operations at the facility. She was only involved in decisions after the decisions were made such as when she was told to cancel vendors or contracts. There were a lot of changes both to vendors, operations, and employee benefits. Former Administrator #800 stated the new owners changed many things without any discussion amongst a Board. She provided an example that the new ownership canceled the contract with the electronic medical record system used within the facility the first month (March 2025) as they thought it was too expensive. The facility then went approximately three months without electronic records until	N 080		

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N 080	Continued From page 5	N 080		

many staff members complained and they resumed electronic health records. Former Administrator #800 confirmed she had been added to a Board of Directors but the Board appeared to be on paper only. Former Administrator #800 stated she sent a written letter to Owner #820 demanding a meeting. There was one meeting after that letter. In July 2025, Former Administrator #800 gave her resignation, effective 08/14/25, as she could not continue as the Administrator when she had no operational control within the facility.

A telephone interview on 12/18/25 at 3:24 P.M. with Owner #820 confirmed he was the owner of the facility but stated his son, CEO #500, primarily oversaw operations within the facility. However, his son was currently on an extended vacation. When asked about the facility's Board of Directors or Board of Managers, Owner #620 stated he had no knowledge about a Board overseeing the facility's operations. Owner #820 confirmed he had taken over ownership effective 03/01/25, and Former Administrator #800 had not had operational control or decision-making within the facility since they took over ownership. Owner #820 again stated he had no knowledge of a Board, and stated to check with ED #501 as she may know.

During the on-site complaint investigation and post-survey revisit to the annual survey, concerns were identified regarding the operational and clinical systems within the facility and the care being provided to facility residents.

2. Review of Resident #15's medical record revealed an admission date of 11/30/23 with diagnoses including Alzheimer's Disease, generalized anxiety disorder and unspecified

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N 080	Continued From page 6 pain. Review of the physician orders revealed Dermaseptin (barrier cream) to the buttocks and coccyx with each incontinence episode written 10/03/25. The resident was currently receiving hospice services. Review of the Nursing Screening/History dated 11/05/25 revealed the resident had previously been admitted due to the inability to provide her own care. The resident was alert and oriented to person but not place and time. The resident was incontinent of bladder at night and always incontinent of bowel. The resident was dependent on staff for all activities of daily living and used a wheelchair for mobility. Review of the plan of care initiated 12/31/23 revealed the resident has an ADL self-care performance deficit related to confusion, dementia and limited mobility. The following information was provided the resident requires (specify what assistance) for (x) staff to turn and reposition in bed (specify frequency) and as necessary. The remainder of the care plan was missing resident specific information based on the nursing assessments. Review of former CNA #620's employee file revealed a hire date of 07/17/25. Review of the Description of Incident of Behavior form dated 10/29/25 revealed on 10/16/25 CEO #501 spoke with the CNA about a care issue regarding her nails. Gel/Acrylic Nails were leaving scratches on the residents. Further review revealed on 10/23/25 Resident #15's family requested CNA #620 no longer provide care to Resident #15. The resident's	N 080		

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N 080	Continued From page 7 family sent video of CNA #620 stating the resident's hygienic care could not be completed due to a lack of staff. The CNA did not perform end of the night hygienic care to the resident. The supervisor's remarks/Corrective Action to Be Taken: Per state guidelines. The House of Loreto is in compliance with staffing needs. The shift was fully staffed. At this time, the company has decided to part ways with CNA #620. Employee Remarks revealed "I try my best to provide the best care I can. I apologize to those whom were affected by my lack of work ethic. I will take this into consideration in the future. Thanks for this experience". The document was signed by CNA #620 but not a facility representative. Review of the House of Loreto Employee Disciplinary Report revealed CNA #620 was dismissed for improper conduct on 10/28/25. On 12/10/25 at 5:55 P.M. interview with ED #500 confirmed there was an "incident" with CNA #620 and Resident #15. The CNA didn't provide care to the resident stating the facility didn't have enough staff for her to provide the requested care. The resident's sister contacted the facility and said she had video footage from an incident with her sister and provided the video to HR #502. The ED verified the investigation that was completed would be found in CNA #620's file. The ED verified, at the time of the incident in October, the facility did not have an Administrator and the Administrator is the facility's Abuse Coordinator. The ED was unable to confirm when the resident did receive care since a thorough investigation was not completed.	N 080		

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N 080	Continued From page 8 On 12/10/25 at 6:00 P.M. interview with the Administrator verified the investigation was not thorough and did not determine if other residents were involved, did not contain interviews or statements from staff and should have been reported to the State Survey Agency as an allegation of abuse through a Self-Reported Incident since the resident didn't receive care. On 12/11/25 at 9:00 A.M. interview with the resident's sister revealed she had a camera in her sister's room due to previous incidents with staff and how they treated her sister and the previous incidents had been addressed. The resident's sister stated she shared the video with the facility regarding the incident with CNA #620 but she wasn't sure if she was able to send the video again. The resident's sister said she would try to send the video again. However, the video was not received. On 12/17/25 at 12:40 P.M. interview with HR #502 revealed the video footage sent by Resident #15's sister showed the resident's sister asked CNA #620 why Resident #15's face wasn't washed and CNA #620 answered her by saying they were short staffed and "it wasn't getting done." The CNA was the only staff member in the room. HR stated there was no name calling and clearly no verbal abuse. Further interviews revealed since they saw the incident on video, they did not gather additional staff or resident interviews. The video was no longer available from the link sent by the resident's sister. Review of the House of Loreto Policy and Procedures Staff to Resident Abuse, dated July 2008, revealed in order to prevent and/or correct staff to resident abuse, the following protocol will be in place: Any staff member suspected or	N 080		

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N 080	Continued From page 9 accused in abuse of any type, verbal, physical or sexual, will be immediately suspended and removed from the facility. There will be a thorough investigation into the merit of any accusation or suspicion of abuse. Any staff member found to be involved in the abuse of a resident will be immediately terminated. Any accusation or finding of abuse will be immediately reported to the residents physician, the Medical Director, the DON, Administrator and family The House of Loreto provides a safe and abuse free environment for all residents and staff. The attached procedures form a policy and procedure for prevention of abuse for residents and staff. It is the policy of the House of Loreto that any actual or suspected abuse will be dealt with in a timely manner. Any staff member who knows or credibly suspects that another staff member is abusive is obligated to report to Administration. Any abuse on the part of a resident also falls under this obligation. This violation represents non-compliance investigated under Complaint Number OH00168644.	N 080		
N 081	O.A.C. 3701-17-06 (B) Responsibility of Administrator O.A.C. 3701-17-06 (B) - Each operator shall appoint an administrator. The administrator is responsible for: (1) Daily operation of the nursing home in accordance with rules 3701-17-01 to 3701-17-26 of the Administrative Code; (2) Implementation of the provisions of section	N 081		

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N 081	Continued From page 10 3721.12 of the Revised Code, including the development of policies and procedure that ensure the rights of residents are not violated; (3) Ensuring that individuals used by the home are competent to perform their job responsibilities and that services are provided in accordance with acceptable standards of practice; and (4) If the nursing home is physically part of a hospital, inform a prospective resident, prior to admission, that the home is licensed as a nursing home and is not part of the acute care service of the hospital. This Rule is not met as evidenced by: Based on observation, record review, personnel file and job description review, Residence Agreement review, policy and procedure review and interview, the facility failed to provide adequate and effective administration to ensure all residents received the necessary care and treatment to maintain their highest level of overall well-being. This resulted in Real and Present Danger and Actual harm beginning on 11/12/25 when the facility failed to implement necessary systems to ensure qualified and available administrative staff were onsite to oversee and direct the implementation of necessary facility practices related to wound care (resulting in Actual Harm/wound infection for Resident #6), infection control, fall management and prevention (resulting in Actual Harm for Resident #12), identification of change in condition with subsequent hospitalization (resulting in Actual	N 081		

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N 081	Continued From page 11 Harm for Resident #16), laboratory testing and monitoring (resulting in Actual Harm for Resident #12 and Resident #27 related to anti-coagulant medication administration and monitoring), medication administration and pharmacy services including medication availability and maintaining narcotics and controlled medications in a manner to prevent potential diversion. This affected 12 residents (#1, #3, #4, #5, #6, #12, #15, #16, #21, #25, #26 and #27) and had the potential to affect all 29 residents residing in the facility. The facility census was 29. On 12/16/25 at 4:52 P.M, the Administrator and Executive Director (ED) #501 were notified Real and Present Danger began on 11/12/25 when the lack of administrative and clinical oversight following turnover of key personnel and gaps in key positions being staffed following a change in ownership earlier in the year placed all residents at risk for serious harm, injury, and/or death as the facility failed to operate in a manner to meet the total care needs of all residents and facility failed to ensure previous issues identified on prior surveys were corrected following a directed plan of correction. The Real and Present Danger remains ongoing as of 01/02/2026. Findings include: Review of a letter dated 06/03/25 from Former Administrator #800 to Owner #820 revealed the State Agency (ODH) had approved her continued service as Administrator under the new (facility) ownership, with a contingency that she remain a participating manager of the Board of Managers. Former Administrator #800 referenced according to the letter dated 01/08/25, the board was to	N 081		

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N 081	Continued From page 12	N 081		

contact her to provide further details about the position, including the first board meeting. It also clearly stated the operational control of the board, including the Administrator, would involve "finances, strategic planning, resident care, operations, and medical". This detail was to satisfy the terms ODH imposed in order to approve the sale (of the facility to new ownership). The letter continued to state there had been no contact, even though she had attempted through Chief Executive Officer (CEO) #500 to make contact. As the Administrator, whose obligations by law included operational control, Former Administrator #800 stated she had no say in any of the above functions other than trying to manage the outcomes after the decisions are made. Former Administrator #800 wrote that the facility was in a crisis regarding medical care and the Board needed to meet to resolve it. The letter concluded by referencing there were other details too detailed to be mentioned in a letter but as the Administrator she was formally requesting a meeting of the Board of Managers to address her concerns.

An interview on 12/17/25 at 4:33 P.M. with the Administrator revealed there was no Board of Directors for the facility that she was aware of.

An interview on 12/18/25 at 9:56 A.M. with Executive Director (ED) #501 revealed there was no Board of Directors for the facility, "or anything like that". When asked about the ownership of the facility, she stated she had worked at the facility since June 2025, she was one of the first ones the new owners hired, and they trusted her. She stated the owners bought the facility sight unseen and did not have the knowledge of running a healthcare facility. She stated they run other businesses, but not healthcare. ED #501

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N 081	Continued From page 13	N 081		

again reiterated there was no Board of Directors or Board of Managers for the facility. When asked about Former Administrator #800, ED #501 confirmed she was the Former Administrator but had not been involved whatsoever since she resigned effective August 2025.

An interview on 12/18/25 at 1:20 P.M. with Former Administrator #800 revealed she had a lot of concerns regarding the facility. Former Administrator #800 revealed when the new owners took over in March 2025, many things changed. Former Administrator #800 stated vendors were changed to save money, and she was no longer involved in any day-to-day operations at the facility. She was only involved in decisions after the decisions were made such as when she was told to cancel vendors or contracts. There were a lot of changes both to vendors, operations, and employee benefits. Former Administrator #800 stated the new owners changed many things without any discussion amongst a Board. She provided an example that the new ownership canceled the contract with the electronic medical record system used within the facility the first month (March 2025) as they thought it was too expensive. The facility then went approximately three months without electronic records until many staff members complained and they resumed electronic health records. Former Administrator #800 confirmed she had been added to a Board of Directors but stated the Board appeared to be on paper only. Former Administrator #800 stated she sent a written letter to Owner #820 demanding a meeting. There was one meeting after that letter. In July 2025, Former Administrator #800 gave her resignation, effective 08/14/25, as she could not continue as the Administrator when she had no operational

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N 081	Continued From page 14 control within the facility. A telephone interview on 12/18/25 at 3:24 P.M. with Owner #820 revealed he was the owner of the facility but his son, CEO #500, primarily oversaw operations within the facility but was (currently) on an extended vacation. When asked about the facility's Board of Directors or Board of Managers, Owner #820 stated he had no knowledge about a Board overseeing the facility's operations. Owner #820 confirmed he had taken over ownership effective 03/01/25, and Former Administrator #800 had not had operational control or decision-making within the facility since they took over ownership. Owner #820 again stated he had no knowledge of a Board and stated to check with ED #501 as she may know if the facility had a Board of Directors or Board of Managers. (See additional findings at N0080). Review of the House of Loreto Nursing Home Private Pay Residence Agreement effective August 3, 2025 revealed the facility agreed to provide the following services for private pay residents, subject to this agreement and in compliance with Ohio Administrative Code (OAC) 3701-17: Nursing and Personal Care: Room, board, laundered linens, bedding, nutritionally balanced meals tailored to dietary needs, routine nursing care, and personal care services (e.g., assistance with bathing, dressing, grooming, mobility) to promote the resident's health, safety and wellbeing; General Duty Nursing: the facility provides general nursing care only. Special duty nursing (e.g. one-to-one care, ventilator support) must be arranged by the responsible party or attending physician at the responsible party's	N 081		

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N 081	Continued From page 15 expense. Review of an undated job description titled "Executive Director/Administrator: Position and Core Responsibilities" revealed the ED/Administrator reports directly to the CEO and is responsible for all operational matters. Key responsibilities included serving as the Executive Director / Administrator, providing comprehensive oversight and leadership for all daily operations and strategic goals. Additional listed responsibilities included acting as the facility Administrator and main point of contact for all regulation issues, ensuring the organization remains in full compliance with all local, state, and federal guidelines, licensing, and reporting requirements. An additional responsibility noted the ED / Administrator had a responsibility to directly address and resolve complex family issues, serving as the high-level point of contact for concerns, complaints, and ensuring high levels of family and resident satisfaction. Review of ED #501's personnel file revealed a hire date of 07/16/25 with the job title listed as sales/marketing on the new hire form. No signed job description was included. An interview on 12/03/25 at 2:02 P.M. with ED #501 confirmed she was not a Licensed Nursing Home Administrator (LNHA). She stated she had previously worked in assisted living facilities but had not been an administrator in a nursing home. ED #501 reported her job was more consistent with an operations and marketing director, who was responsible for building the team, hiring staff members and department heads, and looking at the facility's budgets. She reported she coordinated needed services such as contacting staffing agencies, brought in home health	N 081		

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companies, and set up training for staff. ED #501 confirmed she was not clinical (in background) and stated she had nothing to do with the nursing department. She reported clinical staff had come to her with clinical questions and she would forward the messages to the "appropriate person". She also revealed staff came to her with "everything" because she was the only "consistent face" that had been in the facility. ED #501 reported new owners took over 03/01/25 and she had been employed at the facility since June 2025.

Review of the current Administrator's personnel file revealed a hire 10/22/25 and first day worked as 11/03/25. No application was completed and no signed job description was in the personnel file. Additionally, there were no reference checks completed.

An interview on 12/17/25 at 3:17 P.M. with the Administrator revealed she had not received a job description, nor was she able to locate a job description for her role and responsibilities for daily operations of the facility. The Administrator revealed the "Executive Director / Administrator: Position and Core Responsibilities" document was ED #501's job description.

Review of the undated job description for the Director of Nursing (DON) revealed the facility employs a Director of Nursing pursuant to language in the Ohio Administrative Code (OAC) which requires that each nursing home employ a full-time director of nursing who is a Registered Nurse (RN). Listed duties of the DON included supervision and coordination of all nursing personnel and clinical services, ensuring compliance with federal and state regulations, participation in resident assessments and care

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plans, maintenance of nursing records in accordance with Ohio law, development and enforcement of nursing policies and infection control programs, coordination with the facility Administrator and Medical Director, active participation in the Quality Assurance (QA) / Quality Improvement (QI) processes, and supervision of medication administration per the OAC.

An interview on 12/01/25 at 7:48 A.M. with Registered Nurse #537 revealed she agreed to be the "acting" DON covering for the Interim DON who was off on an extended leave of absence with an unknown return-to-work date. RN #537 reported she worked the 11:00 P.M. to 7:00 A.M. shift and had maintained that schedule and floor nurse responsibilities since she agreed to be the Acting DON. The RN stated she was "thrusted" into the Acting DON position and did not know what her role would be regarding State surveys or with previous plan of correction implementation.

An interview on 12/08/25 at 2:37 P.M. with ED #501 revealed the last date the DON worked was toward the end of October 2025. She reported the DON had gone on medical leave and that a night shift floor nurse agreed to be the Interim DON. ED #501 reported the nurse was still working on the night shift and had not worked any daytime hours since the Former DON went on medical leave.

Intermittent observations conducted during the onsite investigation in the facility from 12/01/25 through 12/30/25 revealed no evidence of the DON or the Interim DON's name displayed for staff, residents or visitors to access. There was also no information posted regarding RN availability when one was not scheduled at the

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N 081	Continued From page 18 facility. On 12/02/25 at 9:38 A.M. interview with the Administrator verified there was no information displayed for visitors or residents who the DON was or the RN on call when one wasn't scheduled in the facility. On 12/17/25 at 4:02 P.M. interview with Licensed Practical Nurse (LPN) #545 revealed RN #537 was the Acting DON and she worked night shift. LPN #545 stated when she needed to contact the DON for questions, the facility nurses have a text thread and they share information and they can contact other nurses through that text thread. Review of the nursing department schedules from 11/30/25 to 12/29/25 revealed RN #537 worked the following shifts as the only direct-care nurse scheduled within the building: The week of 11/30/25 to 12/06/25, RN #537 worked two eight-hour shifts on 11/30/25 and 12/05/25 from 11:00 P.M. to 7:00 A.M. The week of 12/07/25 to 12/13/25, RN #537 worked two eight-hour shifts on 12/11/25 and 12/13/25 from 11:00 P.M. to 7:00 A.M. The week of 12/14/25 to 12/20/25, RN #537 worked three eight-hour shifts on 12/14/25, 12/17/25, and 12/18/25 from 11:00 P.M. to 7:00 A.M. The week of 12/21/25 to 12/27/25, RN #537 worked only one eight-hour shift on 12/24/25 from 11:00 P.M. to 7:00 A.M. She was scheduled one additional shift on 12/27/25, but called off. On 12/29/25 at 11:23 A.M. information provided	N 081		

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via email from the Administrator revealed the facility had not secured a DON as of this date to provide nursing oversite and no additional interviews were currently scheduled. The facility had conducted one interview but the candidate chose an alternate assignment (the candidate was through a leadership staffing agency).

On 12/29/25 at 4:12 P.M. an email received from the Administrator revealed the Administrator was continuing to work on abatement plans for the identified Real and Present Danger situations. However, the Administrator stated "I am a little lost as to how we should audit the labs to ensure none were missed? I could run an order report but I am not sure how far back to go or how to ensure that missed labs would be entered as an order? Also, the same issue for narcotics, how would I direct a nurse to audit this? I have nurses that have agreed to audit both but need further direction."

An interview on 12/30/25 at 3:30 P.M. with the Administrator confirmed RN #537 had been identified as the Acting DON during the current survey. When asked if RN #537 was participating in any day-to-day activities of the facility or in the quality improvement or corrective action efforts, the Administrator revealed she was not. The Administrator additionally confirmed none of RN #537's hours worked were during the day and stated RN #537 refused to work outside of night shift.

As of 12/30/25 at 5:00 P.M. an acceptable removal plan for the Real and Present Danger at data tags N0081 and N0437 had not been received from the facility.

In addition to the lack of corrective action taken

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N 081	Continued From page 20 by the facility to ensure compliance with regulatory requirements, the following resident concerns were identified related to the day-to-day facility operation and lack of administrative and clinical (nursing) oversight of the licensed nursing home, which placed all 29 residents at risk for negative outcomes, actual/potential harm and/or death. 1. Record review revealed the facility had no incident/accident log or system in place for tracking incidents/accidents to identify and track trends and to ensure appropriate and timely nursing follow-up was completed. Review of Resident #3, #5 and #12's medical records revealed a comprehensive, individualized and effective fall prevention program was not implemented. Resident #5 sustained six falls since admission on 11/03/25 including falls with injury/hospitalization. Resident #3 experienced falls without individualized interventions implemented or the root cause of the fall identified. Resident #12 also experienced a fall however the root cause was not investigated and individualized interventions were not added to the resident's care plan to provide a safe environment. On 12/09/25 at 5:40 P.M. interview with the Administrator revealed there was little, if any documentation regarding incidents such as falls for any resident, including Resident #3, #5 and #12's falls. The Administrator verified the facility did not maintain record of incidents/accidents to monitor or track for trends like an incident or accident log and had no way to quickly identify incidents that had occurred in the facility or with residents. She stated she had to review all resident records (29 was the census) for progress	N 081		

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notes to determine who had experienced falls in the facility since November 2025. She also stated if the falls weren't documented in the progress notes, she may have a difficult time determining if a fall or other incident had occurred. The Administrator reported she had located some incident reports and some documentation in the medical records but again, there was no system in place to review resident falls to determine a root cause and ensure appropriate follow-up was completed. The Administrator stated she had no nurses who knew how to update care plans and she did not know why. The Administrator revealed the facility did not currently have a Director of Nursing and stated the lack of a DON to provide oversight and additional input had affected the fall prevention and management program due to incomplete investigations and lack of interventions implemented with falls. (See additional findings at N437).

2. Review of Resident #4, #12, and #27's medical records revealed all three residents were prescribed Warfarin (also known as Coumadin, an oral anticoagulant medication commonly used to prevent blood clots from forming; the medication has a narrow therapeutic range and patients on Warfarin require regular blood testing to monitor clotting time and subsequent adjusting of the medication dosage according to laboratory results) for varied diagnosis.
Therapeutic range of the INR (the laboratory testing for Coumadin) is 2.0 to 3.0 while taking Coumadin/Warfarin.
Continued review of the three resident medical records revealed no specific orders for the frequency of laboratory testing, inconsistent documentation of when testing was completed and communicated to the provider, and the resident records did not consistently contain

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N 081	Continued From page 22 evidence of the laboratory testing being completed when it should have been. Despite orders received from Nurse Practitioner (NP) #543 to adjust Coumadin, administer the antidote Vitamin K due to critical laboratory values and obtain laboratory studies to monitor the effects of Coumadin, the facility failed to have systems in place to ensure comprehensive monitoring was in place and being completed for residents receiving Coumadin. These residents experienced side effects including bleeding due to critically elevated INR results, hematuria and required transport to the emergency room and hospital admission due to elevated INR results. On 12/04/25 at 1:30 P.M. interview with NP #543 revealed she wasn't being notified of laboratory results and orders that she gives were not placed into the electronic medical record (eMAR) related to Coumadin. Further interview revealed she had talked with the facility owner, and he told her they were currently talking with pharmacies to obtain contracts. There had been no changes implemented to correct the issue otherwise. The NP also shared it was difficult to communicate with the facility not having a DON as the DON was usually her point of contact with any concerns she might have. NP #543 further shared she had ordered an unusual amount of Vitamin K for the residents of the facility who require Warfarin therapy. Because of continued elevated results which were abnormal, she checked Resident #12's medication pill packages at the facility and found Warfarin was present in the resident's medication packages after she had discontinued the medication. NP #543 believed the Warfarin medication was still being administered even after being discontinued because the resident's INR levels remained	N 081		

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significantly elevated. NP #543 additionally stated there had been multiple instances when she had not been notified of residents' laboratory results.

On 12/08/25 at 3:03 P.M., interview with the Administrator confirmed the facility did not have a process for generating a list of residents who were to have laboratory testing completed, and no clinical staff within the facility to monitor the laboratory testing orders had been completed/drawn. The Administrator was unable to offer an explanation related to where laboratory reports go once resulted, how the facility knew if the physician was updated if not recorded in the resident's progress notes, or how the facility tracked down laboratory orders and results. The Administrator stated she would expect a DON to monitor this process and confirmed the facility did not currently have a DON.

A follow up interview on 12/09/25 at 5:40 P.M. with the Administrator again verified the lack of a DON had affected nursing oversite and follow-up to ensure interventions were implemented including Coumadin/Warfarin changes and INR results. The Administrator stated the DON was responsible to ensure residents receive appropriate care.

Interview on 12/11/25 at 10:30 A.M. with Physician #546 revealed she had contracted with the facility to be the Medical Director for a short time. During the interview Physician #546 revealed she was aware of issues with PT and INR laboratory testing not getting drawn, and orders not getting changed. Physician #546 and NP #543 were monitoring the Coumadin dosing based on lab values, but we were not getting notified of results or if labs were not drawn as

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N 081	Continued From page 24 ordered and would have to re-order laboratory testing so they could appropriately adjust Coumadin (Warfarin) dosages. Physician #546 and NP #543 had to order Vitamin K multiple times (to treat high INR levels) for the residents of the facility requiring Coumadin/Warfarin therapy. Physician #546 stated she had spoken with her NP and asked her to check the medication carts, and that was when she found Coumadin was still being administered to Resident #12 after it was discontinued, and had also identified wrong doses were being administered. Physician #546 stated she was notified when Vitamin K was not available, but she had ordered the medication STAT and would occasionally have to send residents out to the hospital for evaluation of elevated INR results. Physician #546 reported the expectation was that (physician) orders be carried out as written for both medications and diagnostic testing. Review of the facility's "Policy and Protocol for Blood Thinner Medications" dated July 2008 revealed the facility followed a strict protocol for all residents on blood thinning medications. The facility would maintain and update weekly a "master lift" of all residents receiving blood thinning medications in each nurse's station, all nurses caring for these residents are to be aware of the type and dose of blood thinning medications which the residents is receiving, the PT-INR (laboratory) tests are to be drawn upon order of personal physician. All results of PT-INR results are called, not faxed, to the physician so the physician can adjust doses accordingly. The Director of Nurses will perform an audit for each resident who is ordered blood thinning medication to ensure proper protocol is followed. (See additional findings at N439).	N 081		

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N 081	Continued From page 25 3. Review of the medical record for Resident #16 revealed an admission date of 04/06/21. Medical diagnoses included hydronephrosis (the swelling of one or both kidneys due to a backup of urine, often due to a blockage in the urinary tract), benign prostatic hyperplasia with lower urinary tract symptoms, a history of urinary tract infections, a history of acute kidney failure, and anemia in chronic kidney disease. Review of Resident #16's physician orders revealed the resident had an order dated 04/22/21 to irrigate Foley (indwelling urinary) catheter with normal saline every eight hours as needed. Resident #16 also had an order dated 07/06/21 for his Foley catheter to be emptied every shift, and nursing staff were to document the amount of urinary output every shift. Resident #16's orders did not specify the catheter or balloon size, nor did it include a frequency on how often the resident's indwelling urinary catheter needed to be changed. Resident #16 had an order dated 02/06/24 for loperamide (an antidiarrheal medication) 2 milligrams (mg) one tablet by mouth every four hours as needed for diarrhea. Review of Resident #16's care plan initiated on 02/23/25 revealed the urinary care plan addressing the resident's catheter was incomplete; the care plan noted the resident had a catheter there were spaces indicating the focus, and interventions/tasks required additional information to specify what was relevant but had not been added. The care plan did not include what type of catheter Resident #16 had, nor did it specify the size, frequency of changes, or when the catheter was last changed. The care plan included interventions to monitor and document intake and output per facility policy, monitor for	N 081		

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signs and symptoms of discomfort due to catheter, and report symptoms to the physician including pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, or change in eating habits.

Review of Resident #16's progress note dated 12/25/25 at 11:19 P.M. authored by LPN #545 revealed the resident stated he felt like he was getting a urinary tract infection (UTI) and would like to be seen by the doctor for urinalysis (UA) testing and possible antibiotics. The note did not reference any action LPN #545 took to assess the resident or communicate or address Resident #16's concern. There was no follow-up notes recorded on 12/26/25.

Continued review of Resident #16's progress notes revealed a note dated 12/27/25 at 7:55 P.M. noting the resident was complaining of having frequent loose stools. Resident #16 was offered as needed medication and was assisted to the bathroom where he was noted to have a loose stool on the toilet which was black in color. Resident #16's urinary drainage bag had 50 cubic centimeters of dark yellow urine present. The note did not include any further assessment of Resident #16 nor any indication that the resident's physician was notified. There were no follow-up notes recorded in Resident #16's record on 12/27/25 or 12/28/25.

Continued review of Resident #16's progress notes revealed a note dated 12/29/25 at 2:00 P.M. authored by RN #675 which stated the resident's physician was called regarding the resident having no urinary output thus far into the

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shift. Resident #16's bladder was noted to be slightly firm. Resident #16 stated he did not have pain, and the nurse was requesting an order to either change resident #16's Foley catheter or to flush it but was awaiting a call back from Resident #16's physician. The note referenced Resident #16 appeared ill, he had "runny" and "dark" diarrhea earlier in the morning and had been administered loperamide (an anti-diarrheal medication) earlier in the shift. A follow-up note dated 3:15 P.M. revealed the resident still had no urinary output and was currently having another instance of dark-colored diarrhea. The nurse phoned the facility's Medical Director, Physician #599, who gave the order to send Resident #16 out to a local hospital for evaluation. Resident #16 left the facility on 12/29/25 at 4:00 P.M.

Review of Resident #16's Medication Administration Record (MAR) for December 2025 revealed the resident received five doses of as needed loperamide between 12/26/25 and 12/29/25. Resident #16 had no other doses administered in the month of December 2025 prior to 12/26/25.

Review of Resident #16's Treatment Administration Record (TAR) for December 2025 revealed the resident had orders for his urinary output to be monitored three times daily, once per shift. The urinary output for the evening shift on 12/27/25 and 12/28/25 were blank and contained no evidence Resident #16's urinary output was monitored. Continued review of the TAR revealed there were no recorded instances where Resident #16's catheter had been irrigated as needed.

A follow-up note dated 12/30/25 at 1:57 A.M. revealed the facility nurse had phoned the local hospital for an update on Resident #16. Resident

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N 081	Continued From page 28 #16 was admitted to the hospital with diagnoses including dehydration, abscess of abdominal cavity, anemia of unknown origin, and chronic kidney disease. An interview on 12/30/25 at 3:30 P.M. with the Administrator revealed she was unable to answer why the nurses did not address Resident #16's change in condition earlier and would expect to have seen this followed up on. The Administrator stated she was aware of numerous "holes" in the resident's catheter output. The Administrator reported the facility had no Director of Nursing (DON) in place for clinical oversight and monitoring. An interview on 12/30/25 at 4:15 P.M. with RN #675 revealed Resident #16 went to the hospital on 12/29/25. RN #675 verified the facility had no physician orders for Resident #16's catheter care, routine catheter changes, and the orders did not include the size of the indwelling catheter he had. RN #675 stated she was unsure of how she would know when to change the resident's catheter or what size to use. The facility did not have a policy regarding care or management of indwelling urinary catheters. (See findings at N439). 4. Review of the medical record for Resident #4 revealed an admission date of 06/30/21 with diagnoses including chronic venous insufficiency, atrial fibrillation, and anemia. Review of Resident #4's physician orders revealed an order dated 07/14/25 to cleanse Resident #4's wounds to bilateral lower extremities with normal saline (NS), air dry for 20 minutes, and apply Xeroform (a	N 081		

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petroleum-infused mesh gauze dressing used to maintain a moist environment to aid in wound healing, prevention of infection, and to help minimize pain during dressing changes), calcium alginate with silver (an antimicrobial dressing), rolled abdominal pad to the proximal anterior site, wrap with kerlix (rolled gauze) and an ACE wrap (compression dressing) from toes to below the knees three times weekly on Monday, Wednesday, and Friday. The order was later discontinued on 11/20/25.

Review of Resident #4's Treatment Administration Records (TAR) for October 2025 revealed the ordered treatments were not recorded as completed on 10/08/25, 10/15/25, or 10/22/25.

Review of Resident #4's TAR for November 2025 revealed the ordered treatments were not recorded as completed on 11/05/25, 11/07/25, 11/10/25, 11/14/25, or 11/19/25.

Continued review of Resident #4's medical record revealed no weekly wound monitoring was completed from 11/08/25 to 12/01/25 to assess the wound's progress towards healing.

Review of Resident #4's physician orders revealed an order dated 12/02/25 to cleanse the resident's wounds to her bilateral lower extremities with NS, air dry for 20 minutes, apply calcium alginate with silver to open areas, apply a rolled abdominal pad to the proximal anterior site, wrap with kerlix and an ACE wrap from toes to below the knees three times a week on Monday, Wednesday, and Friday.

An interview on 12/02/25 at 7:45 AM with RN #536 revealed Resident #4 was supposed to have dressing changes completed on night shift

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every Monday, Wednesday, and Friday. The order was changed from days to night shift on 11/20/25. RN #536 further shared that she did not do the dressing when she worked because she did not want to wake Resident #4 up, medicate the resident for pain, then do a dressing change in the middle of the night.

An interview 12/02/25 at 8:05 AM interview with LPN #540 who works day shift revealed the LPN did not complete the dressing changes ordered for Resident #4 because the facility did not have the supplies to do the dressings. However, at the time of the interview observation with LPN #540 verified the ordered treatment supplies were available for use.

An interview on 12/17/25 at 4:30 P.M. with Resident #4's son revealed the son had entered the nurse's station asking to speak with Executive Director #501. He had just returned from the outside wound clinic with Resident #4 and expressed concerns related to a dressing that the wound clinic removed from Resident #4's bilateral lower extremities. He shared the wound clinic had expressed to him that the facility had not used enough adaptic (non-adherent primary wound dressing infused with an emulsion designed to protect healing tissue, prevent sticking, and minimize pain during dressing changes) to completely cover her wounds before applying the ABD (absorbent) pads, which were stuck to her wounds. The son shared pictures with LPN #545 and the state surveyor, which showed vascular wounds to Resident #4's bilateral lower extremities, with open wounds expositing the fat layers. The wounds were red and appeared to have been bleeding. The bilateral leg ulcers were extensive and covered the anterior surface from approximately two

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inches below the knee to just above the resident's ankle. The resident's son shared these wounds were very painful for Resident #4. The son proceeded to inventory Resident #4's supplies and LPN #545 agreed to be the primary nurse to complete the resident's future wound care, promising to even come into the facility on her days off in the future to perform Resident #4's wound care.

An interview on 12/18/25 at 1:00 P.M. with the Administrator revealed the facility did not have a wound nurse who did weekly assessments of wounds and the facility did not have any wound reports for review. A follow up interview on 12/30/25 at 3:30 P.M. with the Administrator revealed Resident #4's lack of wound care was related to the facility not having a current DON to provide clinical oversight of the wound process.

5. Review of the medical record for Resident #6 revealed an admission date of 04/26/23 with diagnoses including iron deficiency anemia, age-related osteoporosis, osteoarthritis, and weakness.

Review of the physician order dated 11/16/25 revealed treatment orders for a left posterior and left distal leg wound. Orders were for Prisma adaptic, cover with bordered foam or dry sterile dressing, and change on Tuesday and Saturday and as needed. The order was discontinued on 12/08/25. An additional order dated 12/08/25 to the left heel called for the left heel wound to be cleansed with normal saline, apply medi-honey (a medical-grade honey-based ointment with natural antibacterial, anti-inflammatory, and debriding properties) to the base of the wound, an abdominal pad, and wrap with kerlix daily. The heel wound had a listed start date of "12/09/25".

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N 081	Continued From page 32 Resident #6 did not have any orders for enhanced barrier precautions (EBP). Review of Resident #6's medical record revealed no evidence of weekly assessments of the resident's wounds from 11/16/25 through 12/20/25 (the date the record review was completed). Review of Resident #6's TAR for November 2025 revealed the resident's treatments were not recorded as completed on 11/01/25, 11/02/25, 11/04/25, 11/05/25, 11/08/25, 11/10/25, 11/13/25, 11/20/25, 11/21/25, 11/22/25, 11/24/25, 11/25/25, or 11/26/25. Review of Resident #6's TAR for December 2025 revealed the resident's treatments were not recorded as completed on 12/02/25, 12/03/25, 12/04/25, 12/06/25, 12/07/25, 12/12/25, 12/15/25, 12/17/25, or 12/20/25. An interview on 12/20/25 at 3:40 P.M. with LPN #545, who worked the afternoon shift, revealed Resident #6's dressings were scheduled daily for 9:00 P.M., but Resident #6 had a private duty nurse who changed her dressings. The LPN reported the facility nurses did not complete any wound care for Resident #6 and all wound care was completed by the private duty nurse and an outside wound clinic. LPN #545 was unable to identify the name of the nurse or when she visited Resident #6 to complete wound care. An interview on 12/20/25 at 3:45 P.M. with Resident #6 revealed the resident did not have a private duty nurse who performed her wound care within the facility. On 12/21/25 at 11:40 A.M. interview with	N 081		

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N 081	Continued From page 33 Resident #6 and her daughter and Power of Attorney (POA) revealed concerns related to wound care. They shared Resident #6 had an in-house acquired pressure area on her left heel and was seen at a local wound clinic every other week. Resident #6 reported the wound center would often change the orders, but the orders would not get started at the facility. Resident #6 further stated her dressings were not getting changed daily at the facility per her current orders, and the only time the dressings did get changed were every other Thursday at the wound clinic. Additionally, the wound was not healing, and the outside wound clinic took wound cultures on her last visit for a possible infection. The daughter reported bone was visible in the wound bed. Resident #6's daughter removed the surgical boot from the resident's left foot and it was observed the dressing on Resident #6's left heel was undated. Observation on 12/22/25 at 5:45 P.M. revealed LPN #545 was observed completing wound care for Resident #6. LPN #545 did not apply a protective gown before performing wound care. LPN #545 proceeded to perform the resident's wound care. Resident #6's left heel wound dressing was removed. The wound was not measured by LPN #545 and she stated at the time of observation she did not know how to measure wounds and did not know if she had anything available to measure a wound with. The heel wound was noted to be covered with slough (dead tissue which obscured the wound base and the wound's true depth) but was an open wound with an approximate opened area of 2 centimeters (cm) in length by 2 cm in width. LPN #545 proceeded to reapply the dressing to Resident #6's left heel. Following the observation, LPN #545 shared that she did not	N 081		

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know what EBP were and verified EBP were not utilized for residents with indwelling medical devices or wounds in the facility. LPN #545 was unsure if the facility had gowns available for staff use.

On 12/30/25 at 3:30 P.M. interview with the Administrator confirmed Resident #6's wound care was not provided because the resident's family did not want the facility staff performing wound care. The Administrator was unsure why and verified this alleged family preference was not care planned and she had no other information to provide other than to state the facility did not have a current DON in place for clinical oversight.

6. Review of Resident #15's medical record revealed an admission date of 11/30/23 with diagnoses including Alzheimer's Disease, generalized anxiety disorder and unspecified pain.

Review of the plan of care initiated 12/31/23 revealed the resident has an ADL self-care performance deficit related to confusion, dementia and limited mobility. The following information was provided the resident requires (specify what assistance) for (x) staff to turn and reposition in bed (specify frequency) and as necessary. The remainder of the care plan was missing resident specific information based on the nursing assessments.

Review of the physician orders revealed Dermaseptin (barrier cream) to the buttocks and coccyx with each incontinence episode written 10/03/25. The resident was currently receiving hospice services.

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N 081	Continued From page 35 Review of former CNA #620's employee file revealed a hire date of 07/17/25. Review of a Description of Incident of Behavior form dated 10/29/25 revealed On October 16, 2025 CEO #501 spoke with the CNA about a care issue regarding her nails. Gel/Acrylic Nails were leaving scratches on the residents. Further review revealed on October 23, 2025 Resident #15's family requested CNA #620 no longer provide care to Resident #15. The resident's family sent video of CNA #620 stating the resident's hygienic care could not be completed due to a lack of staff. The CNA did not perform end of the night hygienic care to the resident. The supervisor's remarks/Corrective Action to Be Taken: Per state guidelines, The House of Loreto is in compliance with staffing needs. The shift was fully staffed. At this time, the company has decided to part ways with CNA #620. Employee Remarks revealed "I try my best to provide the nest care I can. I apologize to those whom were affected by my lack of work ethic. I will take this into consideration in the future. Thanks for this experience". The document was signed by CNA #620 but no facility representative. Review of the House of Loreto Employee Disciplinary Report revealed CNA #620 was dismissed for "improper conduct" on 10/28/25. Review of the Nursing Screening/History dated 11/05/25 revealed the resident had previously been admitted due to the inability to provide her own care. The resident was alert and oriented to person but not place and time. The resident was incontinent of bladder at night and always	N 081		

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incontinent of bowel. The resident was dependent on staff for all activities of daily living and used a wheelchair for mobility.

On 12/10/25 at 5:55 P.M. interview with ED #501 confirmed there was an "incident" with CNA #620 and Resident #15. The CNA didn't provide care to the resident stating the facility didn't have enough staff for her to provide the requested care. The resident's sister contacted the facility and said she had video footage from an incident with her sister and provided the video to Human Resource (HR) #502. The ED revealed the investigation that was completed would be found in CNA #620's file. The ED verified, at the time of the incident in October, the facility did not have an Administrator and the Administrator would be the facility's Abuse Coordinator. The ED was unable to confirm when the resident did receive care since a thorough investigation was not completed.

On 12/10/25 at 6:00 P.M. interview with the Administrator verified the investigation (of this incident) was not thorough and did not determine if other residents were involved, did not contain interviews or statements from staff and should have been reported to the State Survey Agency as an allegation of abuse through a Self-Reported Incident since the resident didn't receive care.

On 12/11/25 at 9:00 A.M. interview with the resident's sister revealed she had a camera in her sister's room due to previous incidents with staff and how they treated her sister and the previous incidents had been addressed. The resident's sister stated she shared the video with the facility regarding the incident with CNA #620.

On 12/17/25 at 12:40 P.M. interview with HR

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N 081	Continued From page 37 #502 revealed the video footage sent by Resident #15's sister showed the resident's sister asked CNA #620 why Resident #15's face wasn't washed and CNA #620 answered her by saying they were short staffed and "it wasn't getting done." The CNA was the only staff member in the room. HR #502 stated there was no name calling and clearly no verbal abuse. Further interviews revealed since they saw the incident on video, they did not gather additional staff or resident interviews. The video was no longer available from the link sent by the resident's sister. Review of the House of Loreto Policy and Procedures Staff to Resident Abuse, dated July 2008, revealed in order to prevent and/or correct staff to resident abuse, the following protocol will be in place: Any staff member suspected or accused in abuse of any type, verbal, physical or sexual, will be immediately suspended and removed from the facility. There will be a thorough investigation into the merit of any accusation or suspicion of abuse. Any staff member found to be involved in the abuse of a resident will be immediately terminated. Any accusation or finding of abuse will be immediately reported to the residents physician, the Medical Director, the DON, Administrator and family. The House of Loreto provides a safe and abuse free environment for all residents and staff. The attached procedures form a policy and procedure for prevention of abuse for residents and staff. It is the policy of the House of Loreto that any actual or suspected abuse will be dealt with in a timely manner. Any staff member who knows or credibly suspects that another staff member is abusive is obligated to report to Administration. Any abuse on the part of a Resident also falls under this obligation.	N 081		

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N 081	Continued From page 38 7. Review of the medical records for Resident #4, #12, and #27 revealed no evidence of monthly pharmacy reviews in residents' records to monitor medication regimens, laboratory studies, or other pharmaceutical needs. An interview on 12/01/25 at 4:00 P.M. with the Administrator revealed the facility got medications from a neighborhood pharmacy that was not used to providing services to long term care facilities. However, the pharmacy was not supplying the facility with the expected monthly pharmacy reviews and pharmacy recommendations. An interview on 12/09/25 at 2:00 P.M. with Pharmacist #547 revealed the pharmacy did not have a contract with the facility but the pharmacy had individual service agreements with the residents. Pharmacist #547 revealed he was unaware of any long-term care requirement of monthly record reviews by a pharmacist and the pharmacy he represented did not offer this service. An interview on 12/11/25 at 10:30 A.M. with Medical Director #546 revealed it was her expectation that monthly pharmacy reviews and recommendations were completed. Medical Director #546 verified she did not receive any monthly pharmacy recommendations during her time as Medical Director for the facility. The facility did not have a policy or procedure related to pharmacy reviews and did not have a current pharmacy contract. 8. Review of the medical records for Residents #4, #12, and #27 revealed concerns regarding medications being available for administration	N 081		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 081	Continued From page 39 and administered to residents as ordered. a. Review of Resident #4's physician's orders revealed an order dated 12/22/22 for Claritin (an over the counter antihistamine medication) 10 milligrams (mg) by mouth at bedtime for allergies, an order dated 06/30/23 for Ferrous sulfate (over the counter supplement) 325 mg by mouth once daily, an order dated 06/14/24 for Lasix (a diuretic) 20 mg by mouth once daily for congestive heart failure (CHF) and for Lasix 40 mg by mouth once daily for CHF, an order dated 06/22/22 for Metoprolol Succinate (a beta blocker used to lower blood pressure and/or heart rate) extended release (ER) 100 mg give 125 mg daily for hypertension, an order dated 12/14/22 for Clorazepate Dipotassium 3.75 mg by mouth once daily for anxiety, and an order dated 12/19/24 for Oxycodone (a narcotic analgesic) 10 mg by mouth twice daily for pain. Review of Resident #4's Medication Administrator Record (MAR) for November 2025 revealed the following: The resident's Claritin was not recorded as administered on 11/01/25 and 11/12/25. The resident's Ferrous Sulfate was not recorded as administered on 11/12/25, 11/13/25, 11/14/25, 11/15/25, 11/16/25, 11/18/24, 11/19/25, 11/24/25, and 11/29/25. The resident's Lasix 20 mg dosage was not recorded as administered on 11/10/25, 11/14/25, and 11/19/25. The resident's Lasix 40 mg dose was not recorded as administered on 11/10/25.	N 081		

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N 081	Continued From page 40 The resident's Metoprolol Succinate ER was not recorded as administered on 11/10/25 and 11/14/25. The resident's morning dose of Clorazepate scheduled for 8:30 A.M. was not recorded as administered on 11/04/25, 11/08/25, 11/10/25, 11/13/25, 11/15/25, 11/16/25, 11/17/25, 11/18/25, 11/19/25, 11/20/25, 11/22/25, 11/23/25, 11/24/25, and 11/27/25. The resident's evening dose scheduled for 6:00 P.M. was not recorded as administered on 11/01/25, 11/04/25, 11/10/25, 11/16/25, 11/17/25, and 11/24/25. The resident's morning dose of Oxycodone scheduled for 8:30 A.M. was not recorded as administered between 11/14/25 and 11/25/25. The resident's evening dose scheduled for 9:00 P.M. was not recorded as administered on 11/01/25 or between 11/13/25 and 11/24/25. A review of Resident #4's progress notes revealed no evidence that a physician was notified of medications not administered and no evidence that the pharmacy was notified of medications not available or evidence as to why the medications were not administered as ordered. b. Review of Resident #12's physician's orders revealed an order dated 03/22/25 for Atorvastatin (a cholesterol-lowering medication) 40 mg by mouth daily in the evening, an order dated 03/22/25 for Diltiazem Hydrochloride ER 120 mg by mouth once daily for atrial fibrillation, and order dated 07/15/25 for Levothyroxine Sodium 150 micrograms (mcg) by mouth once daily for thyroid supplement, and an order dated 07/01/25 for Lexapro 5 mg by mouth daily for depression.	N 081		

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N 081	Continued From page 41 Review of Resident #12's MAR for November 2025 revealed the following: The resident's Atorvastatin was not recorded as administered on 11/01/25, 11/14/25, and 11/15/25. The resident's Diltiazem was not recorded as administered on 11/14/25. 11/15/25, 11/16/25, and 11/18/25. The resident's Levothyroxine was not recorded as administered on 11/01/25. 11/15/25, and 11/16/25. The resident's Lexapro was not recorded as administered on 11/14/25. 11/15/25, 11/16/25, and 11/20/25. A review of Resident #12's progress notes revealed no evidence that a physician was notified of medications not administered and no evidence that the pharmacy was notified of medications not available or evidence as to why the medications were not administered as ordered. c. Review of Resident #27's medical record revealed an order dated 10/04/25 for Allopurinol 100 mg by mouth once daily for elevated uric acid levels, an order dated 07/01/25 for Aspirin 81 mg by mouth daily, an order dated 11/07/25 for Vitamin K 5 mg by mouth one time only for Coumadin (warfarin) therapy, an order dated 06/30/25 for Gabapentin 300 mg by mouth daily at bedtime for pain, and an order dated 09/25/25 for Lexapro 5 mg by mouth once daily for depression. Review of Resident #27's MAR for November	N 081		

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N 081	Continued From page 42 2025 revealed the following: The resident's Allopurinol was not recorded as administered on 11/10/25, 11/11/25, 11/12/25, and 11/15/25. The resident's Aspirin was not recorded as administered on 11/10/25, 11/11/25, 11/12/25, and 11/15/25. The resident's Vitamin K was ordered on 11/07/25 and was not administered until 11/08/25. The resident's Gabapentin was not recorded as administered on 11/10/25 and 11/11/25. The resident's Lexapro was not recorded as administered on 11/10/25, 11/11/25, 11/12/25, 11/14/25, and 11/15/25. A review of Resident #27's progress notes revealed no evidence that a physician was notified of medications not administered and no evidence that the pharmacy was notified of medications not available or evidence as to why the medications were not administered as ordered. An interview on 12/01/25 at 12:00 P.M. with LPN #548 revealed the nurse's use documentation codes on the MAR when medications were not available. The codes prompted the nurse's to make a progress note, but did not require a progress note to save the documentation on the MAR. LPN #548 reported that frequently medications for residents were not available for administration. The RN #537 (identified to be the Acting DON) who worked on the night shift was to do audits and help to order medications from the pharmacy.	N 081		

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N 081	Continued From page 43 An interview on 12/01/25 at 4:00 P.M. with the Administrator revealed she was aware that multiple residents had not had medications available for administration. The Administrator revealed due to not having a Director of Nursing available on day shift, the Administrator had been reading resident progress notes and directed the nurses to order medications if it had been documented medications were not administered. The Administrator confirmed she did not have a proactive plan to prevent missed medications due to medications not being available. An interview on 12/09/25 at 2:00 P.M. with Pharmacist #547 revealed the pharmacy delivered medications in packaged rolls. Each package on the roll was labeled with the resident's medication orders, date, and time for administrations. The rolls were pre-packaged and were delivered on a 28-day cycle. If the resident received a new order, the facility was supposed to fax the order to the pharmacy, and the nurse was to call the pharmacist for guidance and direction on how to dispense the medication from the medications that were available in the packages. Further, Pharmacist #547 shared that the pharmacy was waiting on the facility to provide them with a list of medications in order to start a contingency supply of medications for the facility. 9. Observation on 12/10/25 at 2:30 P.M. of the narcotic drawers on Hall B of medication carts A, B, and C with LPN #542 revealed there was no system in place to verify the amount or date of each controlled medication received. During shift-to-shift reconciliation, there was no comparison of the number of controlled medication sheets and the number of controlled	N 081		

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medication cards to ensure accuracy with controlled medication reconciliation.
Continued observation revealed on Wing C, Cart B Resident #15 had Tramadol 37.5 mg contained in a bubble packet to be administered twice a day. On 11/25/25, 15 tablets were received. On 11/26/25, the count went from 13 tablets at 7:00 P.M. to 41 tablets at 11:00 P.M. Further review revealed on 12/01/25 at 9:45 A.M. 38 tablets remained and one tablet was administered on 12/02/25 at 7:00 P.M. leaving 36 tablets remaining. At the bottom of the controlled substance log sheet, a note was included that indicated "12/02/25 discrepancy count 37" however, at the time of the observation it was not determined where tablet 37 was.

On Wing C, Cart C Resident #1 had Tramadol one half tablet twice a day scheduled and one half tablet twice a day as needed for pain. Review of the controlled substance log revealed on 11/29/25 at 6:00 A.M., 30 tablets were available, one was administered and 29 tablets remained. On 11/29/25 at 9:00 P.M., 29 tablets were available; one was administered leaving 28 tablets available. On 11/30/25 at 9:00 P.M., 29 tablets were available; one was administered leaving 28 Tramadol for administration.

Interview with LPN #542 at the time of the observation revealed she was unsure what was expected with controlled medication reconciliation as the facility had the "most confusing and unusual" narcotic logging system she had encountered. The LPN verified the controlled medication discrepancies and reiterated the facility had the most "confusing" system to log controlled medications she had encountered. LPN #542 shared she was unsure of many of the facility procedures since she only worked as

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N 081	Continued From page 45 needed and had not been employed by the facility long. The facility did not have a policy or procedure related to the management of controlled substances and did not have a current pharmacy contract to identify facility and pharmacy roles in the management of controlled medications and prevention of narcotic misappropriation or diversion. 10. Interview on 11/19/25 at 11:15 A.M., an interview with LPN #540 revealed she had been employed by the facility for less than one month and the facility did not have a contingency supply of medications in the facility in the event medications were ordered for a resident and the facility was unable to timely get the medication from the pharmacy. LPN #540 reported she had voiced her concerns regarding no contingency medication supply to RN #537 (who was identified as the facility current Acting DON) and also to the Administrator and CEO #500. An interview on 12/01/25 at 7:48 A.M. with RN #537 revealed the facility did not have a contingency supply or "starter box" of medications for the facility. RN #537 reported the facility used to have a starter box prior to the new owners taking over the facility. Interview on 12/01/25 at 4:00 P.M. with the Administrator revealed she was aware the facility did not have a contingency supply or medication starter box to timely access common medications ordered by a physician. The Administrator shared CEO #500 had been meeting with pharmacies to arrange for potential services who could provide 24-hour pharmacy services.	N 081		

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N 081	Continued From page 46 Interview and observation on 12/02/25 at 7:45 A.M. with RN #536 revealed the facility had no current contingency supply of medications but did before the new owners took over. Observation at the B-wing nurse's station with RN #536 revealed a contingency box from a cabinet in the nurse's station with a single box of albuterol inhaler observed in it. RN #536 reported this was the only medication available in the starter box, and it was left over from a prior pharmacy. Interview on 12/04/25 at 1:30 P.M. with Nurse Practitioner #543 revealed she was aware the facility did not have contingency medications available to start medications in the event the pharmacy was unable to deliver ordered medication timely. The NP stated she had expressed concerns to CEO #500 and ED #501 "multiple" times. The facility had no policy or procedure for contingency medications. The facility did not have a current pharmacy contract. 11. Review of the current staff roster on 12/10/25 revealed no licensed healthcare professional was identified as the facility infection preventionist. Review of the facility Infection Control Program revealed a log for November 2025 that contained the following information: Resident #21 received Fluconazole for yeast dated 11/02/25 through 11/04/25 and was resolved. Resident #1 received Nitrofurantoin (on-going) for a urinary tract infection since 11/14/25.	N 081		

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N 081	Continued From page 47 Resident #12 received Cefdinir for a UTI from 11/22/25 through 11/29/25. Resident #16 received Cipro with the infection source not indicated from 11/19/25 through 11/26/25. Review of the December 2025 Infection Control Log revealed Resident #4 received Cipro for a wound infection beginning 12/01/25. On 12/09/25 at 5:40 P.M. interview with the Administrator revealed there were no facility infection control logs to track and trend infections in the facility. The Administrator provided this surveyor with the Infection Control Logs she created after the survey team requested infection control logs since November 2025. Further interview with the Administrator revealed the facility did not currently have a licensed healthcare professional overseeing the Infection Prevention and Control Program but CEO #500 completed the Infection Preventionist training but no one with the ability to provide medical input was in the capacity to oversee the program. The Administrator further shared she was aware there were multiple issues with not having effective systems in place and no oversight into the nurses made it difficult because she, as the Administrator, was non-medical and CEO #500 had no long-term care experience. Further interview revealed there was no policy related to a comprehensive infection control program and how to manage the program. The Administrator verified the policies she did have needed updating and had not been revised for some time. The Administrator stated she planned to get a more current policy book.	N 081		

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N 081	Continued From page 48 Review of the Infection Control Policy in the facility policy binder did not include information about the facility infection control program and the over-all monitoring of illness or infections within the facility. The Infection Control Policies were dated July 2008 and June 2011 and included Handwashing and Infection Control Protocol (in reference to assessing the resident with symptoms, notifying the physician and following orders). Review of the Infection Protocol dated July 2008 revealed to assess the resident, check vital (signs) and note symptoms. Call the physician with vitals and symptoms. Take and record orders. Order medications, schedule an X-ray or blood work ordered, use medications from the "as needed" (PRN) box if needed to start regimen. Chart in nurses' notes, daily medical director report, and monthly Administrative Report. In addition, review of information from the Centers for Disease Control (CDC) on Enhanced Barrier Precautions (EBP) revealed Enhanced Barrier Precautions were an infection control intervention to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., resident with wounds or indwelling medical devices). Review of the facility's current list of residents with indwelling urinary catheters revealed Residents #16, #25, and #27 had catheters. Further review of medical records revealed these three residents had no orders for EBP due to the	N 081		

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N 081	Continued From page 49 indwelling urinary catheters. Review of the facility's current list of residents with wounds revealed Residents #4 and #6 currently had orders for dressing changes related to open wounds. There were no orders for EBP related to wound care. An interview on 12/22/25 at 10:00 A.M. with Certified Nursing Assistant (CNA) #531 revealed the facility had gloves available in the hallway on B-wing. Further interview revealed additional personal protective equipment (PPE) including masks and gowns were located off the unit in the supply closet. The CNA stated she would use gloves to provide resident care if blood or other bodily fluids were likely to be encountered. The CNA stated she had never heard of EBP and her infection control education, provided by the facility, did not cover what EBP meant or when it would be implemented. On 12/22/25 at 5:45 P.M. LPN #545 was observed completing wound care for Resident #6. The LPN did not apply a protective gown for wound care. She shared that she did not know what EBP were and verified EBP were not utilized for residents with indwelling medical devices or wounds in the facility. The LPN was unsure if the facility had gowns available for staff use. On 12/22/25 at 6:15 P.M. interview with the Administrator revealed she was aware the facility needed to utilize EBP for wound care and for residents with indwelling catheters but stated she had not discussed the need for interventions to be implemented with the medical director or nursing staff. Review of the facility's infection control policies	N 081		

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and procedures revealed the policy did not include or address EBP to prevent the spread of infection throughout the facility.

12. Review of the facility's prior survey history revealed a complaint and annual licensure survey were completed on 10/07/25 with a violation issued at N437 when Resident #26 (previously identified as Resident #27) left the facility on an unauthorized leave of absence (elopement). The facility completed a plan of correction to include an elopement binder that was created and placed at the front desk and at each nurses' station on 11/05/25.

Review of Resident #26's medical record revealed an admission date of 09/13/21 with diagnoses including chronic pain, chronic kidney disease and mild cognitive impairment.

Review of the resident's Nursing Admission Screening/History Form dated 11/05/25 revealed the resident was independent with most activities of daily living and ambulated independently.

Review of the progress notes from 11/01/25 through 12/01/25 (the day of the record review) revealed no attempts to exit the facility unsupervised had been documented.

On 11/19/25 at 11:15 A.M. interview with LPN #539 revealed there was no elopement binder located at the nurses' station but the LPN stated she would use "clinical judgement" to determine if a resident was an elopement risk. The LPN also revealed she received education regarding elopement on this date (11/19/25) (she did not elaborate what the education included) but stated this was the first time she had received elopement education from the facility.

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N 081	Continued From page 51 On 11/19/25 at 11:32 A.M. interview with Receptionist #650 revealed she had no knowledge of an elopement binder or what an elopement binder was. Observation revealed no elopement binder was located at the reception desk. On 11/19/25 at 11:35 A.M. interview with ED #501 revealed she wasn't aware of an elopement binder in the facility. The ED reported the Administrator wrote the plan of correction for the previous State agency survey and if the Administrator said the facility had an elopement binder, the Administrator "didn't tell anyone else." On 11/19/25 at 11:45 A.M. interview with the Administrator revealed she had removed the elopement binders from the nurses' station and reception area "yesterday" to add "information to them" because she felt they didn't contain enough information in them. The Administrator did not share what information was added to the elopement binders. The Administrator confirmed the elopement binders should have been readily available to the staff and staff should be knowledgeable about the elopement binders that were part of the facility plan of correction. This violation represents non-compliance investigated under Master Complaint Number OH00169143, Complaint Number OH00168644 and Complaint Number OH00168548.	N 081		
N 082	O.A.C. 3701-17-06 (C) Quality Assurance Committee O.A.C. 3701-17-06 (C) - Each nursing home shall establish and maintain an ongoing quality	N 082		

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N 082	Continued From page 52 assurance and performance improvement (QAPI) program to address all systems of care and management practices, including clinical care, quality of life, and resident choice. As part of the QAPI program, each home shall, at minimum: (1) Establish a quality assurance committee that shall meet on an ongoing basis, but at least quarterly to systematically: (a) Monitor and evaluate the quality of care and quality of life provided in the home; (b) Track, investigate, and monitor incidents, accidents, and events that have occurred in the home; (c) Track and monitor the effectiveness of the infection control program; (d) Identify problems and trends; and (e) Develop and implement appropriate action plans to correct identified problems; and (2) Participate in at least one quality improvement project every two years from those approved by the department of aging through the nursing home quality initiative established under section 173.60 of the Revised Code. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to establish and maintain an ongoing quality assurance and performance improvement (QAPI) program to self-identify and address systems of care and management practices within the facility. This had the potential to affect all 29 residents residing in the facility. The facility	N 082		

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N 082	Continued From page 53 census was 29. Findings include: During the on-site complaint and post-survey revisit, concerns were raised about the lack of administrative and clinical oversight following turnover of key personnel and gaps in key positions being staffed following a change in ownership earlier in the year, which placed all residents at risk for serious harm injury, and/or death as the facility failed to operate in a manner to meet the total care needs of residents. Concerns raised during the survey included lack of oversight and implementation of facility practices related to wound care, medication administration, infection control, fall management and prevention, laboratory testing and monitoring, pharmacy services including medication availability and maintaining narcotics and controlled medications in a manner to prevent potential diversion. An interview on 12/17/25 at 3:17 P.M. with the Administrator revealed she had been the Administrator of the facility since early November 2025. The Administrator confirmed there was no current Director of Nursing (DON) working within the facility, and she recognized that was challenging not having a DON, but did not realize how broken some of the clinical systems in the building were. When asked if the facility had previously self-identified any of the concerns identified by the State Agency during the current survey in the facility's QAPI process, the Administrator stated they had not. The Administrator further shared the facility did not have a QAPI system in place. The Administrator stated there had been no QAPI meeting since	N 082		

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N 082	Continued From page 54 she had started and there were no scheduled meetings up and coming. The Administrator did not believe the facility had an established QAPI system for identifying and correcting issues. A follow up interview on 12/30/25 at 3:30 P.M. with the Administrator confirmed RN #537 had been identified as the Acting DON during the current survey. When asked if RN #537 was participating in any day-to-day activities of the facility or in the quality improvement or corrective action efforts, the Administrator confirmed she was not. On 12/31/25 at 4:17 P.M. interview with the Administrator verified the plan of correction for the 10/07/25 survey, with an allegation of compliance date of 11/11/25, indicated all audits completed to monitor for ongoing compliance would be reviewed in QAPI meetings however there was no evidence of QAPI Meetings prior to her beginning employment (from exit of the annual survey 10/07/25) and none since beginning her employment to review violation compliance as indicated in the POC. There were no QAPI documents available during the survey for review and the facility did not have a policy which addressed a QAPI process. This violation represents non-compliance investigated under Master Complaint Number OH00169143 and Complaint Number OH00168644.	N 082		
N 201	O.A.C. 3701-17-08 (B) Personnel Requirements O.A.C. 3701-17-08 (B) - Each nursing home shall:	N 201		

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N 201	Continued From page 55 (1) Employ a registered nurse who shall serve as director of nursing: (a) This requirement may be met by two registered nurses who share the position as co-directors of nursing. (b) The director of nursing or co-directors of nursing shall be on duty five days per week, eight hours per day predominantly between the hours of six a.m. and six p.m. to direct the provision of nursing services. (c) The name of the director of nursing shall be posted in a place easily accessible to residents, resident's families or sponsors, and staff. (2) Designate another registered nurse in its employ to serve as acting director of nursing in the event the director of nursing or co-directors of nursing are absent from the nursing home due to illness, vacation or an emergency situation. The name of the acting director of nursing shall be posted in a place easily accessible to residents, residents' families or sponsors, and staff. This Rule is not met as evidenced by: Based on observation, schedule review, job description review and interview the facility failed to ensure a Director of Nursing Services was employed and available as required. This affected all 29 residents residing in the facility.	N 201		

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N 201	Continued From page 56 Findings include: Review of the undated job description for the Director of Nursing (DON) revealed the facility employs a Director of Nursing pursuant to language in the OAC which requires that each nursing home employ a full-time director of nursing who is a Registered Nurse (RN). Listed duties of the DON included supervision and coordination of all nursing personnel and clinical services, ensuring compliance with federal and state regulations, participation in resident assessments and care plans, maintenance of nursing records in accordance with Ohio law, development and enforcement of nursing policies and infection control programs, coordination with the facility Administrator and Medical Director, active participation in the Quality Assurance (QA) / Quality Improvement (QI) processes, and supervision of medication administration per the OAC. An interview on 12/01/25 at 7:48 A.M. with RN #537 revealed she agreed to be the "acting" DON covering for the Interim DON who was off on an extended leave of absence with an unknown return-to-work date. RN #537 reported she worked the 11:00 P.M. to 7:00 A.M. shift and had maintained that schedule and floor nurse responsibilities since she agreed to be the Acting DON. The RN stated she was "thrusted" into the Acting DON position and did not know what the plan of correction for the prior survey covered or what her role would be with the plan of correction implementation. An interview on 12/08/25 at 2:37 P.M. with ED #501 revealed the last date the DON worked was towards the end of October 2025. She reported	N 201		

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N 201	Continued From page 57 the DON had gone on medical leave and that a night shift floor nurse agreed to be the Interim DON. ED #501 reported the nurse was still working on the night shift and had not worked any daytime hours since the former DON went on medical leave. Observation of the facility on 12/01/25 through 12/30/25 revealed no evidence of the DON or the Interim DON's name displayed for staff, residents or visitors to access. On 12/02/25 at 9:38 A.M. interview with the Administrator verified there was no information displayed for visitors or residents who the DON was or who was covering in her absence. On 12/17/25 at 4:02 P.M. interview with Licensed Practical Nurse (LPN) #545 revealed RN #537 was the acting DON and she worked night shift. LPN #545 stated when she needed to contact the DON for questions, the facility nurses have a text thread and they share information and they can contact other nurses through that text thread. Review of the nursing department schedules from 11/30/25 to 12/29/25 revealed RN #537 worked the following shifts as the only direct-care nurse scheduled within the building: The week of 11/30/25 to 12/06/25, RN #537 worked two eight-hour shifts on 11/30/25 and 12/05/25 from 11:00 P.M. to 7:00 A.M. The week of 12/07/25 to 12/13/25, RN #537 worked two eight-hour shifts on 12/11/25 and 12/13/25 from 11:00 P.M. to 7:00 A.M. The week of 12/14/25 to 12/20/25, RN #537 worked three eight-hour shifts on 12/14/25,	N 201		

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N 201	Continued From page 58 12/17/25, and 12/18/25 from 11:00 P.M. to 7:00 A.M. The week of 12/21/25 to 12/27/25, RN #537 worked only one eight-hour shift on 12/24/25 from 11:00 P.M. to 7:00 A.M. She was scheduled one additional shift on 12/27/25, but called off. On 12/29/25 at 11:23 A.M. information provided via email from the Administrator revealed the facility had not secured a DON as of this date to provide nursing oversite and no additional interviews were currently scheduled. The facility had conducted one interview but the candidate chose an alternate assignment (the candidate was through a leadership staffing agency). An interview on 12/30/25 at 3:30 P.M. with the Administrator confirmed RN #537 had been identified as the Acting DON during the current survey. When asked if RN #537 was participating in any day-to-day activities of the facility or in the quality improvement or corrective action efforts, the Administrator revealed she was not. The Administrator additionally confirmed none of RN #537's hours worked were during the day and stated RN #537 refused to work outside of night shift. This violation represents non-compliance investigated under Complaint Numbers OH00168644 and OH00168548.	N 201		
N 204	O.A.C. 3701-17-08 (D) Personnel Requirements O.A.C. 3701-17-08 (D) - Each nursing home shall have a registered nurse on call whenever one is not on duty in the home. The name of the	N 204		

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N 204	Continued From page 59 registered nurse who is on call shall be posted in a place easily accessible to residents, residents' families or sponsors, and staff. This Rule is not met as evidenced by: Based on observation, and interview the facility failed to ensure the on-call Registered Nurse information was posted for visitors, residents, resident representatives and staff when a registered nurse was not on duty in the facility. This had the potential to affect all 29 residents in the facility. Findings include: Observation of the facility on 12/01/25 and 12/02/25 revealed no evidence of information posted regarding RN availability when one was not scheduled at the facility. Review of the Nursing Department Schedule for 12/01/25 and 12/02/25 revealed only eight hours of RN coverage on both days, 11:00 P.M. to 7:00 A.M. On 12/02/25 at 9:38 A.M. interview with the Administrator verified there was no information displayed for visitors, residents or staff who the RN on call was when one wasn't scheduled in the facility. The facility did not have an RN job description. This violation represents non-compliance investigated under Complaint Number OH00168644 and OH00168548.	N 204		

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N 350	Continued From page 60	N 350		
N 350	O.A.C. 3701-17-11 (A) Infection Control O.A.C. 3701-17-11 (A) - Each nursing home shall establish and implement appropriate written policies and procedures to assure a safe, sanitary and comfortable environment for residents and to control the development and transmission of infections and diseases. Each nursing home shall establish an infection control program to monitor compliance with the home's infection control policies and procedures, to investigate, control and prevent infections in the home, and to institute appropriate interventions. The home shall designate an appropriate licensed health professional with competency in infection control to serve as the infection control coordinator. This Rule is not met as evidenced by: Based on infection control log review, record review, observation, review of the Centers for Disease Control information review, interview and policy review the facility failed to maintain a comprehensive infection control program to monitor the development and transmission of infections throughout the facility. The facility also failed to ensure appropriate licensed medical professionals, competent in infection control practices, participated as the infection control coordinator. The facility also failed to ensure infection control guidelines were implemented during medication administration and a dressing change. This affected Resident #1, #4, #6, #12, #16, #21, #25, #27, #33 but had the potential to affect all residents who resided in the facility. The census was 29.	N 350		

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N 350	Continued From page 61 Findings include: Review of the facility Infection Control Program revealed a log for November 2025 that contained the following information: Resident #21 received fluconazole for yeast dated 11/02/25 through 11/04/25 and was resolved. Resident #1 received nitrofurantoin (on-going) for a urinary tract infection since 11/14/25. Resident #12 received cefdinir for a UTI from 11/22/25 through 11/29/25. Resident #16 received Cipro with the infection source not indicated from 11/19/25 through 11/26/25. Review of the December 2025 Infection Control Log revealed Resident #4 received Cipro for a wound infection beginning 12/01/25. On 12/09/25 at 5:40 P.M. interview with the Administrator revealed there were no facility infection control logs to track and trend infections in the facility. The Administrator provided this surveyor with Infection Control Logs she created after the survey team requested infection control logs since November 2025. Further interview with the Administrator verified the facility did not currently have a licensed healthcare professional overseeing the Infection Prevention and Control Program but the facility owner, Chief Executive Officer (CEO) #500 completed the Infection Preventionist training but no one with the ability to provide medical input was in the capacity to oversee the program. The Administrator further shared she was aware there were multiple issues with not having effective systems in place and no oversight with the nurses made it difficult because she, as the Administrator, was non-medical and CEO #500 had no long-term care experience.	N 350		

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N 350	Continued From page 62 Further interview revealed there was no policy related to a comprehensive infection control program and how to manage the program. The Administrator verified the policies she did have needed updating and had not been revised for some time. The Administrator stated she planned to get a more current policy book. Review of the Infection Control Policy in the facility policy binder did not include information about the facility infection control program and the over-all monitoring of illness or infections within the facility. The Infection Control Policies were dated July 2008 and June 2011 and included Handwashing and Infection Control Protocol (in reference to assessing the resident with symptoms, notifying the physician and following orders). Review of the Infection Protocol dated July 2008 revealed to assess the resident, check vital (signs) and note symptoms. Call the physician with vitals and symptoms. Take and record orders. Order medications, schedule an X-ray or blood work ordered, use medications from the "as needed" (PRN) box if needed to start regimen. Chart in nurses' notes, daily medical director report, and monthly Administrative Report. 2. Review of the Centers for Disease Control (CDC) on Enhanced Barrier Precautions (EBP) revealed Enhanced Barrier Precautions are an infection control intervention to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., resident with wounds or	N 350		

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N 350	Continued From page 63 indwelling medical devices). Review of the facility's current list of residents with indwelling urinary catheters revealed Residents #16, #25, and #27 had catheters. Further review of the medical records revealed these three residents had no orders for EBP due to the indwelling urinary catheters. Review of the facility's current list of residents with wounds revealed Residents #6 and #33 currently had orders for dressing changes related to open wounds. On 12/22/25 at 1:00 P.M. and on 12/23/25 at 10:10 A.M., observations revealed the residents above had no signage or indication for EBP. On 12/22/25 at 2:00 P.M., interviews with Certified Nursing Assistant (CNA) #600 and CNA #601 revealed no knowledge of what EBP were or when they were used. On 12/22/25 at 4:00 P.M., interview with the Administrator revealed she was aware of the use of EBP in long term care and had identified the facility did not use EBP. However, she did not notify the Medical Director or nursing staff to implement the precautions. Review of the facility's infection control policies and procedures revealed the policy did not include or address EBP to prevent the spread of infection throughout the facility. 3. Review of the medical record for Resident #2 revealed an admission date of 06/30/21 with medical diagnoses including type two diabetes	N 350		

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N 350	Continued From page 64 mellitus with hyperglycemia, atrial fibrillation, and major depressive disorder. Review of Resident #2's physician orders revealed an order dated 07/05/23 to check the resident's blood glucose level daily at bedtime and an order dated 07/23/25 revealed an order for Novolog FlexPen (a short-acting insulin) subcutaneously which specified to inject 10 units once daily before breakfast, inject three units once daily before lunch, and inject 5 units daily before supper. An observation on 12/10/25 at 4:00 P.M. with Licensed Practical Nurse (LPN) #545 revealed LPN #545 did not perform hand hygiene prior to preparing Resident #2's medications. LPN #545 did not don gloves to perform a fingerstick glucose check and did not don gloves prior to administering Resident #2's ordered insulin injection. LPN #545 wiped the hub of the insulin pen with an alcohol swab, placed an insulin pen needle on the pen and dialed the pen to 5 units. LPN #545 proceeded to cleanse Resident #2's right lower quadrant of her abdomen with an alcohol swab and injected the resident to administer the insulin. After Resident #2's insulin administration, LPN #545 did not perform hand hygiene and placed the glucometer into the medication cart without proper sanitization of the glucometer. An interview on 12/10/25 at 4:10 P.M. with LPN # 545 P.M. verified that she did not perform hand hygiene before or after medication administration, and that the use of gloves was required anytime that exposure to blood and body fluids was possible. LPN #545 shared that the facility had not supplied the staff with hand sanitizer or sanitation wipes needed for proper cleaning and	N 350		

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N 350	Continued From page 65 sanitization of the glucometer. An interview on 12/10/25 at 4:30 P.M. with the Administrator revealed that hand sanitizer was available from storage and she were not aware that none was available for staff use. The Administrator shared that the facility did not have any germicidal wipes available for staff use and that a supply was ordered. 4. Review of the medical record for Resident #6 revealed an admission date of 04/26/23 with diagnoses including iron deficiency anemia, age-related osteoporosis, osteoarthritis, and weakness. Review of the physician order dated 12/08/25 to the left heel indicated the left heel wound to be cleansed with normal saline, apply medi-honey to the base of the wound, an abdominal pad, and wrap with Kerlix daily. An observation on 12/22/25 at 5:45 P.M. with LPN #545 for wound care for Resident #6 revealed LPN #545 did not place a barrier between the treatment supplies and the table. In addition, LPN #545 did not perform hand hygiene prior to donning gloves to begin the dressing change. LPN #545 removed the dressing to the resident's left heel. The dressing was dry and intact and the wound was without drainage. Without changing her gloves and performing hand hygiene, and without cleaning the wound per physician's orders, the LPN applied the ordered treatment to Resident #6's left heel wound. On 12/22/25, following the observed dressing change, LPN #545 verified she did not perform hand hygiene prior to beginning the treatment or	N 350		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 350	Continued From page 66 when she moved from dirty to clean tasks with the dressing change; she did not place the treatment supplies on a barrier and placed them directly on the table and did not clean the resident's wound per physician order. Review of the Infection Control Policy, dated June 2011, revealed controlling disease transmission is assisted by practicing good personal hygiene. Personnel are to wash their hands (including but not limited to) between each resident contact. Disposable gloves must be worn during resident contact, when handling resident blood or body fluids. Gloves must be changed and disposed of and hands washed between resident contacts. Handwashing Techniques: Proper handwashing is the most effected way to prevent the spread of infection. If hands are not visibly soiled, an alcohol-based hand rub or gel may be used in place of soap and water. Wear gloves when contact with blood or other potentially infectious materials, mucus membranes and nonintact skin could occur. Remove gloves after caring for a patient. Always perform hand hygiene after removing gloves. Review of the Clean Dressing Change Protocol dated July 2008 revealed to keep wounds clean and prevent infection: wash hands, have clean disposable covering on work surface with necessary items; put on clean gloves; remove old dressing and place in disposable bag. Remove and dispose of gloves; wash hands; put on clean gloves; cleanse wound and dry, if applicable, with sterile gauze or pad; use prescribed treatment and dry sterile dressing (DSD); double bag all items and dispose; wash hands; chart on treatment sheet and in nurses notes.	N 350		

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N 350	Continued From page 67 This violation represents non-compliance investigated under Complaint Number OH00168644 and OH00168548. This violation is a recite to the annual survey completed 10/07/25.	N 350		
N 431	O.A.C. 3701-17-14 (A) (1) Plan of Care; Treatment and Care; Discharge O.A.C. 3701-17-14 (A) (1) - The nursing home shall assure that development of a plan of care is initiated upon admission and completed and implemented for each resident within seven days of completion of the initial comprehensive assessment, required by rule 3701-17-10 of the Administrative Code. The plan shall be resident-focused and goal driven, and prepared by an interdisciplinary team that includes the attending physician or other licensed health professional acting within the applicable scope of practice, or both, a registered nurse with responsibility for the resident and other appropriate staff in disciplines as determined by the needs of the resident including, but not limited to dietary, recreation, and social work staff. The home shall offer opportunities for the resident, the resident's sponsor, and those of the resident's choice to participate in the care planning process and will provide necessary information, support, and options for engaging in the process to ensure that the resident/sponsor directs the process to the maximum extent possible and is enabled to make informed choices and decisions. (1) The plan of care shall be consistent with the comprehensive assessment with recognition of the capabilities, preferences and goals of the resident, and shall contain a written description of	N 431		

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N 431	Continued From page 68 what services, supplies and equipment, are needed, when, how often, and by whom services, supplies and equipment will be provided and the measurable goals or outcomes. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure comprehensive care plans were implemented. This affected two residents (Resident #5 and #12) of three residents reviewed for falls. The census was 29. Findings include: 1. Review of Resident #5's medical record revealed an admission date of 11/03/25 with diagnoses including unspecified dementia, (history of) deep vein thrombosis, major depression, essential hypertension and history of falls. Record review revealed no physician orders specific to fall risk / fall interventions were in place on admission. Review of the fall risk assessment dated 11/03/25 and authored by an unidentified "agency nurse" revealed the resident was at high risk for falls due to a history of falls, diagnoses and use of assistive device. The assessment revealed the resident's gait was weak and she overestimated or forgets her limits in regard to cognitive status giving the resident a score of 80 indicating the resident was at high risk for falls (45 and above was considered high risk). No fall safety interventions were noted to be initiated at this time. Review of a progress note dated 11/03/25 at 11:11 A.M. and authored by an unidentified "temp	N 431		

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N 431	Continued From page 69	N 431		

nurse" revealed the resident arrived at the facility accompanied by her family. Call light and belongings within reach.

Review of the Admission Assessment dated 11/09/25 and authored by Registered Nurse (RN) #536 revealed Resident #5 was admitted due to a need for long term care. The assessment revealed the resident was alert and oriented to person. She had an unsteady gait, poor balance and was very impulsive. The resident had a flat affect and disorganized thinking. The assessment revealed the resident was incontinent of bowel and bladder, required staff assistance with mobility and activities of daily living but was independent with eating. Lastly, the assessment noted the resident required the use of a walker for mobility.

Record review revealed the resident did not have a fall prevention or risk care plan implemented upon her admission to the facility or following the admission assessment dated 11/09/25.

Review of a Post Fall Assessment document dated 11/26/25 at 10:58 (not identified as A.M. or P.M.) revealed Resident #5 was lying on the floor and found by Certified Nursing Assistant (CNA) #529 and #528. The assessment included the resident had an unwitnessed fall. The resident stated she got up to use the restroom and lost her balance and documented the resident "refuses" to use her call light. No noted skin issues or injuries. The form indicated the care plan was updated (however please note, the resident did not have a care plan related to falls at the time of the fall or following the fall). Review of side 2 of the form to be completed in full by the DON, was blank.

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N 431	Continued From page 70 The document prompted for the following information on page 2: Diagnosis, new medical conditions, current medications and side effects; recent changes in medications (including addition or discontinuation of medication), dose, frequency, when the change was made, sensory status and if there are any gait problems or assistive devices used. Further review revealed the document prompted the author "based on the above information, draw conclusion as to possible cause of this fall event". The document also requests a review of the resident ' s falls with any emerging patterns over the last six months and the time of day, location and if the fall was witnessed. Additionally, the document asks about care plan review (number of staff assistance required, does the care plan reflect objectives and interventions; staff nurses notified and care plan revised) and finally, what nursing recommendations are made related to the fall. Review of a progress notes dated 11/26/25 at 11:19 P.M. and authored by Licensed Practical Nurse (LPN) #545 revealed Resident #5 got up to go to the bathroom and fell. The LPN documented in the note "She has been told multiple times to use the call light and refuses. She does not appear to have any injuries. Neuro check was fine". Power of Attorney (POA) and physician aware. There was no evidence the resident was assessed related to the ability to use the call light and/or her understanding of the call light. Review of an incident/accident report dated 11/28/25 at 6:05 P.M. authored by CNA #532 revealed Resident #5 fell in her room. CNA #532 reported she brought the resident back to her	N 431		

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N 431	Continued From page 71	N 431		

room from dinner. The resident got out of her wheelchair, took a few steps forward and fell down. CNA #532 reported to the nurse (Nurse #601) the resident hit her head when she fell and she had a scrape on her left leg.

Review of a corresponding nursing progress note completed on 11/28/25 at 6:20 P.M. and authored by an unidentified "temp nurse" revealed Resident #5 got out of wheelchair with no assistance. The nurse documented the resident had been told multiple times to use her call light and refuses. The note revealed the resident appeared to have an abrasion on the front of her head and a skin tear on the left knee and lower leg. The resident was not complaining of any pain at this time. The note revealed the resident was educated on using call light for assistance (however, per surveyor investigation based on the resident's diagnosis of dementia and cognitive impairment it was uncertain if this education was or would be effective to mitigate the resident's fall risk). Call light within reach and (to) be at safe level. Neuro (neurological) checks fine. POA and physician were notified.

Record review revealed no Post-Fall Assessment was completed/provided for review following this fall, no fall care plan was in place prior to the fall or implemented following the fall to ensure individualized, comprehensive and effective interventions were in place to address the resident's fall risk/safety needs.

A plan of care dated 12/03/25 revealed Resident #5 was at risk for falls related to confusion, gait balance problems and unawareness of safety need. Interventions included to anticipate and meet the resident's needs, be sure the resident's call light was within reach and encourage the

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N 431	Continued From page 72 resident to use it for assistance as needed. The care plan revealed the resident needed prompt response to all requests for assistance and ensure the resident was wearing footwear when ambulating or mobilizing in the wheelchair. On 12/15/25 at 9:30 A.M. an interview with CNA #531 revealed there was no written plan related to fall prevention intervention(s) for residents including Resident #5. The CNA stated she knew she needed to be vigilant, keep an eye on the residents and make sure their call light was in reach. The CNA revealed she "pulls up the bed rails on beds" if she knows a resident has a history of falls. However, there was no list of resident's who were at risk for falls. The CNA revealed she had not received any nurse guided direction/education related to individualized fall prevention interventions for any of the residents (including Resident #5) who reside in the facility. On 12/15/25 at 12:02 P.M. a telephone interview with the Administrator verified care plans were not comprehensive and did not include all identified resident concerns when identified. Review of the facility Fall Prevention Policy and Fall Protocol dated July 2008 revealed to reduce the risk of falls: Fill in the fall assessment form when the resident is admitted and quarterly thereafter. If the risk level is moderate or high, address in Plan of Care. 2. Review of Resident #12's medical record revealed an admission date of 03/22/25 with diagnoses including muscle weakness, difficulty walking, cerebral infarction, long term use of anti-coagulants, atrial fibrillation, and falls.	N 431		

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N 431	Continued From page 73 Review of the physician's orders revealed no ordered fall interventions for the resident. Review of the Morse Fall Scale dated 11/03/25 revealed the resident was a high risk for falls. Review of a Nursing Admission Assessment/Screening/History form "dated 11/05/25" revealed the resident was (initially) admitted to the facility for assistance and need for therapy. (Please note, this assessment was not completed due to a re-admission or admission to the facility) The document noted the resident was oriented to person, place and situation but not time. The document included the resident was incontinent of bowel and bladder, was very weak in her left arm, required staff assistance with bed mobility, was dependent on staff for transfers (does not walk), dependent (on staff) for dressing and toilet use, needed staff assistance with eating, dependent (on staff) for bathing and personal hygiene, used wheel chair and recliner and was unable to take Xarelto and was changed from Eliquis to Coumadin but Coumadin had been discontinued. Review of a progress note dated 11/14/25 at 1:31 A.M. and authored by an unidentified "temp nurse" revealed the aide reported to the writer that resident was on the floor. Resident was found lying on her left side in front of her chair. The resident stated that she had slid out of her lift chair. The resident denies pain or injury and is pleasant and cooperative with care. Neuro checks were initiated (no evidence of the frequency or duration); resident reminded to use her call light for assistance. Family, provider, medical director need notification. Neuro checks continued throughout the shift with no notable	N 431		

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N 431	Continued From page 74 abnormalities. Review of an incident/accident report dated 11/27/25 at 4:15 P.M. revealed Resident #12 was found seated upright on the floor by the aide. The resident had been seated in her lift chair. Review of a corresponding nursing progress note dated 11/27/25 at 10:51 P.M. revealed the resident was found by an aide sitting upright on the floor. The resident stated she slid out of the chair. Pupils equal and reactive to light and accommodate. Resident had baseline left sides weakness. Denies pain or injury. Neuro checks initiated at 4:15 P.M. Resident reminded to use her call light for assistance. Lift chair unplugged at this time. Record review revealed a plan of care initiated 12/03/25 reflecting the resident had an actual fall with poor balance, poor communication/comprehension and unsteady gait. Interventions included to monitor/document/report as needed for 72 hours to physician for signs and symptoms of pain of pain, bruises, change in mental status, new onset confusion, sleepiness, inability to maintain posture, agitation, neuro checks and vital signs; take blood pressure lying/sitting/standing once in first 24 hours. (Please note, there were no individualized interventions due to the facility's lack of identification of the root cause of the resident's fall(s)). On 12/09/25 at 5:40 P.M. interview with the Administrator revealed there was little, if any documentation regarding incidents such as falls for any resident, including Resident #12. The Administrator located some incident reports and located some documentation in the medical	N 431		

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N 431	Continued From page 75 records but again, stated there was no system in place to review the falls to determine a root cause and appropriate follow-up. The Administrator stated she had no nurses who knew how to update care plans and she did not know why. On 12/15/25 at 9:30 A.M. an interview with CNA #531 revealed there was no written plan related to fall prevention intervention(s) for residents. The CNA stated she knew she needed to be vigilant, keep an eye on the residents and make sure their call lights were in reach. The CNA revealed she "pulls up the bed rails on beds" if she knows a resident has a history of falls. However, there was no list of resident's who were at risk for falls. The CNA revealed she had not received any nurse guided direction/education related to individualized fall prevention interventions for any of the residents who reside in the facility. This violation represents non-compliance investigated under Complaint Number OH00168644. This violation is also a recite to the survey completed 10/07/25.	N 431		
N 437	O.A.C. 3701-17-14 (D) Plan of Care; Treatment and Care; Discharge O.A.C. 3701-17-14 (D) - Each nursing home shall provide adequate supervision of residents who are assessed for risk of falls, or elopement, or both. This Rule is not met as evidenced by: Based on observation, medical record review,	N 437		

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N 437	Continued From page 76 hospital record review, medication information review, facility policy review and interview the facility failed to ensure a comprehensive, individualized and effective fall prevention program was implemented for Resident #5, who was admitted with cognitive impairment, had a history of falls and required staff assistance for activity of daily living care, to prevent falls including falls with injury. The breakdown in a systemic fall management program for Resident #5 resulted in Real and Present Danger and Actual Harm beginning on 11/26/25 when the lack of facility implemented interventions to address the resident's fall risk/safety resulted in the resident sustaining multiple falls. Resident #5 fell on 11/26/25, 11/28/25, 12/03/25 (actual harm with sutures to her head), 12/06/25 (actual harm with intracranial bleed and clavicle fracture), 12/13/25, 12/21/25, 12/24/25 and 12/30/25 without evidence of effective and necessary interventions being in place to decrease the risk of falls. Following each fall, there was no evidence a thorough investigation with root cause analysis was completed or evidence new fall risk/safety interventions were initiated to address the resident's fall risk/safety needs and to prevent falls. Additionally, concerns that did not rise to the level of Real and Present Danger occurred when the facility failed to implement fall risk/safety interventions to decrease the risk of falls for Resident #3 and #12 and failed to ensure interventions (a planned) were implemented to address Resident #27's exit seeking behaviors/elopement risk. This affected four residents (#3, #5, #12 and #27) of four residents reviewed for accidents. The facility census was 29.	N 437		

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N 437	Continued From page 77 On 12/16/25 at 4:52 P.M. the Administrator and Executive Director #501 were notified Real and Present Danger began on 11/26/25 when an onsite investigation identified systemic breakdowns and lack of a comprehensive fall prevention program with implementation of effective and necessary fall prevention interventions which resulted in Resident #5 experiencing multiple falls, including a fall on 12/06/25 that resulted in an intracranial (brain) bleed and left clavicle fracture. Due to the resident's intracranial bleed, her Eliquis for deep vein thrombosis (DVT) prevention was discontinued and on 12/08/25 the resident returned to the facility. No fall risk/safety interventions were implemented upon the resident's return. On 12/13/25 Resident #5 sustained a fall requiring hospitalization. During the resident's hospital stay, a left lower leg, extensive DVT was identified which could not be treated with anticoagulants due to the resident's intracranial bleed. The resident's family was offered an alternative treatment with surgery to insert a vena cava filter but this option was not selected and the resident returned to the facility with orders for Hospice services. The Real and Present Danger remains ongoing as of 01/02/2026. Findings Include: 1. Review of Resident #5's medical record revealed an admission date of 11/03/25 with diagnoses including unspecified dementia, (history of) deep vein thrombosis, major depression, essential hypertension and history of falls. Review of the physician's orders revealed an	N 437		

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N 437	Continued From page 78	N 437		

order for the anti-coagulant medication Eliquis five (5) milligrams (mg) on admission for DVT. Record review revealed no physician orders specific to fall risk / fall interventions were in place on admission.

Review of the fall risk assessment dated 11/03/25 and authored by an unidentified "agency nurse" revealed the resident was at high risk for falls due to a history of falls, diagnoses and use of assistive device. The assessment revealed the resident's gait was weak and she overestimated or forgets her limits in regard to cognitive status giving the resident a score of 80 indicating the resident was at high risk for falls (45 and above was considered high risk). No fall safety interventions were noted to be initiated at this time.

Review of a progress note dated 11/03/25 at 11:11 A.M. and authored by an unidentified "temp nurse" revealed the resident arrived at the facility accompanied by her family. Call light and belongings within reach.

Review of the Admission Assessment dated 11/09/25 and authored by Registered Nurse (RN) #536 revealed Resident #5 was admitted due to a need for long term care. The assessment revealed the resident was alert and oriented to person. She had an unsteady gait, poor balance and was very impulsive. The resident had a flat affect and disorganized thinking. The assessment revealed the resident was incontinent of bowel and bladder, required staff assistance with mobility and activities of daily living but was independent with eating. Lastly, the assessment noted the resident required the use of a walker for mobility.

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N 437	Continued From page 79 Record review revealed the resident did not have a fall prevention or risk care plan implemented upon her admission to the facility or following the admission assessment dated 11/09/25. Review of a Post Fall Assessment document dated 11/26/25 at 10:58 (not identified as A.M. or P.M.) revealed Resident #5 was lying on the floor and found by Certified Nursing Assistant (CNA) #529 and #528. The assessment included the resident had an unwitnessed fall. The resident stated she got up to use the restroom and lost her balance and documented the resident "refuses" to use her call light. No noted skin issues or injuries. The form indicated the care plan was updated (however please note, the resident did not have a care plan related to falls at the time of the fall or following the fall). Review of side 2 of the form to be completed in full by the DON, was blank. The document prompted for the following information on page 2: Diagnosis, new medical conditions, current medications and side effects; recent changes in medications (including addition or discontinuation of medication), dose, frequency, when the change was made, sensory status and if there are any gait problems or assistive devices used. Further review revealed the document prompted the author "based on the above information, draw conclusion as to possible cause of this fall event". The document also requests a review of the resident ' s falls with any emerging patterns over the last six months and the time of day, location and if the fall was witnessed. Additionally, the document asks about care plan review (number of staff assistance required, does the care plan reflect objectives and interventions; staff nurses	N 437		

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notified and care plan revised) and finally, what nursing recommendations are made related to the fall.

Review of a progress notes dated 11/26/25 at 11:19 P.M. and authored by Licensed Practical Nurse (LPN) #545 revealed Resident #5 got up to go to the bathroom and fell. The LPN documented in the note "She has been told multiple times to use the call light and refuses. She does not appear to have any injuries. Neuro check was fine". Power of Attorney (POA) and physician aware. There was no evidence the resident was assessed related to the ability to use the call light and/or her understanding of the call light.

Review of an incident/accident report dated 11/28/25 at 6:05 P.M. authored by CNA #532 revealed Resident #5 fell in her room. CNA #532 reported she brought the resident back to her room from dinner. The resident got out of her wheelchair, took a few steps forward and fell down. CNA #532 reported to the nurse (Nurse #601) the resident hit her head when she fell and she had a scrape on her left leg.

Review of a corresponding nursing progress note completed on 11/28/25 at 6:20 P.M. and authored by an unidentified "temp nurse" revealed Resident #5 got out of wheelchair with no assistance. The nurse documented the resident had been told multiple times to use her call light and refuses. The note revealed the resident appeared to have an abrasion on the front of her head and a skin tear on the left knee and lower leg. The resident was not complaining of any pain at this time. The note revealed the resident was educated on using call light for assistance (however, per surveyor investigation based on the

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N 437	Continued From page 81 resident's diagnosis of dementia and cognitive impairment it was uncertain if this education was or would be effective to mitigate the resident's fall risk). Call light within reach and (to) be at safe level. Neuro (neurological) checks fine. POA and physician were notified. Record review revealed no Post-Fall Assessment was completed/provided for review following this fall, no fall care plan was in place prior to the fall or implemented following the fall to ensure individualized, comprehensive and effective interventions were in place to address the resident's fall risk/safety needs. A plan of care dated 12/03/25 revealed Resident #5 was at risk for falls related to confusion, gait balance problems and unawareness of safety need. Interventions included to anticipate and meet the resident's needs, be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed. The care plan revealed the resident needed prompt response to all requests for assistance and ensure the resident was wearing footwear when ambulating or mobilizing in the wheelchair. Review of an incident/accident report dated 12/03/25 at 2:00 P.M. and authored by an unknown LPN (illegible signature) revealed the LPN documented a female was in her room and had a laceration on her head with vital signs including (temperature) 97.6 degrees Fahrenheit (F), (pulse) 83 (beats per minute) (bpm) (normal range 60-90 bpm), (respirations)14 breaths per minutes (normal 12-20 breaths per minute) and (blood pressure) (BP)160/48 (millimeters of mercury) (mmHg) (normal 120/60 mmHg). Review of a nursing progress note dated	N 437		

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N 437	Continued From page 82 12/03/25 at 2:31 P.M. and authored by LPN #532, revealed Resident #5 had a fall in her room and hit her head on the corner of her bedroom door. The resident had a "gash" on her head, bleeding was controlled and able to stop. Emergency Medical Services (EMS) were called but the resident refused to go out to the hospital. Educated resident on how important it was to be seen by the doctor due to her being on a blood thinner but the resident still refused. Blood pressure was documented to be elevated at 160/48. Range of motion (ROM) strong on both sides, no complaints of pain, was able to get the resident off the floor with help from another staff (unidentified). Treatment to the back of the head was completed, head was washed and measurements to gash were obtained (not indicated). Doctor was notified and a voicemail was left for the resident's power of attorney. Review of a progress note dated 12/03/25 at 3:53 P.M. and authored by LPN #532 revealed called (ambulance company), resident would be picked up at 5:00 P.M. and taken to (named) hospital. The resident had a laceration to (the) head that was six centimeters with blood gushing. Needs attention from the hospital. Review of a progress note dated 12/03/25 10:49 P.M. and authored by LPN #545 revealed the (named hospital) called. The resident would be returning to the facility and required (two) sutures to her head wound which would need removed in seven to ten days. The progress note revealed to follow up with physician in two to four days. Hydralazine was given for elevated blood pressure. Record review revealed Resident #5's care plan related to falls was not updated related to reflect	N 437		

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N 437	Continued From page 83 any new fall/safety interventions following this fall with injury. Review of a Post-Fall Assessment dated 12/06/25 at 3:25 P.M. revealed Resident #5 was found lying on the floor by CNA #602 after an unwitnessed fall. The resident was in her room and was found lying on her back "in the hall" between her closet and the bathroom. The resident didn't appear to be injured but started vomiting and was unable to clearly state what happened. The POA was notified (no time) and the physician was sent a text message at 3:59 P.M. The back of the Assessment/page 2, was blank. Review of a nursing progress note dated 12/06/25 10:10 P.M. and authored by LPN #545 revealed the resident fell at 3:25 P.M. and was found by CNA #602 on the floor between her closet and the bathroom. When "I" arrived, she was not able to tell me what happened and was not making any sense. Within a few minutes, she was vomiting. Squad was called and arrived at 3:36 P.M. At that time the resident was able to tell this nurse she did not hit her head but when the nurse asked if she hurt anywhere, the resident was unable to answer. The resident had no objections of going with the paramedics. Vital signs were obtained which included blood pressure of 150/101 (hypertensive). The physician and power of attorney were notified. The progress note included, when resident returns, she was to have "eyes laid on her every 15 minutes for 24 hours". Record review revealed this intervention was not added to the resident's fall prevention care plan. Review of a progress note dated 12/07/25 at 7:31 A.M. authored by RN #536 revealed at 5:45 A.M.,	N 437		

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this nurse called (named hospital) to check on resident's status. This nurse talked to (hospital staff member) and was told Resident #5 was admitted to the hospital with a "brain bleed" and fractured clavicle.

Review of the hospital record revealed Resident #5 was admitted (to the hospital) on 12/06/25 after she tripped and fell at the nursing home. Emergency Medical Services were called and enroute (to the hospital) the resident started vomiting and having some trouble breathing (with concerns for aspiration). The resident had a healing laceration to the occiput of the head (from a previous fall) with no other signs of head trauma. The resident's oxygen saturations were 90%. The resident was assessed to be hypertensive. Due to the concerns for aspiration and hypertension, the resident would need to be monitored (for potential bleed with hypertension, nausea, vomiting with a headache). The resident had been hospitalized a few days prior after a fall. A chest x-ray showed deformity to the left clavicle- moderately displaced fracture of the distal left clavicle. Cat scan (CT) of the brain showed interval development of subcortical four millimeter hemorrhage in the left frontal lobe per radiology. Kcentra (reversal agent for Eliquis) was ordered for the intracranial hemorrhage and noted the resident was on Eliquis. The resident required treatment of Zofran for persistent nausea, Hydralazine for elevated blood pressure and aerosols (respiratory inhalation medication) for breathing concerns. The resident then became more tachypneic (fast breathing) and hypoxic (low oxygen levels) with abnormal lung sounds (very wheezy) and was given Solu-Medrol (intravenous steroid), additional aerosols and placed on BiPap thereafter. The emergency department resident spoke with neurosurgery and

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N 437	Continued From page 85 orthopedics. Resident #5 was admitted to trauma surgical intensive care unit (ICU). Clinical Impression intraparenchymal hemorrhage, left clavicle fracture, suspected aspiration pneumonitis, acute hypoxic respiratory failure secondary to suspected aspiration pneumonitis and direct oral anticoagulants (DOAC) coagulopathy- (how anticoagulants affect the body's clotting system, primarily by increasing bleeding risk, causing issues with standard coagulations tests (PT/PTT) and requiring specialized management for bleeding, using agents like Andexanet alfa or idarucizumab for reversal, though these agents can be costly or difficult to access). Review of the hospital neurology consult note dated 12/07/25 at 2:50 P.M. revealed the resident had a small focal punctate contusion that should resolve on its own with resumption of anticoagulation in two weeks. The consult note revealed "will defer to her primary care providers regarding safety and utility of somebody with her due to fall history and remaining on anticoagulation". Review of the hospital Orthopedic Consult dated 12/07/25 revealed Resident #5 was found to have a left distal clavicle fracture, orthopedic surgery was consulted for evaluation and management. The resident would be non-weight bearing to the left upper extremity but there was no plan for orthopedic surgical interventions at this time. The note revealed recommend physical and occupational therapy (PT/OT) and follow-up outpatient in one to two weeks. Review of the resident's hospital discharge instructions dated 12/08/25 revealed Resident #5 was to resume Eliquis on 12/22/25 and follow up with orthopedics in two weeks. The note also	N 437		

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N 437	Continued From page 86 included to follow-up with the resident's primary care physician, Medical Director # 546 in one to two days. PT/OT ordered for frequent falls. The resident's Eliquis was to be held through 12/21/25. Further review of the discharge instructions revealed education materials provided for "understanding your risk for falls". The instructions included it was important to understand your risk for falls. Talk with your health care provider about your risk and what you can do to lower it. There were actions you can take at home to lower your risk. Serious injuries from falls were common. These include broken bones and traumatic brain injury (TBI) as falls were the most common cause of TBI. Serious injuries from a fall most often happen to people older than age 65. The instructions also noted the more risk factors you have for falling, the higher your risk and included documentation of various risk factors. Record review revealed there was no written progress note to indicate the time Resident #5 returned to the facility or her status upon arrival. In addition, record review revealed no comprehensive, individualized or effective fall interventions were implemented upon the resident's return to the facility to decrease her risk for falls and/or to prevent injury. On 12/09/25 at 5:40 P.M. interview with the Administrator revealed there was little, if any documentation regarding incidents such as falls for any resident, including Resident #5. The Administrator revealed she had located some incident reports and some documentation in the medical records but again, there was no system in place to review resident falls to determine a	N 437		

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root cause and ensure appropriate follow-up was completed. The Administrator stated she had no nurses who knew how to update care plans and she did not know why. The Administrator revealed the facility did not currently have a Director of Nursing and stated the lack of a DON to provide oversight and additional input had affected the fall prevention and management program due to incomplete investigations and lack of interventions implemented with falls.

Review of an untitled document dated 12/11/25 (no time) revealed the resident had no known drug allergies and her chief complaint was "falling, went x2 to the hospital". The exam revealed "wheezing, left side. Left leg swollen, alert and oriented x3". The assessment included deep vein thrombosis and wheezing. Albuterol (respiratory medications) and Bactrim DS (antibiotic) one twice a day. Plan: chest x-ray and urinalysis. The document was signed by Medical Director #550 but was not dated when signed.

A nursing progress note dated 12/13/25 at 8:27 P.M. and authored by an unidentified "temp nurse" revealed Resident #5 had an unwitnessed fall at approximately 8:10 P.M. The resident was complaining of lower back and hip pain, nausea and vomiting, was unsteady on (her) feet and confused. Resident #5 was transported to (named hospital) by EMS. A message was left for the resident's first emergency contact and Human Resources #502 notified as well. There was no documented post-fall assessment completed/provided related to this fall.

Review of the hospital record dated 12/13/25 revealed Resident #5 had been discharged from the hospital on 12/08/25. During that admission the resident was under trauma service after she

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N 437	Continued From page 88 had a fall at the facility. The resident was found to have a small parenchymal intracranial hemorrhage. The resident was also treated for acute toxic respiratory failure which was thought to be secondary to aspiration pneumonitis and hypertensive emergency. The resident was evaluated by neurosurgery (for intracranial bleed) as well as orthopedics for a clavicle fracture. Since discharge the resident had another fall. Per reports she did not hit her head or lose consciousness. It was difficult to obtain any history from resident as she has dementia. The resident's hemoglobin was now 8.3 anemic (had been 9.2 on 12/03/25). The record noted the resident's anemia most likely "traumatic and secondary to recent fall". The resident required a blood transfusion. Due to left lower extremity swelling and a history of DVT, the resident required an ultrasound for evaluation (the resident was off anticoagulation currently). The resident was also assessed to have acute sigmoid diverticulitis (bowel infection) without abscess or perforation and noted she would continue on intravenous antibiotics. The resident was admitted to the hospital. Review of the vascular surgery consultation dated 12/15/25 revealed the resident was seen for possible IVC filter (due to presence of DVT and is an umbrella like device inserted into the IVC to prevent blood clots from traveling to the lungs and causing a life threatening pulmonary embolism. This is a treatment option for patients who are unable to take blood thinning medications due to bleeding, recent trauma or surgery and can be temporary or permanent). The consult note revealed the physician spoke with the hospitalist indicating ideally the resident needed to be on some type of anticoagulation (she had a fairly extensive DVT). An IVC filter	N 437		

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N 437	Continued From page 89 certainly was not unreasonable given the resident's repeated falls and dementia (as it may be wise to have that for protection), but it would need consent from the resident's POA prior to proceeding. On 12/15/25 at 9:30 A.M. an interview with CNA #531 revealed there was no written plan related to fall prevention intervention(s) for residents including Resident #5. The CNA stated she knew she needed to be vigilant, keep an eye on the residents and make sure their call light was in reach. The CNA revealed she "pulls up the bed rails on beds" if she knows a resident has a history of falls. However, there was no list of resident's who were at risk for falls. The CNA revealed she had not received any nurse guided direction/education related to individualized fall prevention interventions for any of the residents (including Resident #5) who reside in the facility. On 12/15/25 at 12:02 P.M. a telephone interview with the Administrator verified the falls noted for Resident #5 did not have a thorough investigation nor did the facility identify the root cause of the fall or ensure appropriate (individualized and effective) fall prevention intervention(s) were added to prevent further falls. She verified there was no assessment of the environment at the time of the falls and no way to determine what interventions, if any, were in place at the time of the fall. The Administrator stated if she was able to find additional information related to Resident #5's falls and lack of follow-up or additional information, she would provide the information. However, no additional information was provided during the investigation. During the interview, the Administrator again reported the facility did not have a DON which affected the thoroughness of fall investigations and ensuring appropriate	N 437		

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N 437	Continued From page 90 interventions were implemented. Review of a palliative care consultation dated 12/16/25 revealed a consult for end of life discussion/decision making support. The resident's son stated he was worried about his mother's overall quality of life and her ability to keep herself safe. She was impulsive and unaware of her functional/ambulatory ability. She had repeated falls with injury. There was discussion of hospice philosophy and palliative care philosophy in detail. Following conversation, the resident's son did elect to change Resident #5's code status to do not resuscitate, comfort care arrest. On 12/17/25 at 4:02 P.M. an interview with LPN #545 revealed she had been employed by the facility for approximately eight months. The LPN knew who Resident #5 was and stated she resided on B wing but stated the only time she went to that unit was to administer medications or if "something was wrong." The LPN stated she had just arrived on shift on the date the resident fell, hit her head and had a laceration to the back of her head. In regard to falls (in general) the LPN revealed when a resident falls, there was a fall form that was to be completed and found at the nurse's station and a neurological check form but stated the physician takes the lead on the frequency of the neuro checks. The standard was every 15 minutes for the first hour and then hourly unless there was a change and then staff would notify the physician and they would advise staff what to do. If a resident was on neuro checks, there was usually a paper for them at the nurse's desk. The LPN revealed neuro checks usually go to the DON; however, the facility doesn't have a DON. Further interview revealed when Resident #5 returned from the hospital (on 12/08/25) they	N 437		

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did 15 minute checks but she had "absolutely no idea" who did the 15-minute checks and stated maybe a DON would have a meeting about something like that. The nurse shared she didn't know who would update care plans and didn't know if the residents in the facility had any type of care plans. She shared she was only oriented to medication administration in PCC and not how to enter orders. The LPN shared she was unsure how fall prevention interventions were communicated with staff but stated when residents were admitted, the staff were just told by someone if the resident(s) had a history of falls and if the nurse or aide wasn't there when the resident was admitted, they would get that information in report. During the interview, the LPN revealed if she was getting report from an agency/temp nurse, she doesn't get much information from them about their shift.

Review of a Physical Therapy (PT) Discharge Recommendations and Assessment dated 12/18/25 revealed Resident #5 would benefit from in-house patient therapy if available versus home health therapy. On 12/15/25, venous doppler of the left lower extremity showed acute DVT of the external iliac, common femoral, femoral, deep femoral and posterior tibial veins. The resident was unable to have anticoagulation because of her recent intracranial hemorrhage. IVC filter placement was considered but family declined currently with palliative care consulted.

Review of the Hospital Discharge dated 12/19/25 revealed to follow up with primary care provider in 1-2 days. Stop taking Eliquis.

Review of facility re-admission orders (12/19/25) revealed to admit to Aultman Hospice with diagnosis of dementia. The resident had orders

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF LORETO	2812 HARVARD AVENUE, NW CANTON, OH 44709

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 437	Continued From page 92	N 437		

for Ativan and Oxycodone. Eliquis was noted to be "on hold". There was no mention of the resident's Eliquis upon readmission to the facility.

Review of a progress note dated 12/19/25 at 2:22 P.M. and written by "temp nurse" revealed Resident #5 arrived at approximately 2:00 P.M. by stretcher per morning nurse. This nurse (writer) arrived at 3:00 P.M. and assessed the resident. Spoke with her hospice nurse about medications. Hospice ordered comfort medications of Ativan and Oxycodone which were stat delivered. The note revealed the resident was oriented to self only.

Review of the Nursing Admission Screening/History completed by an "agency nurse' and dated 12/19/25 revealed Resident #5 was admitted for increased weakness and falls. The document included the resident had dementia and recently had another fall. The resident was oriented to self only and had an unsteady gait and weakness. She required assistance of staff with bed mobility, transfers, walking, locomotion, dressing does not occur, and assistance of staff with eating. Toilet use does not occur and personal hygiene and bathing were not assessed. The admission screening/history revealed the resident used a walker. There was no assessment of the resident's fall risk completed at this time.

Record review revealed no new fall/safety care plan/interventions were initiated at the time of re-admission.

Review of a progress notes dated 12/21/25 at 4:24 P.M. and authored by LPN #545 revealed the resident fell stating that she was getting up to make fried chicken for dinner. The note revealed

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N 437	Continued From page 93 CNA #530 witnessed the fall and stated the resident got up and then actually sat on floor. CNA #530 stated the resident did not hit her head. The note included the resident stated she got dizzy so she sat down. The resident's vital signs were assessed and the resident was "educated" it was important to ask for help when getting up so that she doesn't get hurt. There were no visible signs of injury and the resident stated she was not injured. Record review revealed no additional/new interventions implemented to the resident's current fall care plan as a result of the resident's fall on 12/21/25. On 12/21/25 at 10:55 AM. interview with CNA #548 revealed she had worked at the facility for one month and was told when she oriented to the floor which residents were prone to falls but it was not written down anywhere and the CNAs just knew who to "keep an eye on". Lastly, the CNA stated she would expect some type of information sheet for each resident that she was assigned and the information should contain specific information about the residents and ways to prevent their falls. The CNA verified when Resident #5 returned from the hospital the CNAs were not given any updated information related to fall prevention interventions for this resident. On 12/21/25 at 12:05 P.M. observation of Resident #5 revealed she was seated in a wheelchair in the dining room, eating her lunch. The resident was unable to recall returning from the hospital the day prior. The resident was pleasant and had no complaints voiced On 12/22/25 at 12:18 P.M., a telephone interview with Resident #5's son revealed the son was the	N 437		

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resident's power of attorney. The son revealed the resident had lived at home independently and then with him prior to moving into the facility on 11/03/25. He stated the resident had been declining cognitively at home and required a lot of assistance with her care prior to her admission. Resident #5's son revealed the family had hoped the resident would "stabilize" following her admission to the facility but stated they had recently elected to pursue hospice services. During the interview, Resident #5's son revealed when he had been contacted by staff following the resident's fall on 12/21/25, he was told the resident stood up, got dizzy and sat down quickly.

On 12/23/25 at 9:06 A.M. interview with CNA #531 revealed that yesterday (12/22/25) just after lunch the Administrator had come to the B wing and told her to remove the slippers from Resident #5's room. The CNA stated despite frequent reminders for her to use her call light, Resident #5 was unable to remember to use her call light. The CNA also stated the resident needed staff assistance with ADLs and she falls if she stands without staff support.

Review of Resident #5 ' s post fall assessment dated 12/24/25 at 3:55 P.M. and authored by LPN #545 revealed the resident experienced a fall on this date. The resident was escorted to the common area, sat in a chair, reached down and tipped over, headfirst. The resident ' s vital signs obtained and noted to include 76 pulse, 16 respirations 18 and blood pressure 167/99 (hypertensive), sitting. LPN #545 was the first staff member to respond. The resident did hit her head and the fall was documented to be witnessed. The assessment included there were no initial injuries noted and the resident ' s son was notified on 12/24/25 at 4:12 P.M. However,

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N 437	Continued From page 95 there was no evidence of physician notification. The form indicated "(Hospice name) Hospice called (no date or time of the notification). Review of side 2 of the form to be completed in full by the DON, was blank. Review of the progress note dated 12/24/25 at 11:36 P.M. revealed the resident "toppled out of her chair" at 3:55 P.M. landing head first on the floor. Resident then began vomiting. Resident coherent x 2 and answering question appropriately. Son was called and a detailed voice message was left. The progress note revealed the son did call back and the nurse advised him what had happened. (Named) Hospice called to come assess resident for recommendations. Vital signs included blood pressure 167/99, temperature 97.8, oxygen saturation 98%, heart rate 71. The note also revealed hospice nurse here at 4:52 and stated that her vitals were good and to just monitor for any changes. Vital signs at 9:30 P.M. included blood pressure 127/75, heart rate 75, temperature 97.4, and oxygen saturation 97%. The nurse documented "no concerns at this time". Review of the progress note dated 12/25/25 at 11:33 P.M. and authored by LPN #545 revealed resident continued to have spells of vomiting. Zofran given with some relief. The resident's vital signs were obtained and documented and the note revealed "will continue to monitor". Record review revealed the resident ' s care plan was not updated and there was no physician order for any new fall prevention interventions after this fall to decrease the resident's risk of additional falls.	N 437		

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N 437	Continued From page 96 Review of the progress note dated 12/30/25 at 4:39 P.M. and authored by "temp nurse" revealed the resident fell out of chair onto her head. The resident stated she was not in pain, and a small bump was noted on (her) upper right forehead. The resident's vital signs were documented to include a blood pressure of 170/90 (hypertensive) and heart rate of 66. The note included "doctor was notified and patient on neuro checks". Review of a progress notes dated 12/30/25 at 4:51 P.M. and authored by "temp nurse" revealed the nurse contacted (named) (son) and (named) Hospice to alert them regarding (the resident's) fall. The note included a new intervention that the resident would only be seated in the recliner chair with staff present as she lacked trunk control. On 12/31/25 at 4:31 P.M. interview with the Administrator confirmed Resident #5 had experienced an additional fall since 12/24/25 as documented in the progress note. The Administrator stated she directed the nurse to implement an intervention after the fall. The Administrator verified the resident was to only be seated in the common area recliner with staff present. Further interview revealed the Administrator indicated the surveyor would need to contact the facility on 01/02/26 for a post fall assessment as she currently wasn ' t at work and ED #501 would be able to assist but not until 01/02/26. The care plan was not updated to reflect the intervention from 12/30/25. Review of the Eliquis information on www.Eliquis.com revealed there is an increased risk of blood clots if you stop taking Eliquis. Eliquis lowers your chance of having a stroke by	N 437		

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N 437	Continued From page 97 helping to prevent clots from forming. If you stop taking Eliquis, you may have an increased risk of a clot forming in your blood. Eliquis can cause bleeding, which can be serious and may lead to death. Review of the facility Fall Prevention Policy and Fall Protocol dated July 2008 revealed to reduce the risk of falls: Fill in the fall assessment form when the resident is admitted and quarterly thereafter. If the risk level is moderate or high, address in Plan of Care. Use the following precautions: a. Make sure eye glasses are on, fit properly and are clean. b. Make sure shoes are on correctly and tied. c. Answer call lights promptly. d. Make sure all areas are well lit. e. Keep rooms and hallways obstacle free. f. Keep assistive devices-walkers, canes, wheelchairs-within reach. g. Have nightlight on in bathroom at all times. h. Do not allow free standing foot stools. i. Avoid side rails or restraints unless requested by the resident or assessed necessary for safety. j. If possible place residents at high risk for falls close to the nurses' station. k. Instruct residents on how to transfer and change position slowly. l. Make sure hearing aids are working properly. m. Watch for and eliminate or alter unsafe clothing-pant legs too long, long robes, etc. n. Make sure that water mug is within reach, call light is in place and any other item the residents uses i.e. Kleenex, TV remote etc. is within reach of the resident. o. Provide assistance to residents who are at high risk for falls.	N 437		

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N 437	Continued From page 98 In the event of a fall: Do not leave the Resident unless absolutely necessary; Use call light or call out "Dr. Scope" to get help; If more help is needed one staff member calls "Dr. Scope" and the location on the PA system; Staff available will respond, bringing the scoop stretcher; Registered nurse assesses the Resident: range of motion, vitals, etc.; If no injury is noted, two staff members assist resident to stand; Resident is reassessed and vital are checked in 10 minutes; If an injury is suspected, the resident is put on the scoop stretcher and placed on the bed or gurney For all falls: Call the primary physician and proceed with any orders the physician may give; Notify the family of details of fall and Physicians orders. Chart fall on: Medical director's report, administration report, nurses' notes and address the fall in the Plan of Care. If injury is severe, do not move the resident and call 9-1-1. 2. Review of Resident #12's medical record revealed an admission date of 03/22/25 with diagnoses including muscle weakness, difficulty walking, cerebral infarction, long term use of anti-coagulants, atrial fibrillation, and falls. Review of the physician's orders revealed no ordered fall interventions for the resident. Review of the Morse Fall Scale dated 11/03/25 revealed the resident was a high risk for falls. Review of a Nursing Admission Assessment/Screening/History form "dated 11/05/25" revealed the resident was (initially) admitted to the facility for assistance and need for	N 437		

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therapy. (Please note, this assessment was not completed due to a re-admission or admission to the facility) The document noted the resident was oriented to person, place and situation but not time. The document included the resident was incontinent of bowel and bladder, was very weak in her left arm, required staff assistance with bed mobility, was dependent on staff for transfers (does not walk), dependent (on staff) for dressing and toilet use, needed staff assistance with eating, dependent (on staff) for bathing and personal hygiene, used wheel chair and recliner and was unable to take Xarelto and was changed from Eliquis to Coumadin but Coumadin had been discontinued.

Review of a progress note dated 11/14/25 at 1:31 A.M. and authored by an unidentified "temp nurse" revealed the aide reported to the writer that resident was on the floor. Resident was found lying on her left side in front of her chair. The resident stated that she had slid out of her lift chair. The resident denies pain or injury and is pleasant and cooperative with care. Neuro checks were initiated (no evidence of the frequency or duration); resident reminded to use her call light for assistance. Family, provider, medical director need notification. Neuro checks continued throughout the shift with no notable abnormalities.

Review of an incident/accident report dated 11/27/25 at 4:15 P.M. revealed Resident #12 was found seated upright on the floor by the aide. The resident had been seated in her lift chair.

Review of a corresponding nursing progress note dated 11/27/25 at 10:51 P.M. revealed the resident was found by an aide sitting upright on the floor. The resident stated she slid out of the

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N 437	Continued From page 100 chair. Pupils equal and reactive to light and accommodate. Resident had baseline left sides weakness. Denies pain or injury. Neuro checks initiated at 4:15 P.M. Resident reminded to use her call light for assistance. Lift chair unplugged at this time. Record review revealed a plan of care initiated 12/03/25 reflecting the resident had an actual fall with poor balance, poor communication/comprehension and unsteady gait. Interventions included to monitor/document/report as needed for 72 hours to physician for signs and symptoms of pain of pain, bruises, change in mental status, new onset confusion, sleepiness, inability to maintain posture, agitation, neuro checks and vital signs; take blood pressure lying/sitting/standing once in first 24 hours. (Please note, there were no individualized interventions due to the facility's lack of identification of the root cause of the resident's fall(s)). On 12/09/25 at 5:40 P.M. interview with the Administrator revealed there was little, if any documentation regarding incidents such as falls for any resident, including Resident #12. The Administrator located some incident reports and located some documentation in the medical records but again, stated there was no system in place to review the falls to determine a root cause and appropriate follow-up. The Administrator stated she had no nurses who knew how to update care plans and she did not know why. The Administrator revealed the facility did not currently have a DON and stated the lack of a DON to provide oversight and additional input has affected the fall prevention and management program due to incomplete investigations and lack of interventions implemented with falls.	N 437		

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N 437	Continued From page 101 On 12/10/25 at 3:00 P.M. Resident #12 was observed lying in bed with her call light within reach. On 12/15/25 at 9:30 A.M. an interview with CNA #531 revealed there was no written plan related to fall prevention intervention(s) for residents. The CNA stated she knew she needed to be vigilant, keep an eye on the residents and make sure their call lights were in reach. The CNA revealed she "pulls up the bed rails on beds" if she knows a resident has a history of falls. However, there was no list of resident's who were at risk for falls. The CNA revealed she had not received any nurse guided direction/education related to individualized fall prevention interventions for any of the residents who reside in the facility. On 12/15/25 at 12:02 P.M. a telephone interview with the Administrator verified the falls noted for Resident #12 did not have a thorough investigation nor did the facility identify the root cause of the fall or ensure appropriate (individualized and effective) fall prevention intervention(s) were added to prevent further falls. She verified there was no assessment of the environment at the time of the falls and no way to determine what interventions, if any, were in place at the time of the fall. The Administrator stated if she was able to find additional information related to Resident #12's falls and lack of follow-up or additional information, she would provide the information. However, no additional information was provided during the investigation. During the interview, the Administrator again reported the facility did not have a DON which affected the thoroughness of fall investigations and ensuring appropriate	N 437		

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N 437	Continued From page 102 interventions were implemented. 3. Review of Resident #3's medical record revealed an admission date of 06/30/21 with diagnoses including prior fracture, tinnitus, vertigo, heart block and arthritis. Record review revealed a plan of care dated 06/27/22 indicting the resident would be "stable on feet" and "avoid falls". Interventions included the resident would use walker regularly and call for assistance as needed. There were no updated interventions on the plan of care following this date. Record review revealed a plan of care dated 02/14/25 indicating Resident #3 was at risk for falls related to (no information provided as to why the resident is at risk for falls). Interventions included to anticipate the resident's needs, be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed and ensure the resident was wearing appropriate footwear when ambulating and mobilizing in wheelchair. (Please note, there were no individualized interventions due to no identifications of the root cause of the resident's falls). Review of the physician's orders revealed no ordered fall interventions. Review of the Morse fall risk assessment dated 10/21/25 identified Resident #3 was at high risk for falls. Review of an Admission Screening/History form dated 10/21/25 (please note the resident was not a re-admission or new admission on this date) revealed Resident #3 was cognitively intact to	N 437		

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N 437	Continued From page 103 person, place, time and situation but could be confused and had poor short-term memory. The resident had difficulty being understood and understanding others. The document included the resident had normal gait but poor balance and used a front wheeled walker, was hard of hearing and had an involved sister- still living. The documented included the resident preferred to stay in her room, to herself, had macular degeneration and wears glasses. The resident was noted to have an overactive bladder with bladder incontinence- wears incontinence brief with pads and was independent with activities of daily living (ADLs) except she needed staff assistance with showers. Review of a fall assessment dated 11/19/25 revealed at 6:30 (A.M.) Resident #3 was found lying on the floor in her bathroom by aide. She experienced an unwitnessed fall. The resident stated she slipped on the bathroom floor, fell and hit the back of her head. The resident was alert and oriented and had no complaints. Range of motion was documented to be good and there was bruising on the resident's left arm near the wrist and a quarter sized abrasion with swelling on the back of the head. The abrasion was cleansed with wound cleanser. The assessment noted the resident was independent with ambulation. The assessment indicated the resident's care plan was updated by way of quarterly or change of condition review and the assessment prompted for a care planned intervention. Further review the fall assessment prompted the author to make notation in nurses' notes with the date, time, "See post fall assessment" and sign it off. The CNP and family were updated. The assessment was authored by LPN #545.	N 437		

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N 437	Continued From page 104 Review of a nursing progress note dated 11/19/25 at 9:02 P.M. revealed Resident #3 was found in the bathroom and had "apparently fallen". The resident was assessed to find bruise on left arm near wrist and a small abrasion on back of head that was swollen. Wound was cleansed. Neuro checks were "fine" and the resident was alert and answering questions appropriately. Vital signs included blood pressure (elevated at) 158/92 and heart rate (elevated at) 105 beats per minute. The note revealed the resident's power of attorney and physician were notified. Vital signs "taken later" noted the resident was now hypotensive with blood pressure of 84/69 and heart rate of 86. On 12/09/25 at 5:40 P.M. interview with the Administrator revealed there was little, if any documentation regarding incidents such as falls for any resident, including Resident #3. The Administrator located some incident reports and located some documentation in the medical records but again, stated there was no system in place to review the falls to determine a root cause and appropriate follow-up. The Administrator stated she had no nurses who knew how to update care plans and did not know why. The Administrator revealed the facility did not have a DON and stated the lack of a DON to provide oversight and additional input has affected the fall prevention and management program due to incomplete investigations and lack of interventions implemented with falls. On 12/10/25 at 2:25 P.M. Resident #3 was observed standing in her room with shoes on and had her walker. The resident stated she was doing fine when asked. Call light noted to be on her bed. However, there was no evidence of any additional fall prevention interventions being in	N 437		

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place at this time.

On 12/15/25 at 9:30 A.M. an interview with CNA #531 revealed there was no written plan related to fall prevention intervention(s) for residents. The CNA stated she knew she needed to be vigilant, keep an eye on the residents and make sure their call lights were in reach. The CNA revealed she "pulls up the bed rails on beds" if she knows a resident has a history of falls. However, there was no list of resident's who were at risk for falls. The CNA revealed she had not received any nurse guided direction/education related to individualized fall prevention interventions for any of the residents who reside in the facility.

5. Review of the facility's prior survey history revealed a complaint and annual licensure survey were completed on 10/07/25 with a violation issued at N437 when Resident #26 (previously identified as Resident #27) left the facility on an unauthorized leave of absence (elopement). The facility completed a plan of correction to include an elopement binder that was created and placed at the front desk and at each nurses' station on 11/05/25.

Review of Resident #26's medical record revealed an admission date of 09/13/21 with diagnoses including chronic pain, chronic kidney disease and mild cognitive impairment.

Review of the resident's Nursing Admission Screening/History Form dated 11/05/25 revealed the resident was independent with most activities of daily living and ambulated independently.

Review of the progress notes from 11/01/25 through 12/01/25 revealed no attempts to exit the

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facility unsupervised had been documented.

On 11/19/25 at 10:45 A.M. interview with Resident #26 revealed no concerns related to the resident's care. No attempts to exit the facility unsupervised were observed during the onsite investigation with Resident #26.

On 11/19/25 at 11:15 A.M. interview with LPN #539 revealed there was no elopement binder located at the nurses' station but the LPN stated she would use "clinical judgement" to determine if a resident was an elopement risk. The LPN also revealed she received education regarding elopement on this date (11/19/25) (she did not elaborate what the education included) but stated this was the first time she had received elopement education from the facility.

On 11/19/25 at 11:32 A.M. interview with Receptionist #650 revealed she had no knowledge of an elopement binder or what an elopement binder was. Observation revealed no elopement binder was located at the reception desk.

On 11/19/25 at 11:35 A.M. interview with ED #501 revealed she wasn't aware of an elopement binder in the facility. The ED reported the Administrator wrote the plan of correction for the previous State agency survey and if the Administrator said the facility had an elopement binder, the Administrator "didn't tell anyone else."

On 11/19/25 at 11:45 A.M. interview with the Administrator revealed she had removed the elopement binders from the nurses' station and reception area "yesterday" to add "information to them" because she felt they didn't contain enough information in them. The Administrator did not

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N 437	Continued From page 107 share what information was added to the elopement binders. The Administrator confirmed the elopement binders should have been readily available to the staff and staff should be knowledgeable about the elopement binders that were part of the facility plan of correction. Review of the policy "Elopement Response Guidelines Policy" (provided as part of the education for the plan of correction to the 10/07/25 survey) and revised 04/12/23 revealed in the event a resident was missing or unaccounted for, the facility would immediately initiate protocols to locate the resident using available resources and a coordinated effort to locate the resident. If the resident was identified at risk prior to the event, the resident's elopement profile, which includes a picture of the resident, would be copied and ready to distribute. The current facility policy did not include the implementation of an elopement binder. This violation represents non-compliance investigated under Master Complaint Number OH00169143 and Complaint Number OH00168644. This violation is also a recite to the survey completed 10/07/25 and 07/17/25.	N 437		
N 439	O.A.C. 3701-17-14 (F) Plan of Care; Treatment and Care; Discharge O.A.C. 3701-17-14 (F) - The nursing home shall assure that all residents receive adequate, kind, and considerate care and treatment at all times. This Rule is not met as evidenced by: Based on observation, record review, facility policy review, and interview, the facility failed to	N 439		

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N 439	Continued From page 108 ensure all residents of the facility received adequate, kind, and considerate care and treatment at all times. The facility failed to ensure a comprehensive wound management program was in place to routinely assess and treat identified wounds. This resulted in Real and Present Danger and Actual Harm for Resident #4 and Resident #6 whose wounds were not monitored by facility staff for progression towards healing and whose wound dressings were not completed or were not completed appropriately resulting in wound deterioration and/or infection. Additionally, this also affected Resident #18 who had a newly identified wound that was not comprehensively assessed and did not have a treatment or interventions implemented timely. As of 12/27/25, the facility identified only three residents (#4, #6, and #18) with current treatments for wound care. The facility failed to ensure physician ordered laboratory testing related to anti-coagulant medication was completed and reported to the physician for timely adjustment of medication and treatment regimens. This resulted in Real and Present Danger and Actual Harm for Resident #12 and Resident #27, both of whom required inpatient hospitalization for supratherapeutic International Normalized Ratio (INR) levels (a laboratory test which is a standardized calculation that makes PT results comparable; this value is most often monitored for patients on Warfarin (Coumadin) and dosages are adjusted based upon results). In addition, the facility failed to ensure appropriate oversight was provided to ensure residents received appropriate interventions to respond to INR results and medication adjustments. The facility identified only three residents (#12, #27 and #4) who received Warfarin (Coumadin) therapy at the	N 439		

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N 439	Continued From page 109 facility. The facility failed to ensure a change in condition was timely recognized and reported to the physician for Resident #16. This resulted in Real and Present Danger and Actual Harm on 12/25/25 when Resident #16 reported he felt like he was developing a urinary tract infection (UTI). The nurse recorded this entry in the medical record but did not notify the provider for additional orders or direction. Resident #16 was noted to develop additional symptoms including dark-colored stools, diarrhea, and decreasing urinary output over the following days with no evidence of intervention or notification to the provider to address Resident #16's condition. Resident #16 was transferred to the hospital on 12/30/25 after having no urinary output recorded for at least eight hours where he was admitted for dehydration, an abscess of the abdominal cavity, anemia of unknown origin, and chronic kidney disease. This affected six residents (#4, #6, #12, #16, #18, and #27) of 12 residents reviewed for quality of care. The facility census was 29. On 12/16/25 at 4:52 P.M, the Administrator and Executive Director (ED) #501 were notified Real and Present Danger began on 11/12/25 when the lack of administrative and clinical oversight following turnover of key personnel and gaps in key positions being staffed following a change in ownership earlier in the year resulted in resident's not receiving adequate wound/skin management, anti-coagulant medication monitoring and administration and timely and necessary intervention following an acute change in condition. The lack of systems placed all residents at risk for serious harm, injury, and/or death as the facility failed to operate in a manner to meet the total care needs of all residents.	N 439		

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N 439	Continued From page 110 The Real and Present Danger remains ongoing as of 01/02/2026. Findings include: 1. Review of the medical record for Resident #16 revealed an admission date of 04/06/21 with medical diagnoses including hydronephrosis (the swelling of one or both kidneys due to a backup of urine, often due to a blockage in the urinary tract), benign prostatic hyperplasia with lower urinary tract symptoms, a history of urinary tract infections, a history of acute kidney failure, and anemia in chronic kidney disease. Review of Resident #16's physician orders revealed the resident had an order dated 04/22/21 to irrigate Foley (indwelling urinary) catheter with normal saline every eight hours as needed. Resident #16 also had an order dated 07/06/21 for his Foley catheter to be emptied every shift, and nursing staff were to document the amount of urinary output every shift. Resident #16's orders did not specify the catheter or balloon size, nor did it include a frequency on how often the resident's indwelling urinary catheter needed to be changed. Resident #16 had an order dated 02/06/24 for loperamide (an antidiarrheal medication) 2 milligrams (mg) one tablet by mouth every four hours as needed for diarrhea. Review of Resident #16's care plan initiated on 02/23/25 revealed the urinary care plan addressing the resident's catheter was incomplete; the care plan noted the resident had a catheter there were spaces indicating the focus, and interventions/tasks required additional information to specify what was relevant but had	N 439		

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not been added. The care plan did not include what type of catheter Resident #16 had, nor did it specify the size, frequency of changes, or when the catheter was last changed. The care plan included interventions to monitor and document intake and output per facility policy, monitor for signs and symptoms of discomfort due to catheter, and report symptoms to the physician including pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, or change in eating habits.

Review of Resident #16's progress note dated 12/25/25 at 11:19 P.M. authored by Licensed Practical Nurse (LPN) #545 revealed the resident stated he felt like he was getting a urinary tract infection (UTI) and would like to be seen by the doctor for urinalysis (UA) testing and possible antibiotics. The note did not reference any action LPN #545 took to assess the resident or communicate or address Resident #16's concern. There was no follow-up notes recorded on 12/26/25.

Continued review of Resident #16's progress notes revealed a note dated 12/27/25 at 7:55 P.M. noting the resident was complaining of having frequent loose stools. Resident #16 was offered as needed medication and was assisted to the bathroom where he was noted to have a loose stool on the toilet which was black in color. Resident #16's urinary drainage bag had 50 cubic centimeters (cc's) of dark yellow urine present. The note did not include any further assessment of Resident #16 nor any indication that the resident's physician was notified. There were no follow-up notes recorded in Resident #16's record

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N 439	Continued From page 112 on 12/27/25 or 12/28/25. Continued review of Resident #16's progress notes revealed a note dated 12/29/25 at 2:00 P.M. authored by Registered Nurse (RN) #675 which stated the resident's physician was called regarding the resident having no urinary output thus far into the shift. Resident #16's bladder was noted to be slightly firm. Resident #16 stated he did not have pain, and the nurse was requesting an order to either change resident #16's Foley catheter or to flush it but was awaiting a call back from Resident #16's physician. The note referenced Resident #16 appeared ill, he had "runny" and "dark" diarrhea earlier in the morning and had been administered loperamide (an anti-diarrheal medication) earlier in the shift. A follow-up note dated 3:15 P.M. revealed the resident still had no urinary output and was currently having another instance of dark-colored diarrhea. The nurse phoned the facility's Medical Director, Physician #599, who gave the order to send Resident #16 out to a local hospital for evaluation. Resident #16 left the facility on 12/29/25 at 4:00 P.M. Review of Resident #16's Medication Administration Record (MAR) for December 2025 revealed the resident received five doses of as needed loperamide between 12/26/25 and 12/29/25. Resident #16 had no other doses administered in the month of December 2025 prior to 12/26/25. Review of Resident #16's Treatment Administration Record (TAR) for December 2025 revealed the resident had orders for his urinary output to be monitored three times daily, once per shift. The urinary output for the evening shift on 12/27/25 and 12/28/25 were blank and contained	N 439		

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N 439	Continued From page 113 no evidence Resident #16's urinary output was monitored. Continued review of the TAR revealed there were no recorded instances where Resident #16's catheter had been irrigated as needed. A follow-up note dated 12/30/25 at 1:57 A.M. revealed the facility nurse had phoned the local hospital for an update on Resident #16. Resident #16 was admitted to the hospital with diagnoses including dehydration, abscess of abdominal cavity, anemia of unknown origin, and chronic kidney disease. An interview on 12/30/25 at 3:30 P.M. with the Administrator revealed she was unable to answer why the nurses did not address Resident #16's change in condition earlier and would expect to have seen this followed up on. The Administrator stated she was aware of numerous "holes" in the resident's catheter output documentation. The Administrator reported the facility had no Director of Nursing (DON) in place for clinical oversight and monitoring. An interview on 12/30/25 at 4:15 P.M. with RN #675 revealed Resident #16 went to the hospital on 12/29/25. RN #675 verified the facility had no physician orders for Resident #16's catheter care, routine catheter changes, and the orders did not include the size of the indwelling catheter he had. RN #675 stated she was unsure of how she would know when to change the resident's catheter or what size to use. The facility did not have a policy regarding care or management of indwelling urinary catheters. 2. Review of the medical record for Resident #12 revealed an admission date of 03/22/25 with diagnoses including cerebral infarction due to	N 439		

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thrombosis of the right middle cerebral artery, left sided hemiplegia, and atrial fibrillation.

Review of the care plan dated "03/21/25" (prior to the resident's admission) revealed Resident #12 had altered cardiovascular status related to an arrhythmia. The listed goal included that the resident would be free from complications. There was only one listed intervention to monitor vital signs (no frequency specified) and notify the physician of significant abnormalities.

Review of Resident #12's progress notes revealed an order dated 10/09/25 noting Resident #12's order for Xarelto (an anticoagulant that does not require any laboratory monitoring of a therapeutic range) was being discontinued and Coumadin (a brand name for Warfarin, an oral anticoagulant medication commonly used to prevent blood clots from forming; the medication has a narrow therapeutic range and patients on Warfarin require regular blood testing to monitor clotting time and subsequent adjusting of the medication dosage according to laboratory results) was being started.

Review of Resident #12's physician orders revealed an order dated 10/09/25 for a Prothrombin Time (PT, lab test measuring in seconds how long it takes for your blood to clot) and an International Normalized Ratio (INR, a laboratory test which is a standardized calculation that makes PT results comparable; this value is most often monitored for patients on Warfarin and dosages are adjusted based upon results). The order did not specify a frequency, but the order was still active as of 12/17/25.

Continued review of the physician orders revealed on 10/10/25, Resident #12 was ordered

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N 439	Continued From page 115 Warfarin 5 milligrams (mg) by mouth once daily. The order was discontinued on 10/14/25. On 10/14/25, Resident #12 was ordered Warfarin 7.5 mg by mouth once daily. The order was held from 10/17/25 to 10/19/25, and from 10/20/25 to 10/22/25. The order was discontinued on 10/22/25. Record review revealed no corresponding nursing progress note or documentation explaining why the medication was held. There were no nursing progress notes between 10/14/25 and 10/20/25 for the resident. Review of Resident #12's laboratory results dated 10/20/25 (faxed to the facility on 12/03/25) revealed the resident's INR resulted as greater than 8, elevated compared to the therapeutic INR reference range of between 2 to 3 with a target INR value of 2.5. Further review of Resident #12's laboratory results revealed a report dated 10/21/25 indicating the resident's INR result remained greater than 8. Record review revealed there was no explicit physician notification documented but the progress notes on 10/20/25 included an Orders Administration Note - pharmacy to deliver 10/21/25. It does not specify this as Vitamin K, but the next note (dated 10/21/25) references it was Vitamin K. Medical record documentation failed to include a systemic progress being in place to ensure documentation of physician notification and whether new orders were received. Review of Resident #12's progress notes revealed a note dated 10/21/25 timed 12:56 A.M. noting the resident was to receive Vitamin K (an antidote to Warfarin) 5 mg on 10/20/25. The note referenced the order was faxed to the pharmacy for STAT delivery but the pharmacy stated they	N 439		

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were unable to deliver the medication until 10/21/25. The note referenced the resident was to stay in bed and be monitored until the medication was given. A subsequent note timed 11:33 A.M. revealed the Vitamin K was delivered from the pharmacy and given at 10:14 A.M. for an elevated INR.

Review of Resident #12's laboratory results dated 10/24/25 revealed the resident's INR result was 4.8. Subsequent review of Resident #12's progress notes revealed no entry for 10/24/25, and no mention that the physician had been notified of the elevated result, however the medication was listed as "on hold" on the Medication Administration Record (MAR) from 10/24/25 to 10/27/25.

Review of Resident #12's progress notes dated 10/25/25 at 4:25 P.M. revealed the resident's INR result was 5.9 and the physician had been contacted and ordered for the resident's Warfarin to be held for two days with a recheck ordered for 10/27/25. There was no corresponding 10/25/25 laboratory report contained in the resident's chart or provided from the laboratory.

Review of Resident #12's laboratory result dated 10/27/25 revealed the resident's INR result was 5.8. Subsequent review of Resident #12's progress notes revealed no evidence the physician was notified of the elevated result at this time.

Review of Resident #12's October 2025 MAR revealed a dose of Vitamin K was recorded as given on 10/28/25 at 5:08 P.M. Continued review of the MAR revealed the resident's Warfarin was held from 10/24/25 to 10/27/25. On 10/29/25, Resident #12's Warfarin dose was recorded as

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N 439	Continued From page 117 "not available". Review of Resident #12's laboratory result dated 10/30/25 revealed the resident's INR result was 1.1, indicating it was below therapeutic range. There was no evidence the sub-therapeutic result had been reported to the physician and there was no corresponding medication adjustments. Review of Nurse Practitioner (NP) #543's progress note dated 11/06/25 revealed Resident #12 was seen for review of medications and chronic medical problems including "fluctuating INR" results. Resident #12 was noted to have a history of atrial fibrillation and was on Coumadin (Warfarin) 5 mg daily. The note referenced Resident #12's INR result was not rechecked and NP #543 requested a STAT PT/INR result. Review of Resident #12's laboratory result dated 11/07/25 revealed the resident's INR result was greater than 8. While there was no documented evidence of physician notification in the nursing progress note, a corresponding review of Resident #12's MAR revealed an order dated 11/07/25 for Vitamin K 5 mg one time only. On 11/08/25, the MAR noted that chart code "9" was recorded on the MAR indicating to see progress notes. Corresponding progress notes dated 11/08/25 at 12:10 A.M. revealed the Vitamin K medication had not been delivered to the facility and had not been administered. Review of Resident #12's laboratory result dated 11/09/25 revealed the resident's INR result was greater than 8. Review of the progress notes revealed a noted dated 11/09/25 at 1:41 P.M. updating the physician that Resident #12 did not receive the previously ordered Vitamin K. The resident's INR was checked again on 11/09/25	N 439		

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and remained greater than 8. The note concluded that the physician was aware and a subsequent note instructed nursing staff to hold the resident's Warfarin until the resident received the dose of Vitamin K.

Review of Resident #12's MAR for November 2025 revealed the resident received the dose of Vitamin K 5 mg on 11/10/25 at 8:46 P.M.

Review of NP #543's progress note dated 11/13/25 revealed Resident #12 was seen for review of PT/INR results. The note referenced NP #543 had attempted to phone the resident's Power of Attorney (POA) but the voicemail was full. Resident #12 still had a supratherapeutic INR and needed Vitamin K, and the progress note suggested to discuss with the resident's POA about the risks of bleeding and suggestion to stop the Coumadin (Warfarin) as the risks outweigh the benefits.

Review of Resident #12's laboratory result dated 11/14/25 revealed the resident's INR result was greater than 8.

Review of Resident #12's progress notes revealed a note dated 11/14/25 at 1:31 A.M. noting that the aide reported to the nurse that Resident #12 was on the floor. The resident was found lying on her left side on the floor in front of her chair, and stated she slid out of her lift chair. Resident #12 denied pain or injury and was pleasant. The note referenced neurological checks were initiated and Resident #12 was reminded to use her call light for assistance. The note concluded by stating the family, provider, and medical director needed notified. A follow up note dated 11/14/25 timed 11:59 A.M. referenced the physician was notified and Resident #12 was

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N 439	Continued From page 119 ordered to be transferred to a local hospital for further evaluation for her INR result greater than 8. The resident's POA and the facility director was notified. Review of the facility's census records revealed Resident #12 returned to the facility on 11/16/25. Review of Resident #12's laboratory report dated 11/17/25 revealed the resident's INR result was greater than 8. Review of Resident #12's progress notes dated 11/17/25 to 11/21/25 revealed no evidence the resident's physician or NP #543 had been notified of the elevated INR result at this time. Review of NP #543's progress note dated 11/20/25 revealed Resident #12 was hospitalized from 11/14/25 to 11/16/25 for acute encephalopathy and supratherapeutic INR of greater than 8. Resident #12 received Vitamin K and at the hospital was found to have transaminitis (elevated liver enzymes) which improved prior to hospital discharge. The POA's note stated to discontinue the Coumadin (Warfarin) 5 mg and repeat INR STAT. The note referenced NP #543 was awaiting a call back from Resident #12's POA to discuss stopping the Coumadin. Review of Resident #12's laboratory report dated 11/21/25 revealed the resident's INR result remained greater than 8. Review of Resident #12's physician's orders revealed on 11/21/25 Vitamin K 5 mg was ordered as a one time dose. On 11/22/25 the order for Warfarin was discontinued in the electronic medical records system.	N 439		

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N 439	Continued From page 120 Review of Resident #12's nursing progress notes revealed a note dated 11/21/25 at 3:31 P.M. noting the physician had ordered Vitamin K for Resident #12. The pharmacy asked that a script be sent over which was communicated to the physician. The note stated that once the Vitamin K was provided, to repeat the INR STAT and notify the (unspecified) NP with the INR result once received from the laboratory. A follow up note dated 11/21/25 at 7:24 P.M. noted the dose of Vitamin K was given on 11/21/25. Review of Resident #12's laboratory results revealed there was no evidence of a re-check of Resident #12's labs between 11/21/25 and 11/26/25. On 11/26/25, Resident #12's INR was checked and resulted at greater than 8. Review of NP #543's note dated 11/26/25 revealed the resident was seen for a follow up for atrial fibrillation. Resident #12's INR was still resulting at greater than 8, despite discontinuing Coumadin (Warfarin). NP #543 checked the patient's medications, and Coumadin was still inside the patient's medication packages, and noted the patient was possibly still getting Coumadin despite the medication being discontinued. Vitamin K had been administered several times and had also been during hospitalization. Review of Resident #12's laboratory results dated 11/27/25 revealed the resident's INR resulted at 2.9. An interview on 12/02/25 at 7:45 A.M. with Registered Nurse (RN) #536 revealed she had worked at the facility for multiple years. She reported if a nurse got an order for a lab, they	N 439		

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N 439	Continued From page 121 should fill out the handwritten lab request so the lab could pick up the slips. RN #536 reported the laboratory results arrived at the facility via fax, but the fax machine was located in an area of the building not on either patient care unit, but on a room in the other side of the building which did not house residents or have any occupied staff offices. The facility did not have access to a computer laboratory system to enter laboratory orders and the facility did not make a laboratory "draw list" in order to track which residents had laboratory testing drawn or completed and when. RN #536 reported the only way to know if lab results were pending was to get the information in report. RN #536 was unable to explain how the nurse's knew that results were pending to provide that information in report or how to monitor if laboratory draws were missed. Continued review of Resident #12's care plan dated 12/03/25 revealed the resident has had an actual fall related to poor balance, poor communication/comprehension and unsteady gait. Listed interventions included to monitor and report signs and symptoms such as pain, bruising, changes in mental status or new onset confusion, sleepiness or agitation to the physician, obtain neuro checks (no frequency specified), and to monitor vital signs including blood pressure lying/sitting/standing each once in the first 24 hours. Resident #12's care plan did not include any mention that Resident #12 required an anticoagulant medication or any subsequent laboratory monitoring to monitor for therapeutic medication effect. Interview on 12/09/25 at 2:00 P.M. with Pharmacist #547 revealed the facility was not good about notifying the pharmacy of orders changes. The pharmacy started working with the	N 439		

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N 439	Continued From page 122 facility in October 2025. Pharmacist #547 reported he was unaware that Resident #12's Warfarin had been discontinued on 11/11/25, as the pharmacy was still showing Warfarin as an active medication order for Resident #12. 3. Review of the medical record for Resident #27 revealed an admission date of 05/16/25 with medical diagnoses including coronary artery disease, cardiomyopathy, and atrial fibrillation. Review of Resident #27's nursing assessment dated 08/19/25 revealed the resident was alert and oriented, had an unsteady gait and a history of falls. Review of Resident #27's care plan initiated 08/19/25 revealed the resident had limited physical mobility related to disease processes. Interventions included to provide supportive care and assistance with mobility as needed. Additional care plan focuses noted the resident has had an actual fall related to poor balance and unsteady gait. Listed interventions included to provide activities that promote exercise and strength building where possible. Resident #27's nutritional care plan revised on 12/03/25 noted the resident had a nutritional problem or potential nutritional problem related to diagnoses which included atrial fibrillation that the resident was on Warfarin with consistent intake of Vitamin K. Listed interventions included administering medications as ordered, obtaining and monitoring laboratory and diagnostic work as ordered, reporting results to the physician and following up as indicated, and providing diet and supplements as ordered. Review of Resident #27's physician orders revealed an order dated 09/18/25 for a Foley	N 439		

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(indwelling urinary) catheter for urinary retention. Resident #27 also had an order dated 10/20/25 for Warfarin 2.5 mg by mouth once daily for atrial fibrillation.

Review of NP #543's progress note dated 11/06/25 revealed Resident #27 was seen at a local emergency department (ED) on 11/01/25 for hematuria (blood in the urine). The note referenced Resident #27 received Coumadin (Warfarin). The Foley catheter was exchanged, the resident was treated with one dose of Keflex (an antibiotic) at the ED and the resident was discharged from the ED with an order for Cefuroxime (an antibiotic) 500 mg by mouth twice daily for 7 days duration. As of 11/06/25, Resident #27's Foley was noted to still have hematuria. NP #543 noted that the resident's last INR result was 3.4 and was not reported to the provider. NP #543 ordered a STAT PT/INR level to be drawn. The note additionally referenced the resident had not received the Cefuroxime antibiotic which was ordered by the local ED.

Review of Resident #27's laboratory report dated 11/07/25 revealed the resident's INR result was 6.5 (elevated above therapeutic levels).

Review of Resident #27's record revealed no entry regarding the elevated INR result recorded in the resident's progress notes, however there was a new order dated 11/07/25 for Vitamin K 5 mg to be administered one time.

Corresponding review of Resident #27's November 2025 MAR revealed on 11/08/25 at 12:25 A.M. chart code "9 was recorded, which noted to see progress notes.

Review of Resident #27's progress notes

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revealed a note dated 11/08/25 at 12:25 A.M. noting the Vitamin K medication was not at the facility, the pharmacy was notified of importance and that the doctor would be informed when the medication was on-hand and administered due to follow up labs.

Review of Resident #27's laboratory report dated 11/09/25 revealed the resident's INR result was 4.6 (elevated).

Further review of Resident #27's progress notes revealed a note dated 11/09/25 at 3:45 P.M. noting that the resident's Warfarin was on hold until the resident received a dose of Vitamin K. An additional note dated 11/10/25 at 2:34 P.M. revealed the physician was notified of "persistent hematuria" and the physician ordered the resident sent to a local ER.

Review of Resident #27's hospital records revealed on 11/10/25 the resident presented to a local emergency department with concern for blood in his catheter. The nurse at the facility said it was her first day, and she noticed a large amount of blood in the resident's urinary drainage bag; the unnamed nurse did not know what to do so she sent the patient to the emergency department. Resident #27 was found to have a supratherapeutic INR of 5.3 and was admitted to the hospital for further monitoring and treatment of his INR levels and hematuria.

Review of a follow-up note dated 11/12/25 revealed the nurse called the local hospital for an update on the resident and was informed Resident #27 was receiving continuous bladder irrigation and he received a dose of Vitamin K while at the hospital. A follow-up note referenced Resident #27 returned from the hospital on

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N 439	Continued From page 125 11/12/25 at 6:15 P.M. 4. Review of the medical record for Resident #4 revealed an admission date of 06/30/21 with medical diagnoses including anemia, chronic venous insufficiency, and atrial fibrillation. a. Review of the care plan dated 12/20/24 revealed Resident #4 had altered cardiovascular status related to arrhythmia. Goals included the resident would be free from complications of cardiac problems. Listed interventions included assessing fingers and toes for warmth and color, assessing the resident for shortness of breath and cyanosis, and to monitor, document, and report as needed any signs or symptoms of coronary artery disease including chest pain, shortness of breath, sweating or edema. The care plan made no mention that Resident #4 required anticoagulant medication. Review of the physician orders dated 09/30/25 revealed Resident #4 was ordered Warfarin 4 mg by mouth daily in the afternoon for atrial fibrillation. Review of Resident #4's laboratory report dated 10/20/25 revealed the resident's INR result was greater than 8. Review of Resident #4's progress notes revealed no indication the resident's INR result was recognized to be elevated and whether it had been communicated to the physician. Review of Resident #4's physician's orders revealed an order dated 10/21/25 for Vitamin K 5 mg to be given by intramuscular (IM) injection one time only for elevated INR levels. Corresponding review of Resident #4's MAR	N 439		

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revealed the Vitamin K injection was not recorded as given. Continued review of Resident #4's MAR revealed an order for Vitamin K 5 mg by mouth one time for an elevated INR, which was recorded as administered on 10/21/25 at 2:35 P.M. (Record review revealed it was unclear where this order came from- it was not documented who gave the order for this or who (if any physician) gave the order to change the medication from IM to oral (po) or possibly if the nurse just did it because that was what the pharmacy had available).

Review of Resident #4's progress note dated 10/21/25 at 2:24 P.M. revealed an order administration note which stated the pharmacy was able to get pill form and it was given at 2:00 P.M. The note did not indicate whether the provider had been updated that the originally ordered route of administration was unavailable and the pharmacy only had oral medications available.

An interview on 12/04/25 at 1:30 P.M. with NP #543 revealed she had ordered an unusual amount of Vitamin K for the residents at the facility (the facility identified three residents (#12, #27 and #4) who received Coumadin). Due to the continued abnormal laboratory results for the residents, she checked Resident #12's medication pill packages and found that the discontinued blood thinning medication had not been removed from the resident's packages. The orders that were discontinued on the MARs were still present in the medication cart and available for administration. NP #543 believed the medications were still being administered after they were discontinued because the bleeding times continued to be significantly elevated after the medications were discontinued. She further

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N 439	Continued From page 127 shared she had multiple instances of not being notified of laboratory results . An interview on 12/08/25 at 3:03 P.M. with the Administrator confirmed laboratory results were not available in the medical records for Residents #4. #12, and #27. The Administrator confirmed the facility did not have a process for generating a list of residents who were to have laboratory testing completed, and no clinical staff within the facility to monitor that the laboratory testing order had been drawn. The Administrator was unable to offer an explanation related to where laboratory reports go once resulted, how the facility knew if the physician was updated if not recorded in the resident's progress notes, or how the facility tracked down laboratory orders and results. The Administrator stated she would expect a DON to monitor this process and confirmed the facility did not currently have a DON. An interview on 12/09/25 at 7:57 A.M. with Agency RN #550 revealed she worked on the night shift and had occasionally picked up shifts at the facility. She stated she had no knowledge on how the laboratory system worked at this facility. Agency RN #550 reported usually, nurses enter laboratory orders into a computer or laboratory [web]site. She did not receive any orientation to the facility, did not have any type of login information for any laboratory ordering or monitoring system, and stated she was unaware that the facility hand wrote laboratory requisitions. Interview on 12/11/25 at 10:30 A.M. with Physician #546 revealed she had contracted with the facility to be the Medical Director for a short time. During the interview Physician #546 revealed she was aware of issues with PT and INR laboratory testing not getting drawn, and	N 439		

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orders not getting changed. Physician #546 and NP #543 were monitoring the Coumadin dosing based on lab values, but we were not getting notified of results or if labs were not drawn as ordered and would have to re-order laboratory testing so they could appropriately adjust Coumadin (Warfarin) dosages. Physician #546 and NP #543 had to order Vitamin K multiple times for the residents of the facility requiring Coumadin/Warfarin therapy. Physician #546 stated she had spoken with her NP and asked her to check the medication carts, and that was when she found Coumadin was still being administered to Resident #12 after it was discontinued, and wrong doses were being administered. Physician #546 stated she was notified when Vitamin K was not available, but she had ordered the medication STAT and would occasionally have to send residents out to the hospital for evaluation of elevated INR results. Physician #546 reported the expectation was that orders be carried out as written for both medications and diagnostic testing.

Interview on 12/24/25 at 1:00 P.M. with LPN #545 revealed the she did not know who had pending labs when she worked at the facility. LPN #545 further reported she did not know anything about how Coumadin labs, orders, or flowsheets worked as she had no need to look at them. LPN #545 confirmed she worked the evening shift and administered all scheduled Warfarin doses. LPN #545 confirmed she only gives the dose that is on the MAR to be given and does not reference or check for any recent laboratory results.

Interview on 12/24/25 at 5:00 P.M. with the RN #537 (identified to be the facility Acting DON) revealed the facility had a folder located near a fax machine in an area of the building where no

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residents resided and where no offices were occupied. Once laboratory specimens were collected, the laboratory staff would leave a yellow copy of the requisition slip on the desk by the fax machine. RN #537 also reported she believed there was a handwritten calendar that was supposed to be updated when laboratory orders were received. RN #537 confirmed there was no written process for laboratory testing, and confirmed the facility used agency nursing staff. In order for agency nursing staff to know this information they would have to specifically be told this process in shift-to-shift nursing report from a nurse who knew the facility's process.

Review of the facility's "Policy and Protocol for Blood Thinner Medications" dated July 2008 revealed the facility followed a strict protocol for all residents on blood thinning medications. The facility would maintain and update weekly a "master lift" of all residents receiving blood thinning medications in each nurse's station, all nurses caring for these residents are to be aware of the type and dose of blood thinning medications which the residents is receiving, the PT-INR (laboratory) tests are to be drawn upon order of personal physician. All results of PT-INR results are called, not faxed, to the physician so the physician can adjust doses accordingly. The Director of Nurses will perform an audit for each resident who is ordered blood thinning medication to ensure proper protocol is followed.

b. Continued review of Resident #4's medical record revealed a care plan revised on 03/15/23 noting the resident had and pressure ulcer of the right and left lower legs. A listed goal included that the resident's pressure ulcers will show signs of healing and remain free from infection. Listed interventions included to administer medications

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N 439	Continued From page 130 and treatments as ordered, assess, record, and monitor for wound healing (unspecified frequency), follow facility policies and protocols for prevention and treatment of skin breakdown, obtain and monitor laboratory and diagnostic work, and to complete weekly treatment documentation including measurements of each area of skin breakdown's length, width, depth, type of tissue, and exudate (drainage). Review of Resident #4's physician orders revealed an order dated 07/14/25 to cleanse Resident #4's wounds to bilateral lower extremities with normal saline (NS), air dry for 20 minutes, and apply Xeroform (a petroleum-infused mesh gauze dressing used to maintain a moist environment to aid in wound healing, prevention of infection, and to help minimize pain during dressing changes), calcium alginate with silver (an antimicrobial dressing), rolled abdominal pad to the proximal anterior site, wrap with Kerlix (rolled gauze) and an ACE wrap (compression dressing) from toes to below the knees three times weekly on Monday, Wednesday, and Friday. The order was later discontinued on 11/20/25. Review of Resident #4's notes from an outside wound clinic dated 10/22/25 revealed the resident had non-pressure venous ulcers to her bilateral lower extremities. The wound records noted the resident had routine visits to the outside wound clinic for routine visits and adjustments of ordered wound treatments. Review of Resident #4's Treatment Administration Records (TAR) for October 2025 revealed the ordered treatments were not recorded as completed on 10/08/25, 10/15/25, or 10/22/25.	N 439		

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N 439	Continued From page 131 Review of Resident #4's TAR for November 2025 revealed the ordered treatments were not recorded as completed on 11/05/25, 11/07/25, 11/10/25, 11/14/25, or 11/19/25. Continued review of Resident #4's medical record revealed no weekly wound monitoring was completed from 11/08/25 to 12/01/25 to assess the wound's progress towards healing. Review of Resident #4's physician orders revealed an order dated 12/02/25 to cleanse the resident's wounds to her bilateral lower extremities with NS, air dry for 20 minutes, apply calcium alginate with silver to open areas, apply a rolled abdominal pad to the proximal anterior site, wrap with Kerlix and an ACE wrap from toes to below the knees three times a week on Monday, Wednesday, and Friday. An interview on 12/02/25 at 7:45 AM with RN #536 revealed Resident #4 was supposed to have dressing changes completed on night shift every Monday, Wednesday, and Friday. The order was changed from days to night shift on 11/20/25. RN #536 further shared that she did not do the dressing when she worked because she did not want to wake Resident #4 up, medicate the resident for pain, then do a dressing change in the middle of the night. An interview 12/02/25 at 8:05 AM interview with LPN #540 who works day shift revealed the LPN did not complete the dressing changes ordered for Resident #4 because the facility did not have the supplies to do the dressings. However, at the time of the interview observation with LPN #540 verified the ordered treatment supplies were available for use.	N 439		

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N 439	Continued From page 132 An interview on 12/17/25 at 4:30 P.M. with Resident #4's son revealed the son had entered the nurse's station asking to speak with Executive Director #501. He had just returned from the outside wound clinic with Resident #4 and expressed concerns related to a dressing that the wound clinic removed from Resident #4's bilateral lower extremities. He shared the wound clinic had expressed to him that the facility had not used enough adaptic (non-adherent primary wound dressing infused with an emulsion designed to protect healing tissue, prevent sticking, and minimize pain during dressing changes) to completely cover her wounds before applying the ABD (absorbent) pads, which were stuck to her wounds. The son shared pictures with LPN #545 and the state surveyor, which showed vascular wounds to Resident #4's bilateral lower extremities, with open wounds expositing the fat layers. The wounds were red and appeared to have been bleeding. The bilateral leg ulcers were extensive and covered the anterior surface from approximately two inches below the knee to just above the resident's ankle. The resident's son shared these wounds were very painful for Resident #4. The son proceeded to inventory Resident #4's supplies and LPN #545 agreed to be the primary nurse to complete the resident's future wound care, promising to even come into the facility on her days off in the future to perform Resident #4's wound care. An interview on 12/18/25 at 1:00 P.M. with the Administrator revealed the facility did not have a wound nurse who did weekly assessments of wounds and the facility did not have any wound reports for review. A follow up interview on 12/30/25 at 3:30 P.M. with the Administrator revealed Resident #4's lack of wound care was	N 439		

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related to the facility not having a current DON to provide clinical oversight of the wound process.

5. Review of the medical record for Resident #6 revealed an admission date of 04/26/23 with diagnoses including iron deficiency anemia, age-related osteoporosis, osteoarthritis, and weakness.

Review of Resident #6's care plan dated 02/14/25 revealed no evidence of a care plan for an actual or a risk for developing pressure ulcers. Resident #6 had the potential for skin tears with a listed goal that the resident would be free from skin tears. Listed interventions were non-specific to pressure ulcers or actual wounds and included to treat skin tears per protocol, keep skin clean and dry, and to use caution during transfers and bed mobility.

Review of the physician order dated 11/16/25 revealed treatment orders for a left posterior and left distal leg wound. Orders were for Prisma adaptic, cover with bordered foam or dry sterile dressing, and change on Tuesday and Saturday and as needed. The order was discontinued on 12/08/25. An additional order dated 12/08/25 to the left heel called for the left heel wound to be cleansed with normal saline, apply medi-honey (a medical-grade honey-based ointment with natural antibacterial, anti-inflammatory, and debriding properties) to the base of the wound, an abdominal pad, and wrap with Kerlix daily. The heel wound had a listed start date of "12/09/25". Resident #6 did not have any orders for enhanced barrier precautions (EBP).

Review of Resident #6's medical record revealed no evidence of weekly assessments of the resident's wounds from 11/16/25 through

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N 439	Continued From page 134 12/20/25 (the date the record review was completed). Review of Resident #6's TAR for November 2025 revealed the resident's treatments were not recorded as completed on 11/01/25, 11/02/25, 11/04/25, 11/05/25, 11/08/25, 11/10/25, 11/13/25, 11/20/25, 11/21/25, 11/22/25, 11/24/25, 11/25/25, or 11/26/25. Review of Resident #6's TAR for December 2025 revealed the resident's treatments were not recorded as completed on 12/02/25, 12/03/25, 12/04/25, 12/06/25, 12/07/25, 12/12/25, 12/15/25, 12/17/25, or 12/20/25. An interview on 12/20/25 at 3:40 P.M. with LPN #545, who worked the afternoon shift, revealed Resident #6's dressings were scheduled daily for 9:00 P.M., but Resident #6 had a private duty nurse who changed her dressings. The LPN reported the facility nurses did not complete any wound care for Resident #6 and all wound care was completed by the private duty nurse and an outside wound clinic. LPN #545 was unable to identify the name of the nurse or when she visited Resident #6 to complete wound care. An interview on 12/20/25 at 3:45 P.M. with Resident #6 revealed the resident did not have a private duty nurse who performed her wound care within the facility. On 12/21/25 at 11:40 A.M. interview with Resident #6 and her daughter and Power of Attorney (POA) revealed concerns related to wound care. They shared Resident #6 had an in-house acquired pressure area on her left heel and was seen at a local wound clinic every other week. Resident #6 reported the wound center	N 439		

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N 439	Continued From page 135 would often change the orders, but the orders would not get started at the facility. Resident #6 further stated her dressings were not getting changed daily at the facility per her current orders, and the only time the dressings did get changed were every other Thursday at the wound clinic. Additionally, the wound was not healing, and the outside wound clinic took wound cultures on her last visit for a possible infection. The daughter reported bone was visible in the wound bed. Resident #6's daughter removed the surgical boot from the resident's left foot and it was observed the dressing on Resident #6's left heel was undated. Observation on 12/22/25 at 5:45 P.M. revealed LPN #545 was observed completing wound care for Resident #6. LPN #545 did not apply a protective gown before performing wound care. LPN #545 proceeded to perform the resident's wound care. Resident #6's left heel wound dressing was removed. The wound was not measured by LPN #545 and she stated at the time of observation she did not know how to measure wounds and did not know if she had anything available to measure a wound with. The heel wound was noted to be covered with slough (dead tissue which obscured the wound base and the wound's true depth) but was an open wound with an approximate opened area of 2 centimeters (cm) in length by 2 cm in width. LPN #545 proceeded to reapply the dressing to Resident #6's left heel. Following the observation, LPN #545 shared that she did not know what EBP were and verified EBP were not utilized for residents with indwelling medical devices or wounds in the facility. LPN #545 was unsure if the facility had gowns available for staff use.	N 439		

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N 439	Continued From page 136 On 12/30/25 at 3:30 P.M. interview with the Administrator confirmed Resident #6's wound care was not provided because the resident's family did not want the facility staff performing wound care. The Administrator was unsure why and verified this alleged family preference was not care planned and she had no other information to provide other than to state the facility did not have a current DON in place for clinical oversight. 6. Review of the medical record for Resident #18 revealed an admission date of 07/11/22. Medical diagnoses included peripheral vascular disease, anxiety disorder, dementia, and repeated falls. Review of Resident #18's care plan dated 03/16/23 revealed no care plan or interventions were created to indicate Resident #18 was at risk for developing a wound or had a wound. Resident #18 was noted to have an activity of daily living (ADL) self-care performance deficit related to activity intolerance and fatigue. Listed interventions included assisting with personal hygiene and oral care and that the resident required skin inspection to observe for redness, open areas, scratches, cuts, and bruises and noted changes should be reported to the nurse. The care plan did not include any mention of the resident's mobility status. Review of Resident #18's Braden Scale assessment (tool used for predicting an individual's risk for developing pressure sores) dated 11/03/25 revealed the resident was identified to have no impairment to verbal commands. His skin was noted to be occasionally moist and required an extra linen change approximately once per day, he was noted to be chair fast with his ability to walk	N 439		

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N 439	Continued From page 137 severely limited or non-existent. The assessment noted the resident had no limitation in mobility and his ability to make major and frequent changes in position, but the resident was noted to have a potential problem with friction and shearing. Review of Resident #18's nursing progress notes and active physician orders from 12/01/25 to 01/02/26 revealed no indication the resident had a pressure wound noted to his left hip. Resident #18's record revealed no orders had been entered related to any ordered wound care ointment or dressing. Review of the facility's skin observation tool dated 12/27/25 revealed Resident #18 had a pressure wound to his left trochanter (hip area) measuring two centimeters (cm) by one cm. The tool lacked specific details related to the wound, including the color of the wound, presence or characteristic of any drainage, or any smell. There was no indication the family or the physician had been notified of the new area. On 01/02/26 at 3:00 P.M. observation of Resident #18's wound with RN #675 and Certified Nursing Assistant (CNA) #528 revealed the resident was in bed and positioned lying on his left side. A wound observation revealed there was no open area but there was redness to the resident's left hip area. However, interview with RN #675 confirmed there was no padding or offloading in place to Resident #18's hip at the time of observation. An interview with CNA #528 at the time of observation revealed staff had been putting on Vitamin A & D ointment (an over-the-counter topical skin protectant cream) to Resident #18's left hip area.	N 439		

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N 439	Continued From page 138 Interview on 01/02/26 at 3:15 P.M. with ED #501 verified the lack of documentation in Resident #18's record related to wounds. ED #501 stated Resident #18's daughter contacted her on 12/27/25 to inform her that Resident #18 had a "reddened area" to his left hip that could turn into an open wound. ED #501 stated she told the resident's daughter that a cream would be ordered. Interview on 01/02/26 at 3:28 P.M. with Physician #599 revealed Resident #18's daughter contacted her on 12/29/25 to inform her she had observed a reddened area on Resident #18's left hip that had the potential to decline. Physician #599 stated they discussed treatment opens and she would write an order for a topical cream to be applied. Physician #599 could not recall the name of the cream she had ordered and stated she was not informed of Resident #18's wound until the daughter contacted her on 12/29/25. Interview on 01/02/26 at 4:26 P.M. with Resident #18's daughter revealed she visited Resident #18 on 12/26/25 and observed a reddened area on the resident's left hip. The daughter reported she had informed the staff of the area at that time and requested the use of a wedge (positioning tool) for offloading. Facility staff told her they had wedges in the facility they would use. Resident #18's daughter reported she visited again on 12/28/25 and observed the area to be slightly reddened with a break in skin (open area). The daughter stated she contacted the physician on 12/29/25 and was told a cream would be ordered and applied to Resident #18's hip. The daughter stated she visited the facility again on 01/01/26 and was told by an unidentified staff member that there were no orders in the electronic medical record for cream to be applied to Resident #18's	N 439		

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N 439	Continued From page 139 left hip. The daughter further reported she had talked to ED #501 "months ago" with concerns regarding wounds and had suggested placing interventions such as turning on a scheduling and using wedges to offload the resident's hip. Interview on 01/02/25 at 4:37 P.M. with CNA #488 verified Resident #18 was should have his positioned alternated between his back and right side when in bed to heal the area to his right hip. The facility had no policy or procedure for performing wound care or wound assessments. This violation represents non-compliance investigated under Complaint Number OH00168644.	N 439		
N 532	O.A.C. 3701-17-17 (A) (2) Medicines and Drugs O.A.C. 3701-17-17 (A) (2) - The nursing home, in conjunction with the pharmacist or pharmacy service, shall: (a) Maintain an emergency and contingency drug supply for use in the absence of the pharmacist; and (b) Ensure that the contingency drug supply is maintained in accordance with state pharmacy rules. This Rule is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure a contingency and emergency supply of medications were available to meet the pharmaceutical needs of the residents when	N 532		

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pharmacy was unavailable. This had the potential to affect all 29 residents. The census was 29.

Findings include:

Interview on 11/19/25 at 11:15 A.M., an interview with Licensed Practical Nurse (LPN) #540 revealed she had been employed by the facility for less than one month and verified the facility did not have a contingency supply of medications in the facility in the event medications were ordered for a resident and the facility was unable to timely get the medication from the pharmacy. LPN #540 reported she had voiced her concerns regarding no contingency medication supply to Registered Nurse (RN) #537 (who the facility identified as the Acting Director of Nursing) and also to the Administrator and Chief Executive Director (CEO) #500.

An interview on 12/01/25 at 7:48 A.M. with RN #537 revealed the facility did not have a contingency supply or "starter box" of medications for the facility. RN #537 reported the facility used to have a starter box prior to the new owners taking over the facility but the medications were returned to the previous pharmacy.

Interview on 12/01/25 at 4:00 P.M. with the Administrator revealed she was aware the facility did not have a contingency supply or medication starter box in order to timely access common medications ordered by a physician. The Administrator shared that CEO #500 had been meeting with pharmacies to arrange for potential services who could provide 24-hour pharmacy services.

Interview and observation on 12/02/25 at 7:45 A.M. with RN #536 revealed the facility had no

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N 532	Continued From page 141 current contingency supply of medications but did before the new owners took over. Observation at the B-wing nurse's station, RN #536 removed the prior contingency box from a cabinet in the nurse's station and a single box of albuterol inhaler was observed. RN #536 reported this was the only medication available in the starter box but it was left over from a prior pharmacy. Interview on 12/04/25 at 1:30 P.M. with Nurse Practitioner #543 revealed she was aware the facility did not have contingency medications available to start medications in the event the pharmacy was unable to deliver ordered medication timely. The NP stated she had expressed concerns to CEO #500 and ED #501 "multiple" times. The facility had no policy or procedure for contingency medications. The facility did not have a current pharmacy contract. This violation represents non-compliance investigated under Complaint Number OH00168644.	N 532		
N 533	O.A.C. 3701-17-17 (B) Medicines and Drugs O.A.C. 3701-17-17 (B) - Medicines and drugs shall be given only to the individual resident for whom they are prescribed, shall be given in accordance with the directions on the prescription or the physician's orders, and shall be recorded on the resident's medication administration record.	N 533		

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N 533	Continued From page 142 This Rule is not met as evidenced by: Based on observation, interview, record review, and review of manufacturer's instructions, the facility failed to ensure medications were administered in accordance with physician orders and recorded in the resident's medication administration record (MAR). This affected six residents (#2, #3, #4, #5, #12, and #27) of six residents reviewed for medication administration. The facility census was 29. Findings include: 1. Review of the medical record for Resident #2 revealed an admission date of 06/30/21 with medical diagnoses including type two diabetes mellitus with hyperglycemia, atrial fibrillation, and major depressive disorder. Review of Resident #2's physician orders revealed an order dated 07/05/23 to check the resident's blood glucose level daily at bedtime and an order dated 07/23/25 revealed an order for Novolog FlexPen (a short-acting insulin) subcutaneously which specified to inject 10 units once daily before breakfast, inject three units once daily before lunch, and inject 5 units daily before supper. An observation on 12/10/25 at 4:00 P.M. with Licensed Practical Nurse (LPN) #545 revealed LPN #545 prepared to administer the resident's pre-supper Novolog insulin. LPN #545 wiped the hub of the insulin pen with an alcohol swab, placed an insulin pen needle on the pen and dialed the pen to 5 units. LPN #545 proceeded to cleanse Resident #2's right lower quadrant of her abdomen with an alcohol swab and injected the resident to administer the insulin. LPN #545 did not prime the insulin pen after attaching the	N 533		

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insulin needle prior to administering the insulin dose to Resident #2.

An interview at the time of observation with LPN #545 verified she had not primed the insulin pen prior to administering Novolog 5 units to Resident #2. LPN #545 stated she was unaware that she needed to prime an insulin pen.

Review of the manufacturer's instructions for Novolog dated 03/2023 revealed instructions for use regarding the Novolog FlexPen. The instructions included to attach a new needle, turn the dose selector to select two (2) units, hold your Novolog FlexPen with the needle pointed up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to zero (0). A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure up to six times. The instructions noted these steps are used to avoid injecting air and to ensure the proper dose of insulin is being administered.

2. Review of the medical record for Resident #3 revealed an admission date of 06/30/21 with diagnoses including hypertension, hypothyroidism, and chronic venous insufficiency.

Review of Resident #3's physician orders revealed an order dated 12/21/23 for Melatonin (a supplement to aid in regulation of the sleep-wake cycle) 5 milligrams (mg) by mouth daily at 8 P.M. for insomnia, an order dated 05/24/22 for Remeron (an antidepressant) 7.5 mg daily at bedtime for insomnia, an order dated 04/11/24 for Trazodone 12.5 mg by mouth daily at bedtime for insomnia, and an order dated 06/30/25 for

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 533	Continued From page 144 acetaminophen (an over-the-counter mild pain reliever) 1000 mg by mouth three times daily for generalized pain. Review of Resident #3's MAR for November 2025 revealed Resident #3 did not receive her ordered doses of Melatonin, Remeron, and Trazodone on 11/01/25 and 11/20/25. Resident #3 did not receive her ordered Acetaminophen on 11/01/25 at 8:00 P.M. and on 11/10/25 at 2:00 P.M. Review of Resident #3's corresponding progress notes for November 2025 included a note dated 11/10/25 that the facility was awaiting a pharmacy delivery for the resident's ordered Acetaminophen and a note dated 11/20/25 indicating the resident's Remeron and Melatonin were not available. 3. Review of the medical record for Resident #4 revealed an admission date of 06/30/21 with medical diagnoses including anemia, chronic venous insufficiency, and atrial fibrillation. Review of Resident #4's physician order revealed an order dated 09/30/25 for Warfarin 4 mg by mouth daily in the afternoon for atrial fibrillation. Continued review of Resident #4's physician orders revealed an order dated 10/21/25 for Vitamin K (the antidote for Warfarin, prescribed when bleeding time laboratory values are significantly elevated) 5 mg by intramuscular injection one time for an elevated International Normalized Ratio (INR) level (a laboratory test which is a standardized calculation that makes PT results comparable; this value is most often monitored for patients on Warfarin (Coumadin) and dosages are adjusted based upon results). Further review of Resident #4's physician orders revealed an order also dated for 10/21/25 for	N 533		

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N 533	Continued From page 145 Vitamin K 5 mg by mouth one time only for an elevated INR. Review of Resident #4's progress notes dated 10/21/25 at 2:24 P.M. revealed an order administration note which stated the pharmacy was able to get pill form [of Vitamin K] and it was given at 2:00 P.M. The note did not indicate whether the ordering provider had been updated that the originally ordered route of administration was unavailable and the pharmacy only had oral medication available. Review of Resident #4's MAR for October 2025 revealed the Vitamin K by intramuscular injection was not recorded as administered. The resident's Vitamin K by mouth was recorded as administered on 10/21/25 at 2:35 P.M. 4. Review of the medical record for Resident #27 revealed an admission date of 05/16/25 with medical diagnoses including coronary artery disease, cardiomyopathy, and atrial fibrillation. Review of the care plan dated 12/20/24 revealed no evidence that Resident #27 was prescribed an anticoagulant medication. Review of Resident #27's physician orders revealed an order dated 10/20/25 for Warfarin 2.5 mg by mouth once daily for atrial fibrillation. Review of Resident #27's laboratory report dated 11/07/25 revealed the resident's INR result was 6.5 (elevated above therapeutic levels). Review of Resident #27's record revealed no entry regarding the elevated INR result recorded in the resident's progress notes, however there was a new order dated 11/07/25 for Vitamin K 5	N 533		

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N 533	Continued From page 146 mg to be administered one time. Corresponding review of Resident #27's November 2025 MAR revealed on 11/08/25 at 12:25 A.M. chart code "9 was recorded, which noted to see progress notes. Review of Resident #27's progress notes revealed a note dated 11/08/25 at 12:25 A.M. noting the Vitamin K medication was not at the facility, the pharmacy was notified of importance and that the doctor would be informed when the medication was on-hand and administered due to follow up labs. Continued review of Resident #27's medical record revealed no evidence the resident received the medication prior to being sent to the hospital on 11/10/25 for hematuria. Review of Resident #27's hospital records revealed on 11/10/25 the resident presented to a local emergency department with concern for blood in his catheter. The nurse at the facility said it was her first day, and she noticed a large amount of blood in the resident's urinary drainage bag; the unnamed nurse did not know what to do so she sent the patient to the emergency department. Resident #27 was found to have a supratherapeutic INR of 5.3 and was admitted to the hospital for further monitoring and treatment of his INR levels and hematuria. 5. Review of the medical record for Resident #12 revealed an admission date of 03/22/25 with diagnoses including cerebral infarction due to thrombosis of the right middle cerebral artery, left sided hemiplegia, and atrial fibrillation. Review of Resident #12's progress notes	N 533		

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N 533	Continued From page 147 revealed a note dated 11/14/25 at 1:31 A.M. noting that the aide reported to the nurse that Resident #12 was on the floor. The resident was found lying on her left side on the floor in front of her chair, and stated she slid out of her lift chair. Resident #12 denied pain or injury and was pleasant. The note referenced neurological checks were initiated and Resident #12 was reminded to use her call light for assistance. The note concluded by stating the family, provider, and medical director needed notified. A follow up note dated 11/14/25 timed 11:59 A.M. referenced the physician was notified and Resident #12 was ordered to be transferred to a local hospital for further evaluation for her INR result greater than 8. The resident's POA and the facility director was notified. Review of Resident #12's outside hospital records revealed the resident was admitted to the hospital on 11/14/25 where she was found to have a supratherapeutic (elevated) International Normalized Ratio (INR) level (a laboratory test which is a standardized calculation that makes PT results comparable; this value is most often monitored for patients on Warfarin (Coumadin) and dosages are adjusted based upon results) and was also noted to have acute encephalopathy and paroxysmal atrial fibrillation. Upon arrival to the hospital, resident was noted with confusion, believing she lived in Brooklyn with her spouse instead of at the facility. After laboratory testing, the urinalysis completed at the hospital indicated Resident #12 had a urinary tract infection (UTI). She was treated with intravenous antibiotics while at the hospital and the records noted she would be discharged on oral Cefdinir (an antibiotic) to complete the ordered doses. Resident #12 was discharged back to the facility on 11/16/25.	N 533		

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N 533	Continued From page 148 Review of the hospital discharge instructions dated 11/16/25 revealed Resident #12 was ordered Cefdinir 300 mg twice daily for four days. The orders noted the stop date was to be on 11/20/25. Review of the facility's electronic medical record revealed no evidence Resident #12's Cefdinir 300 mg twice daily for four days duration was transcribed upon her return to the facility. Review of Nurse Practitioner (NP) #543's progress note dated 11/20/25 revealed Resident 12 had been hospitalized from 11/14/25 to 11/16/25 for acute encephalopathy and supratherapeutic INR levels which required treatment. Laboratory and imaging tests completed at the hospital also showed Resident #12 had a right upper quadrant ultrasound which showed biliary sludge, and urinalysis testing showed organisms had grown in the urine, and Resident #12 was discharged back to the facility on Cefdinir. Further review of NP #543's note revealed indication that the resident had a UTI, was discharged on Cefdinir 300 mg twice daily, and did not receive that medication since returning to the facility. NP #543 ordered for Resident #12 to restart Cefdinir 300 mg twice daily for a duration of 7 days. Review of Resident #12's physician orders revealed an order 11/22/25 for Cefdinir 300 mg twice daily for a duration of 7 days for a UTI, scheduled to be administered at 8:00 A.M. and 5:00 P.M. Review of Resident #12's MAR for November 2025 revealed the resident's Cefdinir was to start on 11/22/25 at 5:00 P.M., but that dose and both	N 533		

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N 533	Continued From page 149 doses for 11/23/25 were marked as not available. Review of Resident #12's progress notes revealed notes indicating the three missed Cefdinir doses were not available and were awaiting the medication to be delivered from pharmacy. 6. Review of Resident #5's medical record revealed an admission date of 11/03/25 with diagnoses including unspecified dementia, major depression, essential hypertension and history of falls. Review of the physician admission orders revealed atorvastatin 80 milligrams (mg) by mouth (po) at bedtime for hyperlipidemia, Buspar 300 mg po in the morning for depression, Coreg 12.5 mg every morning and at bedtime for hypertension. Hold if systolic (top number) (blood pressure) is less than 100 (millimeters of mercury) or pulse less than 60 (beats per minute), famotidine 20 mg by mouth in the morning for gatroesophageal reflux, losartan 50 mg by mouth in the morning for hypertension, Osteo Bi-flex one per day oral tablet give one tablet by mouth in the morning for supplement, multivitamin give one tablet by mouth in the morning and fluoxetine 40 mg by mouth in the morning for depression. a. Review of the November 2025 Medication Administration Record (MAR) revealed on 11/04/25, 11/05/25, 11/06/25, 11/12/25 the medications were not administered and to reference the progress notes. Review of the progress notes dated 11/03/25 at 11:11 A.M. revealed the resident arrived to the facility accompanied by her family. Call light and belongings within reach.	N 533		

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N 533	Continued From page 150 Review of the progress notes dated 11/03/25 at 12:43 P.M. revealed the physician was notified of admission. No new orders. Review of the progress notes dated 11/04/25 at 1:00 P.M. revealed the medications on order. Further review at 9:47 P.M. revealed medications on order. Review of the progress notes dated 11/05/25 at 3:04 P.M. revealed waiting on medications. Faxed orders to pharmacy. Further review of the progress notes dated 11/05/25 at 7:17 P.M. and 10:49 P.M. revealed medications not "here." Further review of the progress notes dated 11/06/25 at 12:33 P.M. medications (Eliquis) on order. At 12:34 P.M. a progress note reflected "will follow with pharmacy". An additional progress note on 11/06/24 at 8:04 P.M. revealed "meds unavailable, does not have resident in the system." Further review of progress notes dated 11/12/25 at 12:25 P.M. revealed "meds need reordered." Pharmacy and physician aware. Review of the progress notes dated 11/14/25 at 1:59 P.M. revealed Osteo Bi-Flex not available. Waiting on pharmacy to drop. Also note for multi-vitamin waiting on pharmacy drop. Physician aware. An interview on 12/17/25 at 4:02 P.M. with LPN #545 revealed there had been frequent instances where residents did not have medications available for administration. The facility primarily used two different local pharmacies and that the residents had a choice of which pharmacy used.	N 533		

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N 533	Continued From page 151 The pharmacy that most of the residents used was a neighborhood pharmacy that was not open twenty-four hours a day. When the nurse had an order that needed to start immediately, they faxed the order to the pharmacy as a STAT (immediate) order. LPN #545 shared that the interval between a faxed order and arrival of the medication to the facility varied. LPN #545 stated that sometime the medication arrived at the facility the next day and that sometimes the medication did not arrive until several days later. LPN #545 further shared that the Director of Nursing (DON) used to monitor the residents' medication supply to ensure medications were available, but the facility did not currently have a DON to monitor medication supplies for the residents. An interview on 12/18/25 at 4:00 P.M. with the Administrator revealed she was aware that multiple residents on multiple occasions did not have medications available for administration. The Administrator shared that because the facility did not have a DON, the Administrator read the progress notes on the days she worked, then directed the nurses to order medications for any residents whose documentation stated medications were not available. The Administrator did not have a proactive plan that would prevent residents from missing doses of medications due to medications not being available. b. Review of the medication administration record (MAR) for November 2025 and December 2025 revealed no monitoring of the resident's BP or pulse prior to the administration of the resident's Coreg twice per day as ordered. On 12/18/25 at 4:00 P.M. interview with the Administrator verified if the resident's information	N 533		

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N 533	Continued From page 152 was not documented in the medical record to monitor the resident's BP and pulse prior to administration of the resident's Coreg, then the vital signs were not obtained per orders. c. Review of the hospital records, dated 12/06/25, revealed Resident #5 experienced an intracranial bleed after a fall and was administered Kcentra (antagonist for Eliquis). Review of the hospital discharge instructions, dated 12/08/25, revealed Resident #5 was to resume her Eliquis on 12/22/25. On 12/13/25, the resident experienced another fall in the facility and was transferred to the Emergency Room (ER) for evaluation. Due to the resident being off anticoagulation (Eliquis) and having left lower extremity swelling and her history of a deep vein thrombosis (DVT), the physician ordered an ultrasound for evaluation. The resident was admitted to the hospital. Review of the vascular surgery consultation dated 12/15/25 revealed the resident was seen for possible IVC filter (due to presence of DVT and is an umbrella like device inserted into the IVC to prevent blood clots from traveling to the lungs and causing a life threatening pulmonary embolism. This is a treatment option for patients who are unable to take blood thinning medications due to bleeding, recent trauma or surgery and can be temporary or permanent). The consult note revealed the physician spoke with the hospitalist indicating ideally the resident needed to be on some type of anticoagulation (she had a fairly extensive DVT). An IVC filter certainly was not unreasonable given the resident's repeated falls and dementia (as it may be wise to have that for protection), but it would need consent from the resident's POA prior to	N 533		

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N 533	Continued From page 153 proceeding. Review of a palliative care consultation dated 12/16/25 revealed a consult for end of life discussion/decision making support. The resident's son stated he was worried about his mother's overall quality of life and her ability to keep herself safe. She was impulsive and unaware of her functional/ambulatory ability. She had repeated falls with injury. There was discussion of hospice philosophy and palliative care philosophy in detail. Following conversation, the resident's son did elect to change Resident #5's code status to do not resuscitate, comfort care arrest. Review of the Hospital Discharge dated 12/19/25 revealed to follow up with primary care provider in 1-2 days. Stop taking Eliquis. Review of facility re-admission orders (12/19/25) revealed to admit to Aultman Hospice with diagnosis of dementia. The resident had orders for Ativan and Oxycodone. Eliquis was noted to be "on hold" (per the MAR). There was no mention of the resident's Eliquis upon readmission to the facility. Review of a progress note dated 12/19/25 at 2:22 P.M. and written by "temp nurse" revealed Resident #5 arrived at approximately 2:00 P.M. by stretcher per morning nurse. This nurse (writer) arrived at 3:00 P.M. and assessed the resident. Spoke with her hospice nurse about medications. Hospice ordered comfort medications of Ativan and Oxycodone which were stat delivered. The note revealed the resident was oriented to self only. On 12/22/25 at 10:40 A.M. LPN #750 was	N 533		

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N 533	Continued From page 154 observed to prepare medications for Resident #5. The resident's medications were prepackaged from pharmacy and included the resident's Eliquis. Per the MAR, Eliquis was to resume on 12/22/25. Once the medications were placed into the medication cup and LPN #750 verified she was ready to administer the resident's medications and began to approach the resident for administration, the surveyor intervened and asked the nurse to check the resident's hospital discharge orders. Interview with LPN #750 verified she planned to administer the medications to the resident since those medications were current orders on the electronic medical record and she was unaware the resident had experienced a recent fall with a brain bleed and the hospital had ordered for the resident's Eliquis to be discontinued. Review of the MAR for 12/23/25 revealed the resident's morning dose of Eliquis was administered per documentation. On 12/23/25 at approximately 2:20 P.M. interview with LPN #542 revealed the admitting nurse is to review the resident's hospital documents and discharge information so the resident's orders for readmission can be verified. LPN #542 stated this contact with verification is to be documented in the medical record however, there wasn't specific information regarding the medication orders when the resident returned from the hospital on 12/19/25. Further interview with LPN #542 revealed she had contacted the resident's hospice provider (about the communication had upon the resident's return from the hospital on 12/19/25 since the nurse documented contact with hospice regarding medications) and left a message but no return call had been provided from hospice. LPN #542 verified she was unable	N 533		

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N 533	Continued From page 155 to locate the resident's hospital documents from when she returned from the hospital but verified the electronically scanned hospital records the surveyor had stated to discontinue the resident's Eliquis medication. LPN #542 stated she was going to remove the resident's Eliquis from the prepackaged pharmacy medications when the oncoming nurse arrived for her shift. LPN #542 stated there were about 13 packages of medications with Eliquis needing removed and she would contact the pharmacy to alert them the Eliquis had been discontinued so it is not placed in the prepackaged medications for the next delivery/28 day cycle. LPN #542 shared she didn't understand why "this has been an issue" since the nurse had to review the hospital records to verify the resident's orders with the physician. Review of the physician orders dated 12/23/25 at 2:30 P.M. revealed to hold the Eliquis; waiting on physician clarification. Review of the physician orders dated 12/23/25 at 2:55 P.M. revealed to discontinue the Eliquis per hospital orders. Review of the "Medication Administration Policy" dated 11/26/25 revealed the purpose of the policy was to establish standardized, safe, and legally compliant procedures for medication administration, storage, re-ordering, documentation, and disposal. Before administration, staff must verify the six rights: right resident, right medication, right dose, right route, right time, and right documentation. Documentation was to include the medication name, dose, routine, date and time of administration, and signature or initials of the person administering the medications. The policy further noted that refusals should be	N 533		

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N 533	Continued From page 156 documented, held doses should have a reason documentated, and adverse reactions or errors should be documented. The policy further noted that medication supply should be reviewed daily during medication administration to ensure a minimum 48-hour supply notice is always maintained, and should call the local pharmacy to refill if needed. This violation represents non-compliance investigated under Complaint Number OH00168644.	N 533		
N 534	O.A.C. 3701-17-17 (C) Medicines and Drugs O.A.C. 3701-17-17 (C) - Every container of medicine and drugs prescribed for a resident shall be properly and clearly labeled in accordance with applicable state regulations as to the following: (1) Date dispensed. (2) Name of resident. (3) Directions for use. (4) Name of the prescriber. (5) Name of the drug, strength, and prescription number if there is one. This Rule is not met as evidenced by: Based on observation, interview, record review, and review of manufacturer's instructions for use, the facility failed to ensure medications were dated when opened and appropriately labeled. This affected one resident (#2) of six residents	N 534		

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N 534	Continued From page 157 reviewed for medication administration. The facility census was 29. Findings include: Review of the medical record for Resident #2 revealed an admission date of 06/30/21 with medical diagnoses including type two diabetes mellitus with hyperglycemia, atrial fibrillation, and major depressive disorder. Review of Resident #2's physician orders revealed an order dated 07/05/23 to check the resident's blood glucose level daily at bedtime and an order dated 07/23/25 revealed an order for Novolog FlexPen (a short-acting insulin) subcutaneously which specified to inject 10 units once daily before breakfast, inject three units once daily before lunch, and inject 5 units daily before supper. Resident #2 also had an order dated 07/23/25 for Basaglar (a long-acting insulin) Kwik Pen subcutaneously which specified to inject 20 units once daily in the morning. Observation on 12/10/25 at 4:00 P.M. during medication administration with Licensed Practical Nurse (LPN) #545 revealed two opened insulin pens contained in the "B" medication cart on C-wing. One insulin pen was a Novolog Flex Pen and the other was a Basaglar Kwik Pen. Neither of the insulin pens were labeled with a resident's name or the date that the insulin pens were opened. An interview on 12/10/25 at 4:15 P.M. with LPN #545 verified the insulin was for Resident #2. She knew that because Resident #2 was the only resident with insulin in the "B" cart. LPN #545 further verified the two pens were not dated when opened and they were unsure how long the pens	N 534		

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N 534	Continued From page 158 had been opened for. Review of the manufacturer's instructions for Basaglar Kwik Pen dated 11/2022 revealed instructions for use regarding the Basaglar Kwik Pen. The instructions stated to throw away the Pen you are using after 28 days, even if it still has insulin left in it. Review of the manufacturer's instructions for Novolog dated 03/2023 revealed instructions for use regarding the Novolog FlexPen. The instructions stated the Novolog flex pen should be thrown away after 28 days, even if it still has insulin in it. This violation represents non-compliance investigated under Complaint Number OH00168644.	N 534		
N 539	O.A.C. 3701-17-17 (H) Medicines and Drugs O.A.C. 3701-17-17 (H) - Controlled substances shall be ordered, dispensed, administered, and disposed of in accordance with state and federal laws and regulations. This Rule is not met as evidenced by: Based on observation, open and closed record review and interview the facility failed to ensure a comprehensive controlled medication dispensing system was in place to monitor the distribution of controlled medications and prevent the potential for diversion. This affected eight residents (#1, #4, #8, #9, #11, #15, #16, #18) of eight current residents and one discharged resident (#50) reviewed for controlled medication storage. The facility identified 12 residents (#1, #4, #5, #7, #8, #9, #11, #15, #16, #18, #21, #25) of 29 residents	N 539		

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N 539	Continued From page 159 who received controlled medications in the facility. The census was 29. Findings include: Observation on 12/10/25 at 2:30 P.M. of the narcotic drawers on Wing C of medication carts A, B, and C with Licensed Practical Nurse (LPN) #542 revealed there was no system in place to verify the amount or date of each controlled medication received. During shift-to-shift reconciliation, there was no comparison of the number of controlled medication sheets and the number of controlled medication cards to ensure accuracy with controlled medication reconciliation. On Wing C, medication Cart A the following controlled medications and cards were reviewed: 1. From 2:30 P.M. to approximately 2:45 P.M. the following observations and interviews were completed: a. Review of Resident #50's closed medical record revealed an admission date of 06/30/21 with diagnoses including hypertension, restless leg syndrome and altered mental status. The resident died in the facility on 11/11/25 with hospice care. Review of Resident #50's Narcotic Count/Controlled Substance Log Form for morphine sulfate 100 milligrams (mg) per five milliliters (ml) with directions to administer 0.5 ml orally every two hours as needed. There was no date the medication was received or the amount of medication received documented on the form however, 28 ml were available on 11/17/25, six days after the resident had expired and no	N 539		

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N 539	Continued From page 160 documentation on the Log where the two milliliters of morphine went (liquid morphine is dispensed in a pre-filled and sealed bottle until administration and the seal is broken. The bottle is always filled with 30 ml of medication). No staff had identified 2 ml of the medication wasn't documented on the log. Review of Resident #50's Narcotic Count/Controlled Substance Log Form for Ativan 0.5 mg give one tablet every four hours as needed. There was no date received or the amount of tablets received. However, the Ativan reflected 11 tablets beginning on 11/17/25, six days after the resident had expired. Interview with LPN #542 at the time of the observation verified the resident's narcotic/controlled medications had not been removed from the facility med cart despite the resident having been discharged/deceased. The LPN stated she was unsure what the facility procedure was with the removal of narcotic medications after a resident expired but other places she has worked, immediately removes the medications to prevent the potential for narcotic diversion and to keep staff from having to continually count controlled medications no longer in use. The LPN verified there was no way to know how many of each medication was received but verified Morphine comes in a 30 ml bottle and the form said 28 ml remained. The LPN verified the bottle had been opened and 28 ml remained as per the Controlled Substance Log. b. Review of Resident #4's Narcotic Count/Controlled Substance Log Form revealed Clorazepate 3.75 mg, 56 tablets were received on 11/26/26 and to administer one tablet twice a day. There was no evidence the nurses were counting	N 539		

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N 539	Continued From page 161 the number of narcotic cards with the number of controlled/narcotic medication sheets. c. Review of Resident #9's Narcotic Count/Controlled Substance Log Form revealed 50 mg of Tramadol was received however the date and quantity received were not indicated on the form. The directions stated to give one tablet three times a day as needed. Further review revealed 10 tablets were received when the nurse administered one tablet on 12/05/25 at 6:15 A.M., leaving 9 tablets. Interview with LPN #542 at the time of the observation revealed she was unsure what was expected with controlled medication reconciliation as the facility had the "most confusing and unusual" narcotic logging system she had encountered. The LPN verified the controlled medication discrepancies and reiterated the facility had the most "confusing" system to log controlled medications she had encountered. LPN #542 shared she was unsure of many of the facility procedures since she only worked as needed and had not been employed by the facility long. 2. Continued observations on Wing C Cart B revealed the following observations and interviews were completed: a. Review of Resident #15's Narcotic Count/Controlled Substance Log revealed diphenoxylate/atropine (Lomotil) revealed no date received and quantity received of the medication. On 11/29/25 29 tablets were on hand. No comparison of the number of narcotic sheets and cards to ensure accuracy. b. Review of Resident #15's Narcotic	N 539		

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N 539	Continued From page 162 Count/Controlled Substance Log revealed Tramadol 37.5 mg 15 tablets were received on 11/25/25. On 11/26/25 at 7:00 P.M. revealed 13 tablets remained and then on 11/27/25 at 11:00 P.M. 41 tablets were available and one tablet was given and 40 tablets remained. there was no reason provided why the number oftramadol had increased. c. Review of Resident #16's Narcotic Count/Controlled Substance Log revealed Hydrocodone 5/325 with no date received and no quantity received. The initial amount on hand was 21 tablets but there was no comparison of the number of narcotic count sheets and medication cards to ensure accuracy. d. Review of Resident #11's Narcotic Count/Controlled Substance Log revealed oxycodone 5 mg with no date received or the quantity of tablets received. There is no comparison of the number of cards and narcotic sheets for the resident. e. Review of Resident #8's Narcotic Count/Controlled Substance Log revealed Hydrocodone APAP 5/325 with no date received and no quantity received. The current count was nine tablets and was correctly reflected on the card. There was no comparison to the number of narcotic sheets and the number of medication cards to ensure accuracy. 3. Continued observations on Wing C Cart C revealed the following observations and interviews: a. Resident #1 had Tramadol one half tablet twice a day scheduled and one half tablet twice a day as needed for pain. Review of the controlled	N 539		

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N 539	Continued From page 163 substance log revealed on 11/29/25 at 6:00 A.M., 30 tablets were available, one was administered and 29 tablets remained. On 11/29/25 at 9:00 P.M., 29 tablets were available; one was administered leaving 28 tablets available. On 11/30/25 at 9:00 P.M., 29 tablets were available; one was administered leaving 28 Tramadol for administration. b. Review of Resident #18's Narcotic Count/Controlled Substance Log revealed Hydrocodone 5/325 give one tablet twice a day revealed 28 tablets were delivered on 11/25 (unsure if this was the date of 11/25/25 or 11/2025). The first entry documented reflected 18 tablets were remaining at 12/01/25 at 7:30 A.M. There was no record of the other 10 hydrocodone tablets. c. Review of Resident #18's Narcotic Count/Controlled Substance Log revealed lorazepam 0.5 mg give one tablet every bedtime for two weeks. There was no date received or the quantity of tablets received. The first entry on the form was a count of 13 tablets on 12/04/25. Interview with LPN #542 at the time of the observation revealed she was unsure what was expected with controlled medication reconciliation as the facility had the "most confusing and unusual" narcotic logging system she had encountered. The LPN verified the controlled medication discrepancies and reiterated the facility had the most "confusing" system to log controlled medications she had encountered. LPN #542 shared she was unsure of many of the facility procedures since she only worked as needed and had not been employed by the facility long.	N 539		

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N 539	Continued From page 164 The facility did not have a policy or procedure related to the management of controlled substances and did not have a current pharmacy contract to identify facility and pharmacy roles in the management of controlled medications and prevention of narcotic misappropriation or diversion. This violation demonstrates noncompliance identified under Complaint Number OH00168644.	N 539		
N 540	O.A.C. 3701-17-17 (I) Medicines and Drugs O.A.C. 3701-17-17 (I) - The nursing home shall ensure that the pharmaceutical needs of each resident are met and that the drug regimen of each resident is reviewed and documented at least once a month by a pharmacist. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure monthly pharmacy reviews were completed to verify the pharmaceutical needs of the residents were met as required. This affected three residents (Resident #4, #12 and #27) of three residents reviewed for pharmacy reviews but had the potential to meet all residents residing in the facility. The census was 29. Findings include: 1. Review of the medical record for Resident #4 revealed an admission date of 06/30/21 with medical diagnoses including anemia, chronic venous insufficiency, and atrial fibrillation. Review of Resident #4's physician orders revealed medications including warfarin	N 540		

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N 540	Continued From page 165 (anticoagulant), Celexa (antidepressant), ferrous sulfate (iron replacement), Claritin (allergy medication) and Lasix (diuretic). Further review of the medical record revealed no evidence of monthly pharmacy reviews for the month of November 2025. An interview on 12/01/25 at 4:00 P.M. with the Administrator revealed the facility got medications from a neighborhood pharmacy that was not used to providing services to long term care facilities. However, the pharmacy was not supplying the facility with the expected monthly pharmacy reviews and pharmacy recommendations. An interview on 12/09/25 at 2:00 P.M. with Pharmacist #547 revealed the pharmacy did not have a contract with the facility but the pharmacy had individual service agreements with the residents. Pharmacist #547 revealed he was unaware of any long-term care requirement of monthly record reviews by a pharmacist and the pharmacy he represented did not offer this service. An interview on 12/11/25 at 10:30 A.M. with Medical Director #546 revealed it was her expectation that monthly pharmacy reviews and recommendations were completed. Medical Director #546 verified she did not receive any monthly pharmacy recommendations during her time as Medical Director for the facility. 2. Review of Resident #12's medical record revealed an admission date of 03/22/25 with diagnoses including left sided hemiplegia, atrial fibrillation, and cerebral infarction due to thrombosis of the right middle cerebral artery.	N 540		

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N 540	Continued From page 166 Review of the physcian orders revealed medications including Synthroid (thyroid hormone replacement), atorvastatin (cholesterol medication), diltiazem ER (anti-arrhythmic), Lexapro (antidepressant) Potassium (electrolyte replacement), and warfarin (anticoagulant medication). Further review of the medical record revealed no evidence of monthly pharmacy reviews for the month of November 2025. An interview on 12/01/25 at 4:00 P.M. with the Administrator revealed the facility got medications from a neighborhood pharmacy that was not used to providing services to long term care facilities. However, the pharmacy was not supplying the facility with the expected monthly pharmacy reviews and pharmacy recommendations. An interview on 12/09/25 at 2:00 P.M. with Pharmacist #547 revealed the pharmacy did not have a contract with the facility but the pharmacy had individual service agreements with the residents. Pharmacist #547 revealed he was unaware of any long-term care requirement of monthly record reviews by a pharmacist and the pharmacy he represented did not offer this service. An interview on 12/11/25 at 10:30 A.M. with Medical Director #546 revealed it was her expectation that monthly pharmacy reviews and recommendations were completed. Medical Director #546 verified she did not receive any monthly pharmacy recommendations during her time as Medical Director for the facility. 3. Review of Resident #27's medical record revealed an admission date of 05/16/25 with	N 540		

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N 540	Continued From page 167 medical diagnoses including coronary artery disease, cardiomyopathy, and atrial fibrillation. Review of the physician orders revealed medications including Coumadin, allopurinol (used for elevated uric acid levels), aspirin, atorvastatin (medication to treat elevated blood cholesterol levels), Lasix (diuretic), gabapentin (treats nerve pain), Lexapro (antidepressant), midodrine (treats low blood pressure), Potassium (replacement) and Vitamin D3 for supplementation. Further review of the medical record revealed no evidence of monthly pharmacy reviews for the month of November 2025. An interview on 12/01/25 at 4:00 P.M. with the Administrator revealed the facility got medications from a neighborhood pharmacy that was not used to providing services to long term care facilities. However, the pharmacy was not supplying the facility with the expected monthly pharmacy reviews and pharmacy recommendations. An interview on 12/09/25 at 2:00 P.M. with Pharmacist #547 revealed the pharmacy did not have a contract with the facility but the pharmacy had individual service agreements with the residents. Pharmacist #547 revealed he was unaware of any long-term care requirement of monthly record reviews by a pharmacist and the pharmacy he represented did not offer this service. An interview on 12/11/25 at 10:30 A.M. with Medical Director #546 revealed it was her expectation that monthly pharmacy reviews and recommendations were completed. Medical Director #546 verified she did not receive any	N 540		

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N 540	Continued From page 168 monthly pharmacy recommendations during her time as Medical Director for the facility. The facility did not have a policy or procedure related to pharmacy reviews and did not have a current pharmacy contract. This violation represents non-compliance investigated under Complaint Number OH00168644.	N 540		
N 558	O.A.C. 3701-17-18 (I) Food and Nutrition O.A.C. 3701-17-18 (I) - The nursing home shall monitor each resident's nutritional intake and make adjustments in accordance with the resident's needs. Notification of any significant unplanned or undesired weight change shall be made to the resident's attending physician and the dietitian required by paragraph (K) of this rule. "Significant unplanned or undesired weight change" means a five per cent weight gain or loss over a one month period, a seven and one-half per cent or more weight gain or loss over a three month period, or a ten per cent or more weight gain or loss over a six month period. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents' weights were obtained and monitored as ordered, failed to ensure nutritional concerns were timely discussed with the facility's dietitian, and failed to ensure nutritional interventions were provided as ordered. This affected four residents (#4, #6, #24, and #27) of four residents reviewed for nutrition. The facility census was 29.	N 558		

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N 558	Continued From page 169 Findings include: 1. Review of Resident #4's medical record revealed an admission date of 06/30/21 with medical diagnoses including anemia, chronic venous insufficiency, and atrial fibrillation. Review of Resident #4's physician orders revealed the resident had an order dated 10/21/23 to weigh the resident daily on day shift to monitor for worsening edema. Review of Resident #4's nutritional risk assessment dated 09/24/25, completed by Registered Dietitian (RD) #544 revealed the resident had a body mass index (BMI) of between 19-27 with no weight changes. Comments included the resident had a 6.6% planned/desired weight gain in the last 30 days. Her oral intake was estimated to meet between 26-75% of her estimated needs. The assessment noted the resident took a daily diuretic, was ambulatory, alert, and able to feed herself with no chewing or swallowing problems. The assessment noted that Resident #4 had skin impairment marked and was followed by the wound clinic every two weeks. The resident was noted to be overall at a moderate nutritional risk. Review of Resident #4's weights recorded in the electronic medical record for October 2025 revealed on 10/06/25 the resident weighed 123.8 pounds (lbs) and on 10/11/25 the resident weighed 122.8 lbs. Review of Resident #4's weights recorded in the electronic medical record for November 2025 revealed no weights had been obtained or recorded.	N 558		

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N 558	Continued From page 170 Review of Resident #4's Treatment Administration Record (TAR) for November 2025 revealed notation that the resident was to receive daily weights on day shift. Each day of the month had an "X" in the box and had no resident-specific weight or data entered by the nursing staff. Review of Resident #4's weight recorded in the electronic medical record on 12/02/25 revealed the resident weighed 111.0 lbs. Review of Resident #4's care plan revised on 12/03/25 revealed the resident has a nutritional problem or potential nutritional problem related to impaired skin, polypharmacy, advanced age, daily diuretic, and unintentional weight changes. Listed interventions included to monitor medications as ordered, provide milk at breakfast and offer for lunch and dinner per resident request, monitor weights as available, obtain and monitor laboratory and diagnostic work as ordered, and administer supplements as ordered. Review of subsequent weights for Resident #4 for December 2025 revealed on 12/15/25 the resident was recorded to weigh 85.0 lbs, on 12/16/25 the resident weighed 118.0 lbs, and on 12/30/25 the resident weighed 113.8 lbs. None of the weights were struck out. Corresponding progress notes for Resident #4 revealed no explanation for the weight discrepancy, nor any notification or collaboration with the physician or RD #544 to discuss Resident #4's weights. The facility was unable to provide any evidence of meal intakes for Resident #4 during the survey. Interview on 12/01/25 at 8:19 A.M. with Cook #518 revealed occasionally, food is returned on trays that residents had not eaten. Cook #518	N 558		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF LORETO	2812 HARVARD AVENUE, NW CANTON, OH 44709

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 558	Continued From page 171	N 558		

reported one of the residents who consistently had food left on her tray was Resident #4. Cook #518 believed Resident #4 was not eating because she cannot chew as her teeth hurt. Cook #518 reported the resident was on a regular diet, but she had been giving Resident #4 ground meat to make it easier for her to chew. The facility did have a dietitian who comes to the facility between six and eight hours per month which started approximately three months prior. The new dietitian has staff fill out a form with percentages of what the residents eat and leave the form on her desk so she can evaluate their nutritional needs when she visits.

Interview on 12/02/25 at 8:05 A.M. with Licensed Practical Nurse (LPN) #540 revealed the facility had no other weights than what was recorded other than the ones documented in the electronic medical record. LPN #540 confirmed weights had not been done for Resident #4 as it kept "flagging" for her that Resident #4's weight needed done. LPN #540 thought that night shift staff got resident weights instead of day shift staff.

2. Review of the medical record for Resident #6 revealed an admission date of 04/26/23 with diagnoses including iron deficiency anemia, age-related osteoporosis, osteoarthritis, and weakness.

Review of Resident #6's physician orders revealed an order dated 06/16/23 for monthly weights.

Review of Resident #6's nutritional risk assessment dated 09/24/25 revealed the resident had no significant weight changes, consumed between 50-75% of meals, was ambulatory, alert

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N 558	Continued From page 172 and able to feed self with no chewing or swallowing problems, and had intact skin. The resident was noted to be overall at a moderate nutritional risk. Review of Resident #6's care plan dated 09/24/25 revealed the resident has a nutritional problem or potential nutritional problem related to medical diagnoses, altered laboratory values, and advanced age. Listed interventions included to administer medications as ordered, monitor weights as available, obtain and monitor laboratory and diagnostic work as ordered, and provide and serve diet as ordered, monitor intakes and record for each meal. Review of Resident #6's progress notes revealed on 10/08/25, a pressure "spot" was noted on the resident's left heel. The resident was advised to keep the heel elevated. There was no evidence of communication or collaboration with RD #544 for review of the resident's nutritional regimen since the resident had developed a pressure wound. Review of Resident #6's weights recorded in the electronic medical record revealed on 10/10/25 the resident weighed 120.8 lbs and on 12/02/25 the resident weighed 116.8 lbs. There was no recorded entry for November 2025. The facility was unable to provide any evidence of meal intakes for Resident #6 during the survey. Interview on 12/02/25 at 8:05 A.M. with Licensed Practical Nurse (LPN) #540 revealed the facility had no other recorded weights other than the ones documented in the electronic medical record.	N 558		

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N 558	Continued From page 173 3. Review of the medical record for Resident #24 revealed an admission date of 07/23/25 with diagnosis of Parkinson's disease, major depressive disorder, generalized anxiety, and hypertensive heart disease. Review of Resident #24's physician orders revealed an order dated 07/23/25 for a regular diet with thin liquids. Review of Resident #24's nutritional risk assessment dated 07/30/25 completed by RD #544 revealed Resident #24 was determined to be at high risk for weight loss. The assessment referenced Resident #24 as eating 50-100 percent (%) of meals. The assessment did not indicate the resident had a goal to lose weight. There was no additional nutritional assessments available for Resident #24. Review of Resident #24's care plan dated 07/30/25 and revised on 12/03/25 revealed the resident had a nutritional problem or potential nutritional problem related to Parkinson's disease, depression, anxiety, hypertension, gastroesophageal reflux disease (GERD) and diabetes mellitus. The care plan referenced the resident also had a colostomy and desired weight loss with a goal weight of 140 lbs. Listed interventions included to administer medications as ordered, monitor weights as available and per protocol, provide and serve diet as ordered, and monitor and record intakes every meal. Further review of Resident #24's physician orders revealed an order dated 11/03/25 through 12/08/25 for weekly weights to be completed weekly for a duration of four weeks. Review of Resident #24's weight records	N 558		

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N 558	Continued From page 174 revealed on 10/07/25 the resident weighed 142.8 lbs. There was no recorded weight for Resident #24 for November 2025. On 12/02/25 the resident weighed 153 lbs. There was no evidence weekly weights had been completed between 11/03/25 and 12/08/25 as ordered. The facility was unable to provide any evidence of meal intakes for Resident #24 during the survey. Interview on 12/02/25 at 8:05 A.M. with Licensed Practical Nurse (LPN) #540 revealed the facility had no other recorded weights other than the ones documented in the electronic medical record. 4. Review of Resident #27's medical record revealed an admission date of 05/16/25 with diagnoses of hypertension, coronary artery disease, congestive heart failure (CHF), and atrial fibrillation. Review of Resident #27's physician orders revealed an order dated 06/30/25 for a house supplement 4 ounces (oz) by mouth twice daily. Review of Resident #27's nutritional risk assessment dated 09/12/25 completed by RD #544 revealed the resident was assessed to be at moderate risk for weight loss. Resident #27 was noted to only have one tooth, was noted to have a BMI outside of recommended range and/or a weight change of 5% in 30 days, 7.5% or more in 90 days, or greater than 10% change within six months. The assessment referenced Resident #27 was to receive a house nutritional supplement 4 oz twice daily. Review of Resident #27's care plan dated 09/12/25 revealed the resident had a nutritional	N 558		

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N 558	Continued From page 175 problem or potential nutritional problem related to hyperlipidemia, an elevated BMI, daily diuretic medication and prone to weight changes, missing teeth, and Warfarin therapy. Listed interventions included to administer medications as ordered, monitor weights as available, obtain and monitor laboratory and diagnostic work as ordered, provide and serve supplements as ordered, provider and serve diet as ordered, and to monitor and record meal intakes every shift. Review of Resident #27's physician orders revealed an order dated 10/06/25 for a regular diet with thin liquids. Review of Resident #27's weight history revealed on 07/01/25 the resident weighed 224.3 lbs. On 08/05/25 the resident weighed 246 lbs. On 09/02/25 the resident weighed 225 lbs. On 10/14/25 the resident weighed 179 lbs, and on 11/18/25 the resident weighed 186.6 lbs. There was no evidence that Resident #27's weight had been monitored weekly as ordered. Review of Resident #27's medical record revealed no documentation on whether the ordered house supplement was administered and how much of the supplement Resident #27 accepted. The facility was unable to provide any evidence of meal intakes for Resident #27 during the survey. Interview on 12/02/25 at 12:00 P.M. with RD #544 revealed she had been coming to the facility for four to five months. RD #544 reported that communication within the facility was a problem because there was no Director of Nursing (DON) available for her to communicate with. RD #544 reported she would normally communicate with	N 558		

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N 558	Continued From page 176 the DON for dietary recommendations related to supplement needs or to obtain clinical changes which could affect residents' nutritional needs. RD #544 reported she has trouble finding laboratory orders and results, reported weights are incomplete or inaccurate, and the facility did not follow any type of protocol for obtaining weights or reweighs when weights are outside of baseline for the resident. RD #544 reported she was unable to find meal intakes and reported there were books available for the nursing staff to write down intakes, but they are not consistently filled out. She is unable to pull reports or identify changes from the electronic medical record system and has trouble obtaining the data to ensure her assessments are accurate. RD #544 reported no one in the facility reported any information to her, she has had to work through the facility residents one-by-one to get an assessment completed and update the resident's care plan. When RD #544 has recommendations, she emails the Executive Director (ED) #501, Chief Executive Officer (CEO) #500, and the Administrator, but the orders frequently do not get obtained. When she does get supplement orders, they are not put into the electronic medical record properly and do not populate on the medication administration record (MAR) so that nurses know to administer and can document that they were given or how much was consumed by the resident. RD #544 stated supplements only worked if they were consumed and she had voiced her concerns to CEO #500, the Administrator, and ED #501. The facility did not have a policy or procedure for assessing, monitoring, or addressing residents' nutritional needs. This violation represents non-compliance	N 558		

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N 558	Continued From page 177 investigated under Complaint Number OH00168644.	N 558		
N 640	O.A.C. 3701-17-24 (A) Temperature Regulation in Homes O.A.C. 3701-17-24 (A) - For the purposes of this rule: (1) "Resident area" means any area within a nursing home that is occupied at any time by a resident except for an area, such as a greenhouse, that is specifically designed to be kept at a higher temperature. (2) "Temperature range" means between seventy-one degrees fahrenheit and eighty-one degrees fahrenheit. This Rule is not met as evidenced by: Based on observation, record review and interviews the facility failed to keep the facility temperature within the required range of 71-81 degrees Fahrenheit and at a comfortable level. This affected Resident #26 and #29 and had the potential to affect all the residents in the facility. The census was 29. Findings include 1. A review of the medical record for Resident #26 revealed an admission date of 09/13/21 with diagnosis including essential hypertension, chronic kidney disease, and mild cognitive impairment.	N 640		

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N 640	Continued From page 178 An observation on 12/09/25 at 9:30 A.M. revealed that the facility felt cold in the main dining room, the common are outside the chapel and on B wing. Certified Nursing Assistant (CNA) #531 was wearing a zip up sweatshirt on the unit. A portable thermometer in the common area on B wing read the temperature at 60 degrees Fahrenheit. An interview on 12/09/25 at 11:20 A.M. with Resident #26 revealed that their room was too cold. 2. A review of the medical record for Resident #29 revealed an admission date of 04/14/24 with diagnosis including Alzheimer's disease, diabetes mellitus, and malignant tumor of the prostate. An interview 12/09/25 at 11:00 A.M. with Resident #29 revealed that they were cold and that they wanted the heating fixed. An interview on 12/09/25 at 9:45 A.M. with Executive Director (ED) #501 revealed Maintenance Director #506 was at a dentist appointment that was scheduled for 9:30 A.M. and that the facility had two boilers running and a third one on standby. The outside temperature had fallen to 10 degrees Fahrenheit the previous night. An observation on 12/09/25 at 1:00 P.M. with Maintenance Director #506 revealed the ambient room temperature in the main dining room read 60 degrees Fahrenheit, the B wing common area temped at 62 degrees Fahrenheit, Resident #26's room had an ambient temperature of 58 degrees Fahrenheit, and Resident #29's room had an ambient temperature of 60 degrees Fahrenheit.	N 640		

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N 640	Continued From page 179 An interview on 12/09/25 at 1:30 P.M. with Maintenance Director #506 revealed that dampers on the pipe supplying steam heat to B wing were in the closed position and that he had opened all the dampers which allowed the steam to enter the heating system and provided heat to that side of the building. An observation on 12/09/25 at 3:30 P.M. with Maintenance Director #506 revealed that the ambient temperature in the main dining room was 68 degrees Fahrenheit, the B wing common area was 70 degrees Fahrenheit, Resident #26's room had an ambient temperature of 68 degrees, and Resident #29's room had an ambient temperature of 72 degrees Fahrenheit. An interview on 12/23/25 at 9:20 AM with Maintenance Director #506 revealed that he did not know how many boilers to run at any given time to maintain the facility temperature at a comfortable and appropriate temperature. On 12/16/25, an outside heating and cooling vendor came to the facility and looked at the boilers. The heating vendor educated Maintenance Director #506 on how many boilers needed to run based on the outside temperature readings. Maintenance Director #506 shared that if the outside temperature was between 40 to 50 degrees Fahrenheit they needed one boiler running, if the outside temperature was between 30-40 degrees Fahrenheit they needed two boilers running, if the outside temperature was between 20 to 30 degrees Fahrenheit the facility needed three boilers running, if the outside temperature was between 10 to 20 degrees Fahrenheit they needed four boilers running, if the outside temperature was between 0-10 degrees Fahrenheit the facility needed five boilers running,	N 640		

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N 640	Continued From page 180 and if the outside temperature was below zero they would need to run the sixth boiler. This violation represents non-compliance investigated under Complaint Numbers OH00168644 and OH00168548.	N 640		
N 711	O.R.C. 3721.13 (A) (2) Rights of Residents O.R.C. 3721.13 (A)(2) - The rights of residents of a home shall include, but are not limited to, the following: (2) The right to be free from physical, verbal, mental, and emotional abuse and to be treated at all times with courtesy, respect, and full recognition of dignity and individuality; This Rule is not met as evidenced by: Based on record review, review of a self-reported incident, interview and policy review the facility failed to ensure residents received timely and dignified care, allegations of abuse were thoroughly investigated and the abuse policy was current to identify and direct staff on how to proceed with allegations of staff to resident abuse. This affected one resident (Resident #15) but had the potential to affect all 29 residents. The census was 29. Findings include: Review of Resident #15's medical record	N 711		

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N 711	Continued From page 181 revealed an admission date of 11/30/23 with diagnoses including Alzheimer's Disease, generalized anxiety disorder and unspecified pain. Review of the physician orders revealed Dermaseptin (barrier cream) to the buttocks and coccyx with each incontinence episode written 10/03/25. The resident was currently receiving hospice services. Review of the plan of care initiated 12/31/23 revealed the resident has an ADL self-care performance deficit related to confusion, dementia and limited mobility. The following information was provided the resident requires (specify what assistance) for (x) staff to turn and reposition in bed (specify frequency) and as necessary. The remainder of the care plan was missing resident specific information based on the nursing assessments. Review of the Nursing Screening/History dated 11/05/25 revealed the resident had previously been admitted due to the inability to provide her own care. The resident was alert and oriented to person but not place and time. The resident was incontinent of bladder at night and always incontinent of bowel. The resident was dependent on staff for all activities of daily living and used a wheelchair for mobility. Review of former CNA #620's employee file revealed a hire date of 07/17/25. Review of the Description of Incident of Behavior form dated 10/29/25 revealed on 10/16/25 CEO #501 spoke with the CNA about a care issue regarding her nails. Gel/Acrylic Nails were leaving scratches on the residents.	N 711		

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N 711	Continued From page 182 Further review revealed on 10/23/25 Resident #15's family requested CNA #620 no longer provide care to Resident #15. The resident's family sent video of CNA #620 stating the resident's hygienic care could not be completed due to a lack of staff. The CNA did not perform end of the night hygienic care to the resident. The supervisor's remarks/Corrective Action to Be Taken: Per state guidelines. The House of Loreto is in compliance with staffing needs. The shift was fully staffed. At this time, the company has decided to part ways with CNA #620. Employee Remarks revealed "I try my best to provide the best care I can. I apologize to those whom were affected by my lack of work ethic. I will take this into consideration in the future. Thanks for this experience". The document was signed by CNA #620 but not a facility representative. Review of the House of Loreto Employee Disciplinary Report revealed CNA #620 was dismissed for improper conduct on 10/28/25. On 12/10/25 at 5:55 P.M. interview with Executive Director (ED) #500 confirmed there was an "incident" with CNA #620 and Resident #15. The CNA didn't provide care to the resident stating the facility didn't have enough staff for her to provide the requested care. The resident's sister contacted the facility and said she had video footage from an incident with her sister and provided the video to HR #502. The ED verified the investigation that was completed would be found in CNA #620's file. The ED verified, at the time of the incident in October, the facility did not have an Administrator and the Administrator is the facility's Abuse Coordinator. The ED was unable	N 711		

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N 711	Continued From page 183	N 711		

to confirm when the resident did receive care since a thorough investigation was not completed.

On 12/10/25 at 6:00 P.M. interview with the Administrator verified the investigation was not thorough and did not determine if other residents were involved, did not contain interviews or statements from staff and should have been reported to the State Survey Agency as an allegation of abuse through a Self-Reported Incident since the resident didn't receive care. The Administrator also verified the facility abuse policy had not been documented as reviewed or updated since 2008, according to the policy.

On 12/11/25 at 9:00 A.M. interview with the resident's sister revealed she had a camera in her sister's room due to previous incidents with staff and how they treated her sister and the previous incidents had been addressed. The resident's sister stated she shared the video with the facility regarding the incident with CNA #620 but she wasn't sure if she was able to send the video again. The resident's sister said she would try to send the video again. However, the video was not received.

On 12/17/25 at 12:40 P.M. interview with HR #502 revealed the video footage sent by Resident #15's sister showed the resident's sister asked CNA #620 why Resident #15's face wasn't washed and CNA #620 answered her by saying they were short staffed and "it wasn't getting done." The CNA was the only staff member in the room. HR stated there was no name calling and clearly no verbal abuse. Further interviews revealed since they saw the incident on video, they did not gather additional staff or resident interviews. The video was no longer available

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N 711	Continued From page 184 from the link sent by the resident's sister. Review of the House of Loreto Policy and Procedures Staff to Resident Abuse, dated July 2008, revealed in order to prevent and/or correct staff to resident abuse, the following protocol will be in place: Any staff member suspected or accused in abuse of any type, verbal, physical or sexual, will be immediately suspended and removed from the facility. There will be a thorough investigation into the merit of any accusation or suspicion of abuse. Any staff member found to be involved in the abuse of a resident will be immediately terminated. Any accusation or finding of abuse will be immediately reported to the residents physician, the Medical Director, the DON, Administrator and family The House of Loreto provides a safe and abuse free environment for all residents and staff. The attached procedures form a policy and procedure for prevention of abuse for residents and staff. It is the policy of the House of Loreto that any actual or suspected abuse will be dealt with in a timely manner. Any staff member who knows or credibly suspects that another staff member is abusive is obligated to report to Administration. Any abuse on the part of a resident also falls under this obligation. This violation represents non-compliance investigated under Complaint Number OH00168644.	N 711		
N 801	O.A.C. 3701-17-19 (A)(1) Records and Reports O.A.C. 3701-17-19 (A) (1) - Nursing homes shall keep the following records and such other records as the director may require:	N 801		

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N 801	Continued From page 185 (1) An individual medical record shall be maintained for each resident. Such record shall be started immediately upon admission of a resident to the home and shall contain the following: (a) Admission record. Name, residence, age, sex, race/ethnicity, religion, date of admission, name and address of nearest relative or guardian, admission diagnoses from referral record and name of the resident's physician and, if applicable, other licensed health professional acting within the applicable scope of practice. (b) Referral record. All records, reports, and orders which accompany the resident as required by rule 3701-17-10 of the Administrative Code. (c) Nursing notes and care notes. A note of the condition of the resident on admission and subsequent notes as indicated to describe changes in condition, unusual events or accidents. Other individuals rendering services to the resident may enter notes regarding the services they render. (d) Medication administration record. A doctor's order sheet upon which orders are recorded and signed by the physician or other licensed health professional acting within the applicable scope of practice, including telephone orders as required by rule 3701-17-13 of the Administrative Code; a nurse's treatment sheet upon which all treatments or medications are recorded as given, showing what was done or given, the date and hour, and signed by the nurse giving the treatment or medication; or other documentation authenticating who gave the medication or	N 801		

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N 801	Continued From page 186 treatment. (e) Resident progress notes. A sheet or sheets upon which the doctor, dentist, advanced practice nurse and other licensed health professionals may enter notes concerning changes in diagnosis or condition of the resident. Resident refusal of treatment and services shall also be documented in the progress notes. (f) Resident assessment record. All assessments and information required by rule 3701-17-10 of the Administrative Code. (g) Care plan. The plan of care required by rule 3701-17-14 of the Administrative Code. (h) Photograph. A photograph is only necessary for residents who have been identified as being a elopement risk. The photograph of the resident shall be updated annually. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to maintain accurate and comprehensive medical records and agency staff who administered medications and/or provided direct nursing care could be easily identified through documentation, failed to ensure laboratory results were timely filed on the medical record and failed to ensure staff had access to hospital records when residents returned to the facility after a hospital stay. This affected five residents (#3, #4, #5, #12, and #27) of 12 residents reviewed for quality of care. The facility census was 29.	N 801		

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N 801	Continued From page 187 Findings include: 1. Review of Resident #5's medical record revealed an admission date of 11/03/25 with diagnoses including unspecified dementia, (history of) deep vein thrombosis, major depression, essential hypertension and history of falls. a. Review of the physician admission orders revealed atorvastatin 80 milligrams (mg) by mouth (po) at bedtime for hyperlipidemia, Buspar 300 mg po in the morning for depression, Coreg 12.5 mg every morning and at bedtime for hypertension. Hold if systolic (top number) (blood pressure) is less than 100 (millimeters of mercury) or pulse less than 60 (beats per minute), famotidine 20 mg by mouth in the morning for gatroesophageal reflux, losartan 50 mg by mouth in the morning for hypertension, Osteo Bi-flex one per day oral tablet give one tablet by mouth in the morning for supplement, multivitamin give one tablet by mouth in the morning and fluoxetine 40 mg by mouth in the morning for depression. Review of the nurse progress notes and assessments revealed the following documentation without an identified nurse as the author of the progress note: Review of the fall risk assessment dated 11/03/25 and authored by an unidentified "agency nurse" revealed the resident was at high risk for falls due to a history of falls, diagnoses and use of assistive device. The assessment revealed the resident's gait was weak and she overestimated or forgets her limits in regard to cognitive status giving the resident a score of 80 indicating the resident was at high risk for falls (45 and above	N 801		

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N 801	Continued From page 188	N 801		

was considered high risk). No fall safety interventions were noted to be initiated at this time.

Review of a progress note dated 11/03/25 at 11:11 A.M. and authored by an unidentified "temp nurse" revealed the resident arrived at the facility accompanied by her family. Call light and belongings within reach.

Review of a nursing progress note completed on 11/28/25 at 6:20 P.M. and authored by an unidentified "temp nurse" revealed Resident #5 got out of wheelchair with no assistance. The nurse documented the resident had been told multiple times to use her call light and refuses. The note revealed the resident appeared to have an abrasion on the front of her head and a skin tear on the left knee and lower leg. The resident was not complaining of any pain at this time. The note revealed the resident was educated on using call light for assistance (however, per surveyor investigation based on the resident's diagnosis of dementia and cognitive impairment it was uncertain if this education was or would be effective to mitigate the resident's fall risk). Call light within reach and (to) be at safe level. Neuro (neurological) checks fine. POA and physician were notified.

Review of the Medication Administration Records (MAR) revealed the following dates when agency staff were assigned a shift and medications were documented by "xxx": 11/03/25 7:00 A.M. to 3:00 P.M.; 11/28/25 3:00 P.M. to 11:00 P.M.

On 12/09/25 at 5:40 P.M. interview with the Administrator revealed there was no seperate log in for each agency nurse used when working a shift at the facility. The Administrator verified the

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N 801	Continued From page 189 reader was unable to determine the author of the progress note since it always called the author "temp nurse". The Administrator also verified when agency nurses administered medications at the facility, all agency staff use the same log in to the electronic medical record and this is identified as "xxx" on the Medication Administration Record (MAR). The Administrator verified the facility had knowledge this needed corrected but nothing had been done to provide log-in information to each individual agency nurse when they worked at the facility. b. Review of the hospital records, dated 12/06/25, revealed Resident #5 experienced an intracranial bleed after a fall and was administered Kcentra (antagonist for Eliquis). Review of the hospital discharge instructions, dated 12/08/25, revealed Resident #5 was to resume her Eliquis on 12/22/25. On 12/13/25, the resident experienced another fall in the facility and was transferred to the Emergency Room (ER) for evaluation. Due to the resident being off anticoagulation (Eliquis) and having left lower extremity swelling and her history of a deep vein thrombosis (DVT), the physician ordered an ultrasound for evaluation. The resident was admitted to the hospital. Review of the vascular surgery consultation dated 12/15/25 revealed the resident was seen for possible IVC filter (due to presence of DVT and is an umbrella like device inserted into the IVC to prevent blood clots from traveling to the lungs and causing a life threatening pulmonary embolism. This is a treatment option for patients who are unable to take blood thinning medications due to bleeding, recent trauma or surgery and can be temporary or permanent).	N 801		

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N 801	Continued From page 190 The consult note revealed the physician spoke with the hospitalist indicating ideally the resident needed to be on some type of anticoagulation (she had a fairly extensive DVT). An IVC filter certainly was not unreasonable given the resident's repeated falls and dementia (as it may be wise to have that for protection), but it would need consent from the resident's POA prior to proceeding. Review of a palliative care consultation dated 12/16/25 revealed a consult for end of life discussion/decision making support. The resident's son stated he was worried about his mother's overall quality of life and her ability to keep herself safe. She was impulsive and unaware of her functional/ambulatory ability. She had repeated falls with injury. There was discussion of hospice philosophy and palliative care philosophy in detail. Following conversation, the resident's son did elect to change Resident #5's code status to do not resuscitate, comfort care arrest. Review of the Hospital Discharge dated 12/19/25 revealed to follow up with primary care provider in 1-2 days. Stop taking Eliquis. Review of facility re-admission orders (12/19/25) revealed to admit to Aultman Hospice with diagnosis of dementia. The resident had orders for Ativan and Oxycodone. Eliquis was noted to be "on hold" (per the MAR). There was no mention of the resident's Eliquis upon readmission to the facility. Review of a progress note dated 12/19/25 at 2:22 P.M. and written by "temp nurse" revealed Resident #5 arrived at approximately 2:00 P.M. by stretcher per morning nurse. This nurse	N 801		

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N 801	Continued From page 191 (writer) arrived at 3:00 P.M. and assessed the resident. Spoke with her hospice nurse about medications. Hospice ordered comfort medications of Ativan and Oxycodone which were stat delivered. The note revealed the resident was oriented to self only. On 12/22/25 at 10:40 A.M. LPN #750 was observed to prepare medications for Resident #5. The resident's medications were prepackaged from pharmacy and included the resident's Eliquis. Per the MAR, Eliquis was to resume on 12/22/25. Once the medications were placed into the medication cup and LPN #750 verified she was ready to administer the resident's medications and began to approach the resident for administration, the surveyor intervened and asked the nurse to check the resident's hospital discharge orders. Interview with LPN #750 verified she planned to administer the medications to the resident since those medications were current orders on the electronic medical record and she was unaware the resident had experienced a recent fall with a brain bleed and the hospital had ordered for the resident's Eliquis to be discontinued. Review of the MAR for 12/23/25 revealed the resident's morning dose of Eliquis was administered per documentation. On 12/23/25 at approximately 2:20 P.M. interview with LPN #542 revealed the admitting nurse is to review the resident's hospital documents and discharge information so the resident's orders for readmission can be verified. LPN #542 stated this contact with verification is to be documented in the medical record however, there wasn't specific information regarding the medication orders when the resident returned from the hospital on	N 801		

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N 801	Continued From page 192 12/19/25. LPN #542 verified she was unable to locate the resident's hospital documents from when she returned from the hospital but verified the electronically scanned hospital records the surveyor had stated to discontinue the resident's Eliquis medication. LPN #542 stated she was going to remove the resident's Eliquis from the prepackaged pharmacy medications when the oncoming nurse arrived for her shift. LPN #542 stated there were about 13 packages of medications with Eliquis needing removed and she would contact the pharmacy to alert them the Eliquis had been discontinued so it is not placed in the prepackaged medications for the next delivery/28 day cycle. LPN #542 shared she didn't understand why "this has been an issue" since the nurse had to review the hospital records to verify the resident's orders with the physician. Review of the physician orders dated 12/23/25 at 2:30 P.M. revealed to hold the Eliquis; waiting on physician clarification. Review of the physician orders dated 12/23/25 at 2:55 P.M. revealed to discontinue the Eliquis per hospital orders. 2. Review of Resident #12's medical record revealed an admission date of 03/22/25 with diagnoses including muscle weakness, difficulty walking, cerebral infarction, long term use of anti-coagulants, atrial fibrillation, and falls. Review of the nurse progress notes revealed the following documentation without an identified nurse as the author of the progress note: Review of a progress note dated 11/14/25 at 1:31 A.M. and authored by an unidentified "temp nurse" revealed the aide reported to the writer	N 801		

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N 801	Continued From page 193	N 801		

that resident was on the floor. Resident was found lying on her left side in front of her chair. The resident stated that she had slid out of her lift chair. The resident denies pain or injury and is pleasant and cooperative with care. Neuro checks were initiated (no evidence of the frequency or duration); resident reminded to use her call light for assistance. Family, provider, medical director need notification. Neuro checks continued throughout the shift with no notable abnormalities.

Review of the Medication Administration Records (MAR) revealed the following dates when agency staff were assigned a shift and medications were documented by "xxx": 11/03/25 7:00 A.M. to 3:00 P.M.; 11/28/25 3:00 P.M. to 11:00 P.M.

3. Review of Resident #3's medical record revealed an admission date of 06/30/21 with diagnoses including prior fracture, tinnitus, vertigo, heart block and arthritis.

Review of the Medication Administration Records (MAR) revealed the following dates when agency staff were assigned a shift and medications were documented by "xxx": 11/03/25 7:00 A.M. to 3:00 P.M.; 11/28/25 3:00 P.M. to 11:00 P.M.

On 12/09/25 at 5:40 P.M. interview with the Administrator revealed there was no seperate log in for each agency nurse used when working a shift at the facility. The Administrator verified the reader was unable to determine the author of the progress note since it always called the author "temp nurse". The Administrator also verified when agency nurses administered medications at the facility, all agency staff use the same log in to the electronic medical record and this is identified as "xxx" on the Medication Administration Record

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N 801	Continued From page 194 (MAR). The Administrator verified the facility had knowledge this needed corrected but nothing had been done to provide log-in information to each individual agency nurse when they worked at the facility. 4. Review of Resident #4, #12, and #27's medical records revealed all three residents were prescribed Warfarin (also known as Coumadin, an oral anticoagulant medication commonly used to prevent blood clots from forming; the medication has a narrow therapeutic range and patients on Warfarin require regular blood testing to monitor clotting time and subsequent adjusting of the medication dosage according to laboratory results) for varied diagnosis. Therapeutic range of the INR (the laboratory testing for Coumadin) is 2.0 to 3.0 while taking Coumadin/Warfarin. Continued review of the three resident medical records revealed no specific orders for the frequency of laboratory testing, inconsistent documentation of when testing was completed and communicated to the provider, and the resident records did not consistently contain evidence of the laboratory testing being completed when it should have been. On 12/04/25 at 1:30 P.M., interview with NP #543 revealed she wasn't being notified of laboratory results and orders that she gives were not placed into the electronic medical record (eMAR) related to Coumadin. The NP also shared it was difficult to communicate with the facility not having a DON as the DON was usually her point of contact with any concerns she might have. On 12/08/25 at 3:03 P.M., interview with the Administrator confirmed the facility did not have a	N 801		

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N 801	Continued From page 195 process for generating a list of residents who were to have laboratory testing completed, and no clinical staff within the facility to monitor the laboratory testing orders had been completed/drawn. The Administrator was unable to offer an explanation related to where laboratory reports go once resulted, how the facility knew if the physician was updated if not recorded in the resident's progress notes, or how the facility tracked down laboratory orders and results. The Administrator stated she would expect a DON to monitor this process and confirmed the facility did not currently have a DON. The Administrator verified she had been uable to locate laboratory results during the survey for Residents #4, #12, and #27 and had reached out to the laboratory the facility uses for testing to have them fax over all of Resident #4, #12, and #27's results. The Administrator confirmed the residents' laboratory results should be contained in their medical record. This violation represents non-compliance investigated under Complaint Number OH00168644.	N 801		

Exhibit B

House of Loreto Abatement Plan

Effective Date: 1-7-26

Administration:

- Qualified DON-Leaderstat and Tobin & Assoc- contracts are pending for interim DON assignment. Both companies are actively looking for candidates.

Nursing Policy and Procedure

- All residents (28) assessed for wounds, identification of 1 new resident with a wound. New wound reported to MD and orders obtained. Wound care orders audited by RN for accuracy on 12-31-25. Facility Nurses (4) were educated on wound assessment expectations on 1-7-26 by the Administrator. Monitoring of wound assessments will be completed by DON or designee 3x week x 4 weeks and periodically thereafter. Results will be reported to QAPI x 3 months.
- Infection Preventionist training will be completed by the Administrator. Enrollment was completed 12-16-25, the program will be completed by 1-16-25. The Administrator has an BS in Biology and a Master's in Public Health which included courses in Biostatistics and Epidemiology. Progress will be reported to QAPI x 3 months
- Pharmacy contract is pending with Remedi pharmacy. The start date is 1-28-26. The Executive Director (ED) and Owner will be responsible for ensuring the contract is executed.
- Laboratory Services
    - All Residents assessed by Administrator on 12-29-25 for laboratory lapses, 0 identified with missed labs without followup completed. Coumadin Lab flow sheets were established 1-7-26 by the Administrator. Facility nurses (4) were educated 1-7-26 by the Administrator on the procedure to complete the flow sheet. Monitoring of completion of laboratory services will be monitored by DON or designee 3 x week x 4 weeks and periodically thereafter. Results will be reported to QAPI x 3 months.
    -

- Medication Management

    - Narcotic- New narcotic monitoring sheet obtained by Administrator from Remedi on 12-30-25 and reviewed and approved by facility RN. Education provided to nurses 4 on 1-7-26 regarding proper procedure for controlled substance accounting by facility RN and Administrator. Monitoring will be completed by DON or designee 3 residents, 2x week x 4 weeks and periodically there after. Results reported to QAPI x 3 months.
    - Emergency Medications- Emergency medications will be provided by Remedi onsite per the contract. All nurses (4) will be educated on emergency supply during Remedi training/onboarding and upon hire going forward.

- Abuse identification/investigation

EXHIBIT
B

    - All residents were assessed for potential abuse on 12-31-25 by the Administrator. Education will be given to all employees on 12-17-25 regarding Abuse program including reporting and investigation of allegations by the Administrator/Executive Director All department heads were additionally educated on starting and the contents of an investigation by the Administrator on 12-31-25.
    - The Administrator/DON will serve as the lead on all abuse investigations.
- Incident/Accidents-fall investigations- All residents 28 were assessed for fall risk on 1-5-26 by RN. All identified residents had interventions assigned to prevent future falls and care plans updated. Residents #3, #5, #12 were reassessed for recent falls, new orders in place, care plan updated and notification to floor staff completed 12-31-25. Nursing staff (4) were educated on 1-7-26 on use of the Post Fall Assessment form, procedure for implementing fall interventions, notification to family/physician, post fall documentation and communication of interventions to other nursing staff by the Administrator. DON/Administrator will audit fall investigations 3x week x 4 weeks and periodically thereafter. Results will be reported to QAPI x 3 months
- Nursing Documentation- All Nurses (4) were educated by the Executive Director on 12-17-15 and 1-7-26 as to required documentation in PCC. Progress Notes will be audited 3x/week x 4 weeks by DON/designee and periodically thereafter. DON or designee will monitor progress notes 3x/week x 4 weeks. Results will be presented to QAPI x 3 months.
- Communication-RDLD and MD
    - Nursing staff (were educated on accurate documentation of meal intakes, obtaining monthly weights, reporting procedures to RDLD on 1-7-26 by the Administrator. Residents #24, #27, #29 were assessed by RDLD for weight changes 12-31-25. DON or designee with audit 5x/week for 4 weeks.

<u>Medical Records</u>

- Loose medical records were reviewed by the Administrator on 12-10-25. All medical records present on the units were alphabetized by the receptionist on 12-11-25. Larger medical record charts were received by the facility on 12-16-25. The receptionist will have all records transferred by 1-7-26. Medical record filing will be maintained by the night nurse/designee. DON or designee will audit unit medical records mailbox 3x week x 4 weeks and periodically thereafter. Results will be reported to QAPI x 3 months

<u>Equipment Maintenance</u>

- Boiler System maintenance-Kolp will continue to maintain and service the boiler system and as needed. Kolp has maintained the boiler system since its installation in the facility. The maintenance director will keep a boiler log of events/service dates. The Maintenance Director will take periodic ambient temperatures in the facility 3x/week for 4 weeks. Logs will be reported to QAPI monthly x 3 months.

Exhibit C

Monitoring Visit- 01/10/2026

In House Census: 27

On 01/10/2026 an onsite monitoring visit revealed the facility failed to implement corrective action to remove the identified Real and Present Danger situations. No corrective action plan was provided for review at the time of monitoring visit. The Real and Present Danger violations (at N0081, N437 and N439) remained ongoing as of 01/10/2026.

The facility Administrator was not present onsite during the monitoring survey, but was available to the executive director by phone. The Administrator indicated she had a personal commitment on this date which prevented her from being onsite.

The facility Executive Director (ED) #501 was notified of the onsite State Agency visit by the laundry supervisor after the surveyor entered at 8:00 A.M. The ED arrived at approximately 10:15 A.M.

The following new concerns were identified as a result of the monitoring visit:

On 01/10/26 at 8:00 A.M. upon entrance to the facility, a laundry supervisor was identified to be the manager in charge. There was no nursing / clinical manager present. Review of the licensed nursing staff revealed there was one licensed nurse on duty to provide care for the 27 facility residents. Interview with the licensed nurse revealed she was a Licensed Practical Nurse (LPN) who was working at the facility on this date through an agency. The LPN indicated this was her second time working in the facility. When asked if she had been trained and/or was knowledgeable of the resident care needs, she indicated she had been provided a list of names/phone numbers of people she could call if she had any questions. The LPN reported she had to call Executive Director (ED) #501 due to an issue with a medication order. The ED was unable to assist and directed her to contact a hospice provider. The LPN indicated she was just trying to figure things out.

The facility had not hired nor did they have in place a full time Director of Nursing (DON) as of 01/10/2026.

The facility identified three current residents who were receiving Coumadin therapy:

Review of the medical record for Resident #12 revealed the resident had an order for a PT/INR to be drawn on 01/05/26. Record review and interview with staff revealed there were no laboratory results available from this testing. ED #501 revealed the lab work had been completed; however, she was unable to locate the results or provide any evidence of follow-up from this testing. The facility continued to lack a system to ensure laboratory testing was being monitored for anti-coagulant medication use.

The facility identified two residents (Resident #18 and Resident #26) who had sustained falls since 01/02/26 (the date of the survey exit):

Resident #18, who had a history of falls, sustained an unwitnessed fall from bed on 01/04/26 at 3:35 P.M. Progress notes and a Post Fall Assessment document revealed the resident had slid out of a low bed and was found on the floor. No injuries were documented. However, the assessment document indicated the resident was to have a mat to the floor beside his bed. There was no evidence the mat was in place at the time of the fall. In addition, there was no information as to when the resident had been assisted to bed by staff or evidence the resident's call light was in place at the time of the fall. No new interventions were initiated as a result of the fall or to prevent additional falls. The post fall assessment revealed staff were "reminded" bed in lowest position, mat on floor next to bed, call light, check resident "more frequently", leave bedroom door half open.

Resident #26, who had cognitive impairment/dementia and a history of falls, sustained an unwitnessed fall on 01/06/2026 at 1:45 P.M. Documentation on a Post Fall Assessment Form revealed a "State Tested Nursing Assistant (STNA)" came to the nurse (to report) resident observed sitting on "bottom" with bowel movement (BM) on floor and resident. "Asked "R" what she was doing she

said trying to clean up". Review of the assessment completed by the nurse at the time of the fall revealed no evidence fall/safety interventions were in place at the time of the fall or evidence the resident's call light was in reach or used prior to the fall. The resident did not have any type of plan of care related to activity of daily living needs and a fall risk plan of care included to ensure call light in reach and anticipate and provide prompt response to all requests. A Post Fall Assessment to be completed by the DON indicated the resident had diagnosis of chronic kidney disease and had no recent medication changes. The form included a section stating: "Based on above information, draw conclusion as to possible cause of this fall event". A response of "incontinence" was noted. A care plan review on the documentation included: Does plan clearly indicate 1 or 2 person assist for resident? Yes was circled. However, this information was no noted on the actual/fall or at risk for fall care plan. Nursing recommendations on the assessment form included to toilet every two (2) hours and call light within reach. The resident's plan of care was not updated to reflect the toileting plan following the fall. In addition, the form was not signed or dated by the person who wrote the responses.

Neither fall assessment included evidence of a thorough investigation or root cause analysis. There were no staff statements provided for either fall to determine when either resident had last received care from staff and/or when the residents had last been seen by staff. In addition, there was no evidence the facility had implemented a comprehensive and individualized fall management system to ensure new fall interventions were implemented and/or that current safety interventions were adequate and effective to decrease fall risk for the residents.

The facility identified Resident #16 was currently hospitalized:

Resident #16 returned from the hospital on 01/03/26 after his stay related to dehydration, abscess of abdominal cavity, anemia of unknown origin and chronic kidney disease. Review of the medical record revealed the resident

returned to the facility on Hospice services. Urine was draining from the resident's suprapubic area and the hospital had attached an ostomy bag.

Review of the telephone orders dated 01/03/26 revealed the resident was to be admitted to hospice services and had orders to receive Ativan 0.5mg every 6 hours as needed and hydrocodone every 4 hours as needed. However, these medications were not available until 01/04/26 at 5:30 P.M.

On 01/04/26 (time unknown per documentation) the resident was very agitated and asked for the hospice nurse to come and sit with him. Hospice had no staff available to send so they called the sisters who did sit with him for a while. The medications ordered on admission to address the resident's anxiety/pain were not available. LPN #545 documented she contacted the pharmacy to get his medications and the medications arrived around 5:30 P.M. He then received Ativan and hydrocodone per orders. Staff documented the resident tolerated well and "appeared" calmer. However, review of the medication administration record (MAR) does not reflect administration of the hydrocodone until 01/05/26 at 4:00 P.M. and the narcotic log reflected no dose administered until 01/07/26 at 4:00 P.M despite delivery on 01/04/26.

Further review of the medical record revealed there were inconsistencies with the Ativan and hydrocodone orders compared to the MAR which reflected medication errors occurred which appeared to not have been identified by facility staff. Despite warning messages from the electronic record informing the nurses the doses were outside the usual frequency, the warning was bypassed in the system. The orders were then clarified by Hospice on 01/06/26.

Further review of the resident's record revealed the resident continued to experience bleeding from his suprapubic area and having bloody stools. Due to a critically low hemoglobin level of 5.1, the resident elected to discontinue hospice services and was transported to the hospital. The resident was transported on 01/09/26 at 10:05 P.M. and was admitted to the hospital with a GI hemorrhage, anemia and renal insufficiency.

Interview on 01/10/26 at 3:43 P.M., with the oncoming LPN, who is working second shift through an agency on this date revealed this was the first time she had worked in the facility. The LPN stated the daytime nurse gave a quick report on how residents take their medications. The LPN stated no tour was provided or information related to supplies, foods like applesauce for medication administration, fresh water, overflow, or contact list of administration.

Interview on 01/10/26 at 3:46 P.M., with an STNA revealed Resident #26 could toilet herself but required “gentle reminders” to complete the task. The STNA stated the resident could ambulate self throughout the facility.

Interview with the ED throughout the monitoring visit revealed the facility was unable to provide certain documents for the visit as requested due to lack of access. The ED (who was the facility point of contact for the monitoring visit) stated several times that she was “limited” due to not having a nursing services background.