STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365088	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Englewood Health and Rehab	425 Lauricella Court Englewood, OH 45322

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492 Based on record review, staff interview and policy review, the facility failed to ensure appropriate written authorization were obtained to manage a resident's personal funds. This affected one (#246) of five residents reviewed for personal funds. The facility census was 83. Findings include: Review of the medical record revealed Resident #246 was admitted to the facility on [DATE] with a primary diagnosis of unspecified heart failure and was discharged on [DATE]. Review of document titled Authorization and Agreement to Handle Resident Funds revealed Resident #246 had a non-transferring resident Fund account. The form was unsigned and undated. Review of the Resident statement revealed Resident #246's account was opened on 12/14/23 with a cash deposit of $245.00. The account was paid out and closed on 01/22/24. During an interview conducted on 04/25/24 at 9:09 A.M. Business Office Manager #49 stated someone had given the resident cash and turned it over to the business office to open the account. BOM #49 stated she deposited the money on 12/14/23 but failed to get Resident #246 to sign the paperwork before she discharged from the facility. Review of policy titled Resident Personal Funds dated February 2023 revealed the facility acted as the fiduciary of a resident's funds upon written agreement from the resident.

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

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on record review, observations, resident and staff interviews, review of Resident Assessment Instrument (RAI) Manual and policy review, the facility failed to ensure an Minimum Data Set (MDS) assessment was completed/coded accurately. This affected two (#59 and #57) out of 22 residents sampled during the survey for MDS assessments. The facility census was 83. Findings include 1. Medical record review for Resident #59 revealed the resident was admitted to the facility on [DATE]. Diagnoses include acute kidney failure, chronic heart failure, respiratory failure, hypertension, obesity, sleep apnea, spinal stenosis, pressure ulcer sacral region, gastroesophageal disease, peptic ulcer, irritable bowel syndrome, anxiety, polyneuropathy, restless leg syndrome diabetes mellitus, insomnia, low back pain, depression. Review of the quarterly MDS dated [DATE] revealed Resident #59 impaired cognition. Resident # 59 independent with eating. Resident #59 required supervision for bed mobility, transfers, and toileting. Resident #59 was coded as no mouth or facial pain discomfort or difficulty with chewing. Review of the Quarterly MDS dated [DATE] for Resident #59 revealed no broken or loosely fitting full or partial dentures. Resident #59 denied mouth or facial pain, discomfort or difficulty with chewing. Review of the Dental Health Services progress notes dated 10/25/21 to 10/04/23 for Resident #59 revealed nine visits to the dental clinic. Observation on 04/23/24 at 10:45 A.M. of Resident #59 oral cavity revealed extensive dental caries with teeth eroded at the gum line. Resident #59 had red and inflamed gums throughout with oral cavity and heavy accumulation of white material on teeth at gum line. Interview on 04/23/24 at 10:45 A.M. with Resident #59 confirmed she has dental problems. Observation 04/25/24 10:00 A.M. of Resident #59's oral cavity with Unit Manager Registered Nurse (RN) #47 verified multiple teeth with heavy decay and exposed dental roots. Interview on 04/25/24 at 10:07 A.M. with MDS RN #13 verified she did not visually exam Resident #59 oral cavity for problems with teeth and she should have. RN #13 verified Resident #59's MDS was coded incorrectly. Review of the RAI manual page L2 revealed that steps for assessment included an examination of the residents lips and oral cavity using a light source to visualize the oral cavity, checking for abnormal mouth tissue and inflamed or bleeding teeth. 49771 2. Resident #57 was admitted on [DATE] with diagnoses of cerebral infarction affecting right dominant side, aphasia, dysphagia, vascular dementia, psychotic disturbance, and chronic hepatitis. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS quarterly assessment dated [DATE] revealed Resident #57 had severely impaired cognition, impaired range of motion on the right side, and a required a two-person mechanical lift for transfers. Resident #57 was dependent for bowel and bladder incontinence, bathing, and dressing, and moderate assistance for eating and oral hygiene. It was revealed Occupational Therapy started 03/08/24 with no documentation of a brace or splint being utilized. Review of the Occupational Therapy Evaluation for the period of 03/08/24 to 04/05/24 revealed Resident #57 had a new goal of a right wrist/hand splint with patient tolerating for eight hours a day and target date of 03/22/24. The Evaluation was signed by OT #21 on 03/08/24 and Medical Director #203 on 03/19/24. Review of Care Plan with target date of 05/03/24 for Resident #57 revealed no reference to a right wrist/hand contracture or Occupational Therapy recommendation for application of a splint to the right wrist/hand contracture. Review of Care Conference notes dated 04/17/24 for Resident #57 revealed no reference to a right wrist/hand contracture or Occupational Therapy recommendation for application of a splint to the right wrist/hand contracture. Review of emails dated 03/15/24 to 04/23/24 between the facility and a procurement company utilized by the facility's parent organization revealed knowledge Resident #57 required a splint for the contracture of the right wrist/hand. On 03/15/24 at 11:34 A.M. the facility requested a specific brace to be ordered for the Resident. At 12:54 P.M. a representative from the procurement company responded asking if an alternative brace could be utilized. At 1:33 P.M. the facility confirmed the alternative brace would be acceptable. On 04/23/24 at 12:32 P.M. the facility asked the procurement company for an update on the status of the splint ordered. Observation on 04/23/24 at 10:01 A.M. of Resident #57 revealed a contracture of the right wrist/hand and no splint in place. Subsequent observations on 04/24/24 at 8:51 A.M. and 04/25/24 at 8:35 A.M. also revealed no right wrist/hand splint in place. Interview on 04/24/24 at 8:51 A.M. with Resident #57 revealed Resident's desire for a brace to be used for the contracted right wrist/hand. Interview on 04/24/25 at 9:45 A.M. with MDS Coordinator #16 revealed no knowledge of a splint recommended by Occupational Therapy to be applied to the right wrist/hand of Resident #57. MDS Coordinator #16 confirmed this would make the MDS assessment inaccurate. Interview on 04/25/24 at 11:44 A.M. with Administrator confirmed Resident #57 does not have the right wrist/hand splint as was recommended by Occupational Therapy on 03/08/24. Review of the Resident Mobility and Range of Motion Policy and Procedure revealed Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in Range of Motion. And As part of the resident's comprehensive assessment, the nurse will also identify conditions that place the resident at risk for complications related to Range of Motion and mobility, including contracture's.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on medical record review, observations, staff interviews, policy review and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure the comprehensive plan of care included dental care. This affected one (#7) of four residents reviewed for dental services. The facility census was 83. Findings included: Medical record review for Resident #7 revealed an admission on 06/30/21 with diagnoses including end stage renal disease, hypertensive chronic kidney disease, altered mental status, chronic obstructive pulmonary disease, hypertension, heart failure, gastroesophageal disease, and type 2 diabetes. Review of the annual Minimum Data Set (MDS) dated [DATE] for Resident #7 revealed cognitive impairment. Resident #7 required set up assistance for oral hygiene. Resident #7 had no broken of loosely fitting dentures or mouth pain or difficulty chewing. Review of the plan of care for Resident #7 was silent for dental services. Review of dental services for Resident #7 dated 08/10/23 revealed an oral exam with extractions. Progress notes identified heavy plague, and moderate to severe periodontal disease. Additionally the treatment record identified Resident #7 had pain related to seven teeth. Review of the dental services note for Resident #7 dated 10/04/23 revealed the resident was ill and did not receive dental services. Review of the dental services not for Resident #7 dated 02/22/24 revealed a dental cleaning was completed and the resident refused to have the one remaining tooth extracted. Observation on 04/24/24 at 11:15 A.M. with Dietary Tech #800 revealed a moist oral cavity with one remaining tooth on right upper gum. Interview on 04/24/24 at 11:20 A.M. with Resident #7 stated that the dentist had pulled all his teeth and told resident that the new dentures would be the next step. Resident #7 stated he would like to have them so he could eat preferred food. Interview on 04/24/24 at 1:45 P.M. with the Director of Nursing (DON) verified the plan of care was silent for any dental concerns and it should have been included. Request for policy regarding dental services was requested during the annual survey and was advised the facility follows the RAI Manual. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the RAI manual version 3.0, section 4-1 states the facility must develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet a residents medical, nursing, mental and psychological needs that are identified in the comprehensive assessment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on record review, observations, resident and staff interviews, and policy review, the facility failed to provide nail care for dependent residents. This affected one (#57) of two residents reviewed for Activities of Daily Living (ADL) care. The census was 83. Findings include: Resident #57 was admitted on [DATE] with diagnoses of cerebral infarction affecting right dominant side, aphasia, dysphagia, vascular dementia, psychotic disturbance, and chronic hepatitis. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #57 had severely impaired cognition, impaired range of motion on the right side, and a required a two-person mechanical lift for transfers. Resident #57 was dependent for bowel and bladder incontinence, bathing, personal hygiene, and dressing, and moderate assistance for eating and oral hygiene. Review of the Care Plan dated for review on 05/03/24 for Resident #57 revealed facility staff are to monitor ADL's for assistance and render care as needed. Observation on 04/22/24 at 10:57 A.M. of Resident #57's revealed the residents fingernails were extending approximately one-half to three-quarters of an inch beyond the tip of the fingers and with a brown substance under the nails. Subsequent observations on 04/22/24 at 5:00 P.M., 04/23/24 at 8:26 A.M., and 04/23/24 at 9:57 A.M. revealed no change in Resident #57's fingernails condition. Interview on 04/23/26 at 8:26 with Director of Nursing at bedside of Resident #57 confirmed the condition of the Resident #57's fingernails to be in need of ADL care. Review of the Activities of Daily Living (ADL's) Policy and Procedure revealed a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal hygiene.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on medical record review, observations, staff and Physician interviews and policy review, the facility failed to accurately assess, monitor, and implement wound care interventions for a newly identified non-pressure skin condition. This affected one (#24) of four residents reviewed for wound care. The facility census was 83. Findings included: Review of Resident #24's chart revealed Resident #24 admitted to the facility on [DATE] with diagnoses including congestive heart failure, abnormal posture, localized edema, hyperlipidemia, hypertension, anxiety disorder and calculus of kidney. Review of Resident #24's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident to be cognitively intact and Resident #24 required set up assistance with eating. Resident #24 required supervision with oral hygiene, and Resident #24 was dependent with toileting hygiene, showering, lower body dressing, putting on and taking off footwear, personal hygiene, chair transfers, toilet transfers, and tub transfers. Resident #24 required maximal assistance with upper body dressing, sitting to lying, and lying to sitting, and moderate assistance with rolling left and right. Resident #25 was reported to have three stage three pressure ulcers and was listed as having a pressure reducing device for the bed, a pressure reducing device for the chair, a turning and repositioning program, nutrition and hydration interventions to manage skin problems, pressure ulcer and injury care, application of non surgical dressings other than to feet and applications of ointments and medications other than to feet. Review of Resident #24's physician orders from 01/01/24 to 04/25/24 revealed no orders related to Resident #24's medial calf wound. Review of Resident #24's progress notes from 01/01/24 to 04/25/24 revealed no information related Resident #24's medial calf wound. Review of Resident #24's wound physician note dated 04/25/24 revealed Resident #24 had a stage venous wound of the left medial calf with full thickness. The wound was listed as healing and was 2.3 cm by 3 cm by 0.1 cm. Leptospermum honey apply once daily for 23 days and gauze island with border apply once daily for 23 days were listed as the treatment plan. Repositioning per facility protocol, low air loss mattress, turning side to side in the bed every one to two hours if able and elevate legs were also recommended. Observation of Wound Care Physician #227, Licensed Practical Nurse (LPN)/Unit Manager (UM) #47 and LPN UM #96 performing wound care on Resident #24 on 04/25/24 at 1:40 P.M. revealed Resident #24 had a new venous wound to her right medial calf that had an undated dressing on it and a new pressure area to the right lower back. The area to the calf measured 2.3 cm by 3 cm with a pink wound bed. Resident #24 was observed laying on a regular mattress and she did not have a low air loss mattress. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/25/24 at 1:40 P.M. with Wound Care Physician #227, LPN UM #47 and LPN UM #96 verified Resident #96 had a new wound to her right medial calf that had a undated dressing on it. Wound Care Physician #227 confirmed the area was a new venous wound to the right calf measured 2.3 cm by 3 cm with a pink wound bed. Interview with the Director of Nursing (DON) on 04/25/24 at 5:11 P.M. verified Resident #24 had a venous wound of the left medial calf that was found by Wound Care Physician #227 on 04/25/24. The DON verified there was a dressing in place at the time the wound was found on 04/25/24 and the facility did not have any orders for a treatment or assessments of the calf wound prior to 04/25/24. Review of the facility's wound care policy dated October 2010 revealed the type of wound care given, the date and time the wound care was given, any change in the resident's condition, all assessment data obtained when inspecting the wound and any problems or complaints made by the resident related to the procedure should be recorded in the resident's medical record.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on medical record review, observations, staff and Physician interviews and policy review, the facility failed to timely assess, provide ongoing monitoring and timely implement treatments for a resident's pressure ulcers. Additionally, the facility failed to implement a wound physicians recommendations for a specialty mattress to promote healing of a resident's pressure ulcers. This affected one (#24) out of four residents reviewed for pressure ulcer care. The facility census was 83. Findings included: Review of Resident #24's chart revealed Resident #24 admitted to the facility on [DATE] with diagnoses including congestive heart failure, abnormal posture, localized edema, hyperlipidemia, hypertension, anxiety disorder and calculus of kidney. Review of Resident #24's pressure ulcer care plan dated 06/13/23 revealed Resident #24 had a history of pressure ulcer related to the sacrum, left posterior upper thigh, right posterior upper thigh, left distal buttock, and right distal buttock related to impaired mobility and incontinence. Interventions included monitor labs as ordered by practitioner, provide pressure reducing wheelchair cushion, provide pressure reduction and relieving mattress, treatments as ordered, turning and repositioning as tolerated and weekly wound assessments. Review of Resident #24's physician progress note dated 11/30/23 revealed Resident #24 had a small open sore at the coccyx area that was 1 centimeter (cm) by 1 cm. The progress note stated the area was most likely a stage two decubitus ulcer. Duoderm or foam dressing was recommended. Review of Resident #24's physician order dated 11/30/23 revealed Resident #24 had an order to cleanse coccyx area with soap and water, pat dry, and apply Duoderm or foam dressing every two days until healed. The order was discontinued on 04/06/24. Review of Resident #24's nurse practitioner (NP) progress note dated 12/21/23 revealed Resident #24 had a small open sore that was a stage two to the coccyx. The area was 1 cm by 1 cm. Review of Resident #24's progress note dated 02/01/24 at 6:09 A.M. revealed Resident #24 was admitted to the hospital for Respiratory Syncytial Virus Infection (RSV) and bronchitis. Review of Resident #24's progress note dated 02/15/24 at 7:54 P.M. revealed Resident #24 arrived at the facility at approximately 7:54 P.M. by stretcher assisted with two emergency medical technician personnel. Resident #24's daughter and on call was notified. Medications were reviewed and changes were adjusted. Resident #24 complained of pain upon arrival and as needed was administered and was effective. Resident #24 was resting in bed talking with roommate and the call light was in reach. Review of the admission data collection form dated 02/15/24 revealed no wounds were listed on the admission assessment and the assessment stated to see the treatment administration report. Licensed Practical Nurse (LPN) #90 signed the assessment. However, further review revealed there was no further skin assessment conducted for Resident #24 including assessment, measurement or staging of any pressure ulcers upon readmission. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #24's weekly skin integrity assessment dated [DATE] at 1:26 A.M. revealed the skin was clear with no change of condition assessed. However, further review revealed there was no further skin assessment conducted for Resident #24 including assessment, measurement or staging of any pressure ulcers with the weekly skin integrity assessment dated [DATE]. Review of Resident #24's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident to be cognitively intact and Resident #24 required set up assistance with eating. Resident #24 required supervision with oral hygiene, and Resident #24 was dependent with toileting hygiene, showering, lower body dressing, putting on and taking off footwear, personal hygiene, chair transfers, toilet transfers, and tub transfers. Resident #24 required maximal assistance with upper body dressing, sitting to lying, and lying to sitting, and moderate assistance with rolling left and right. Resident #25 was reported to have three stage three pressure ulcers and was listed as having a pressure reducing device for the bed, a pressure reducing device for the chair, a turning and repositioning program, nutrition and hydration interventions to manage skin problems, pressure ulcer and injury care, application of non-surgical dressings other than to feet and applications of ointments and medications other than to feet. Review of Resident #24's physician order dated 02/26/24 revealed Resident #24 was ordered Zinc Oxide External Cream 22 % apply to buttocks and perineum topically every shift for wound treatment. Further record review revealed between 02/15/24 through 02/29/24 there was no assessment, measurements or staging by the facility of Resident #24's pressure ulcers. Review of Resident #24's wound physician note dated 02/29/24 revealed Resident #24 had a stage two pressure wound to the sacrum with partial thickness. The wound was listed as healing and was 4.5 cm length by 2 cm width by 0.1 cm depth. Leptospermum honey apply once daily for 30 days and gauze island with border apply once daily for 30 days were listed as the treatment plan. Resident #24 also had a stage two pressure wound to the left posterior upper thigh with partial thickness. The wound was listed as healing and was 3.5 cm length by 2 cm width and 0.1 cm depth. Leptospermum honey apply once daily for 30 days and gauze island with border apply once daily for 30 days were listed as the treatment plan. Resident #24 also had a stage two pressure wound to the right posterior upper thigh with partial thickness. The wound was listed as healing and was 0.8 cm length by 1 cm width and 0.1 cm depth. Leptospermum honey apply once daily for 30 days and gauze island with border apply once daily for 30 days were listed as the treatment plan. Repositioning per facility protocol and turning side to side in the bed every one to two hours if able were also recommended. Review of Resident #24's physician order dated 02/29/24 revealed a wound treatment to the sacrum was ordered. The order stated cleanse area with saline, pat dry and apply nickel thick layer of medihoney and cover with bordered gauze once daily. Review of Resident #24's physician order dated 02/29/24 and discontinued 04/15/24 revealed Resident #24 had a wound treatment to right upper posterior hip. The order stated cleanse area with saline and pat dry. Apply nickel thick layer of medihoney and cover with bordered gauze once daily every day for wound care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #24's physician order dated 02/29/24 and discontinued 04/15/24 revealed Resident #24 had a wound treatment to right upper posterior hip. The order stated cleanse area with saline and pat dry. Apply nickel thick layer of medihoney and cover with bordered gauze once daily every 6 hours as needed and may replace if missing or soiled. Review of Resident #24's physician order dated 02/29/24 and discontinued 04/18/24 revealed Resident #24 had a wound treatment to the sacrum. The order stated cleanse area with saline and pat dry. Apply nickel thick layer of medihoney and cover with bordered gauze once daily every six hours as needed may replace if soiled or missing. Review of Resident #24's physician order dated 02/29/24 and discontinued 04/15/24 revealed a wound treatment to the left posterior thigh was ordered. The order stated cleanse area with saline, pat dry and apply nickel thick layer of medihoney and cover with bordered gauze once daily. Review of Resident #24's wound physician note dated 03/07/24 revealed Resident #24 had a stage two pressure wound to the sacrum with partial thickness. The wound was listed as healing and was 4.2 cm length by 1.2 cm width by 0.1 cm depth. Leptospermum honey apply once daily for 23 days and gauze island with border apply once daily for 23 days were listed as the treatment plan. Resident #24 also had a stage two pressure wound to the left posterior upper thigh with partial thickness. The wound was listed as healing and was 3.2 cm length by 1.5 cm width and 0.1 cm depth. Leptospermum honey apply once daily for 23 days and gauze island with border apply once daily for 23 days were listed as the treatment plan. Resident #24 also had a stage two pressure wound to the right posterior upper thigh with partial thickness. The wound was listed as healing and was 0.5 cm length by 1.1 cm width and 0.1 cm depth. Leptospermum honey apply once daily for 23 days and gauze island with border apply once daily for 23 days were listed as the treatment plan. Repositioning per facility protocol and turning side to side in the bed every one to two hours if able were also recommended. Review of Resident #24's wound physician note dated 03/14/24 revealed Resident #24 had a stage two pressure wound to the sacrum with partial thickness. The wound was listed as healing and was 4 cm length by 0.8 cm width by 0.1 cm depth. Leptospermum honey apply once daily for 16 days and gauze island with border apply once daily for 16 days were listed as the treatment plan. Resident #24 also had a stage two pressure wound to the left posterior upper thigh with partial thickness. The wound was listed as healing and was 3.4 cm length by 1.7 cm width and 0.1 cm depth. Leptospermum honey apply once daily for 16 days and gauze island with border apply once daily for 16 days were listed as the treatment plan. Resident #24 also had a stage two pressure wound to the right posterior upper thigh with partial thickness. The wound was listed as healing and was 6.5 cm length by 15 cm width and 0.1 cm depth. Leptospermum honey apply once daily for 16 days and gauze island with border apply once daily for 16 days were listed as the treatment plan. Repositioning per facility protocol and turning side to side in the bed every one to two hours if able were also recommended. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #24's wound physician note dated 03/21/24 revealed Resident #24 had a stage two pressure wound to the sacrum with partial thickness. The wound was listed as healing and was 3.5 cm length by 1.5 cm width by 0.1 cm depth. Leptospermum honey apply once daily for nine days and gauze island with border apply once daily for nine days were listed as the treatment plan. Resident #24 also had a stage two pressure wound to the left posterior upper thigh with partial thickness. The wound was listed as healing and was 2.9 cm length by 10.8 cm width and 0.1 cm depth. Leptospermum honey apply once daily for nine days and gauze island with border apply once daily for nine days were listed as the treatment plan. Resident #24 also had a stage two pressure wound to the right posterior upper thigh with partial thickness. The wound was listed as healing and was 9 cm length by 14.5 cm width and 0.1 cm depth. Leptospermum honey apply once daily for nine days and gauze island with border apply once daily for nine days were listed as the treatment plan. Resident #24 also had a stage three pressure wound of the left distal buttock full thickness. The wound was listed as healing and was 3 cm by 2 cm by 0.1 cm. Leptospermum honey apply once daily for nine days and gauze island with border apply once daily for nine days were listed as the treatment plan. Resident #24 also had a stage two pressure wound of the right distal buttock partial thickness. The wound was listed as healing and was 0.3 cm by 0.3 cm by 0.1 cm. Leptospermum honey apply once daily for nine days and gauze island with border apply once daily for nine days were listed as the treatment plan. Repositioning per facility protocol, low air loss mattress and turning side to side in the bed every one to two hours if able were also recommended. Review of Resident #24's wound physician note dated 03/21/24 revealed Resident #24 was not seen due to Resident #24 being in the hospital. Review of Resident #24's wound physician note dated 03/28/24 revealed Resident #24 was not seen due to Resident #24 being in the hospital. Review of Resident #24's wound physician note dated 04/18/24 revealed Resident #24's stage two pressure wound to the sacrum with partial thickness was resolved. Resident #24 also had a stage two pressure wound to the left posterior upper thigh with partial thickness. The wound was listed as healing and was 3.5 cm length by 1.5 cm width by 0.1 cm depth. Leptospermum honey apply once daily for 30 days and gauze island with border apply once daily for 30 days were listed as the treatment plan. Resident #24 also had a stage two pressure wound to the right posterior upper thigh with partial thickness. The wound was listed as healing and was 5.5 cm length by 12.5 cm width and 0.1 cm depth. Leptospermum honey apply once daily for 30 days and gauze island with border apply once daily for 30 days were listed as the treatment plan. Resident #24 also had a stage three pressure wound of the left distal buttock full thickness. The wound was listed as healing and was 8.2 cm by 1.5 cm by 0.1 cm. Leptospermum honey apply once daily for 30 days and gauze island with border apply once daily for 30 days were listed as the treatment plan. Resident #24 also had a stage two pressure wound of the right distal buttock that was resolved. Repositioning per facility protocol, low air loss mattress and turning side to side in the bed every one to two hours if able were also recommended. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #24's wound physician note dated 04/25/24 revealed Resident #24's stage two pressure wound to the left posterior upper thigh with partial thickness. The wound was listed as healing and was 1.4 cm length by 1.6 cm width by 0.1 cm depth. Leptospermum honey apply once daily for 23 days and gauze island with border apply once daily for 23 days were listed as the treatment plan. Resident #24 also had a stage two pressure wound to the right posterior upper thigh with partial thickness. The wound was listed as healing and was 7 cm length by 13.5 cm width and 0.1 cm depth. Leptospermum honey apply once daily for 23 days and gauze island with border apply once daily for 23 days were listed as the treatment plan. Resident #24 also had a stage three pressure wound of the left distal buttock full thickness. The wound was listed as healing and was 7.5 cm by 2 cm by 0.1 cm. Leptospermum honey apply once daily for 23 days and gauze island with border apply once daily for 23 days were listed as the treatment plan. Resident #24 a had a stage two pressure wound of the right lower back with partial thickness. The wound was listed as healing and was 1.1 cm by 1.3 cm by 0.1 cm. Leptospermum honey apply once daily for 23 days and gauze island with border apply once daily for 23 days were listed as the treatment plan. Resident #24 had a stage venous wound of the left medial calf with full thickness. The wound was listed as healing and was 2.3 cm by 3 cm by 0.1 cm. Leptospermum honey apply once daily for 23 days and gauze island with border apply once daily for 23 days were listed as the treatment plan. Repositioning per facility protocol, low air loss mattress and turning side to side in the bed every one to two hours if able were also recommended. Further medical record review for Resident #24 revealed the recommendation from the wound care physician for a low air loss mattress revealed the intervention was not implemented. Interview with Licensed Practical Nurse Unit Manager (LPN UM) #48 revealed all of Resident #24's has a history of multiple pressure ulcers. LPN UM #48 stated Resident #24 discharged to the hospital on 02/01/24 and returned from the hospital on 02/15/24 with the pressure ulcer to the thighs and coccyx. LPN UM #48 stated Resident #24 had a treatment (Duoderm) to her coccyx that was ordered 11/30/23 was continued upon her return from the hospital on 02/15/24 but the area was not assessed upon readmission. LPN UM #48 confirmed the Duoderm treatment to Resident #24's coccyx continued through 04/06/24 and when Wound Care Physician #227 came in on 02/29/24 he assessed/measured an area that he described as being on the sacrum and initiated another treatment. LPN UM #48 confirmed the nurse did not assess, measure or stage any of Resident #24's wounds/pressure ulcers upon readmission on 02/15/24. LPN UM #48 stated Resident #24 was seen by Wound Care Physician #227 on 02/29/24 and at that time all of the residents pressure ulcers were assessed, measured and staged. LPN UM #48 verified there was no order put in place for Resident #24's wound to her right posterior thigh or left posterior thigh on 02/15/24 when Resident #24 returned from the hospital. LPN UM #48 also confirmed no order for Resident #24's right posterior thigh or left posterior thigh wounds were entered until 02/29/24 when Resident #24 was seen by the wound physician. Observation of Wound Care Physician #227, LPN UM #47 and LPN UM #96 performing wound care on Resident #24 on 04/25/24 at 1:40 P.M. revealed Resident #24 also had an area to the left posterior thigh that measured 1.4 cm by 1.6 cm; an area to the right posterior thigh that was 7 cm by 13.3 cm with a cluster that was 85 percent of the skin; and an area to the left buttocks that was 7.5 cm by 2 cm that was a clustered wound with four open areas that were clustered together. Resident #24 was observed laying on a regular mattress and she did not have a low air loss mattress. There was no pressure ulcer or open area observed on Resident #24's coccyx or sacrum. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/25/24 at 1:40 P.M. with Wound Care Physician #227 verified Resident #96 has a history of multiple pressure ulcers. Wound Care Physician #227 confirmed a recommendation was made for Resident #96 to have a low air loss mattress but the intervention was not implemented by the facility. Interview with LPN UM #47 and LPN UM #96 on 04/25/24 at 2:28 P.M. verified Resident #24 did not have a low air loss mattress as recommended by Wound Care Physician #227 and the resident had a regular pressure reducing mattress. Review of the facility's wound care policy dated October 2010 revealed the type of wound care given, the date and time the wound care was given, any change in the resident's condition, all assessment data obtained when inspecting the wound and any problems or complaints made by the resident related to the procedure should be recorded in the resident's medical record. Review of the facility's prevention of pressure injuries policy dated April 2020 revealed the facility should conduct a comprehensive skin assessment upon admission and weekly as needed. The facility should evaluate, report and document potential changes in skin.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on record review, observation, staff and resident interviews and policy review, the facility failed to ensure a wrist/hand splint was applied as recommended per therapy. This affected two (#57 and #59) of two residents reviewed for position and mobility. The census was 83. Findings include: 1. Resident #57 was admitted on [DATE] with diagnoses of cerebral infarction affecting right dominant side, aphasia, dysphagia, vascular dementia, psychotic disturbance, and chronic hepatitis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #57 had severely impaired cognition, impaired range of motion on the right side, and a required a two-person mechanical lift for transfers. Resident #57 was dependent for bowel and bladder incontinence, bathing, personal hygiene, and dressing, and moderate assistance for eating and oral hygiene. It was revealed Occupational Therapy (OT) started 03/08/24 and no documentation of a brace or splint being utilized. Review of the OT Evaluation for the period of 03/08/24 to 04/05/24 revealed Resident #57 had a new goal of a right wrist/hand splint with patient tolerating for 8 hours a day and target date of 03/22/24. The Evaluation was signed by OT #21 on 03/08/24 and Medical Director #203 on 03/19/24. Review of Care Plan with target date of 05/03/24 for Resident #57 revealed no reference to a right wrist/hand contracture or OT recommendation for application of a splint to the right wrist/hand contracture. Review of Care Conference notes dated 04/17/24 for Resident #57 revealed no reference to a right wrist/hand contracture or OT recommendation for application of a splint to the right wrist/hand contracture. Review of emails dated 03/15/24 to 04/23/24 between the facility and a procurement company utilized by the facility's parent organization revealed knowledge Resident #57 required a splint for the contracture of the right wrist/hand. On 03/15/24 at 11:34 A.M. the facility requested a specific brace to be ordered for the Resident. On 03/15/24 at 12:54 P.M. a representative from the procurement company responded asking if an alternative brace could be utilized. On 03/15/24 at 1:33 P.M. the facility confirmed the alternative brace would be acceptable. On 04/23/24 at 12:32 P.M. the facility requested an update on the status of the splint ordered. Review of the Resident Mobility and Range of Motion Policy and Procedure revealed Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in Range of Motion. And As part of the resident's comprehensive assessment, the nurse will also identify conditions that place the resident at risk for complications related to Range of Motion and mobility, including contracture's. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/23/24 at 10:01 A.M. of Resident #57's revealed a contracture of the right wrist/hand and no splint in place. Subsequent observations on 04/24/24 at 8:51 A.M. and 04/25/24 at 8:35 A.M. also revealed no right wrist/hand splint in place. Interview on 04/24/24 at 8:51 A.M. with Resident #57 revealed the resident's desire for a brace to be used for the contracted right wrist/hand. Interview on 04/24/25 at 9:45 A.M. with MDS Coordinator #16 revealed no knowledge of a splint recommended by OT to be applied to the right wrist/hand of Resident #57. MDS Coordinator #16 confirmed this would make the MDS assessment inaccurate. Interview on 04/25/24 at 11:44 A.M. with Administrator confirmed Resident #57 does not have the right wrist/hand splint as was recommended by OT on 03/08/24. 39702 2. Medical record review for Resident #59 revealed acute kidney failure, chronic heart failure, respiratory failure, hypertension, obesity, sleep apnea, spinal stenosis, pressure ulcer sacral region, peptic ulcer, irritable bowel syndrome, anxiety, polyneuropathy, restless leg syndrome diabetes mellitus, insomnia, low back pain, and depression. Review of the quarterly MDS dated [DATE] revealed Resident #59 had impaired cognition. Resident # 59 required set up for eating. Resident #59 required maximal assistance for bed mobility, and toileting and dependent for transfers. Resident # 59 has limitations on one side of her body. Resident #59 received occupational therapy during the assessment period. Review of the plan of care for Resident #59 was silent for any splint applications or monitoring. Review of the active physician orders for Resident #59 for the month of April 2024 was silent for any splint application or monitoring. Review of the discontinued physician orders for Resident #59 from 05/22/2022 to 04/24/24 was silent for any splint application or monitoring. Observation on 04/22/24 at 12:02 P.M. of Resident #59 revealed left hand contracture and blue soft foam splint on bedside table. Interview on 04/22/24 at 12:04 P.M. with Resident #59 stated therapy gave her the splint and she was to put it on every evening after her evening meal. Resident #59 stated the facility staff help her put it on because she is unable to. Interview on 04/25/24 at 10:45 A.M. with Licensed Practical Nurse (LPN) #37 verified the present of the splint in Resident #59's room and the splint was provided by therapy. LPN #37 states Resident #59 will have staff put it on her arm/hand every night after her evening meal LPN #37 verified there was not any orders for the splint or documented monitoring that she is aware of. Interview on 04/25/24 at 1:10 P.M. with the Director of Nursing (DON) verified there is not an order for splint placement at this time. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/25/24 at 2:20 P.M. with Interim Director of Therapy #600 verified there is not any active therapy progress notes related to the blue splint identified in Resident #59's room. Interim Director of Therapy #600 stated they do not have access to the previous therapy notes that may include the documentation related to splint usage.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on medical record review, observations, staff and Nurse Practitioner interviews and policy review, the facility failed to document a physician's orders for catheter care in a resident's medical record. This affected one (#71) out of one resident reviewed for urinary catheter care. The facility census was 83. Findings include: Medical record review for Resident #71 revealed an admission 12/08/22 with diagnosis including but not limited to ileus, diabetes type two, cerebral infarction, paralytic syndrome, stroke, neuromuscular dysfunction of bladder, hemiplegia affecting right side, chronic kidney disease, hypertension, and methicillin resistant staphylococcus. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #71 revealed the resident had impaired cognition. Resident #71 was coded as having an indwelling urinary catheter during the look back period. Review of the plan of care for Resident #71 dated 01/25/23 revealed resident has an indwelling catheter due to neuromuscular bladder dysfunction. Interventions include catheter care daily and as needed, change catheter as ordered by physician, observe for pain near catheter and report to nursing, observe urine output for dark color, presence of odor, blood, signs of infection and report to nursing, position catheter below bladder, ensure tubing has no kinks, and secure for safety. Review of the Nurse Practitioner (NP) #201 for urology progress notes dated 08/18/23 revealed Resident #71 was being followed by urology for neurogenic bladder with Foley catheter. NP documents resident reports his catheter is somewhat uncomfortable. Progress note continues to state that Resident #71 has a history of urinary tract infections with the last one being in 05/2023. Assessment and plan documented on the progress note states staff to care for urinary catheter per protocol, exchange indwelling catheter every 30 days and as needed if occluded, follow up in eight weeks. Review of the physician orders for Resident #71 for the month of October 2023 was silent for orders to change Foley catheter. Review of the facility progress notes for Resident #71 dated 10/02/23 at 5:32 A.M. stated Foley replacement due to Foley not draining properly and have leakage. Resident tolerated procedure well without complaints of pain or discomfort. Foley is now patent and functioning properly. Review of the urology NP's #201 progress notes dated 10/12/23 for Resident #71 stated resident Foley catheter has not been leaking since they changed it out. Progress note state staff to care for urinary catheter per protocol. Discussed with resident suprapubic catheter verses indwelling urinary catheter, discussed the risks of a surgically inserted catheter and resident declined further evaluation. Assessment and plan documented on the progress note states staff to care for urinary catheter per protocol, catheter care every shift and as needed, exchange indwelling catheter every 30 days and as needed if occluded, follow up in eight weeks. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's orders for Resident #71 for the month of December 2023 was silent for orders to change Foley catheter. Review of the progress note for Resident #71 dated 12/18/23 at 6:32 P.M. stated writer replaced resident catheter. Resident has a 16 French with 30 cubic centimeters (cc) balloon. Zero signs and symptoms of distress noted at the time of insertion and will continue to monitor. Review of the NP #201 urology progress notes dated 3/26/24 revealed resident reported the catheter has not been leaking since they changed it out. Resident reports that the catheter is somewhat uncomfortable and has a history of urinary tract infections. Assessment and plan states staff to care for indwelling urinary catheter per protocol, exchange indwelling catheter every 30 days and as needed if occluded, follow up in eight weeks. Observation on 04/22/24 at 9:22 A.M. of Resident #71 revealed resident laying in bed with urinary catheter drainage bag hanging on bed frame containing dark colored liquid. Interview on 04/23/24 03:22 P.M. Licensed Practical Nurse (LPN) #37 verified there was no physicians order to change Resident #71's indwelling catheter monthly and there should have been. LPN #37 stated she could not remember the exact date but was told in report that the catheter for Resident #71 had been changed in the month of April 2024. LPN #37 verified the facility policy was to change indwelling urinary catheters every 30 days and would write the order. Interview on 04/23/24 at 3:47 P.M. with Unit Manager Registered Nurse (RN) #47 verified the facility policy for urinary catheters were to be changed every thirty days. Observation on 04/23/24 at 4:05 P.M. of LPN #37 revealed nurse had handwritten the order for the catheter to be changed monthly and as needed for Resident #71. A copy was requested by surveyor. Interview on 04/23/24 at 5:15 P.M. with Director of Nursing (DON) when a copy of the physician order was provided it stated indwelling Foley catheter- 16 French 30 cc balloon, change Foley and drainage bag for any dysfunction as needed and signed by the DON on 04/23/24 at 4:35 P.M. DON stated she called NP #202 for Resident #71 and received the current order. Additionally, the DON stated the order written by LPN #37 was incorrect and they were following the current Centers of Disease Control (CDC) guidelines for the exchanges of the Foley catheter. DON was interviewed why Resident #71's Foley catheter orders were different than all the other residents with catheters orders and was unable to clarify. Interview with 04/24/24 at 7:40 A.M. with NP #202 verified that he was called by the DON on 04/23/23 at 4:23 P.M. regarding an order for Resident #71's catheter as there was not one for the resident. NP #202 stated he usually orders a catheter change every thirty, but the DON spoke of the CDC regulations related to the catheters being changed only as needed when there is a problem. NP #202 stated he gave the order as suggested by the DON. Interview on 04/24/24 at 4:15 P.M. with DON when she provided the last NP urology visit for Resident #71 dated 03/26/24. DON stated the orders stating exchange catheter every 30 days or as needed was interpreted as one or the other not both. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/25/24 at 2:26 P.M. with Urology NP #201 verified the orders for urinary catheter exchange should have been changed every 30 days and as needed if the catheter became occluded. NP #225 stated she was unaware of any urinary tract infections resulting in hospitalization s. Request for a facility policy related to the time frames for the indwelling Foley catheter replacements was requested during the survey and not provided for review.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on record review, staff interviews and policy review, the facility failed to adequately monitor resident weight loss and implement weight loss interventions. This affected two (#28 and #84) out of three residents reviewed for nutrition. The facility census was 83. Findings include: 1. Review of Resident #28's chart revealed the resident was admitted to the facility on [DATE] with diagnoses including type two diabetes mellitus with diabetic chronic kidney disease, insomnia, chronic kidney disease stage three, other low back pain, anxiety disorder, depression, opioid dependence, weakness, other irritable bowel syndrome, mixed hyperlipidemia, foot drop, morbid obesity due to excess calories and acute kidney failure. Review of Resident #28's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident to be moderately cognitively impaired and Resident #28 required supervision with toileting, upper body dressing, lower body dressing, putting on and taking off footwear, sitting to standing, chair transfers, and walking ten feet. Resident #28 was independent for eating, rolling left and right, sitting to lying, and lying to sitting and Resident #28 required set up assistance with oral hygiene, and personal hygiene. Resident #28 required moderate assistance with showering, toilet transfers, and tub transfers and Resident #28 had a loss of five percent or more in the last month or a loss of ten percent of more in the last six month. Resident #28 was not on a prescribed weight loss regimen. Review of Resident #28's malnutrition care plan revised on 02/26/24 revealed Resident #28 was at risk for malnutrition and dehydration related to chronic disease, potential weight and intake decline, disease progression, use of a therapeutic diet, use of a diuretic with potential weight fluctuations, edema with weight fluctuations, slight weight loss, and adjustment to the facility. Resident #28 had weight loss, and her body mass index remained at morbid obesity. Resident #28 had a significant weight loss and had fortified foods. Interventions included provide diet per order, honor food preferences, monitor percent of meal consumed, assist with meals as needed, encourage Resident #28 to eat and drink, obtain weight as ordered and monitor, report significant weight changes to the physician and responsible party, monitor skin status, provide fluids on meal tray and at bedside, monitor for signs of dehydration, monitor labs, assess diet tolerance, administer medication per order and monitor side effects of medications. Review of Resident #28's weights from 10/04/24 to 04/19/24 revealed Resident #28 weighed 224.6 pounds (lbs) on 10/04/23, 222 lbs on 11/01/23, 196.2 lbs on 12/06/23, 208 lbs on 01/04/24, 188 lbs on 02/12/24, 174 lbs on 03/01/24, 178.8 lbs on 03/14/24, 175.6 lbs on 04/04/24, and 175.6 lbs on 04/19/24. Review of Resident #28's nutritional note by Dietetic Technician (DT) #800 dated 12/27/23 at 1:15 P.M. revealed Resident #28 was noted with a significant change however different scales were used. DT #800 anticipated no weight change with the same scale used. A regular diet was provided with intakes noted at 50 to 100 percent consumed at meals. No recommendations were made and DT #800 will continue to monitor. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #28's nutritional note by DT #800 dated 01/19/24 at 1:49 P.M. revealed Resident #28 was noted with weight fluctuations. Resident #28 was provided with a regular diet, regular texture, and thin liquids. Resident #28 was diagnosed with congestive heart failure with weight fluctuations. Resident #28 was provided with diuretic per physician orders. Resident #28's intake was noted at 50 to 100 percent. No recommendations that that time. Review of Resident #28's nutritional note by DT #800 dated 02/21/24 at 1:46 P.M. revealed Resident #28 was noted with significant weight loss with no reweight noted. Resident #28's body mass index remained obese, and Resident #28 was provided a regular diet, regular texture, and thin liquids. Resident #28's intakes were noted at 25 to 100 percent with refusals noted. Resident #28 received an order on 02/13/24 from the physician for zofran related to complaints of nausea. DT #800 recommended a reweight for monitoring and fortified foods at all meals. DT #800 will continue to monitor. Review of Resident #28's nutritional note by DT #800 dated 03/11/24 at 10:58 A.M. revealed Resident #28 was noted with a seven percent weight loss for one month. A reweight was recommended for monitoring. Resident #28 was provided with a regular diet, regular texture, thin liquids, and intakes were noted at 75 to 100 percent. The last labs were reviewed, and no pressure injury was noted. A reweight was recommended and DT #800 will continue to monitor. Review of Resident #28's nutritional note by DT #800 dated 04/17/24 at 2:00 P.M. revealed Resident #28 was noted with a significant change for three and six months. Resident #28's weights were being monitored by different scales which may be related to significant weight changes. Resident #28 was provided with a regular diet with regular texture and thin liquids. Resident #28's intake was 75 to 100 percent. A gastroenterology consult was pending related to recurrent nausea and lesions. No recommendations were made, and the facility recommended scale monitoring. Review of Resident #28's physician order dated 10/25/23 revealed Resident #28 was ordered a regular diet with regular texture and regular liquids. Review of Resident #28's physician order dated 12/04/23 revealed Resident #28 was ordered Ondansetron (Zofran) four milligrams (mg) give one tablet every eight hours as needed for nausea. The order was discontinued on 02/11/24. Review of Resident #28's physician order dated 02/13/24 revealed Resident #28 was ordered Ondansetron (Zofran) four mg give one tablet every six hours as needed for nausea for seven days. The order was discontinued on 02/20/24. Review of Resident #28's physician order dated 02/23/24 revealed Resident #28 was ordered Ondansetron (Zofran) four mg give one tablet every six hours as needed for nausea for seven days. The order was discontinued on 03/01/24. Review of Resident #28's physician order dated 03/04/24 revealed Resident #28 was ordered Ondansetron (Zofran) four mg give one tablet every eight hours as needed for nausea. The order was discontinued on 03/05/24. Review of Resident #28's physician order dated 03/05/24 revealed Resident #28 was ordered Ondansetron (Zofran) four mg give one tablet every eight hours as needed for nausea. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with DT #800 on 04/24/24 at 2:38 P.M. verified Resident #28 had a 21.62 percent weight loss in four months from 11/01/23 to 03/01/24 when she weighed 222 lbs on 11/01/23, 196.2 lbs on 12/06/23, 208 lbs on 01/04/24, 188 lbs on 02/12/24, and 174 lbs on 03/01/24. DT #800 also verified she recommended fortified foods and a reweight for Resident #28 on 02/21/24 but the reweight was never completed by the facility until the facility obtained Resident #29's March 2024 weight. DT #800 also confirmed Resident #28 continued to lose weight after the reweight recommendation was made on 02/21/24 and never completed. DT #800 stated Resident #28 weighed 188 lbs on 02/12/24, and 174 lbs on 03/01/24. DT #800 verified Resident #28 had 11.62 percent weight loss in one month from 11/01/23 to 12/06/23 but DT #800 did not assess Resident #28 until 21 days later on 12/27/23, Resident #28 had 9.62 percent weight loss in one month from 01/04/24 to 02/12/24 but DT #800 did not assess Resident #28 until for 9 days later on 02/21/24 and Resident #28 had 7.45 percent weight loss in one month from 02/12/24 to 03/01/24 but DT #800 did not assess Resident #28 until for 10 days later on 12/27/23. Telephone interview with Registered Dietitian (RD) #801 on 04/25/24 at 11:20 A.M. verified she had never seen or assessed Resident #28 at the facility. RD #801 stated she only sees high risk residents at the facility, and she was never made aware that Resident #28 had a 21.62 percent weight loss in four months from 11/01/23 to 03/01/24 when she weighted 222 lbs on 11/01/23, 196.2 lbs on 12/06/23, 208 lbs on 01/04/24, 188 lbs on 02/12/24, and 174 lbs on 03/01/24. RD #801 reported she would have considered Resident #28 a high risk resident for nutrition due to Resident #28 having a significant weight loss of 48 lbs from 11/01/23 to 03/01/24 and she most likely would have monitored with weekly weights. 2. Review of Resident #84's chart revealed the resident was admitted to the facility on [DATE] with diagnoses including non traumatic intracerebral hemorrhage in brain stem, dysarthria following cerebral infarction, type two diabetes mellitus without complications, hypertension, hemiplegia, and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, cerebral infarction, and gastrointestinal hemorrhage. Review of Resident #84's quarterly MDS assessment dated [DATE] revealed the resident to be moderately cognitively impaired and Resident #84 required supervision with oral hygiene, toileting, upper body dressing, lower body dressing, putting on and taking off footwear, personal hygiene, rolling left and right, lying to sitting, chair transfers, toilet transfers, and walking ten feet. Resident #84 required moderate assistance with showering, tub transfers, and sitting to standing, and set up assistance with sitting to lying. Resident #84 was noted with a feeding tube without weight loss on the MDS. Review of Resident #84's malnutrition care plan dated 01/10/24 revealed Resident #84 was at risk for malnutrition and dehydration related to chronic disease. Resident #84 uses a feeding tube. Resident #84 had a history of decreased weight and intakes per the hospital notes and Resident #84's body mass index was in the normal range. Resident #84 complained of being hungry and Resident #84 had a significant weight loss in 30 days. Resident #84's tube feed was increased to 60 milliliters (ml) per hour for 24 hours and flush at 300 ml every six hours. Interventions included obtained weight as ordered and monitored, report significant weight changes to the physician and responsible party, monitor skin status, monitor for signs of dehydration, monitor labs, consult with the speech therapist, administer medications per order, monitor effectiveness and side effects of medications, provide tube feedings per order, monitor tube feeding tolerance, flush tube per order, monitor for reflux, check resident for tube feeding residuals as ordered, keep head of the bed raised 30 degrees at all times while in bed and assess for signs and symptoms of aspiration. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #84's physician order dated 12/13/24 revealed Resident #84 was ordered no food by mouth. Review of Resident #84's physician order dated 01/11/24 revealed Resident #84 was ordered a Glucerna 1.2 at 65 milliliters (ml) per hour for 24 hours with a 300 ml flush every six hours. Review of Resident #84's weights from 03/01/24 to 04/24/24 revealed Resident #84 weighed 117.2 pounds (lbs) on 04/05/24 and 102 lbs on 04/11/24. Resident #84 did not have any other recorded weights after 04/11/24. Review of Resident #84's nutritional note by DT #800 dated 04/17/24 at 2:08 P.M. revealed Resident #84 had a potential weight error. A reweight was recommended due to possible error. Resident #84 was provided Glucerna 1.2 at 65 ml per hour with a 300 ml flush every 6 hours. Resident #84 was to have a modified barium swallow on that date with result pending. Further record review for Resident #84 revealed there was no documentation of a reweight following DT #800's recommendation on 04/17/24. Interview with DT #800 on 04/24/24 at 2:38 P.M. verified Resident #84 had a 12.97 percent weight loss from 04/05/24 to 04/11/24 when Resident #84 weighed 117.2 lbs on 04/05/24 and 102 lbs on 04/11/24. DT #800 also verified she recommended a reweight on 04/17/24 but the reweight had not been completed and there were no other weights in the system as of 04/24/24. DT #800 confirmed that no weight loss interventions were put in place for Resident #84 between 04/11/24 and 04/24/24 and that she did not assess Resident #84 after Resident #84's 12.97 percent weight loss until six days later on 04/17/24. Telephone interview with RD #801 on 04/25/24 at 11:20 A.M. revealed she was never made aware of Resident #84's 12.97 percent weight loss from 04/05/24 to 04/11/24 and that she did not put any weight loss interventions in place from 04/11/24 to 04/25/24 due to her not being aware of the weight loss. Review of the weight assessment and intervention policy dated March 2022 revealed resident weights are monitored for undesirable or unintended weight loss or gain.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on record review, resident and staff interview, and review of the facility policy, the facility failed to ensure a resident received medications as physician ordered. This affected one (#45) of one resident reviewed for medications. The facility census was 83. Findings include: Review of medical record reveals Resident #45 was admitted on [DATE] with diagnoses of encounter for surgical aftercare following surgery on the circulatory system (right above knee amputation with wound vac in place on stump), acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, and moderate protein-calorie malnutrition. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #45 is cognitively intact and has an enteral feeding tube (PEG) through the abdomen for nutrition. Resident #45 requires supervision for oral hygiene, maximal assistance for dressing, bed mobility, toileting, and transfers, and dependent for bathing. Review of physician orders for April 2024 revealed Resident #45 receives the following medications to be administered via PEG-Tube: Trazodone HCL oral tablet 50 milligram (mg) give one tablet via PEG-Tube at bedtime for insomnia, Spironolactone oral tablet 25 mg give one tablet via PEG-Tube a day for edema, Sertraline HCL oral tablet 50 mg give one tablet via PEG-Tube at bedtime for Post Traumatic Stress Disorder (PTSD) and Obsessive-Compulsive Disorder, Theragran-M oral tablet (Multiple Vitamins with Minerals) give one tablet via PEG-Tube one time a day for Vitamin supplement, Atorvastatin Calcium oral tablet 80 mg (Atorvastatin Calcium) give one tablet via G-Tube one time a day for cholesterol, Famotidine oral tablet 20 mg (Famotidine) give one tablet via G-Tube every morning and at bedtime to prevent ulcers, Methocarbamol oral tablet 500 mg (Methocarbamol) give one tablet via G-Tube every six hours as needed for muscle spasms, Apixaban oral tablet 5 mg (Apixaban) give one tablet via G-Tube every morning and at bedtime for Deep Vein Thrombosis (DVT) prevention. Review of progress note dated 04/17/24 revealed Resident #45 had his PEG-tube removed on 04/17/24 at 11:44 A.M. due to all nutrition being taken by mouth. Review of Medication Administration Record (MAR) dated April 2024 revealed Resident #45 was documented as receiving medications from licensed nursing staff via PEG-Tube or G-Tube for the period of 04/17/24 to 04/23/24, after PEG-Tube was removed and prior to physician ordering administration of all medications via mouth to start on 04/24/24. Interview on 04/23/24 at 5:15 P.M. with Resident #45 confirmed his PEG-Tube was removed last week and that he is taking all his medications by mouth. Interview on 04/23/24 at 5:15 P.M. with Licensed Practical Nurse (LPN) #90 confirmed Resident #45 no longer has a PEG-Tube and all medications are administered by mouth which conflicts with orders stating to administer by PEG-Tube. LPN #90 confirmed physician orders are not being followed pertaining to route of administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/23/24 at 5:23 P.M. with Director of Nursing (DON) confirmed Resident #45's PEG-Tube was removed 04/17/24 and licensed nursing staff were documenting medications route of administration as via PEG-Tube. Review of the facility policy titled, Administering Medications, revised April 2019, revealed the individual administering the medication checks the label to verify the right resident, the right medication, right dosage, right time and right method (route of administration) before giving the medication.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on record review, staff interviews and review of medication information, the facility failed to psychotropic medication were given with adequate indications for use and a resident's as needed anti-anxiety medication order had a stop date. This affected three (#28, #42 and #55) out of five residents reviewed for unnecessary medications. The facility census was 83. Findings include: 1. Review of Resident #28's chart revealed the resident was admitted to the facility on [DATE] with diagnoses including type two diabetes mellitus with diabetic chronic kidney disease, insomnia, chronic kidney disease stage three, other low back pain, anxiety disorder, depression, opioid dependence, weakness, other irritable bowel syndrome, mixed hyperlipidemia, foot drop, morbid obesity due to excess calories and acute kidney failure. Review of Resident #28's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident to be moderately cognitively impaired and Resident #28 required supervision with toileting, upper body dressing, lower body dressing, putting on and taking off footwear, sitting to standing, chair transfers, and walking ten feet. Resident #28 was independent for eating, rolling left and right, sitting to lying, and lying to sitting and Resident #28 required set up assistance with oral hygiene, and personal hygiene. Resident #28 required moderate assistance with showering, toilet transfers, and tub transfers and Resident #28 was on a anti depressant during the MDS review period. Review of Resident #28's physician order dated 02/10/24 revealed Resident #28 was ordered sertraline (zoloft) 100 milligrams (mg) give one tablet by mouth at bedtime related to insomnia. Interview with the Director of Nursing (DON) on 04/24/24 at 4:02 P.M. verified Resident #28 was ordered sertraline (zoloft) 100 mg give one tablet by mouth at bedtime related to insomnia. The DON verified insomnia was not an appropriate diagnosis for sertraline (zoloft). Review of the Zoloft Prescribing Information dated December 2016 revealed zoloft was indicated for treatment of major depressive disorder, obsessive compulsive disorder, panic disorder, post traumatic stress disorder, social anxiety disorder and premenstrual dysphoric disorder. Common adverse reactions include insomnia. 49771 2. Review of the medical record for Resident #42 revealed an admitted [DATE] with diagnoses of unspecified dementia, vascular dementia, cerebral infarction with hemiplegia and hemiparesis affecting left side, hypoxemia, major depressive disorder, psychotic disorder, encephalopathy, and diabetes mellitus type II. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS assessment dated [DATE] revealed Resident #42 is moderately cognitively impaired and has no functional limitation in range of motion for both upper and lower extremities. Resident requires set up assistance for eating, supervision for oral and personal hygiene, moderate assistance for toileting, dressing, and transfers, and maximal assistance for bathing. The Resident was documented to receive antipsychotic medication during the MDS assessment period. Review of physician orders revealed Resident #42 is receiving Seroquel oral tablet 50 mg. (Quetiapine Fumarate) give one tablet by mouth at bedtime for Behavioral and Psychological Symptoms of Dementia (BPSD) related to unspecified dementia, unspecified severity, with other behavioral disturbance. Review of the Black Box Warning from the pharmacy associated with this Seroquel order for Resident #42's revealed an increased mortality in elderly patients with dementia-related psychosis. Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Quetiapine (Seroquel) is not approved for the treatment of patients with dementia-related psychosis. Suicidal thoughts and behavior. Review of indications for Seroquel provided by the pharmacy revealed Seroquel is an atypical antipsychotic indicated for the treatment of schizophrenia, bi-polar disorder manic episodes, and bi-polar disorder depressive episodes. There is a specific warning for increased mortality in elderly patients with dementia-related psychosis. Review of the Highlights of Prescribing Information for Seroquel provided by the pharmacy reveals Seroquel is not approved for elderly patients with dementia-related psychosis and that elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Interview on 04/25/24 at 12:01 P.M. with the DON confirmed Resident #42 is being administered Seroquel for a diagnosis of Behavioral and Psychological Symptoms of Dementia (BPSD) related to unspecified dementia, unspecified severity, with other behavioral disturbance and the DON confirmed this is not an adequate indicate of use for the Seroquel. 39702 3. Medical record review for Resident #55 revealed an admission on 09/29/2020 with diagnoses that include but not limited to dementia, attention and concentration deficit, adult failure to thrive and depression. Review of the quarterly MDS assessment dated [DATE] for Resident #55 revealed the resident had impaired cognition. Resident #55 required total assistance for eating, toileting, bed mobility and transfers. Review of the plan of care for Resident #55 dated 06/26/23 revealed alteration in respiratory status risk for shortness of breath. Interventions include administer oxygen as needed and observe for changes in level of consciousness, restlessness, confusion and, anxiety, somnolence, apprehension and lethargy. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the discontinued physician's orders for Residents #55 revealed an order dated 06/20/23 and a discontinued on 08/07/23 for Ativan 0.5 milligrams (mg) every six hours as needed for shortness of breath. Review of the active physician orders for the month of April 2024 for Resident #55 revealed an order dated 12/02/23 for Ativan 0.5 milligrams (mg) every six hours as needed for anxiety. Interview on 04/25/24 at 4:54 P.M. with the DON verified Resident #55's as needed Ativan order was not written with a 14 day stop date and no re-evaluation was conducted for the continued use of the antianxiety medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on record review, observations, resident and staff interviews and policy review, the facility failed to ensure medications were properly stored. This affected two (#24 and #63) out of 83 residents in the facility. The facility census was 83. Findings include: 1. Review of Resident #24's chart revealed the resident was admitted to the facility on [DATE] with diagnoses including congestive heart failure, abnormal posture, localized edema, hyperlipidemia, hypertension, anxiety disorder and calculus of kidney. Review of Resident #24's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident to be cognitively intact and Resident #24 required set up assistance with eating. Resident #24 required supervision with oral hygiene, and Resident #24 was dependent with toileting hygiene, showering, lower body dressing, putting on and taking off footwear, personal hygiene, chair transfers, toilet transfers, and tub transfers. Resident #24 required maximal assistance with upper body dressing, sitting to lying, and lying to sitting, and moderate assistance with rolling left and right. Review of Resident #24's physician orders dated 04/22/24 revealed no orders indicating Resident #24 could store or administer her own medications. Review of Resident #24's nursing assessments from 10/05/21 to 04/22/24 revealed no nursing assessments were completed indicating Resident #24 could store or administer her own medications. Observation of Resident #24's room on 04/22/24 at 10:27 A.M. revealed Resident #24 was lying in bed with her bedside table in front of her. Resident #24 had three pills in a medication cup in front of her on her bedside table. Interview with Registered Nurse (RN) #112 on 04/22/24 at 10:27 A.M. verified Resident #24 had two collagen vitamin c oral tablet 1000-10 milligrams (mg) and one docusate sodium oral capsule 50 milligrams (mg) pills in a medication cup at bedside. Interview with the Director of Nursing (DON) on 04/25/24 at 7:38 A.M. verified Resident #24 was not assessed to be able to store or administer her own medications and Resident #24 did not have an order to store or administer her own medications. Review of the facility's administering medications policy dated April 2019 revealed residents may self administer their own medications only if the attending physician in conjunction with the interdisciplinary care planning team has determined that they have the decision making capacity to do so safely. 39702 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #63 revealed an admitted [DATE] with diagnoses including but not limited to hypertensive urgency, urinary retention, anxiety, depression, and hypertension. Review of the quarterly MDS assessment dated [DATE] for Resident #63 revealed the resident had impaired cognition. Resident #63 required maximal assistance for bed mobility, toileting, and transfers. Resident #63 is independent for eating. Review of the active physicians' orders for Resident #63 revealed orders for Norvasc oral tablet 2.5 milligrams (mg) give 2.5 mg by mouth one time a day for hypertension take 1 tab by mouth daily. Hold for systolic blood pressure less than (<) 120 dated 10/1/2023, Apixaban oral tablet 5 mg-give 5 mg by mouth two times a day dated 11/4/2023, Lidocaine External Patch 4 % apply to right shoulder topically one time a day for pain Remove after 12 hours dated 01/12/24, Tamsulosin HCl Oral Capsule 0.4 mg-give 1 capsule by mouth one time a day dated 10/01/23, Ativan tablet 1 mg-give 1 tablet by mouth two times a day dated 12/02/23, trazodone oral tablet 50 mg-give 50 mg by mouth at bedtime for depression dated 04/26/24, Omeprazole oral tablet delayed release 20 mg-give 2 tablets by mouth one time a day for gastroesophageal disease dated 10/01/23, Remeron oral tablet give 7.5 mg by mouth at bedtime for depression dated 10/02/23, acetaminophen oral tablet 325 mg-give 2 tablet by mouth every six hours for pain dated 09/30/23, polyethylene glycol 3350 oral powder 17 grams-give 17 gram by mouth one time a day for constipation dated 10/01/23, and Senokot S oral tablet 8.6-50 mg-give 1 tablet by mouth two times a day for constipation dated 09/30/2023. Further reveal of physician's orders were silent for any medications to be left in the room with the resident. Review of the assessment tab in the electronic record for Resident #63 was silent for any assessment related to self-administration. Observation on 04/24/24 at 9:41 A.M. of medication administration with Licensed Practical Nurse (LPN) #30 revealed medications were at Resident #63's bedside which included two bottles of opened Balance of Nature dietary supplements (one fruit and one Veggies), a opened bottle of nystatin powder dated 08/17/23 and a medication administration cup with approximately 15 cubic centimeters (cc) of clear colored ointment. Interview on 04/24/24 at 9:44 A.M. with Resident #63 stated that her sister brought the bottles of veggies and fruit in for her to take, the bottle of nystatin was brought in with her from the hospital on admission and she uses it under her breasts every couple of days. Additionally, Resident #63 stated the ointment was given to her by a facility nurse a few days ago for a cold sore on the inside of her nose. Interview on 04/24/24 at 9:50 A.M. with LPN #30 verified Resident #63 did not have orders for any of the items on her bedside tablet (Balance of Nature dietary supplements, nystatin powder or triple antibiotic ointment). LPN #30 verified the items should not be at the bedside without an order and would let the unit manager now. Interview on 04/25/24 at 10:30 A.M. with Unit Manager Registered Nurse (UM RN) #47 verified the items should not have been left in the residents room. UM RN #47 further stated Resident #63 does not have orders for the medications observed at the residents bedside and the resident cannot self-administer any medication. (continued on next page)

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	365088	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Englewood Health and Rehab	425 Lauricella Court Englewood, OH 45322

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Administering Medication dated 04/2019, stated only persons licensed or permitted by this stat to prepare, administer and document the administration of medication may do so.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on observation, staff interviews and policy review, the facility failed to ensure an ice machine was maintained in a sanitary manner and food items were stored in a manner to prevent potential foodborne illness. This had the potential to affect 81 out of 83 residents residing in the facility who receive their food/meals from the kitchen, the facility identified two residents (#68 and #71) that receive no food by mouth. The facility census was 83. Findings include: Observation of the facility's kitchen on [DATE] at 8:15 A.M. revealed there were two expired loafs of wheat bread on the bread rack that were dated [DATE] and one expired loaf of bread on the bread rack dated [DATE]. Further observation of the facility's kitchen revealed there was white colored build up in interior the crevasses and on the ledge of the ice machine that were in contact with the ice. Interview on [DATE] at 8:15 A.M. with Dietary Manager #61 verified there were two expired loafs of wheat bread on the bread rack that were dated [DATE], one expired loaf of bread on the bread rack dated [DATE] and white colored build up in interior the crevasses and on the ledge of the ice machine that were in contact with the ice. Interview with the Administrator on [DATE] at 11:40 A.M. revealed the facility did not have a policy on food storage, expired food, or maintenance of kitchen equipment. The facility confirmed 81 out of 83 residents receive food/meals from the kitchen and there are two residents (#68 and #71) that do not receive food/meals by mouth. Observation of the dogwood unit nutritional refrigerator on [DATE] at 7:28 A.M. revealed there were two open bottles of water that were not labeled or dated, two boxes of pizza that were not labeled or dated, a covered salad that was not dated, an expired yogurt cup with an expiration date of [DATE], an expired container of french dip with an expiration date of [DATE], a one third full coffee cup with the drinking spout exposed that was not labeled or dated, a opened and updated stick of butter with pieces of the butter exposed that contained red color dots, an expired salad dated [DATE] that was brown in color, a container of pineapple that was unlabeled and undated, and two bags of restaurant left overs that were unlabeled and undated. Interview with Licensed Practical Nurse (LPN) #92 on [DATE] at 7:28 A.M. verified there were two open bottles of water that were not labeled or dated, two boxes of pizza that were not labeled or dated, a covered salad that was not dated, an expired yogurt cup with an expiration date of [DATE], an expired container of french dip with an expiration date of [DATE], a one third full coffee cup with the drinking spout exposed that was not labeled or dated, a opened and updated stick of butter with pieces of the butter exposed that contained red color dots, an expired salad dated [DATE] that was brown in color, a container of pineapple that was unlabeled and undated, and two bags of restaurant left overs that were unlabeled and undated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's food brought in by family and visitors policy dated [DATE] revealed food brought in by family and visitors that is left with the resident to consume later will be labeled and stored in a manner that is clearly distinguishable from facility prepared food. The nursing staff will discard perishable food within three to five days.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on medical record review, staff and hospice staff interviews and policy review, the facility failed to collaborate with hospice in the development of a comprehensive plan of care. This affected one (#55) of one reviewed for hospice services. The facility census is 83. Findings include Medical record review for Resident #55 revealed the resident was admitted to the facility on [DATE] with diagnosis that include but not limited to dementia, apraxia, attention and concentration deficit, adult failure to thrive, altered mental status, depression, dehydration, pseudobulbar, malnutrition. Review of the significant modification of Minimum Data Set (MDS) assessment dated [DATE] for Resident #59 revealed resident was admitted into the hospice program. Review of the recertification of hospice plan of care revealed the resident admitted to hospice on 6/19/23. Review of the most recent quarterly assessment dated [DATE] for resident #55 revealed an impaired cognition. Resident had no behaviors. No impairments. Resident # 55 was dependent on staff for all care eating, transfers, bed mobility, and toileting. Resident #55 was coded as receiving hospice services. Review of the hospice plan of care for Resident #55 dated 04/22/24 revealed resident will have the following provider visits beginning 04/12/24. Skilled nursing visits one to two visits every week for nine weeks, three visits as needed for changes in mental status, pain or loss of appetite, State tested Nursing Assistant (STNA) three times a week for nine weeks, chaplain visits three visits as needed, and one to two times a month for two months. Review of the facility plan of care for Resident #55 was silent for any hospice visits, number of visits to be made and what services the hospice staff would be providing. Interview on 04/25/24 at 10:16 A.M. with Hospice Registered Nurse (RN) #601 verified she was the primary nurse for Resident #55 and did not have any meeting with the facility regarding the development of a collaborated plan of care. Interview on 05/01/24 at 10:01 A.M. with MDS RN #13 stated there was no care plan meeting or care conferences between hospice staff and facility staff to collaborate and develop the plan of care for Resident #55. RN #13 verified the services on the hospice plan of care were not on the facility plan of care and should have been. Review of the facility policy titled Hospice Program, dated 07/2017 stated under Number 12 states the facility has a designated staff member who will collaborate with hospice representatives for the care planning process.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on medical record review, observations and staff interviews, the facility failed to ensure resident medications were handled in a sanitary manner during medication administration pass. This affected two (#70 and #63) out of six residents observed for medication administration. The facility census was 83. Findings include: 1. Review of the medical record for Resident #70 revealed an admitted [DATE] with diagnoses including but not limited to type two diabetes, hypertensive urgency, heart disease and anemia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #70 revealed the resident had impaired cognition. Resident #19 required maximal assistance for bed mobility, toileting, and transfers. Resident #19 is independent for eating. Review of the active physicians orders for Resident #70 revealed orders for Levothyroxine Sodium oral tablet 50 micrograms (mcg)- give 1 tablet by mouth in the morning for hypothyroidism dated 02/14/2023, Imodium A-D oral tablet 2 milligrams (mg)-give 1 tablet by mouth two times a day for loose stools hold for constipation dated 3/29/2024 and Sertraline oral tablet 50 mg give 1 tablet by mouth one time a day for anxiety/depression dated 03/21/2023. Observation on 04/24/24 at 5:35 A.M. of medication administration with Registered Nurse (RN) #91 revealed the nurse did not perform hand hygiene or clean the top of the medication cart surface before removing Resident #70's medication from the medication cart which included Levothyroxine Sodium oral tablet 50 mcg, Imodium A-D oral tablet 2 mg and Sertraline oral tablet 50 mg. RN #91 touched the medication cart keys, medication cart drawers, and touched the individual medication boxes for each medication. RN #91 pushed the Imodium out of a blister pack onto the medication cart top surface. RN #91 picked up the pill with her bare hands and placed the pill into the medication administration cup with the other opened medications. RN #91 then administered medication to Resident #70. Interview on 04/24/24 at 5:40 A.M. with RN #91 confirmed she picked up Resident #70's pill when it spilled onto the medication cart top surface using her bare hands and placed it into the medication cup with the other opened medication and carried them into the room for administration to the resident. RN #91 verified there was not a bottle of hand sanitizer on the medication cart at the time of the observation. 2. Review of the medical record for Resident #63 revealed an admitted [DATE] with diagnoses including but not limited to hypertensive urgency, urinary retention, anxiety, depression and hypertension. Review of the quarterly MDS assessment dated [DATE] for Resident #63 revealed the resident had an impaired cognition. Resident #63 required maximal assistance for bed mobility, toileting, and transfers. Resident #63 is independent for eating. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the active physicians orders for Resident #63 revealed orders for Norvasc oral tablet 2.5 mg-give 2.5 mg by mouth one time a day for hypertension, hold for systolic blood pressure less than (<) 120, dated 10/01/23; Apixaban oral tablet 5 mg-give 5 mg by mouth two times a day dated 11/04/23; Lidocaine External Patch 4% apply to right shoulder topically one time a day for pain, remove after 12 hours dated 01/12/24; Tamsulosin HCl Oral Capsule 0.4 mg-give 1 capsule by mouth one time a day dated 10/01/23; and Ativan tablet 1 mg-give 1 tablet by mouth two times a day dated 12/2/23. Observation on 04/24/24 at 9:41 A.M. of medication administration with Licensed Practical Nurse (LPN) #30 revealed nurse did not clean the top of the medication cart prior to initiation of medication administration for Resident #63. LPN #30 cut open the package containing the lidocaine patch and placed the item on the medication cart. LPN #30 then handled the medication cart keys and placed the keys on the medication cart surface. LPN #30 pushed Norvasc tablet from the bubble pack onto the medication cart surface missing the medication administration cup. LPN #30 then used two spoons to pick up the Norvasc and place it into the medication administration cup. LPN #30 then administered the medication to Resident #63. Interview on 04/24/24 at 9:50 A.M. with LPN #30 verified she dropped the Norvasc tablet unto the uncleaned medication cart surface and then proceeded to administer the medication to Resident #63 and should have disposed the medication instead of providing it to the resident. Interview on 04/24/24 at 4:09 P.M. with Director of Nursing (DON) verified the facility staff are not to touch the medication with their bare hands or administer medication that have been dropped onto the medication cart surface.