STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365185	A. Building B. Wing	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Center Healthcare and Rehabilitation	5665 South Ave Youngstown, OH 44512

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation, interview, record review and review of facility policy, the facility did not ensure all residents were treated with a dignified dining experience due to serving meal trays without providing knives to cut food and apply condiments to their foods. This affected all 64 residents receiving meals from the kitchen excluding two residents the facility identified as receiving pureed diets (Resident #8 and #85) and 24 residents (#6, #7, #10, #15, #30, #33, #34, #37, #39, #40, #41, #45, #53, #55, #59, #64, #68, #70, #72, #75, #78, #80, #86, and #89) who resided on the secured behavior unit where knives were not provided at meal times for safety. The facility also did not ensure Resident #45 had a privacy curtain. This affected one resident (#45) of 92 residents reviewed for privacy curtains. The facility census was 92. Findings include: 1. Observation of the tray line on 04/16/24 at 12:10 P.M. revealed a Hawaiian ham slice, four ounces of red skin potatoes, four ounces of carrots, a dinner roll and four ounces of banana pudding were being served for lunch. All 92 meal trays had a fork and a spoon but no knife. Interview on 04/16/24 at 12:37 P.M. with Food Service Director (FSD) #499 confirmed knives should have been placed on the meal trays, and it would be difficult to cut a ham slice without a knife. FSD #499 stated the facility had an adequate supply of knives. Observation on 04/16/24 at 12:47 P.M. of Resident #17 eating lunch at the bedside revealed there was no knife on the tray, so the resident had picked up the ham slice with their hands to eat it. Observation on 04/16/24 at 12:48 P.M. of State tested Nursing Assistant (STNA) #416 asking FSD #499 for knives, because she couldn't cut the ham without a knife. Interview at the time of observation with STNA #416 confirmed there were usually no knives on the meal trays. Interviews were conducted on 04/17/24 from 10:04 A.M. through 10:42 A.M. with Residents #1, #4, #22, #29 and #54 at the resident council meeting. The residents were alert and oriented to person, place, time, and situation. Residents revealed they were never given a knife at mealtime, only a spoon and fork, so they could not cut their foods. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 04/18/24 at 9:45 A.M. with Registered Dietitian (RD) #503 revealed she had seen missing knives on the residents' meal trays and sent emails to the administrator, Director of Nursing, unit managers and she had told FSD #499 about the missing knives. RD #503 stated the speech therapist has told her the facility was still not putting knives on the residents' trays. Review of facility policy Resident Rights, revised August 2009, revealed our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity. 49774 2 .Record review revealed Resident #45 was admitted to facility on 04/29/21 with diagnoses including occlusion and stenosis of bilateral carotid arteries, ischemic cardiomyopathy, type two diabetes, major depressive disorder, recurrent severe without psychotic features, chronic obstructive pulmonary disease, unspecified dementia, unspecified severity with other behavioral disturbance, and post-traumatic stress disorder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #45 had moderate cognitive impairment. Resident #45 was independent with eating, required supervision or touching assistance for oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing and personal hygiene, and required partial to moderate assistance for putting on and taking off footwear. Resident #45 was always continent of bowel and occasionally incontinent of urine. Observation on 04/18/24 at 8:25 A.M. revealed Resident #45's bed was the first bed observed upon entering the room which was shared with another resident. Resident #45's bed was approximately six feet from the bathroom entrance in the room. No privacy curtain was observed separating Resident #45's bed from the entrance to the room or from the entrance to the bathroom. A privacy curtain was observed between Resident #45's bed and his roommate which gave his roommate privacy. Due to the lack of a privacy curtain, Resident #45 was unable to section off his bed and personal space to provide privacy upon entry to the room. Interview on 04/18/24 at 8:26 A.M. with Resident #45 revealed he had been without a privacy curtain since his admission to the facility. Resident #45 reported he previously asked the facility's maintenance man directly if he could have a privacy curtain but was unable to recall when the conversation occurred. Interview on 04/22/24 at 9:19 A.M., with STNA #449 confirmed Resident #45 did not have a privacy curtain. Review of facility work orders from October 2023 to April 2024 revealed no work order was placed for a privacy curtain for Resident #45. Review of facility policy titled Quality of Life - Homelike Environment (2009) revealed the facility staff and management were to maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of facility policy titled Resident Rights (2009) revealed the facility would make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on observation, interview and record review, the facility failed to ensure call lights were within reach for Resident #8 and #67. This affected two residents (#8 and #67) of 32 residents reviewed for call light accessibility. The facility census was 92. Findings include: 1. Review of the medical record for Resident #8 revealed an admitted [DATE]. Diagnoses included muscle wasting, irregular heartbeat, schizophrenia, emphysema and repeated falls. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment date 03/17/24 revealed the resident was rarely or never understood. He required supervision for eating, partial or moderate assistance for oral hygiene and substantial/maximum assistance of toileting, showering and dressing. Review of the care plan dated 01/18/24 revealed the resident was at risk for falls due to impaired balance, involuntary movements, medication side effects and decreased safety awareness. Interventions included minimizing the risk for falls, ensuring the call bell was in reach, having commonly used articles within reach and providing assistance with transfers and ambulation as needed. Observation on 04/15/24 at 11:18 A.M. revealed the resident's call light was hanging from a box to the right upper side of his bed, and not within reach. Interview at the time of the observation with State tested Nurse Aide (STNA) #429 confirmed resident #8's call light was not in reach. 2. Review of the medical record for resident #67 revealed an admitted [DATE]. Diagnoses included diabetes, hypertension, paralysis of left dominant side due to stroke and muscle weakness. Review of the comprehensive MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired. She was independent in eating, required partial to moderate assistance for oral and personal hygiene, substantial or maximum assistance for showering and dependent for toileting. Review of the care plan dated 02/02/24 revealed the resident was at risk for falls due to diabetes, paralysis affecting the left dominant side and an overactive bladder. Interventions included ensuring the call light was reach, changing positions slowly and having commonly used articles within reach. Observation on 04/15/24 at 11:03 A.M. revealed no evidence the call light was within reach for Resident #67. Interview at the time of the observation with Resident #67 confirmed she did not know where her call light was. Interview on 04/15/24 at 11:20 A.M. with STNA #429 confirmed the resident's call light had fallen behind her dresser and the resident was unable to reach it. Review of the facility policy titled Answering the Call Light dated October 2010 revealed call lights would be within easy reach of the resident.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Honor the resident's right to organize and participate in resident/family groups in the facility. 46195 Based on record review and interviews, the facility failed to resolve ongoing food related concerns expressed at resident council. This affected five residents (Resident # #1, #4, #22, #29 and #54) of 92 residents receiving meals from the kitchen. The facility census was 92. Findings Include: Review of Resident Council meeting minutes from 09/28/23 to 03/26/24 revealed on 10/26/23 dietary still unsatisfactory', on 11/28/23 Food Service Director (FSD) #499 had responded to dietary concerns and Resident Council was not satisfied with the response, on 01/18/24 dietary continued to have same issues and the Administrator was always busy, on 02/21/24 dietary continued to have same issues and the administrator still too busy to attend, on 03/26/24 the residents voiced concerns related to not enough food, being tired of peanut butter and jelly sandwiches, and Food Service Director (FSD) #499 was not supportive of the residents concerns related to double portions. The Administrator attended and stated he would follow up with the kitchen issues. Interviews were conducted on 04/17/24 from 10:04 A.M. through 10:42 A.M. with Residents #1, #4, #22, #29 and #54 at the Resident Council meeting. The residents were alert and oriented to person, place, time, and situation. The residents revealed they were served chicken and rice all the time and they did not receive enough food, even when they asked for double portions. Double portions usually consisted of double of only one menu item instead of all items. They were not offered milk at each meal, only at breakfast. If the residents wanted cottage cheese they would have to order it in place of their meal because it was never offered in addition to the meal. They revealed if they did not want what was posted on the menu, they needed to request it an hour before meal service otherwise you might not get the alternate. If they were served the scheduled daily meal and then decided they did not want it, they would tell a nurse, but most often did not get anything else. When asked about preferences, the residents stated they could identify items they did not like, but substitutions were not offered in their place. For example, if you did not like peas and peas were on the menu, you did not get an alternate vegetable. Residents revealed they were never given a knife at meal time, only a spoon and fork. Residents revealed there had been issues with the food at the facility for as long as they could remember. They reported talking about it every month at the Resident Council meeting but nothing ever changed. Interview conducted on 04/17/24 between 10:45 and 10:48 A.M. with Dietary Supervisor #500 confirmed there were times when a resident didn't like a certain item, they would not receive a replacement, and there were times when an alternate meal item request for a grilled cheese was not made. Interview on 04/18/24 at 9:45 A.M. with Registered Dietitian (RD) #503 revealed the main issue at the facility was the quality of food, and it depended on the cook if recipes were followed. She stated the menu could be adjusted, the Spring/Summer menu would start next week, and she hadn't had a chance to look at what meal items were included on the menu. Interview on 04/23/24 at 2:59 P.M. with Director of Nursing (DON)and Senior Administrator #504 revealed the kitchen concerns have been ongoing. The residents were not happy with the menu and were asking for more food activities. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interviews conducted on 04/24/24 between 9:01 A.M. and 9:36 A.M. with the DON revealed she was aware of the food concerns of the residents and the food concerns were discussed during the Quality Assurance Performance Improvement (QAPI) meeting, but the interdisciplinary team really couldn't do much with food concerns, since it was more of an Administrator and FSD #499 issue. The DON stated the facility needed to conduct more checks and balances and more follow-up with concerns.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. 49774 Based on review of resident funds accounts, medical record review and staff interview, the facility failed to ensure resident funds were maintained under the Medicaid limit. This affected one resident (#8) of five residents reviewed for personal funds. The facility census was 92. Findings include: Record review revealed Resident #8 was admitted to facility on 10/05/12 with diagnoses including other secondary Parkinsonism, dysphagia, muscle wasting and atrophy, schizophrenia, anxiety, emphysema, and hypertension. Review of the resident fund account for Resident #8 revealed the facility managed his funds however Resident #8 had a guardian of person and estate. Further review of Resident #8's resident fund account revealed Resident #8 had a balance of $4,253.24 on 09/30/23, a balance of $4,408.45 on 12/31/23, and a balance of $4,565.29 on 03/31/24 in his resident funds account. Interview on 04/22/24 at 3:55 P.M. with Business Office Manager #472 confirmed Resident #8's guardian was not notified that Resident #8 had reached and exceeded the amount limit set by Medicaid.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on medical record review, interview, and facility policy review the facility failed to ensure a resident's wishes regarding end-of-life measures were clearly identified in the medical record. This affected one resident (Residents #196) of three residents reviewed for Advanced Directives. The facility census was 92. Findings include: Review of the medical record for resident #196 revealed an admitted [DATE]. Diagnoses included end stage renal disease, colitis, anxiety and depression. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was cognitively intact. She was independent in eating, oral hygiene and showering and required supervision or touch assistance for dressing and personal hygiene. Review of the physician orders for April 2024 revealed no evidence of a code status. Interview on 04/16/24 at 12:47 P.M. with Licensed Practical Nurse (LPN) #434 revealed code status was listed in the electronic medical record (EMR) next to the resident's photo and allergies. She confirmed the EMR for resident #196 did not have a code status. Review of the facility policy titled Advance Directives dated April 2008 revealed information about advance directives would be displayed prominently in the medical record.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 48565 Based on observation, interview and policy review the facility failed to repair or replace broken window blinds for 14 residents (#11, #17, #24, #36, #42, #43, #46, #49, #54, #56, #60, #62, #71 and #91) and failed to provide an adequately clean room for Resident #16. This affected a total of 15 residents out of 92 residents reviewed for a safe/clean/comfortable environment. The facility census was 92. Findings include: On 04/15/24 at 10:35 A.M. an observation of the room for Resident #16 revealed built-up visible dust on the chair rail going around the room. State tested Nurse Aide (STNA) #415 verified the built-up visible dust on the chair rail at the time of the observation. On 04/17/24 between 10:10 A.M. and 10:55 A.M. an observation of resident rooms for Residents #11, #17, #24, #36, #42, #43, #46, #49, #54, #56, #60, #62, #71 and #91 revealed broken window blinds in need of repair or replacement. The broken window blinds were verified at the time of the observation by STNAs #416 and #426. On 04/18/24 at 10:49 A.M. an interview with. the Director of Environmental Services (DES) #487 revealed resident rooms are cleaned daily and resident rooms deep cleaned monthly and upon discharge. Deep cleanings are scheduled monthly. The facility utilizes a computer program (TELLS) to input work orders for repairs. Nurses will input repairs needed in TELLS system and housekeeping will write repairs needed on a list. DES #487 stated he does not do monthly audits for repairs needed or cleanliness of rooms. DES #487 stated he was aware of broken blinds and did an audit yesterday to see what blinds needed replaced. DES #487 stated several blinds have been replaced over the last three weeks. This surveyor asked for the list of replaced blinds. The list was not provided. A review of the document titled, Park Center Daily Housekeeping Room Checklist that was undated revealed resident rooms are to be dusted daily. A review of the document titled, Room Cleaning Policy, undated, revealed the policy was established to ensure resident rooms within the Skilled Nursing Facility are maintained in a clean, sanitary, and safe condition to promote the health and wellbeing of residents. Under the subtitle Frequency of Cleaning it is stated resident rooms will be cleaned on a regular basis according to a predetermined schedule and high touch surfaces will be cleaned and disinfected daily. Under the subtitle Cleaning Procedures it is stated the facility will follow established cleaning procedures and protocols to ensure thorough and effective cleaning of resident rooms. A review of the policy titled, Quality of Life-Homelike Environment, dated August 2009, revealed residents are provided with a safe, clean, comfortable, and homelike environment. The policy also stated the facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47568 Based on record review, interview, review of a Self-Reported Incident (SRI) and facility policy review the facility failed to thoroughly investigate potential resident to resident abuse as required. This affected two residents (#33 and #346) of three residents reviewed for abuse. The facility census was 92. Findings include: 1. Review of the medical record for Resident #33 revealed an admitted [DATE]. Medical diagnoses included Alzheimer's disease, bipolar disorder, schizoaffective disorder bipolar, major depressive disorder, generalized communication deficit, and unspecified mood disorder. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #33 was severely cognitively impaired, had delusions and was observed to have physical behavioral symptoms. Review of Resident #33's care plan dated 02/20/23 revealed the resident was independent with ambulation and transfers. Review of a Body Audit dated 04/10/24 revealed Resident #33 was found to have a new left hand skin tear. 2. Review of medical record for Resident #346 revealed an admitted [DATE] and a discharge date of [DATE]. Medical diagnoses included unspecified dementia with other behavioral disturbance, other psychoactive substance abuse, ventral hernia without obstruction or gangrene, type two diabetes mellitus, unspecified asthma, radiculopathy cervical region, benign and innocent cardiac murmurs, essential primary hypertension and insomnia. Review of Medicare 5-Day MDS 3.0 assessment dated [DATE] revealed Resident #346 was severely cognitively impaired, had delusions and was observed to show physical behavioral symptoms directed towards others as well as not directed toward others and verbal behavioral symptoms directed towards others. Resident #346 showed the behavior of wandering. Review of Resident #346 care plan dated 04/04/24 revealed the resident was at risk for behavior symptoms and was known to become verbally aggressive toward staff related to diagnosis of dementia with behavioral disturbance. Resident #346 was known to show exit seeking behavior, throw objects at staff and wander into other resident rooms. Resident #346 was not easily redirected. Review of a Body Audit dated 04/10/24 revealed Resident #346 refused skin to be observed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility SRI dated 04/10/24 revealed an allegation of physical abuse was made when Resident #346 wandered into Resident #33's room looking and touching Resident #33's belongings. Resident #33 attempted to stop Resident #346 and leave his room and contact was made which resulted in a couple minor scratches and skin tear to Resident #33's hand. Residents were separated, skin assessments were completed on both residents, resident representatives and Nurse Practitioner were notified and staff were to monitor to ensure residents were kept at distance from one another. Further review of the SRI revealed as a result of the investigation interviews were completed on all parties present and involved in the incident, residents were assessed and treated, Psych Services Nurse Practitioner and Psych Counselor were consulted for further assessment and medication adjustment. Resident #346 was sent to the hospital for medication adjustment. Facility to consider a room change to create more distance between the two residents involved. Facility unsubstantiated allegation of physical abuse due to the evidence found indicated abuse did not occur. Further review of facility SRI documentation revealed facility staff who worked the unit on the day of the incident were interviewed regarding Resident #346 and Resident #33. SRI documentation did not show any evidence that there were interviews completed on like residents who could have potentially been affected by unwitnessed behavior or skin assessments on residents who were not able to provide meaningful information due to their cognitive status. There was no evidence facility staff were educated on abuse or the facility abuse policy after completion of investigation. Interview on 04/22/24 at 2:45 P.M. with the Director of Nursing (DON) stated that SRI regarding allegation of physical abuse between Resident #346 and Resident #33 was unsubstantiated due to no evidence actual willful intent of physical abuse took place. The DON stated as part of the investigation she had interviewed those who worked the unit the day of the allegation. The DON stated no interviews or skin assessments were completed on other residents who resided on the unit and no staff education was completed regarding abuse since October 2023. Review of facility untitled and undated policy regarding abuse revealed the Administrator or DON was responsive to receive and investigate all alleged violations of abuse timely, thoroughly and objectively.

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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** 45441 Based on observation, record review and interview, the facility failed to ensure resident assessments accurately reflected the dental status for Resident #28 and #196. This affected two residents (Residents #28 and #196) of 32 residents reviewed for accurate resident assessments. The facility census was 92. Findings include: 1. Review of the medical record for resident #28 revealed an admitted [DATE]. Diagnoses included muscle weakness, dysphagia, neuropathy and need for assistance with personal care. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was moderately cognitively impaired. He required set up or clean up assistance for eating and oral hygiene, partial or moderate assistance for personal hygiene and substantial or maximum assistance for toileting, showering and dressing. He had no broken or missing teeth. Review of the care plan dated 04/04/24 revealed the resident had an oral health problem related to carious (cavities or decaying) teeth. Interventions included administering medications as ordered, assisting with oral hygiene and reporting changes in oral status and chewing as needed. Observation and interview on 04/17/24 at 9:22 A.M. with resident #28 revealed the resident did have some of his natural teeth, but he was missing some of them. He denied any issues with chewing or swallowing. Interview on 04/17/24 at 3:00 P.M. with Licensed Practical Nurse (LPN) #451 confirmed resident #28's MDS assessment did not accurately reflect his dental status. 2. Review of the medical record for resident #196 revealed an admitted [DATE]. Diagnoses included end stage renal disease, colitis, anxiety and depression. Review of the comprehensive MDS 3.0 assessment dated [DATE] revealed the resident was cognitively intact. She was independent in eating, oral hygiene and showering and required supervision or touch assistance for dressing and personal hygiene. She had no problems eating, drinking or swallowing and had no broken or missing teeth. Review of the care plan dated 04/08/24 revealed the resident had no natural teeth and did not wear her dentures. Interventions included administering medications as ordered, assisting with oral hygiene as needed, referring to the dentist for evaluation as needed and reporting changes in oral cavity and chewing as needed. Observation and interview on 04/17/24 at 9:25 A.M. with resident #196 revealed she did not have her own natural teeth. The resident stated she did have dentures, but chose not to wear them. She denied problems with chewing or swallowing. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/17/24 at 3:00 P.M. with LPN #451 confirmed resident #196's MDS assessment did not accurately reflect her dental status. Review of the facility policy titled Charting and Documentation undated, revealed charting would be complete and accurate, reflecting treatment and response to care as well as progress.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on record review and interview, the facility failed to ensure care plans were updated to accurately reflect resident's needs. This affected three residents (residents #31, #50, and #71) of 32 residents reviewed for care plans. The facility census was 92. Findings include: 1. Review of the medical record for resident #31 revealed an admitted [DATE]. Diagnoses included acute kidney failure, hypothyroidism, diabetes, dementia and cognitive communication deficit. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was moderately cognitively impaired. He was independent with eating and required supervision for oral care, showering and personal hygiene. He had no behaviors and was not on an antipsychotic or antidepressant. Review of the physician's orders for April 2024 revealed an order for Olanzapine (Zyprexa), an antipsychotic medication, 5 milligrams (mg) one tablet by mouth (po) once per day (QD) for an antipsychotic. The order began on 01/23/24. There was also an order for Namenda, used to treat dementia, 5 mg po two times per day (BID) with no indication for its use. The order began 01/24/24. Review of the care plan dated 02/08/24 revealed no evidence of interventions for psychosis or dementia. 2. Review of the medical record for resident #71 revealed an admitted [DATE]. Diagnoses included dementia, bipolar disorder, depression, insomnia and heart failure. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed the resident was severely cognitively impaired. She was independent in eating and toileting and required supervision or oral hygiene, showering and personal hygiene. Review of the physician's orders for April 2024 revealed an order for an Exelon patch, used to treat dementia, transdermal (applied to the skin) one patch at bedtime (QHS) for unspecified dementia. The order began on 03/14/24. There was also an order for Namenda 5 mg PO BID for dementia, which began on 03/22/24. Review of the care plan dated 03/07/24 revealed no evidence dementia had been addressed. Interview on 04/17/24 at 3:00 P.M. with LPN #451 confirmed there was no evidence dementia care had been addressed in resident #71's care plan and there was no evidence psychosis or dementia care were addressed in resident #31's care plan. 46195 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical record for Resident #50 revealed an admitted [DATE]. Diagnoses included pneumonia, acute kidney failure, depression, anxiety disorder, type two diabetes mellitus without complications, dysphagia (difficulty swallowing), essential hypertension (high blood pressure), and personal history of transient ischemic attack (TIA) and cerebral infarction (stroke) without resident deficits. Review of Resident #50's physician orders revealed an order written 03/29/24 for a consistent carbohydrate diet (CCHO)/no added salt (NAS) diet, mechanically altered ground texture, thin liquid consistency. Review of the most recent MDS 3.0 ssessment dated 03/11/24 revealed Resident #50 was severely impaired cognitively, required supervision or touch assistance for eating, and was on a mechanically altered diet. Resident #50 would hold food in mouth, cough when eating, complain of difficulty or pain when swallowing and had no significant weight change. Review of Resident #50's weights from 03/07/24 to 03/30/24 revealed a weight of 156 pounds on 03/07/24, a weight of 150.2 pounds on 03/25/24, and a weight of 145.0 pounds on 03/30/24 which reflected a significant weight loss of 11 pounds, or seven percent, between 03/07/24 and 03/30/24. Further review of Resident's #50's medical record revealed a dietary note, dated 04/04/24 and authored by Dietitian #503, indicated Resident #50 had a significant weight loss over five percent in thirty days. Review of care plan created on 03/14/24 revealed Resident #50 had a nutritional problem or potential nutritional problem related to nutrition, hydration, poly pharmacy, depression, type two diabetes, and mechanically altered diet. There was no indication of the resident having had a significant weight loss. Interview on 04/18/24 at 9:26 A.M. with Dietitian #503 confirmed Resident #50's care plan hadn't been updated to reflect Resident #50's significant weight loss. Review of the facility policy titled Goals and Objectives Care Plans dated October 2009 revealed care plan goals were derived from information contained in the resident's comprehensive assessment would be measurable, contain timetables to meet the resident's needs in accordance with the comprehensive assessment and goals and objectives would be entered on the resident's care plan so that all disciplines had access to information and were able to report whether or not the desired outcomes were being achieved. Goals and objectives were reviewed and revised quarterly. Review of the facility policy titled Charting and Documentation undated, revealed care plans would reflect the effectiveness of interventions and the status of goals.

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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** 45441 Based on observation, interview and record review, the facility failed to ensure showers and nail care were provided consistently and according to resident preference. This affected two residents (resident #28 and #50) of five reviewed for assistance with daily living (ADL)'s. The facility census was 92. Findings include: 1. Review of the medical record for resident #28 revealed an admitted [DATE]. Diagnoses included muscle weakness, dysphagia, neuropathy and need for assistance with personal care. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was moderately cognitively impaired. He required set up or clean up assistance for eating and oral hygiene, partial or moderate assistance for personal hygiene and substantial or maximum assistance for toileting, showering and dressing. It was very important for him to choose between a tub bath, shower, bed bath or sponge bath. Review of the physician's orders for April 2024 revealed the resident preferred to have a shower or bath on Wednesday and Saturday. Refusals would be documented. Interview on 04/16/24 at 7:29 A.M. with resident #28 revealed he was supposed to get a shower twice a week because he prefered showers, but did not always get one as prefered. Observation at the time of the interview revealed the resident appeared fairly groomed with no apparent odor or neglect of ADLs. Review of the shower sheets dated 01/03/24 through 03/27/24 revealed the resident received a shower on 01/03/24, 01/21/24, 01/27/24, 02/08/24, 02/24/24 and 03/19/24. He received a bed bath on 03/01/24 and 03/23/24. Of the 14 shower sheets reviewed, six did not indicate what type of hygiene was provided. No refusals were documented. Review of the nursing progress notes dated 01/03/24 through 04/09/24 revealed no evidence the resident received or refused a shower, bed bath or sponge bath. Interview on 04/17/24 at 3:00 P.M. with Licensed Practical Nurse (LPN) #451 confirmed showers and refusals were not documented consistently for resident #28. She could provide no further evidence the resident received a shower based on his preference and physician's order. 46195 2. Review of the medical record for Resident #50 revealed an admitted [DATE]. Diagnoses included pneumonia, acute kidney failure, depression, anxiety disorder, type two diabetes, muscle weakness, and need for assistance with personal care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent Minimum Data Set (MDS) 3.0 assessment, dated 03/11/24, revealed Resident #50 was severely impaired cognitively. He required partial/moderate assistance from staff for oral hygiene; substantial/maximal assistance from staff to shower/bathe self and with personal hygiene; and was dependent on staff for toileting hygiene. He had not rejected any evaluations or care. Review of care plan, created on 03/11/24, revealed Resident #50 had a self-care deficit related to pneumonia, type two diabetes mellitus, generalized muscle weakness, and history of a cerebrovascular accident (stroke) without residual effects. Interventions included assisting with daily hygiene, grooming, dressing, oral care and eating as needed. Interview on 04/15/24 at 1:17 P.M. with Resident #50 revealed he wanted his fingernails cut and was unsure when they were last cut. Observation at the time of the interview revealed the resident's fingernails were grown out approximately one quarter to one-half inch past the end of his fingers with a brown substance beneath right thumb nail and right middle fingernail. Interview on 04/15/24 at 1:20 P.M. with LPN #442 confirmed Resident #50's nails were long and dirty. Interview on 04/17/24 at 1:50 P.M. with Resident #50 revealed his nails still hadn't been trimmed and he still wanted them cut. Observation of Resident #50's nails at the time of interview revealed nails continue to be long and brown substance remains beneath some of the nails. Interview on 04/17/24 at 1:52 P.M. with State tested Nursing Assistant (STNA) #421 confirmed Resident #50's nails were long and there was a brown substance under his nails. She stated nails were to be trimmed during showers, but if the resident was a diabetic, the nurse had to cut the nails. Review of facility policy Activities of Daily Living (ADLs), Supporting, revised March 2018, revealed appropriate care and services will be provided for residents will be provided for residents who are unable to carry out ADLs independently including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care).

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565 Based on observation, interview, and record review the facility did not ensure all residents were provided therapeutic activities as scheduled and in the evenings to meet their needs and preferences. This affected all 92 residents residing in the facility. The facility census was 92. Findings include: Record review of the facility activity calendar dated November 2023 revealed coffee social took place every day at 10:00 A.M., one-to-one visits every day and there were no activities scheduled after 2:30 P.M. except one day on 11/24/23 there was black Friday bingo at 3:00 P.M. There were no religious services scheduled for the month. There was no activity calendar specific to the residents residing on the secured behavior unit (unit 3A). Record review of the facility activity calendar dated December 2023 revealed the latest activity was scheduled at 4:00 P.M. on 12/13/23 and on the weekends the last activity, coffee social, was scheduled at 10:00 A.M. with activity packets also indicated on Saturdays. No religious services were scheduled for the entire month. There was no activity calendar specific to the residents residing on the secured behavior unit (unit 3A). Record review of the facility activity calendar dated January 2024 revealed one-to-one visits and coffee social would be provided daily, on Saturdays was coffee social and activity packets, Sundays was coffee social except for Sunday 01/21/24 wild uno was on the calendar but crossed off. There were no activities scheduled after 2:30 P.M. except for six days there was a 5:30 P.M. activity listed on the calendar. There was no activity calendar specific to the residents residing on the secured behavior unit (unit 3A). Record review of the facility activity calendar for February 2024 revealed there were no scheduled activities on the weekends except for coffee social from 10:00 A.M. to 11:00 A.M. and activity packets and one-to-one visits. Monday through Friday during this month there were no activities scheduled after 4:00 P.M. except for late bingo at 5:00 P.M. on 02/23/24. There was a trip to Walmart on 02/08/24 which was circled in ink and did not go written next to it. There was one weekend activity on Sunday 02/11/24 other than resident coffee social and one-on-one visits. There were no religious services scheduled for the month of February. There was no activity calendar specific to the residents residing on the secured behavior unit (unit 3A). Record review of the facility activity calendar for March 2024 revealed no activities were scheduled after 4:00 P.M. and the weekend activities consisted of only one-to-one visits with no other times listed for scheduled activities. An activity listed as Fun with [NAME] was scheduled for every Sunday., however, there was no time or description on the calendar for the activity. There were no religious services scheduled for the month of March. There was no activity calendar specific to the residents residing on the secured behavior unit (unit 3A). (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Record review of the facility activity calendar for April 2024 revealed there were no activities scheduled after 4:00 P.M., and on weekends there were no activities scheduled after 1:00 P.M. There was a shopping trip scheduled for 04/04/24 but it was canceled. Activity packets were to be handed out on Saturday 04/06/24. There were no religious services scheduled for this month. A review of the document titled Facility Assessment Tool updated on 02/21/24 revealed on page four the facility will provide opportunities for social activities/life enrichment (individual, small group, community). On page eight under the subtitle services the document stated religious, exercise, recreational music and activities would be provided. Record review of the activity packets for the residents revealed the packets consisted of adult coloring pages, sudoku and word find puzzles which would not be appropriate for all residents in the facility. Some of the word find puzzles were written in very small font and would be difficult to read if visually impaired. A record review was conducted of the facility meal delivery schedules as it related to activity times on the calendar. This review revealed the 4:00 P.M. activity schedule conflicted with the dinner meal which occurred between 4:00 P.M. and 5:00 P.M. A review of the facility Activity Attendance books for April 2024 revealed 39 (#6, #8, #10, #12, #13, #15, #17, #20, #21, #24, #25, #27, #31, #32, #34, #36, #38, #44, #46, #47, #48, #50, #51, #52, #56, #60, #61, #63, #65, #67, #69, #74, #78, #81, #82, #83, #84, #88 and #195) residents had no activity attendance documented. A review of the facility One on One attendance book for April revealed 50 (#7,#8, #9, #10, #13, #15, #16, #17, #21, #27, #31, #32, #33, #34, #35, #36, #37, #38, #40, #44, #45, #46, #47, #48, #50, #51, #52, #56, #59, #60, #61, #63, #64, #65, #67, #69, #70, #71, #72, #74, #75, #80, #81, #82, #83, #84, #86, #87, #88 and #195) residents had no documented one-on-one room visits. A review of the personnel file for AD #492 revealed a date of hire of 10/07/22 as an activity aide. AD #492 signed the job description for the activity director position on 04/20/23. A certificate from the Activity Directors Network revealed AD #492 completed the course for certification on 03/21/24. A review of the document titled Job Description and Performance Standards, Position Title: Activity Director revealed some of the primary functions and responsibilities of the position are: (1) Plan, schedule, and implement a program of individual and group activities based on residents' schedule. (2) Document all interaction with resident and or family in the assessment, care plan and progress notes as required by federal and state requirements. (3) Plan and implement Reality Orientation programs when appropriate. (4) Plan and implement evening and weekend functions as necessary. (5) Organize and schedule community events related to residents' interests. (6) Plan, schedule and implement room visits and in-room activities for residents unable to leave their rooms. (7) Plan, schedule and implement indoor and outdoor activity programs. (8) Maintain an activity attendance record for each resident. The document also revealed the Activity Director reports to the Administrator of the facility. The document was signed by AD #492 on 04/20/23. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Observations conducted throughout the survey on 04/15/24 from 10:50 A.M. to 11:25 A.M., 04/16/24 3:45 P. M. to 4:00 P.M., 04/17/24 2:30 P.M. to 3:15 P.M. and 04/18/24 10:50 A.M. to 11:25 A.M. revealed residents on the secured behavior unit (unit 3A) were observed sitting in common areas entertaining themselves with watching television and talking with other residents. Several residents were observed walking the hallways with no engagement from staff. Remaining Residents were observed in resident rooms sleeping or talking with their roommates. No activity calendar was observed to be posted on the unit. Residents were observed to be taken off this unit by staff for therapy and smoking breaks during observations. On 04/15/24 at 9:16 A.M. an interview with resident #196 revealed there were no activities held at the facility that she enjoyed. Resident #196 revealed the facility would only do things they chose to do, and the residents did not get to go on outings. Resident #196 confirmed residents were given papers to complete for activities and she would like to leave the facility on outings. On 04/15/24 at 9:19 A.M. an interview with Resident #83 revealed activities did not come to her room. Resident #83 also stated she would like to go to Bingo, but no one would take her. There was an activity calendar titled December 2023 hanging on the clothing cabinet in her room. State tested Nursing Assistant (STNA) # 416 was present and verified the activity calendar date of December 2023 at the time of the interview. On 04/15/24 at 9:27 A.M. an interview with resident #38 revealed activities are not the same. The activities department often changes or cancels the activities on the calendar or cancels them, so he does not go anymore. On 04/15/24 at 9:50 A.M. an interview with resident #26 confirmed the facility only held activities when they wanted to, the residents received papers to complete as an activity and they did not get to leave the facility to go shopping. On 04/15/24 at 10:21 A.M. an interview with Resident #35 revealed residents did not get to go anywhere or do anything. Resident #35 stated would like to go shopping at Walmart, but they must give a list of things they need to staff, and they do the shopping for them. Resident #34 said she would also enjoy karaoke, watching square dancers or other shopping outings. On 04/16/24 at 12:13 P.M. an interview with the Activities Director (AD) #492 revealed one of the activities held at the facility included a coffee social. For residents who could not or chose not to come out of their rooms, they would take coffee to them and complete a one-on-one activity such as talking with them. She confirmed she did not ask for input from any of the residents about what activities they would like to see offered, and outings have been cancelled for the past few months because there is no one available to drive the facility van. She confirmed November 2023 was the last outing the residents had attended. On 04/17/24 at 7:56 A.M. an interview with Resident #41 and #53, who resided on the secured unit, revealed they did not have an updated activity calendar and there were no activities on the weekends. Both confirmed the activity staff had not asked them what they like to do for activities. On 04/17/24 at 8:06 A.M. an interview was conducted with Resident #80, who resided on the secured unit, revealed she was not asked to attend activities nor asked to attend resident council to share her thoughts on activities that she would prefer or want to attend. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	On 04/17/24 at 10:10 A.M. an interview with Resident #79 revealed she had never received an activity packet. On 04/17/23 at 10:17 A.M. an interview with Resident #83 revealed she has never received an activity packet. Resident #83 stated she would like that because she likes art. On 04/17/23 at 10:30 A.M. an interview with Resident #47 revealed he had never received an activity packet. On 04/17/24 at 10:35 A.M. an interview with Resident #9 who is alert and oriented to person, place, and time, revealed she has never had a one-on-one visit. Resident #9 stated it would be nice to have a one-on-one visit as she is very limited in her mobility. Resident #9 stated she would not get a visit because, that would be the right thing to do. Resident #9 stated she has never gotten an activity packet. Resident #9 stated there had not been a shopping trip for months. She also stated afternoon activities were scheduled during mealtimes, so no one goes. On 04/17/24 from 10:04 A.M. through 10:42 A.M. a resident council meeting was held with the surveyor with Resident #1, #4, #22, #29 and #54 present for the meeting. The residents were alert and oriented to person, place, time, and situation. The meeting was scheduled during the residents' coffee hour. The residents revealed they had not been provided opportunities to give input into what activities were put on the activity calendar. They identified interests such as painting, shopping, music, and pet therapy. They reported there were no activities in the evenings or on the weekend, particularly on Sundays, so they primarily stayed in their rooms. Resident #22 revealed activities were sometimes cancelled but could not recall ever being told an activity was cancelled, or anything else being done in its place. She also revealed she had talked with AD #492 about wanting to go on outings and was told she does not have a license so she can't take the residents anywhere. There have been no activities or holidays parties as far as any of the residents could remember. Resident #54 revealed the activity department was good about three years ago under the previous Administrator. Since that time activities have been very minimal. On 4/17/24 at 4:17 P.M. an observation revealed there were no residents for the sewing activity that was scheduled for 4:00 P.M. The activity room was empty with no set up for the activity. An interview with AD #492 at the time of the observation revealed there was not an activity happening. AD #492 stated she would only get stuff out if residents came down for activity. This surveyor asked if they ever went and got residents and AD #492 stated sometimes but they know what is going on. When asked about one-on-one activities for alert and oriented residents, AD #492 stated everyone needed one on one time. This surveyor asked why Resident #83 had no documented one-on-one visits. AD #492 stated the resident refuses. This surveyor asked if that was documented anywhere. AD #492 stated no. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	On 04/18/24 08:33 A.M. an interview with STNA #418 and STNA #449 revealed the secured unit (3A) used to have activity calendars in every room plus the dining room, but they do not get them anymore. Both stated that many residents expressed a desire to go to activities and believe the reason they do not have any calendars is, so the residents remain unaware of activities, so they don't ask to attend. STNA #418 stated she expressed her complaints to the DON and administration multiple times about the unit having activities, but no changes have been implemented. STNA #418 stated residents do not receive any one-on-one activities either. STNA #418 also stated even with y'all (state surveyors) here, they still ain't doing nothing STNA #449 Stated that the residents are neglected as far as activities. Stated activities will come at 10:00 A. M. for coffee and take residents to smoke but does not feel those are activities. She expressed being embarrassed on Easter because there were no activities planned for when family visited and stated the entire activity department took Easter off. STNA #449 expressed her disdain that the activity department does not do any activities that involve inviting family to participate. On 04/18/24 at 8:26 AM an observation of hall 3A (locked unit: rooms 301-314) revealed no activity calendars were hanging in the hallways, nurses' station or in the dining room/common area. Observation of resident rooms for Resident #15, #41, #45, #64, #70, #80 and #89 revealed no activity calendars. On 04/18/24 at 1:12 P.M. an interview with the Administrator revealed the facility did have a van which was operational. He thought it held approximately 12 people. He confirmed any licensed driver had the ability to drive the van however, AD #492 had only driven it once and was not comfortable driving it so the residents were not going on any social outings with the activity staff. 04/22/24 at 1:30 P.M. an interview with AD #492 revealed she does not schedule one-on- one visits. AD#492 stated whatever documentation was in the one-on-one visit book is what was done. AD #492 also stated there are no special activities for the secured unit so there was no specific calendar for the residents on that unit. On 04/23/24 at 10:55 A.M. an interview with STNA #419 revealed for the 3A unit (secured unit) they think coffee and donuts was an activity. At one time they were doing bingo up there. Activities may come do an activity on the secured unit when there was a special holiday but really the only activity they got was coffee and donuts four times a week. The other day they took some of the residents out of the unit for an activity but that was very rare. There were really no activities on the secured unit. They used to do more but that has dwindled. STNA #419 stated one of the women in room [ROOM NUMBER] loves bingo, but they will only do bingo with her occasionally. On 04/23/24 at 11:46 A.M. an interview AD #492 revealed usually, a day or two before the end of the month, activities will go and hang up calendars. AD #492 said the activity staff post in rooms and post in the elevator and outside elevator doors. There was a church service last night, but it was impromptu. The person called the day before to see if she could come in. On 04/23/24 at 3:00 P.M. an interview with AD #492 revealed she did not receive any training from the Administrator when she took over the position of activity director. (continued on next page)

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	365185	A. Building B. Wing	04/29/2024

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Park Center Healthcare and Rehabilitation	5665 South Ave Youngstown, OH 44512

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	On 04/23/24 at 3:10 P.M. an interview with Licensed Nursing Home Administrator (LNHA) #504 who was covering the facility for the Administrator revealed AD #492 would have been trained by the Administrator of the facility and the Administrator of the facility should make sure they are trained. AD #492 would have spent time at a sister facility with their activity director. AD #492 spent time at his facility and has called the AD there for her guidance. There is no formal checklist for activity director training. An interview was conducted on 04/25/24 at 9:17 A.M. with AD #492 who verified any 4:00 P.M. activity listed on the activity calendar was scheduled at the same time as the evening meal service which started at 4:00 P. M. AD #492 stated it was trial and error to have an activity at this time. When asked how the residents were going to attend the 4:00 P.M. activity if it was mealtime, AD #492 said usually after they get done eating, they will come down after that, but only a couple people participate at that time. AD #492 explained there was one activity aide in the facility from 9:00 A.M. to 6:00 P.M. on Saturdays and Sundays yet the expectation was that each resident would be provided a one-to-one activity and there was no time to document if it was completed with each resident. AD #492 said the one-to-one activity was passive and was not being done with all the residents like she wanted because the activity staff have their favorites and for those residents who do not participate in group activities the one-to-one would be very important for them. AD #492 stated that for every residents care plan, she had selected that they receive one-to-one activities. AD #492 also stated that every other week there was one activity aide Monday through Friday from 10:00 A.M. to 1:00 P. M. and that person was a runner who would go out to shop for the residents in addition to covering smoke break and coffee social at 10:00 A.M. AD #492 verified the staff does the shopping for the residents instead of the residents going shopping. A review of the policy titled Programming for Residents with Cognitive Impairments and other special needs, dated August 2006, revealed activity programs are provided for the maintenance and enhancement of each resident's quality of life while promoting physical, cognitive and emotional health. The facility will offer meaningful programs for residents with cognitive impairments that use reality and sensory awareness techniques. A review of the policy titled Preparation for Activities dated August 2006 revealed residents requiring assistance to and from scheduled activities will be assisted by the Activity Department, Nursing Services, and facility volunteers. It also revealed the Activity Director is responsible for the scheduling of all activity functions. A list of activities scheduled for the month is posted on the resident bulletin board. Activity schedules are also provided individually to residents who cannot access the bulletin board. Also, within the policy it was stated activities should start on time as stated on the Activities Calendar. If an outside provider delays or cancels a program, an alternate, similar type of program is provided at the same time and place of the canceled event.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47568 Based on record review, observation, interview, and facility policy review the facility failed to ensure Resident #24 who was at risk for elopement was adequately supervised while outside smoking, did not ensure for Resident #4 that the appropriate safe smoking equipment and supervision were provided during smoking break, and did not ensure fall interventions were in place for Resident #72. This affected three residents (#4, #24 and #72) of five residents reviewed for accidents/hazards. The facility census was 92. Findings include: 1. Review of medical record for Resident #24 revealed an admitted [DATE]. Medical diagnoses included unspecified focal traumatic brain injury with loss of consciousness, metabolic encephalopathy, schizoaffective disorder, dementia with other behavioral disturbance, opioid abuse with intoxication, alcohol abuse, cocaine abuse, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #24 was severely cognitively impaired. Resident #24 displayed no behaviors regarding wandering. Resident #24 was independent with eating, and required setup or clean-up assistance with oral hygiene, toileting hygiene, shower/bathe, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. Review of physician orders for Resident #24 revealed a physician order dated 05/26/23 for Resident #24 to have a wanderguard to left ankle, staff to check placement and function every shift for safety and elopement risk. Review of Resident #24's elopement assessments revealed on 08/25/21 resident was found to be at risk for elopement. Further review of elopement assessments revealed as of 04/16/24 no elopement assessments had been completed since 08/25/21. Review of Resident #24's care plan dated 12/28/17 revealed Resident #24 was at risk of elopement related to poor cognition and history of elopement. Intervention included a wanderguard/alarming bracelet per physician orders and when exhibiting exit seeking behavior redirect to an appropriate area and provide supervision. Further review of the medical record revealed Resident #24 had not had any documented elopements or attempts to elope from the smoking area. Observation on 04/16/24 at 4:14 P.M. with Receptionist #420 revealed Resident #24 was outside the facility entrance doors unsupervised by staff in the smoking area with two additional residents. This smoking area was directly in front of the main entrance/exit of the facility on the bottom level of the facility and within line of sight of the reception area where residents and visitors signed in and out. However, depending on where the resident was seated or standing in the smoking area, the view of the resident could become limited and/or completely obstructed from the view of the receptionist. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/16/24 at 4:40 P.M. with Assistant Director of Nursing (ADON) #451 confirmed Resident #24 did not have a follow up elopement assessment since 08/25/21 and if a resident is at risk of elopement, they should be supervised if outside. Review of facility policy titled Wandering, Unsafe Resident dated 12/07 revealed staff will institute a detailed monitoring plan, as indicated for residents who are assessed to have a high risk of elopement or other unsafe behavior. 2. Review of medical record for Resident #4 revealed an admitted [DATE]. Medical diagnoses included type two diabetes mellitus with hyperglycemia, major depressive disorder, hypertension, schizophrenia, delusional disorder, hallucinations, bipolar disorder, legal blindness, cocaine abuse, alcohol abuse, nicotine dependence, unspecified psychosis and brief psychotic disorder. Review of quarterly MDS 3.0 assessment dated [DATE] revealed Resident #4 had moderate cognitive impairment, required set up or clean up assistance with eating, and required supervision or touching assistance with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. Review of the care plan dated 02/17/15 revealed Resident #4 was at increased health risks related to tobacco use. Resident #4 had been educated on potential side effects of tobacco product use and continues to smoke. Per policy all smokers are supervised. Resident #4 needed assistance with walking to and from the smoking pavilion. Review of Smoking Risk Form dated 04/03/24 revealed Resident #4 had cognitive loss and had a visual deficit. Resident #4 smokes two to five times a day in the morning, afternoon and evenings. Resident #4 can not light her own cigarette. Resident #4 assessed to need to wear a smoking apron and be supervised. Further review of the medical record revealed no incidents or accidents related to smoking for Resident #4. Observation on 04/16/24 at 4:14 P.M. with Receptionist #420 revealed Resident #4 was outside smoking unsupervised with no smoking apron on. Interview on 04/16/24 at 4:20 P.M. with MDS Registered Nurse (RN) #438 confirmed Resident #4 should not have been outside unsupervised smoking since Resident #4's smoking assessment indicated Resident #4 should be supervised and wearing a smoking apron. Review of facility undated policy titled Tobacco-Restrictive Policy Acknowledgement revealed every resident who smokes will be assessed for safety. Staff will dispense the resident's cigarettes, light the cigarette and stay with the resident until the cigarette is properly extinguished. All residents smoke with supervision and will do so only in the designated area at designated times. All cigarettes, lighters and any other smoking materials will be kept at the nurses' station. Residents may smoke outside in the designated smoking area in the back patio at designated times and under supervision. Safety aprons are required if resident fails the smoking assessments. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of medical record for Resident #72 revealed an admitted [DATE]. Medical diagnoses included Alzheimer's disease, unspecified dementia with mood disturbance, personal history of traumatic brain injury, post traumatic seizures, paranoid schizophrenia, unspecified psychosis, hypertension, and anxiety disorder. Review of the annual MDS 3.0 assessment dated [DATE] revealed Resident #72 was severely cognitively impaired. Resident #72 required supervision or touching assistance with eating, required partial to moderate assistance with oral hygiene, shower/bathe, and upper body dressing, required substantial to maximal assistance with toileting hygiene, lower body dressing, and personal hygiene. Resident #72 has had two or more falls with no injury. Review of Resident #72's care plan dated 02/22/23 revealed Resident #72 was at risk for falls due to a traumatic brain injury associated cognitive loss, unsteady gait, generalized muscle weakness, and use of antipsychotic, anticonvulsant medications that increased risk of falls. Interventions included to have call light in reach, fall mat next to bed for injury prevention related to frequent falls, and toileting program per physician order, upon rising, before and after meals, at bedtime and as needed throughout the night. Review of Resident #72's fall risk reviews revealed on 10/10/23 and 03/04/24 Resident #72 was identified to be at high risk for falling. Review of Resident #72 progress notes revealed a nursing note dated 09/01/24 7:08 A.M. that stated resident was found on the floor, urinary catheter dislodged, resident sent to the hospital for catheter reinsertion. Further review of progress notes revealed a nursing note dated 10/04/24 7:17 P.M. that stated resident alarm was sounding and resident was found sitting on the floor, resident stated he had slipped out of bed. Review of fall incident report for Resident #72 dated 09/01/24 revealed interventions that were initiated post fall included bed alarm and fall mat. Review of fall incident report for Resident #72 dated 10/04/24 revealed intervention that was initiated post fall was a perimeter overlay to mattress. Observation on 04/16/24 at 3:57 P.M. revealed Resident #72 was laying in bed, bed was in lowest position, no floor mat or perimeter overlay was in place. Observation on 04/17/24 at 2:50 P.M. revealed fall mat was in place to the right side of Resident #72's bed, however no perimeter overlay mattress was observed. Observation was confirmed at time of observation by Registered Nurse (RN) #437. Interview on 04/17/24 at 3:08 P.M. with the Assistant Director of Nursing (ADON) #451 stated Resident #72 was no longer ordered a bed alarm as he was assessed to not need the alarm anymore. Review of physician orders for Resident #72 revealed an order dated 10/25/23 for a perimeter overlay mattress. Further review of physician orders revealed an order dated 09/01/23 for a fall mat to right side of bed, check placement every shift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Managing Falls and Falls Risk dated 12/07 revealed based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling to try to minimize complications.

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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** 46195 Based on record review and staff interview the facility failed to ensure accurate weights were obtained as ordered. This affected two residents (Residents #50 and #196) of three residents reviewed for nutrition. The facility census was 92. Findings Include: 1. Review of the medical record for Resident #50 revealed an admitted [DATE]. Diagnoses included pneumonia, acute kidney failure, depression, anxiety disorder, type two diabetes mellitus without complications, dysphagia (difficulty swallowing), essential hypertension (high blood pressure), and personal history of transient ischemic attack (TIA) and cerebral infarction (stroke) without resident deficits. Review of the most recent Minimum Data Set assessment dated [DATE] revealed Resident #50 was severely impaired cognitively, required supervision or touch assistance for eating, and was on a mechanically altered diet. Resident #50 would hold food in mouth, cough when eating, complain of difficulty or pain when swallowing and had no significant weight change. Review of care plan created on 03/14/24 revealed Resident #50 had a nutritional problem or potential nutritional problem related to nutrition, hydration, poly pharmacy, depression, type two diabetes, and mechanically altered diet. Interventions included monitor/record/report to physician significant weight loss of three pounds in one week, greater than five percent weight loss in one month, greater than seven and a half percent weight loss in three months and greater than ten percent weight loss in six months. Review of Resident #50's physician orders revealed an order written 03/29/24 for a consistent carbohydrate diet (CCHO)/no added salt (NAS) diet, mechanically altered ground texture, thin liquid consistency. Review of Resident #50's weights from 03/07/24 to 03/30/24 revealed the resident weighed 156 pounds (lbs) on 03/07/24 (admission) and wasn't weighed until 03/25/24 (18 days later) when he weighed 150.2 lbs. Interview on 04/18/24 at 9:26 A.M. with Registered Dietitian (RD) #503 revealed weights should be done on admission then weekly for four weeks then monthly unless on daily weights. RD #503 confirmed weekly weights were not done for four weeks for Resident #50. RD #503 stated she sent an email weekly to the unit managers and the director of nursing of the weights that still need to be obtained for residents. She stated there are still weights not obtained but it was getting better. Interview on 04/18/24 at 10:23 P.M. with Assistant Director of Nursing (ADON) #451 stated the residents' treatment administration record (TAR) would indicate when a weight needed to be obtained, and it was the responsibility of the nurse to let the state tested nursing assistants aware of who needed to be weighed. ADON #451 revealed Dietitian #503 did send an email indicating residents who still needed weights. She stated they get after staff to get the weights done but confirmed weights were still being missed. (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 facility policy Weight Assessment and Intervention, revised December 2008, revealed nursing staff would measure resident weights on admission, the next day, and weekly for two weeks thereafter. any weight change of 5% or more since the last weight assessment would be retake the next day for confirmation. 45441 2. Review of the medical record for resident #196 revealed an admitted [DATE]. Diagnoses included end stage renal disease, colitis, anxiety and depression. Review of the comprehensive MDS 3.0 assessment dated [DATE] revealed the resident was cognitively intact. She was independent in eating, oral hygiene and showering and required supervision or touch assistance for dressing and personal hygiene. She had no problems eating, drinking or swallowing and had no broken or missing teeth. Review of the physician's orders for April 2024 revealed an order for weekly weights. The order began on 11/13/24. Review of the nutrition assessment dated [DATE] revealed the resident would be weighed on a weekly basis for at least four weeks. Review of the weight record revealed weights were obtained on 11/27/23, 01/23/24, 02/02/24, 02/13/24, 02/22/24, 03/22/24, 03/29/24 and 04/12/24. No significant weight loss was identified. Review of the progress notes dated 11/13/24 through 03/27/24 revealed no evidence the resident refused to be weighed. Interview on 04/18/24 at 9:27 A.M. with RD #503 revealed weights were usually ordered weekly for four weeks after admission, then monthly. She worked in the facility on Thursdays and reviewed weights at that time. She confirmed weights were not obtained weekly as ordered for resident #196. Review of the facility policy titled Weight Assessment and Intervention dated December 2008 revealed the facility would obtain the residents' weight on admission, the next day and weekly for two weeks thereafter. If no weight concerns were noted, weights would be obtained monthly. Weights would be recorded in the resident's chart or medical record.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on observation, interview and record review, the facility failed to ensure oxygen and nebulizers were stored and administered according to physician's orders. This affected five residents (Residents #16, #45, #52, #71, and #246) of five reviewed for respiratory care. The facility identified 10 residents as using oxygen and/or nebulizer treatments. The facility census was 92. Findings include: 1. Review of the medical record for resident #52 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), lung cancer, muscle weakness, depression and insomnia. Review of the physician's orders for April 2024 revealed orders for Albuterol solution 0.5-2.5 milligrams (mg) every four hours, Symbicort inhalation aerosol 160-4.5 micrograms (mcg) two puffs per day and oxygen at four liters continuously. Oxygen tubing was to be changed weekly. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was cognitively intact. She required supervision for eating and oral care, partial to moderate assistance for personal hygiene, substantial or maximum assistance for showering and was dependent for toileting. Review of the care plan dated 2/29/24 revealed Resident #52 was at risk for a respiratory impairment due to COPD and lung cancer. Interventions include maintaining the residents airway, administering medications and treatments as ordered, four liters of oxygen via nasal cannula and nebulizer treatments as ordered. The resident was able to self administer nebulizer treatments and maintain the nebulizer at bedside. 2. Review of the medical record for resident #71 revealed an admitted [DATE]. Diagnoses included dementia, depression, heart failure and neuropathy. Review of the physician's orders for April 2024 revealed an order for Albuterol 108 mcg two puffs every four hours for shortness of breath which began on 09/07/23, 0.5 to 2.5 mg every six hours for shortness of breath which began on 09/16/22 and Stiolto aerosol 2.5 mcg two puffs one per day (QD) which began on 10/05/23. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed the resident was severely cognitively impaired. She was independent in eating and toileting and required supervision for oral hygiene, showering and hygiene. Observation on 04/15/24 at 9:53 A.M. revealed two nebulizer masks on the floor in resident #71's room with the tubing undated. Interview at the time of the observation with State tested Nurses Aide (STNA) #415 confirmed the masks should not be on the floor and the tubing did not have a date. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Observation on 04/15/24 at 10:49 A.M. revealed resident #52's oxygen tank was set at six liters. The oxygen tubing and nebulizer tubing were both undated. Interview at the time of the observation with resident #52 revealed she thought her oxygen should be set at six liters. She could not identify when or if her oxygen or nebulizer tubing had been changed. A sign on the back on the residents' door revealed reminder to reset the resident's oxygen to six liters after toileting. Interview on 4/15/24 at 11:06 AM with STNA #429 confirmed resident #52's oxygen was set at six liters. She believed this was the correct setting. She also confirmed the oxygen and nebulizer tubing were both undated. Review of the facility policy titled Oxygen and Nebulizer Policy undated revealed the facility would ensure safe and appropriate use of oxygen and nebulizer treatments including cleaning and disinfecting, and following orders as written. 46195 3. Review of medical record for Resident #246 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia (lack of oxygen), adult failure to thrive, and anxiety disorder. Review of the most recent MDS 3.0 assessment dated [DATE] revealed Resident #246 was cognitively intact. He was independent for eating and required supervision or touch assistance for oral hygiene, toileting hygiene, showering/bathing self, and personal hygiene. He hadn't rejected any care. Review of Resident #246's physician orders revealed an order dated 04/09/24 for two liters/minute via nasal cannula to maintain oxygen levels above 92 percent, an order dated 04/09/24 change oxygen tubing weekly and as needed, and an order dated 04/09/24 for ipratropium-albuterol inhalation solution, a medication used to treat COPD(0.5-2.5 (3) milligram (mg)/3 milliliter (ml) , 3 ml inhale orally every four hours as needed for shortness of breath related to COPD. Review of the care plan created on 03/25/24 indicated Resident #246 had respiratory impairment related to COPD, chronic respiratory failure, and centrilobular emphysema (a form of COPD). Interventions included administering medications/treatments per physician orders and oxygen at two liters/minute via nasal cannula. Observation on 04/15/24 at 11:05 A.M. revealed Resident #246's oxygen tubing had a date of 04/03/24 and there was no date on the nebulizer tubing. Interview on 04/15/24 at 11:08 A.M. with Licensed Practical Nurse (LPN) #442 confirmed the date on Resident #246's oxygen tubing was 04/03/24 and there was no date on the nebulizer tubing. She stated the oxygen tubing should be dated weekly, but she was unsure if the nebulizer tubing should be dated. Interview on 04/15/24 at 11:13 A.M. with Registered Nurse (RN) #435 stated the attached tubing to the nebulizer should be dated. 47568 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	4. Review of medical record for Resident #45 revealed an admitted [DATE]. Medical diagnoses included occlusion and stenosis of bilateral carotid arteries, congestive heart failure, ischemic cardiomyopathy, acute ischemic heart disease, chest pain, type two diabetes mellitus, chronic obstructive pulmonary disease, hypertension, post-traumatic stress disorder, major depressive disorder, and anxiety disorder. Review of quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #45 had mild cognitive impairment, was independent for eating, required supervision or touching assistance for oral hygiene, toileting hygiene, shower/bathing, upper body dressing, lower body dressing and personal hygiene, and required partial to moderate assistance with putting on and taking off footwear. Resident #45 did not show any behaviors of rejection of care. Review of the care plan dated 09/29/21 revealed Resident #45 had and was at risk for respiratory impairment related to chronic obstructive pulmonary disease. Review of physician orders for Resident #45 revealed an order for an aerosol treatment iprtopium-albuterol solution 0.5 mg per three ml to receive one application daily at bedtime via inhalation. Observation on 04/15/24 at 9:23 A.M. revealed Resident #45's nebulizer mask sitting on bedside table uncovered and attached tubing had no date attached to indicate last time the tubing was changed. Interview on 04/15/24 at 11:13 A.M. with RN #435 confirmed nebulizer tubing was not dated and nebulizer mask was not covered. RN #435 stated all nebulizer masks should be covered with a bag and the attached tubing should be dated. 48565 5. Record review for Resident #16 revealed a date of admission of 03/07/24. Diagnoses included Alzheimer's Disease, anxiety, adult failure to thrive, chronic respiratory failure with hypoxia (low oxygen levels) and major depressive disorder. Physician orders included oxygen 3 liters per minute per nasal cannula as needed to keep oxygen saturation above 92%, change oxygen tubing weekly and as needed, place in dated bag when not in use, and ipratropium-albuterol solution 0.5-2.5 mg per/3 ml, inhale 3 ml via nebulizer every six hours as needed for shortness of breath. On 04/15/24 at 10:35 A.M. an observation in the room of Resident #16 revealed the nebulizer mask was on the floor uncovered. The nebulizer tubing was not dated as to when it was changed. The nasal cannula for oxygen delivery was laying on the bed without being bagged as ordered. The nasal cannula tubing was undated as to when it had been changed. STNA #415 verified the nebulizer mask was on the floor and was undated. STNA #415 also verified the nasal cannula for oxygen delivery was unbagged and undated at the time of the observation. A review of the policy titled, Oxygen and Nebulizer Policy that was undated revealed no information in regard to the proper storage of oxygen and nebulizer equipment when not in use to prevent contamination and the spread of infection.

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Park Center Healthcare and Rehabilitation	5665 South Ave Youngstown, OH 44512

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on record review and interview, the facility failed to ensure dialysis orders were accurate and assessments were completed before and after dialysis. This affected one resident (Resident #196) of two reviewed for dialysis. The facility census was 92. Findings include: Review of the medical record for resident #196 revealed an admitted [DATE]. Diagnoses included end stage renal disease, colitis, anxiety and depression. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was cognitively intact. She was independent in eating, oral hygiene and showering and required supervision or touch assistance for dressing and personal hygiene. She was on dialysis. Review of the physician's orders for April 2024 revealed an order for hemodialysis on Tuesday, Thursday and Saturday and an order to check the bruit and thrill every shift. No blood draws were to be obtained from an unspecified arm. Review of the care plan dated 04/08/24 revealed the resident had renal insufficiency with a dependence on dialysis. Interventions included administering medications as ordered, arranging for transportation to and from the dialysis facility, conferring with the physician and/or dialysis facility regarding changes and coordinating dialysis care with the dialysis facility. Review of the pre and post dialysis assessments dated 01/25/24 through 04/13/24 revealed vitals and weights were obtained on 01/25/24, 01/27/24, 02/08/24, 02/10/24, 02/13/24, 02/15/24, 02/17/24, 02/20/24, 02/22/24, 02/27/24, 02/29/24, 03/07/24, 03/16/24, 03/19/24, 03/21/24, 03/26/24, 03/28/24, 4/11/24 and 04/13/24 which was not inclusive of all days the resident went to dialysis during this time frame and should have received pre and post dialysis assessments from the facility. Interview on 04/17/24 at 2:17 P.M. with resident #196 revealed she was asked by Licensed Practical nurse (LPN) #443 where to get the papers from dialysis because the facility did not do them. Interview on 04/17/24 at 2:20 P.M. with Registered Nurse (RN) #440 revealed the facility did not do pre and post dialysis assessments. She confirmed they checked bruit and thrill and weights were normally obtained weekly. Interview on 04/17/24 at 3:00 P.M. with LPN #451 confirmed the order for not obtaining blood draws did not specify which arm should be used. LPN #451 revealed the resident was aware enough to tell staff which arm to use. She also confirmed pre and post dialysis assessments were not completed consistently and refusals should be documented. She confirmed no evidence that refusals had been documented from 01/25/24 through 04/13/24. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled End Stage Renal Disease, Care of a Resident with dated September 2010 revealed staff caring for residents with end stage renal disease would document relevant information about the resident's condition on a daily or on a per shift basis, care for the resident's graphs and fistulas and exchange information between the facility and the dialysis facility.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on interview, record review, review of the facility assessment, and review of facility policy, the facility failed to ensure staff were aware of known triggers for three residents (#5, #45, and #81) with a diagnosis of post traumatic stress disorder (PTSD). This affected three residents (#5, #45 and #81) of three residents reviewed for trauma informed care. The facility identified five residents #5, #20, #42, #45, and #81 with a diagnosis of PTSD. The facility census was 92. Findings include: 1.Review of the medical record for Resident #81 revealed an admitted [DATE]. Diagnoses included fracture of left femur, chronic obstructive pulmonary disease (COPD), cerebral palsy, bipolar disorder, generalized anxiety, post-traumatic stress disorder (PTSD), and major depressive disorder. Review of most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated Resident #81 was cognitively intact. The resident hadn't exhibited any potential indicators of psychosis, behavioral symptoms, or rejection of care. Resident #81 was independent for eating and oral hygiene, and required supervision or touch assistance for toileting hygiene, showering/bathing self, and transfers. Review of the care plan, created on 05/24/23, revealed Resident #81 was at risk for changes in mood related to bipolar disorder, anxiety, depression, and PTSD. Interventions included administer medication per physician orders; assess for physical/environmental changes that may precipitate change in mood; and monitor for signs/symptoms of PTDS exacerbation and ensure consistent care, avoid excess noise and avoid potential PTSD triggers. Interview on 04/15/24 at 4:14 P.M. with Resident #81 indicated when a nurse, who he was not familiar with their voice, woke him when he was sleeping, it would trigger his PTSD. Interview on 04/17/24 at 8:56 A.M. with Social Services #474 revealed when Resident #81 was first admitted he didn't want to talk to anybody about his PTSD. He has since started to talk more and he had never mentioned what his triggers were for his PTSD. Social Services #474 stated she hadn't followed up since admission to ask what his triggers were. When reviewing Resident #81's care plan with the state surveyor, Social Services #474 confirmed the care plan interventions included avoid potential PTSD triggers, and no one knew what Resident #81's triggers were. Interview on 04/23/24 11:11 AM with State tested Nursing Assistant #419 stated she had never been told what Resident #81's triggers were when it came to his PTSD. When asked where she could find his triggers, she stated the triggers might be listed in a folder somewhere or they might be in the computer, which she didn't have access to seeing. 45441 2.Review of the medical record for resident #5 revealed an admitted [DATE]. Diagnoses included neuropathy, chronic respiratory failure, diabetes, anxiety and post traumatic stress disorder (PTSD). (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the comprehensive MDS assessment dated [DATE] revealed the resident was cognitively intact. She required set up or clean up help for eating, supervision or touch assistance for oral hygiene, partial or moderate assistance for personal hygiene, substantial or maximum assistance for showering and was dependent for toileting. Review of the care plan dated 03/21/24 revealed the resident was at risk for changes in mood related to anxiety and PTSD. Interventions included accepting care and medications as prescribed, maintaining involvement in activities of daily living and social activities, administering medications per orders, and assessing for physical or mental changes that may precipitate a change in mood. Interview on 04/17/24 at 11:52 A.M. with resident #5 revealed her ex-husband was abusive, and she sometimes had a hard time working with men. She confirmed she told the facility about her history so when she was assigned a male aide, they would understand her anxiety and fear in working with her. Interview on 04/17/24 at 3:00 P.M. with licensed practical nurse (LPN) #451 confirmed there were no triggers or specific techniques to address PTSD in resident #5's care plan. 47568 3. Review of medical record for Resident #45 revealed an admitted [DATE]. Medical diagnoses included occlusion and stenosis of bilateral carotid arteries, ischemic cardiomyopathy, acute ischemic heart disease, chest pain, unspecified convulsions, type two diabetes mellitus, chronic obstructive pulmonary disease, unspecified dementia, post-traumatic stress disorder (PTSD), major depressive disorder, suicidal ideations, personality disorder, anxiety disorder, other psychoactive substance abuse. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #45 was moderately cognitively impaired. Resident #45 showed no mood or behavior concerns and did not exhibit the behavior of rejection of care. Resident #45 was independent with eating, required supervision or touching assistance with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, and personal hygiene. Resident #45 had diagnosis of PTSD. Review of the care plan dated 09/29/21 revealed Resident #45 had cognitive loss related to dementia, PTSD, anxiety, and sequelae of cerebrovascular accident. Interventions included to allow adequate time to respond, do not rush or supply words, attempt to provide consistent routines and caregivers and to identify self when speaking with resident. Resident #45, known to show verbal and physical agitation or aggression related to alcohol and drug withdrawal, has a history of substance abuse. Resident #45 was known to make statements referring to hurting himself at times and can become verbally and physically aggressive toward staff. Resident #45 may need one on one interaction for de-escalation during behaviors. Resident #45 had a history of throwing furniture or other objects when agitated. Further review of care plan for Resident #45 revealed no care plan related to residents PTSD and associated triggers. Interview on 04/16/24 at 3:32 P.M. with Social Service Designee (SSD) #474 stated that if a resident was admitted with a diagnosis of PTSD, the diagnosis should be part of their care plan with identified triggers, so staff were aware of how to interact and care with the resident. Interview on 04/16/24 at 3:35 P.M. with the MDS Registered Nurse (RN) #438 confirmed Resident #45 care plan did not address his PTSD. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility undated policy titled Trauma-Informed Policy revealed the goal is to create a safe, supportive, and empowering environment that promotes healing and resilience. Staff members will incorporate trauma-informed care practices into their daily interactions and routines, including approaches that promote safety, empowerment and resilience. Trauma triggers will be identified and minimized whenever possible and residents will be supported with developing coping strategies and skills to manage stress and emotions.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on record review, interview and facility policy review, the facility failed to document appropriate justifications for declining a gradual dose reduction (GDR) recommendation for Resident #31. This affected one resident (#31) out of seven residents reviewed for unnecessary medications and had the potential to affect all residents in the facility. The facility census was 92. Findings include: Review of the medical record for Resident #31 revealed an admitted [DATE] with diagnoses including acute kidney failure, hypothyroidism, diabetes, dementia, and cognitive communication deficit. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 was moderately cognitively impaired. He was independent with eating and required supervision for oral care, showering, and personal hygiene. He had no behavior problems and was not on an antipsychotic or antidepressant. Review of the document titled Pharmacists Recommendation to the Provider dated 02/19/24 revealed a recommendation to clarify the approved diagnosis and justification for the use of Olanzapine, an antipsychotic medication, and to update the client's electronic medical record (EMR). The note was signed by the Director of Nursing (DON) on 02/22/24 with a note stating it would be addressed at the next visit by the psychiatric nurse practitioner. Interview on 04/17/24 at 3:00 P.M. with Licensed Practical Nurse (LPN) #451 confirmed there was no evidence the pharmacist's recommendation from 02/19/24 had been addressed for Resident #31. Review of the facility policy titled Antipsychotic Medication Use, dated April 2007, revealed the physician would follow up on medications by changing or stopping medications when necessary or documenting why the benefits of the medication outweighed the risks.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on record review, interview and facility policy review, the facility failed to ensure non-pharmacological interventions were attempted prior to the administration of pain medication for Resident #52. This affected one resident (#52) of seven residents reviewed for unnecessary medication. The facility census was 92. Findings include: Review of the medical record for Resident #52 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), lung cancer, muscle weakness, depression, and insomnia. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 was cognitively intact. She required supervision for eating and oral care, partial to moderate assistance for personal hygiene, substantial or maximum assistance for showering, and was dependent for toileting. Review of the physician's orders for April 2024 revealed orders for Morphine Sulfate 0.25 milliliters (ml) (opioid pain medication) by mouth (PO) every hour as needed (PRN) for pain. The order began 02/08/24. There was also an order for Tylenol 1000 milligrams (mg) (analgesic and fever reducer) PO daily (QD) as needed for pain which began on 03/22/24. Review of the Medication Administration Record (MAR) for February 2024 revealed Resident #52 received two doses of morphine on 02/08/24 for a pain level of zero, one dose on 02/09/24 for a pain level of zero and one does for a pain level of five, three doses on 02/11/28 two for pain levels of zero and one for pain level of six, three doses on 02/12/24 two for a pain level of zero and one for a pain level of five, one dose on 02/13/24 for a pain level of zero, one dose on 02/14/24 for a pain level of zero, three doses on 02/15/24 for a pain level of zero, and one dose on 02/28/24 for a pain level of five. Review of the MAR for March 2024 revealed Resident #52 received one dose of morphine on 03/19/24 for a pain level of zero, one dose on 03/20/24 for a pain level of zero, one dose on 03/20/24 for a pain level of seven, and one dose on 03/20/24 for a pain level of eight, and one dose on 3/21/24 for a pain level of zero. Review of the MAR for April 2024 revealed Resident #52 received one dose of morphine on 04/06/24 for a pain level of seven, one dose on 04/09/24 for a pain level of zero, one dose on 04/14/24 for a pain level of zero, and one dose on 04/14/24 for a pain level of five. The resident received one dose of Tylenol on 04/14/24 for a pain level of three. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/17/24 at 3:00 P.M. with Licensed Practical Nurse (LPN) #451 confirmed the physician's order did not specify when to administer Tylenol versus Morphine. She revealed if nonpharmacological interventions were attempted, they would be documented in the progress notes; she confirmed there were none noted. She also revealed she would use her judgment and determining whether to administer Tylenol or Morphine; generally, if a resident reported a pain level of five or higher, she would administer Morphine. Review of the facility policy titled Pain Assessment and Management, dated March 2020, revealed the facility would identify and use specific strategies for different levels and sources of pain.

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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** 45441 Based on record review, interview and facility policy review, the facility failed to ensure appropriate diagnoses for medications and failed to ensure behaviors were tracked for medication efficacy. This affected three residents (#31, #35 and #71) of seven residents reviewed for unnecessary medications. The facility census was 92. Findings include: 1. Review of the medical record for Resident #31 revealed an admitted [DATE] with diagnoses including acute kidney failure, hypothyroidism, diabetes, dementia, and cognitive communication deficit. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 was moderately cognitively impaired. He was independent with eating and required supervision for oral care, showering, and personal hygiene. He had no behavior problems and was not on an antipsychotic or antidepressant. Review of the physician's orders for April 2024 revealed an order for Namenda, used to treat dementia, five mg by mouth (PO) two times per day (BID) with no indication for its use. The order began 01/24/24. There was also an order for Olanzapine (Zyprexa), an antipsychotic medication, five mg one tablet PO once per day (QD) for an antipsychotic which began on 01/23/24 and Duloxetine 30 mg PO QD for depression which began on 01/24/24. Interview on 04/17/24 at 2:49 P.M. with Licensed Practical Nurse (LPN) #451 confirmed there was no evidence of a diagnosis for the use of Olanzapine for Resident #31. She also confirmed behaviors were usually tracked as a result of the medication order. She confirmed there was no evidence behaviors were being tracked for Resident #31. 2. Review of the medical record for Resident #35 revealed an admitted [DATE] with diagnoses including diabetes, anxiety disorder, asthma, morbid obesity, muscle contracture of the right lower leg, and edema. Review of the quarterly MDS assessment dated [DATE] revealed Resident #35 was cognitively intact. She was independent in eating, required supervision for oral care, partial to moderate assistance for personal hygiene, substantial to maximum assistance for showering, and was totally dependent for toileting. Review of the care plan dated 03/21/24 revealed Resident #35 was at risk for changes in mood due to anxiety, depression, and borderline personality disorder. Interventions included accepting care and medication as prescribed, maintaining involvement with activities of daily living (ADL) and social activities, administering medications per the physician's order, and assessing the environment for changes that may affect her mood. (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 physician's orders for April 2024 revealed an order for Effexor, used to treat depression, 225 mg PO QD. The order began on 04/05/23. There was also an order for Hydroxyzine mg one capsule PO three times a day (TID) for anxiety which began on 11/15/23, and Klonopin 0.25 mg PO QD and 1 mg PO QD for anxiety which began on 11/22/23. Interview on 04/17/24 at 2:49 P.M. with LPN #451 confirmed behaviors were usually tracked as a result of the medication order. She confirmed there was no evidence behaviors were being tracked for Resident #35. 3. Review of the medical record for Resident #71 revealed an admitted [DATE] with diagnoses including dementia, bipolar disorder, depression, insomnia, and heart failure. Review of the quarterly MDS assessment dated [DATE] revealed Resident #71 was severely cognitively impaired. She was independent in eating and toileting and required supervision or oral hygiene, showering, and personal hygiene. Review of the care plan dated 03/07/24 revealed Resident #71 was at risk for behavior symptoms including wearing multiple layers of clothing, refusing to shower, suicidal ideation, and making false accusations. Interventions included observing mental status and behavioral changes inconsistent approaches when giving care. She also suffered from cognitive loss with interventions including allowing adequate time to respond, explaining each activity or care procedure before beginning and identifying yourself when speaking with the resident. Review of the physician's orders for April 2024 revealed an order for an Exelon, used to treat dementia, transdermal (applied to the skin) one patch at bedtime (HS) for unspecified dementia. The order began on 03/14/24. There were also orders for Namenda 5 mg PO BID for dementia, which began on 03/22/24, Depakote 250 mg BID for other mental disorders which began on 06/16/23, and Olanzapine 2.5 mg PO BID for depression which began on 02/02/24. Interview on 04/17/24 at 2:49 P.M. with LPN #451 confirmed behaviors were usually tracked as a result of the medication order. She confirmed there was no evidence behaviors were being tracked for Resident #71. Review of the facility policy titled Antipsychotic Medication Use, dated April 2007, revealed residents would only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated including, schizoaffective disorder, mood disorders, psychosis, schizophrenia, delusional disorder, and dementia with behavioral symptoms and nursing staff would document the resident's targeted symptoms.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	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. 48565 Based on observation, interview and facility policy review, the facility failed to store Tuberculin Purified Protein (serum used for intradermal injection to test for tuberculosis) and Lispro Insulin in a manner to ensure efficacy of the medication. This affected one resident (#18) whom the Lispro Insulin was prescribed for and had the potential to affect all residents residing in the facility. The facility census was 92. Findings include: On 04/17/24 at 8:54 A.M. an observation of the medication storage room with Registered Nurse (RN) #440 on 2A hall revealed an open container of Tuberculin Purified Protein one milliliter in the refrigerator. There was approximately one-half milliliter of serum in the vial. The container was undated as to when it was opened. There was also an open vial of Lispro Insulin for Resident #18. The vial was undated as to when it was opened. Interview with RN #440 on 04/17/24 at the time of the observation verified both vials of medication were undated as to when they were opened. A review of the package insert for the Tuberculin Purified Protein revealed vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency. A review of the package insert for Lispro at www.accessdata.fda.gov revealed Lispro insulin should be used within 28 days of opening or discarded. A review of the facility policy titled Administering Medications, dated December 2009, revealed when opening a multi-dose container, the date shall be recorded on the container.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 46195 Based on interview and record review, the facility failed to ensure they had a qualified food service director. This had the potential to affect 92 residents who received food from the kitchen. The facility identified all residents in the facility received food from the kitchen. The facility census was 92. Findings include: Interviews conducted on 04/15/24 between 8:09 A.M. and 04/18/24 at 2:35 P.M. with Food Service Director (FSD) #499 revealed the dietitian was at the facility weekly and wasn't involved in the kitchen so had not been providing regular consultations to FSD #499. FSD #499 stated she had not been a food service director until she had moved into the position of food service director, had no formal dietary education, but had a food protection manager certificate. Interview on 04/15/24 at 10:49 A.M. with resident #52 revealed the food was horrible. She revealed the person running the kitchen used to work in laundry and she did not believe she was qualified to run the kitchen. Interview on 04/18/24 at 9:45 A.M. with Registered Dietitian #503 revealed it depended on the cooks if recipes are followed and the recipes were not always followed. She stated the main issue at the facility was the quality of food. Interview on 04/18/24 at 2:20 P.M. with Human Resources #472 revealed FSD #499 had been the housekeeping director from 03/08/21 until 11/15/22, and then she moved into her new position as food service director on 11/16/22. Review of the personnel file for Food Service Director (FSD) #499 revealed she was not a certified dietary manager, did not have a similar national certification for food service managment and safety from a national certifying body, did not have at least an associate degree in food service management or hospitality, did not have two or more years in a position of director of food and nutrition services in a nursing facility prior to moving into the food service director position but had successfully completed the standard set forth for the Food Protection Manager on 11/02/23, which was valid through 11/02/28. Review of website www.always foodsafe.com, where FSD #499 had received her certificate as a food protection manager, revealed the Food Protection Manager program was the same level as the ServSafe program. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of the facility's Job Description and Performance Standards for Food Service Director revealed the purpose of this position is to implement and maintain effective, efficient systems to operate the dietary department and provide food service to residents in a cost-effective, efficient manner to safely meet residents' needs in compliance with federal, state, and local requirements. Authority is delegated to the individual in this position to implement dietary and food service policies to meet residents' needs; supervise preparation of menus to meet residents' dietary needs; assess residents' dietary needs and develop appropriate dietary plans; and supervise the entire operation of the dietary department.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 46195 Based on observation, interviews, and review of facility policy, the facility failed to ensure the facility menu was well balanced in regards to calcium sources for all residents. This had the potential to affect all 92 residents receiving meals from the kitchen. The facility identified zero residents as receiving nothing by mouth (NPO). The facility census was 92. Findings include: Interview on 04/16/24 at 8:56 A.M. with the Ombudsman #507 revealed her biggest concern at the facility was the food. She stated she had gone back and forth with the Administrator about almost no residents getting milk on their lunch and dinner trays. She stated she had advocated for all residents to be asked what they want. Observation of tray line on 04/16/24 from 12:00 P.M. to 12:33 P.M. revealed there were three residents (#15, #53, and #84) meal trays with milk placed on them out of the 92 resident meals being served at the meal. Interview on 04/16/24 at 12:01 P.M. with Dietary Cook #498 revealed the beverage carts were stocked with Kool aid and coffee. Milk and supplements were placed on the resident's individual meal trays. Observation of lunch and dinner meals being passed on the Three B unit on 04/16/24 between 12:33 P.M. and 4:44 P.M. revealed there was a beverage cart which consisted of a carafe of coffee and a plastic square dispenser of Kool aid. There was no observation of any milk items on the beverage cart. Interview on 04/17/24 at 7:57 A.M. with Resident #27 revealed he didn't want milk for lunch and dinner, but he didn't know he could have cottage cheese or yogurt as a calcium replacement. Interview on 04/18/24 at 9:45 A.M. with Dietitian #503 confirmed there was no documentation on the tray card or in the medical chart indicating a resident did not want milk at lunch or dinner or if they were offered a calcium alternate. Dietitian #503 confirmed dietary preferences weren't being consistently obtained from the residents. Interview on 04/18/24 at 11:43 A.M. with the Administrator revealed the facility had found that generally residents were not drinking milk at lunch and dinner. The facility had sent all the residents a letter that as a standard residents would only receive milk at breakfast, and residents could receive milk at lunch and dinner upon request. The Administrator indicated the letter was sent last year and again two months ago. The Administrator was unsure how new residents who were admitted after the letter was sent would know milk was only served at breakfast unless requested by the resident. The Administrator thought the information was in the admission packet. The Administrator confirmed the residents hadn't been offered other calcium options at lunch and dinner, such as yogurt or cottage cheese. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Interviews were conducted on 04/17/24 from 10:04 A.M. through 10:42 A.M. with Residents #1, #4, #22, #29 and #54 at the resident council meeting. The residents were alert and oriented to person, place, time, and situation. They were not offered milk at each meal, only at breakfast. If the residents wanted cottage cheese, they would have to order it in place of their meal since it was never offered in addition to the meal. Observation of the 04/18/24 menus posted at the two elevators on each floor revealed a choice of milk would be provided for breakfast, lunch, and dinner. There was no observation of any posting stating milk would only be provided at breakfast, unless requested by the resident for lunch and dinner. Review of the facility admission packet revealed there was nothing in the admission packet regarding when milk would be served. Interview on 04/23/24 at 9:53 A.M. with Assistant Director of Nursing (ADON) revealed during the admission process, nursing didn't go over any dietary areas, which included when a resident wanted milk. Review of facility policy Menus, revised December 2008, the Resident Council would be included in menu planning. Menus would provide a variety of foods from the basic daily food groups and will indicate standard portion at each meal. if a food group was missing from a resident's daily diet (e.g. dairy products) the resident would be provided an alternate means of meeting the resident's nutritional needs (e.g. calcium supplement or fortified non dairy alternatives).

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 46195 Based on observation, interviews, record reviews and review of facility policy, the facility failed to ensure resident food preferences were honored and appropriate substitutions were made per resident preferences. This had the potential to affect all 92 residents who received meals from the kitchen. The facility identified zero residents as receiving nothing by mouth (NPO). The facility census was 92. Findings include: Interview on 04/16/24 at 8:56 A.M. with the Ombudsman #507 revealed her biggest concern at the facility was the food. She stated she had advocated for all residents to be asked what they want to eat. Observation of tray line on 04/16/24 at 12:00 P.M. revealed on the steam table was ham, mechanical soft ham, carrots, roast red skin potatoes, and fish patties. (There was no alternate vegetable prepared). Interview on 04/16/24 at 12:33 P.M. with Food Service Director (FSD) #499 stated the residents don't like the recipes. She stated the number of meal item dislikes that could be listed on a resident's tray card was limited, which left the staff to memorize what the residents disliked if they had multiple dislikes. FSD #499 confirmed the facility did not offer a select menu to any of the residents, so the residents were served whatever the kitchen prepared for the day which may or may not be what was listed on the menu. Interview on 04/17/24 at 7:57 AM with Resident #27 revealed he didn't want milk for lunch and dinner and didn't know he could have cottage cheese or yogurt as a milk replacement. Interviews were conducted on 04/17/24 from 10:04 A.M. through 10:42 A.M. with Residents #1, #4, #22, #29 and #54 at the resident council meeting. The residents were alert and oriented to person, place, time, and situation. They were not offered milk at each meal, only at breakfast. If the residents wanted cottage cheese they would have to order it in place of their meal, it was never offered in addition to the meal. They revealed if they did not want what was posted on the menu, they needed to request it an hour before meal service otherwise, you might not get the alternate. If you were served the scheduled daily meal and then decided you did not want it, you could tell your nurse, but you most likely did not get anything else. When asked about preferences, the residents stated they could identify items they did not like, but substitutions were not offered in their place. For example, if you did not like peas and peas were on the menu, you did not get an alternate vegetable. Residents revealed there had been issues with the food at the facility for as long as they could remember. They reported talking about it every month at the Resident Council meeting but nothing ever changed. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Interview on 04/17/24 at 10:45 A.M. with Dietary Supervisor #500 confirmed for lunch on 04/16/24 she hadn't made an alternate vegetable. She stated she knew Resident #38 disliked carrots but had not given him an alternate vegetable for that meal. When asked what she would offer if the resident did not want ham or fish, she stated she would offer a cold sandwich even if they requested a grilled cheese she would refuse to make it if the kitchen was short staffed that day. Review of the tray card for lunch 04/16/24 revealed Resident #38 disliked carrots. Interview on 04/17/24 at 10:48 A.M. with Food Service Director #499 confirmed there were times when a request for a grilled cheese sandwich from a resident was not made. Interview on 04/17/24 at 1:55 P.M. with Registered Nurse (RN) #440 revealed everybody complained about the food. The kitchen refused to make alternates at times which was sad. Interview on 04/18/24 at 9:45 A.M. with Dietitian #503 confirmed food preferences from the residents are not being routinely done, and if a resident doesn't like a particular food item, an alternate should be given instead of the food item being eliminated. She confirmed there was no documentation on the tray card or in the medical chart indicating a resident did not want milk at lunch or dinner or if they were offered a calcium alternate. Dietitian #503 stated the quality of food was the main issue at the facility. She stated she was able to alter the menu. Dietitian #503 stated the new Spring menu was starting next week, but she hadn't had a chance to look at the new menu and had no idea what was on the menu. Interview on 04/18/24 at 11:35 A.M. with Resident #82 revealed she didn't like any of her breakfast and had never been asked about her food preferences. Interview on 04/18/24 at 11:43 A.M. with the Administrator revealed the facility had found that generally residents were not drinking milk at lunch and dinner. The facility had sent all the residents a letter that as a standard residents would only receive milk at breakfast and residents could receive milk at lunch and dinner upon request. The Administrator indicated the letter was sent last year and again two months ago. The Administrator was unsure how new residents who were admitted after the letter was sent would know that milk was only served at breakfast unless requested by the resident. The Administrator thought the information was in the admission packet. The Administrator confirmed the residents hadn't been offered other calcium options at lunch and dinner, such as yogurt or cottage cheese. Observation of the 04/18/24 menus posted at the two elevators on each floor revealed a choice of milk would be provided for breakfast, lunch, and dinner. Observation of the admission packet revealed there nothing in the admission packet regarding when milk would be served. Interview on 04/23/24 at 9:53 A.M. with Assistant Director of Nursing (ADON) revealed during the admission process, nursing didn't go over any dietary areas, which included when a resident wanted milk. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Interview on 04/23/24 at 2:59 P.M. with Administrator #504, who is senior administrator over the building and the administrator of a sister facility, and the Director of Nursing revealed the residents were not happy with the menu and were asking for more food activities since they don't like the menu. Administrator #504 stated his facility shared the same ombudsman who had shared her concerns with him regarding dietary. Review of facility policy Menus, revised December 2008, the Resident Council would be included in menu planning. Menus would provide a variety of foods from the basic daily food groups and will indicate standard portion at each meal. if a food group was missing from a resident's daily diet (e.g. dairy products) the resident would be provided an alternate means of meeting the resident's nutritional needs (e.g. calcium supplement or fortified non dairy alternatives). Review of facility policy Resident Rights, revised August 2009, revealed our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46195 Based on observation, interview, and review of facility policy, the facility failed to ensure proper sanitation was followed in the kitchen and during meal tray delivery. This had the potential to affect all 92 residents in the facility. The facility identified zero residents as receiving nothing by mouth (NPO). The facility census was 92. Findings include: 1. Observation of the tray line process on 04/16/24 from 12:00 P.M. to 12:33 P.M. revealed at 12:14 P.M. Dietary Cook #498 and Dietary Aide #506 took a food cart out of the kitchen for delivery. Upon return to the kitchen at 12:16 P.M. Dietary Cook #498 and Dietary Aide #506 did not wash their hands. At 12:19 P.M. Dietary Cook #498 and Dietary Aide #506 took another food cart out of the kitchen for delivery. Upon return to the kitchen at 12:22 P.M., they did not wash their hands. At 12:24 P.M. Dietary Cook #498 and Dietary Aide #506 took another food cart out of the kitchen for delivery. Upon return to the kitchen at 12:31 P.M., they did not wash their hands. Interview on 04/16/24 at 12:33 P.M. with Food Service Director #499 confirmed Dietary Cook #498 and Dietary Aide #506 had not washed their hands upon entering the kitchen after delivering the meal trays and stated kitchen staff should be washing their hands upon entering the kitchen. Review of facility policy Preventing Foodborne Illness-Employee Hygiene and Sanitary, revised December 2008, revealed employees must wash their hands whenever entering or re-entering the kitchen. 2. Observation of tray line process on 04/16/24 from 12:00 P.M. to 12:33 P.M. revealed Dietary Cook #498 was observed with artificial nails approximately one inch to one and a half inches from the end of the finger with three-dimensional art observed on the nails. Interview on 04/16/24 at 12:33 P.M. with Food Service Director (FSD) #499 confirmed Dietary Cook #498 was wearing artificial nails with three-dimensional art. FSD #499 revealed she didn't know the facility's policy on false nails in the kitchen. Review of facility policy Park Center Health Care and Rehabilitation Employee Dress Code, effective date 01/15/16, revealed for dietary employee's nails must be kept short (no more than 1/4 from top of finger). Fingernail polish and acrylic nails were not permitted. 3. Observation of items being pureed on 04/17/24 10:50 A.M. revealed Dietary Supervisor (DS) #500 took two servings of cake and placed them into a commercial blender and processed the items until it achieved the appropriate puree consistency with the addition of milk. DS #500 took a spatula and evenly divided the pureed cake into two small bowls. DS #500 then took the bowl and lid of the commercial blender and the spatula and washed them in a bucket of soapy water and rinsed them with running water in the three-compartment sink. There was no observation of the items being sanitized. DS #500 returned from the three compartment sink with the commercial blender bowl, lid and spatula. DS #500 placed the bowl and lid on the base of the commercial blender and proceeded to puree one hotdog and bun. DS #500 used the spatula to spoon the pureed hotdog into a small bowl. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Interview on 04/17/24 at 10:55 A.M. with DS #500 confirmed she washed the items in soapy water and rinsed with running water and the items were not sanitized. Review of facility policy Sanitation, revised December 2008, revealed manual washing and sanitizing will employ a three step process for washing, rinsing and sanitizing. 4. Observation on 04/16/24 from 12:33 P.M. to 12:55 P.M. of two unidentified state nursing assistants walking meal trays up the Three B hallway with coffee and Kool Aids uncovered. Interview on 04/16/24 at 12:35 P.M. with Food Service Director #499 confirmed the coffee and Kool Aid were uncovered as state tested nursing assistants passed meal trays down the hallway. FSD #499 stated the staff should take the beverage carts as they deliver the meal trays, or the beverages should be covered. Observation on 04/16/24 from 4:41 P.M. to 4:55 P.M. revealed State tested Nursing Assistant (STNA) #416 poured coffee into empty coffee cups in the resident lounge located at the end of the Three B hallway and placed the uncovered filled coffee cups on a tray on the meal cart and proceeded to walk the food cart down the hallway to deliver meal trays. STNA #415 was observed pouring Kool Aid in eight-ounce plastic cups (uncovered) in the same resident lounge and placed them on the second tier of a three tier cart. She then proceeded to push the three-tier cart down the hallway and stopped at resident rooms to see if a resident wanted Kool Aid to drink. Interview on 04/16/24 at 4:55 P.M. with FSD #499 confirmed the beverages were served uncovered and the beverage cart should be taken to the room instead of walking the beverages down the hall uncovered.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Dispose of garbage and refuse properly. 46195 Based on observation, interview, and review of the facility policy, the facility did not maintain garbage and refuse properly in a closed dumpster free of surrounding litter. This had the potential to affect all residents residing in the facility. The census was 92. Findings include: Observation of the dumpster area during the initial kitchen tour on 04/15/24 from 8:09 A.M. to 8:29 A.M. with Food Service Director (FSD) #499 revealed the left lid was open and the right lid was closed. There was a buildup of debris around the base of the dumpster, which included approximately 20 blue medical examination gloves, numerous plastic white spoons, numerous cigarette butts, one broken blue storage bin observed to be approximately six inches by six inches, one small unidentifiable white plastic bottle with a lid, and numerous dried up white papers, which appeared to be paper towels or napkins. This lack of sanitation predisposed the faciity to the risk of pests such as rodents and insects although no pests were seen at the time of the observation. Interview on 04/15/24 at 8:20 A.M. with FSD #499 confirmed the area around the dumpster was full of debris, and the lid to the dumpster was open. FSD #499 stated the lids to the dumpster should be closed when not in use, and the area around the dumpster should be kept clean. Review of facility policy Food-Related Garbage and Rubbish Disposal, revised December 2008, revealed outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 47568 Based on observation, record review, job description review, and interview the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This had the potential to affect all 92 residents who resided in the facility. The facility census was 92. Findings include: Review of facility document titled Job Description and Performance Standards for position of Administrator revealed the Administrator had a signed job description on 12/16/21. The description revealed the purpose of this position is to establish and maintain systems that are effective and efficient to operate the facility in a manner to safely meet residents' needs in compliance with federal, state, and local requirements. To establish and maintain systems that are effective and efficient to operate the facility in a financially sound manner. The Administrator was to establish systems to enforce the facility policies and procedures, supervise all department supervision and administration staff, observe all infection control policies and procedures, assume responsibility for identification, investigation, and follow up on concerns identified in the facility quality indicator report, and assume responsibility for implementation of an effective Quality Assurance program. Review of facility document titled Job Description and Performance Standards for position of Director of Nursing Services revealed the Director of Nursing (DON) had a signed job description on 05/03/22. The description revealed the purpose of the position was to provide nursing management, set resident care standards for all direct care providers and provide complete supervision and management for the nursing department. The Director of Nursing Services was to assume accountability for the development, organization and implementation of approved policies and procedures, direct, evaluate and supervise all resident care and initiate corrective action as necessary, assess resident care needs and assist in the development of individualized plans of resident care, analyze quality indicator reports, identify concerns and implement corrective action to improve resident care, report problems to the Administrator, conduct daily resident rounds and initiate corrective action as necessary, observe infection control procedures, observe all facility policies and procedures, and constantly work cooperatively with residents, resident representatives, facility staff, physicians, consultants and ancillary service providers. During an interview on 04/24/24 at 9:01 A.M. with the DON regarding the identified survey findings, the DON was asked if they were currently working on any Quality Assurance Performance Improvement (QAPI) projects in these areas. The DON indicated they had not identified the below concerns and/or had not developed any type of quality improvement plans in these areas. During the annual survey, observations, record reviews and interviews resulted in concerns related to the overall operation of the facility including but not limited to activities, infection control, dietary, and environment. The facility failed to provide evidence administrative staff, including the Administrator and/or DON had effective systems in place to timely identify and correct quality, care and environmental concerns. (continued on next page)

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	365185	A. Building B. Wing	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Center Healthcare and Rehabilitation	5665 South Ave Youngstown, OH 44512

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	A. The facility failed to ensure all residents were provided therapeutic activities as scheduled and, in the evenings, to meet their needs and preferences. This had the potential to affect all 92 residents in the facility and resulted in substandard quality of care. Review of the facility activity calendars dated November 2023 through April 2024 revealed no religious services routinely scheduled for the months, no activity calendar specific to the secured behavior unit (3A), a lack of therapeutic activities on weekends for all residents, a lack of evening activities that did not conflict with the evening meal times and met the needs and interests of the residents, and a lack of community outings since November 2023. Interviews conducted on 04/15/24 through 04/17/24 with Residents #196, #83, #1, #4, #22, #29 and #54 confirmed a lack of therapeutic activities to meet the needs and interests of the residents. Observations conducted throughout the survey on 04/15/24 from 10:50 A.M. to 11:25 A.M., 04/16/24 3:45 P. M. to 4:00 P.M., 04/17/24 2:30 P.M. to 3:15 P.M. and 04/18/24 10:50 A.M. to 11:25 A.M. revealed residents on the secured behavior unit (unit 3A) were observed sitting in common areas entertaining themselves with watching television and talking with other residents. Several residents were observed walking the hallways with no engagement from staff. Remaining Residents were observed in resident rooms sleeping or talking with their roommates. No activity calendar was observed to be posted on the unit. Residents were observed to be taken off this unit by staff for therapy and smoking breaks during observations. Interviews conducted on 04/18/24 with State tested Nursing Assistants (STNA) #418 and #449 confirmed a lack of therapeutic activities on the secured behavior unit (3A) and a lack of a calendar of activities on that unit. Interview with the Activity Director on 04/23/24 at 3:00 P.M. and again on 04/25/24 at 09:17 A.M. revealed she did not receive any training from the Administrator when she took over the position of activity director and her expectations was for all residents to receive one-on-one activities which was not being done as she had care planned for all residents. On 04/23/24 at 3:10 P.M. an interview with Licensed Nursing Home Administrator (LNHA) #504 who was covering the facility for the Administrator revealed AD #492 would have been trained by the Administrator of the facility and the Administrator of the facility should make sure they are trained. AD #492 would have spent time at a sister facility with their activity director. AD #492 spent time at his facility and has called the AD there for her guidance. There is no formal checklist for activity director training. B. The facility failed to develop and oversee an effective infection control program. Throughout the duration of the survey, multiple concerns were noted regarding infection control. Observation on 04/15/24 at 7:20 A.M. of the 200-hall revealed one resident (#15) had a sign on their door that stated the resident was on contact precautions. Review of the facility provided resident matrix dated 04/15/24 revealed Resident #32 was the only resident in the facility on contact precautions. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Interview on 04/15/24 at 9:53 A.M. with Assistant Director of Nursing (ADON) #451 revealed the matrix provided was inaccurate and Residents #2 and #32 were supposed to be on contact precautions while Residents #5, #9, #27, #31, #46, #49, #79, #195 and #197 were supposed to be on enhanced barrier precautions. ADON #451 revealed the residents on enhanced barrier precautions officially went on the precautions on 04/01/24, most of them for chronic wounds, and two for catheters. ADON #451 confirmed she did not do any formal education with staff when placing residents in contact or enhanced barrier precautions and only verbally told them. Observations on 04/15/24 between 9:53 A.M. to 11:13 A.M. revealed Residents #16, #45, #52, #71, and #246 nebulizer equipment was not properly stored following infection control practices, nebulizer masks were observed laying on the floor, and on bedside tables uncovered. Interview and observation on 04/18/24 at 11:12 A.M. with Housekeepers #479 and #484 revealed both clean and dirty laundry entered and exited the laundry room through the same door. Housekeeper #484 revealed she knew dirty laundry should come in one door and once cleaned go out a separate door however, Housekeeper #479 revealed she did not follow that practice and all laundry, both clean and dirty, went in and out the same door. Interview on 04/23/24 at 9:50 A.M. with Director of Environmental Services #487 revealed he believed Legionella testing should be performed annually but had only been employed by the facility for the last three months and had no evidence the Legionella Water Management policy had been implemented. Observations on 04/17/24 at 8:10 A.M. revealed Licensed Practical Nurse (LPN) #430 cleansed multi-use glucometer with an alcohol wipe after checking Resident #84's blood sugar. A second observation was made on 04/17/24 at 8:36 A.M. when Registered Nurse (RN) #440 cleansed a multi-use glucometer with an alcohol wipe after checking Resident #50's blood sugar. Interview on 04/17/24 at 11:00 A.M. with the Assistant Director of Nursing (ADON) #451 revealed the multi-use glucometer machines should be cleansed with a disposable germicidal cloth. Interview on 04/24/24 at 9:53 A.M. with the DON revealed the Assistant Director of Nursing (ADON) was responsible for in-servicing staff on enhanced barrier and transmission-based precautions. The DON believed the lack of staff knowledge regarding which residents were on precautions and what type of precaution was because the ADON had not yet in-serviced all staff. The DON had no knowledge of any concerns with Legionella water management, nebulizer storage or laundry and confirmed administration had not identified any recent issues regarding infection control. C. The facility failed to ensure dietary staff followed proper infection control measures in the kitchen, provided milk with all meals per resident choice and follow up with resident dietary concerns that were brought up during resident council and food audits. Interview on 04/15/24 with Food Service Director #499 revealed the residents didn't like the recipes and Dietitian #503 was slowly switching items on the menu. The dietitian wasn't involved in the kitchen. Observation during tray line on 04/16/24 from 12:00 P.M. to 12:33 P.M. revealed Dietary Cook #498 and Dietary Aide #506 did not wash hands upon entering the kitchen after delivering meal trays. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Observation of lunch and meal items being served on 04/16/24 between 12:00 P.M. and 4:44 P.M. revealed recipes for Hawaiian Ham for lunch and cheesy potatoes for dinner were not followed, an alternate vegetable choice wasn't served for lunch for residents who didn't carrots, and tray tickets indicated the residents would receive a choice of milk however only three residents had milk placed on their meal trays. Observation of staff passing meal trays on the second floor on 04/16/24 between 4:41 PM and 4:50 P.M. revealed State tested Nursing Assistants (STNAs) #415 and #416 passing koolaid and coffee uncovered down the 200 hallways as meal trays were delivered. Interview on 04/17/24 at 10:45 A.M. with FSD #499 and Dietary Supervisor #500 revealed there were times when they refused to make grilled cheese for a resident's alternate meal request. Observation of a puree process on 04/17/24 at 10:50 A.M. with Dietary Supervisor #500 revealed the bowl and lid to the commercial blender and the spatula was not properly sanitized between use. Interview on 04/18/24 at 9:45 A.M. with Dietitian #503 revealed recipes are not always followed, milk was not being provided with lunch and dinner meals unless requested by the resident, but calcium alternative hadn't been offered to residents as a replacement for the milk at lunch and dinner, and residents' food and beverage preferences weren't always being obtained. Review of resident food audits completed by facility staff from 01/24/24 from 04/14/24 revealed most audits indicated at least 25 percent of the residents interviewed did not feel the food was appealing or the food was good. Review of Resident Council minutes from 11/28/23 t 03/26/24 revealed the same dietary issues were being brought up each month. Interview on 04/24/24 at 9:01 A.M. with the Director of Nursing (DON) revealed there was definitely room to be made for improvements. The facility needed more check and balances and more follow-up with concerns. D. The facility did not ensure a clean, safe, homelike environment for Residents #27, #81 and #82. Interview and observation on 04/15/24 at 10:44 A.M. with Resident #82 revealed the call light was not functioning in the bathroom. Resident #82 stated she had told a couple aides months ago about it not working. Resident #82 stated she now carries her cell phone with her when she needs to use the bathroom in case, she needs to get ahold of someone. Observation of call light in the bathroom revealed when the string was pulled there was no light or sound outside the door indicating the call light had been activated. Interview on 04/15/24 at 10:57 A.M. with LPN #442 verified the bathroom call light was not functioning for Resident #82. Interview and observation on 04/15/24 at 4:21 P.M. with Resident #81 revealed his call light on his wall did not work. Observation at the time of interview revealed the call light would not light up or sound when activated. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Interview on 04/15/24 at 4:23 P.M. with Maintenance Assistant #488 confirmed the call light was not working. Interview and observation on 04/15/24 at 3:03 P.M. with Resident #27 revealed his call light was not working. Observation at the time of the interview revealed when the call light activated, the light did not turn on at the wall or outside the room. Interview on 04/15/24 at 4:25 P.M. with Maintenance Assistant #488 confirmed Resident #27's call light was not working. Interview on 04/23/24 at 1:30 P.M. with Director of Environmental Services #487 at 1:30 P.M. revealed the only way a maintenance staff member knew if a call light wasn't functioning was if a work order was made by a staff member. The maintenance department did not conduct routine audits to ensure call lights were functioning. Review of work orders for non-working call lights from 10/09/23 to 04/18/24 revealed there was no work order made for Residents #27, #81, #82's nonfunctioning call lights. E. The facility failed to repair or replace broken window blinds for 14 residents (#11, #17, #24, #36, #42, #43, #46, #49, #54, #56, #60, #62, #71 and #91). Observation on 04/17/24 between 10:10 A.M. to 10:55 A.M. revealed broken window blinds for Residents #11, #17, #24, #36, #42, #43, #46, #49, #54, #56, #60, #62, #71 and #91. Interview on 04/18/24 at 10:49 A.M. with the Director of Environmental Services #487 revealed the facility utilized a computer program (TELS) to input work orders for repairs. Nurses will input repairs needed in TELS system and housekeeping will write repairs needed on a list. Director of Environmental Services #487 stated he did not do any audits for repairs needed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47568 Based on medical record review, interview, observation and policy review the facility failed to ensure daily weights were documented per physician orders related to congestive heart failure monitoring for Resident #45. The facility also failed to ensure Resident #196's diet order accurately reflected the resident's dietary needs. This affected two resident's (#45 and #196) of 32 residents reviewed for documentation. In addition, the facility failed to have documented evidence of weekly body audits on Resident #79 as ordered to monitor the status of wounds. This affected one resident (#79) of three residents reviewed for pressure ulcers and had the potential to affect nine additional residents (#9, #27, #42, #43, #46, #49, #58, #74, and #195) identified by the facility as having wounds. The facility census was 92. Findings include: 1. Review of medical record for Resident #45 revealed an admitted [DATE]. Medical diagnoses included occlusion and stenosis of bilateral carotid arteries, congestive heart failure, ischemic cardiomyopathy, acute ischemic heart disease, chest pain, type two diabetes mellitus, chronic obstructive pulmonary disease, hypertension, post-traumatic stress disorder, major depressive disorder, and anxiety disorder. Review of quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #45 had mild cognitive impairment, was independent for eating, required supervision or touching assistance for oral hygiene, toileting hygiene, shower/bathing, upper body dressing, lower body dressing and personal hygiene, and required partial to moderate assistance with putting on and taking off footwear. Resident #45 did not show any behaviors of rejection of care. Resident #45 had none or unknown weight loss or weight gain. Review of Resident #45's care plan dated 09/29/21 revealed the resident had cardiac disease related to ischemic cardiomyopathy, coronary artery disease, congestive heart failure, history of myocardial infarction, hyperlipidemia, hypertension and presence of a cardiac pacemaker. Review of physician orders for Resident #45 revealed an order dated 04/24/23 for daily weights to be obtained for heart failure, notify physician if Resident #45 had gained or lost four pounds or more. Review of Medication Administration Records (MAR) and Treatment Administration Records (TAR) for January 2024, February 2024, March 2024 and April 2024 revealed no weights or refusals were documented for 01/01/24, 01/03/24, 01/04/24, 01/06/24, 01/13/24, 01/14/24, 01/15/24, 01/17/24, 01/18/24, 01/19/24, 01/21/24, 01/23/24, 01/24/24, 01/25/24, 01/26/24, 01/27/24, 01/28/24, 01/30/24, 01/31/24, 02/06/24, 02/07/24, 02/09/24, 02/10/24, 02/14/24, 02/15/24, 02/16/24, 02/18/24, 02/19/24, 02/20/24, 02/21/24, 02/24/24, 02/25/24, 02/26/24, 02/29/24, 03/01/24, 03/03/24, 03/05/24, 02/09/24, 03/11/24, 03/14/24, 03/15/24, 03/16/24, 03/19/24, 03/20/24, 03/22/24, 03/25/24, 03/27/24, 03/29/24, 03/30/24, 03/31/24, 04/01/24, 04/03/24, 04/11/24, 04/12/24, and 04/16/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/16/24 at 3:49 P.M. with Assistant Director of Nursing (ADON) #451 confirmed Resident #45 was ordered to have daily weights and confirmed there was no documentation that weights were obtained for 01/01/24, 01/03/24, 01/04/24, 01/06/24, 01/13/24, 01/14/24, 01/15/24, 01/17/24, 01/18/24, 01/19/24, 01/21/24, 01/23/24, 01/24/24, 01/25/24, 01/26/24, 01/27/24, 01/28/24, 01/30/24, 01/31/24, 02/06/24, 02/07/24, 02/09/24, 02/10/24, 02/14/24, 02/15/24, 02/16/24, 02/18/24, 02/19/24, 02/20/24, 02/21/24, 02/24/24, 02/25/24, 02/26/24, 02/29/24, 03/01/24, 03/03/24, 03/05/24, 02/09/24, 03/11/24, 03/14/24, 03/15/24, 03/16/24, 03/19/24, 03/20/24. Review of undated facility policy titled Charting and Documentation revealed the purpose of charting and documentation is to provide a complete account of the residents, care, treatment, response to the care, signs and symptoms as well as the progress of the resident's care. Staff are to document daily treatment, vital signs in the appropriate location. 2. Review of the medical record for resident #196 revealed an admitted [DATE]. Diagnoses included end stage renal disease, colitis, anxiety and depression. Review of the physician orders for April 2024 reflected a regular diet order for Resident #196. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was cognitively intact. She was independent in eating, oral hygiene and showering and required supervision or touch assistance for dressing and personal hygiene. She had no problems eating, drinking or swallowing and had no broken or missing teeth. Review of the care plan dated for 04/08/24 revealed the resident was at risk for renal insufficiency due to end stage renal disease with a dependence on dialysis. Interventions included administering medications per physician's orders, conferring with the physician and/or dialysis treatment center regarding changes in medication administration times or dosage prior to dialysis, following the resident's diet per physicians orders and obtaining labs as ordered and notifying the physician of results. Review of the meal ticket dated 04/16/24 for resident #196 revealed the resident was on a liberalized renal diet. Interview on 04/18/24 at 9:27 A.M. with Registered Dietician (RD) #503 revealed Resident #196 should in fact be on a liberalized renal diet and not a regular diet. RD #503 verified the regular diet order did not accurately reflect Resident #196's liberalized renal diet. 3. Review of the medical record for Resident #79 revealed an admitted [DATE] with diagnoses including cellulitis of the left lower extremity, morbid obesity, malignant neoplasm of the large intestine, and major depression. Review of the care plan dated 02/01/24 revealed Resident #79 was care planned for actual skin breakdown related to a Stage IV pressure ulcer (Full thickness tissue loss with exposed bone, tendon, or muscle. Slough may be present on some parts of the wound bed. Often include undermining and tunneling.) to the left heel. Review of the April 2024 physician's orders included an order for weekly body audits. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the medical record for April 2024 revealed no documented evidence weekly body audits were completed as ordered by the physician. On 04/16/24 at 3:45 P.M. an interview with the Assistant Director of Nursing (ADON)/Licensed Practical Nurse (LPN) #451 who is also the wound care nurse, verified there was no documentation within Resident #79 records indicating the weekly body audits were completed on 04/05/24 and 04/12/24 as ordered. LPN #451 stated she was behind on inputting body audits. LPN #451 stated body audits were completed for Resident #79 on 04/05/24 and 04/12/24, but she did not have any documented evidence to verify they were completed. Observation of wound care on 04/17/24 at 11:22 A.M. with LPN #451 revealed the left heel wound was improving and almost healed. A review of the policy titled, Prevention of Pressure Ulcers dated September 2013 revealed the facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family, and addressed.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 46195 Based on observations, record reviews and interviews the facility failed to develop and implement a system to address, analyze, monitor and resolve quality assurance and performance improvement related to the pervasive and ongoing food quality concerns in the facility. This had the potential to affect all 92 residents residing in the facility, as the facility identified zero residents who did not eat by mouth (NPO). The facility census was 92. Findings Include: Review of food audits conducted by facility staff from 01/24/24 to 04/14/24 revealed on 01/24/24 two out of the four residents interviewed didn't feel the food was appealing or good, on 01/18/24 two out of the four residents interviewed didn't feel the food was good or appealing, on 01/20/24 one out of the four residents interviewed didn't feel the food was good or appealing, on 02/06/24 four out of four residents interviewed didn't feel the food was appealing and those four residents had asked for alternate for the meal, on 02/26/24 four out of four residents interviewed felt the food was good and appealing, on 03/07/24 one out of four residents interviewed didn't feel the food was good or appealing, on 03/13/24 all three residents interviewed felt the food was good and appealing, on 03/19/24 one resident out of three interviewed felt the food wasn't appealing and all three interviewed didn't feel the food was good, on 04/02/24 two out of four residents interviewed didn't feel the food was good or appealing, on 04/10/24 all four residents interviewed felt the food was good and appealing, and on 04/14/24 one out of four residents interviewed didn't feel the food was appealing or good. Review of Resident Council meeting minutes from 09/28/23 to 03/26/24 revealed on 10/26/23 dietary still unsatisfactory', on 11/28/23 Food Service Director (FSD) #499 had responded to dietary concerns and Resident Council was not satisfied with the response, on 01/18/24 dietary continues to have same issues and the Administrator was always busy, on 02/21/24 dietary continues to have same issues and the administrator still too busy to attend, on 03/26/24 the residents voiced concerns related to not enough food, being tired of peanut butter and jelly sandwiches, and FSD #499 not being supportive regarding resident concerns about double portions. The Administrator attended and stated he would follow up with the kitchen issues. Interview on 04/16/24 at 8:56 A.M. with Ombudsman #507 revealed her biggest concern with the facility had to do with the food complaints from the residents and the Administration was aware of these concerns. Interviews conducted on 04/16/24 between 12:33 P.M. and 12:37 P.M. with FSD #499 confirmed the residents had been complaining about the food quality. FSD #499 confirmed standardized recipes were not being followed and residents did not like what items were on the facility menus. Interview on 04/16/24 at 5:11 P.M. with Dietary Supervisor (DS) #500 confirmed she did not follow standardized recipes. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Interviews were conducted on 04/17/24 from 10:04 A.M. through 10:42 A.M. with Residents #1, #4, #22, #29 and #54 at the Resident Council meeting. All in attendance confirmed there were multiple food quality concerns brought up month after month and as long as they could remember. The concerns included being served chicken and rice all the time, not getting enough food even when they ask for double portions, not being offered milk to drink, not being aware of or being offered a milk substitute such as cottage cheese and not receiving an alternate if they did not like what was served. Interviews conducted on 04/17/24 between 10:45 and 10:48 A.M. with DS #500 confirmed there were times when a resident didn't like a certain item, they would not receive a replacement, and there were times when an alternate meal item request was not made. Interview on 04/18/24 at 9:45 A.M. with Dietitian #503 revealed the main issue at the facility was the quality of food, and it depended on the cook if recipes were followed. She stated the menu could be adjusted, the Spring/Summer menu were starting next week, and she hadn't had a chance to look at what meal items were included on the menu. Interview on 04/23/24 at 2:59 P.M. with Director of Nursing (DON)and Senior Administrator #504 revealed the kitchen concerns have been ongoing. The residents were not happy with the menu and were asking for more food activities. Interviews conducted on 04/24/24 between 9:01 A.M. and 9:36 A.M. with the DON revealed she was aware the food was being audited, but there had been no additional investigation into the root cause of the food concerns. She indicated it varied from week to week if the food concerns were getting better. She stated the food concerns were discussed during the Quality Assurance Performance Improvement (QAPI) meeting, but the interdisciplinary team really couldn't do much with food concerns, since it was more of an Administrator and FSD #499 issue. The DON stated there was room to be made for improvements regarding QAPI, and the facility needed to conduct more checks and balances and more follow-up with concerns. The DON confirmed although food quality was identified as a systemic problem and food audits had been done, there had been no analysis or corrective performance improvement plan put into place to address it. Review of facility policy Quality Assurance and Performance Improvement (QAPI) Plan, revised April 2014, revealed the facility shall develop, implement, and maintain an ongoing, facility-wide QAPI plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on observation, interview, record review and facility policy review, the facility failed to ensure appropriate infection control procedures were followed regarding transmission-based precautions (TBP) and enhanced barrier precautions (EBP), failed to separate clean and dirty linens, failed to ensure an effective Legionella water management program, failed to ensure appropriate nebulizer and oxygen tubing storage, and failed to clean multiuse glucometers according to facility policy. This affected 17 residents (#2, #5, #9, #16, #27, #31, #32, #43, #45, #46, #49, #50, #58, #79, #84, #195 and #197) of 32 residents reviewed for infection control and had the potential to affect all 92 residents residing in the facility. Findings include: 1. Review of the facility provided resident matrix dated 04/15/24 revealed Resident #32 was the only resident in the facility on TBP precautions. Observation on 04/15/24/at 7:20 A.M. of the 200-hall revealed Resident #27 had a sign on his door that stated the resident was on contact precautions as well as a cart of personal protective equipment (PPE) next to his door. Observation on tour of the facility 04/15/24 between 7:20 A.M. and 7:37 A.M. revealed Residents #27 was the only resident isolation precaution signage on the door of the room and a cart with PPE outside of the room. Interview on 04/15/24 at 9:53 A.M. with Assistant Director of Nursing (ADON)/ Licensed Practical Nurse (LPN) #451, the facility infection preventionist, revealed the matrix provided was inaccurate and Residents #2 and #32 were supposed to be on contact precautions while Residents #5, #9, #27, #31, #46, #49, #79, #195 and #197 were supposed to be on EBP. She revealed the residents on EBP officially went on the precautions on 04/01/24, most of them for chronic wounds, and two for indwelling urinary catheters. She confirmed she did not do any formal education with staff when placing residents in contact or EBP and only verbally told them. Interview on 04/15/24 at 2:53 P.M. with State tested Nurse's Aides (STNAs) #427 and #429 revealed Resident #32 was in isolation and on contact precautions, and Residents #5, #31 and #58 were on contact precautions. Both STNA #427 and #429 confirmed none of the rooms had signs on the doors indicating what type of isolation precautions were in place and neither knew what PPE or precautions they should take prior to entering the resident's room. Review of the medical record for Resident #2 revealed an admitted [DATE] with diagnoses including diabetes, chronic kidney disease, anemia, fatigue, and pneumonia. Review of the medical record revealed no physician's orders for TBP or EBP. Review of the medical record for Resident #5 revealed an admitted [DATE] with diagnoses including neuropathy, chronic respiratory failure, diabetes, anxiety, and post-traumatic stress disorder (PTSD). Review of the medical record revealed no physician's orders for TBP or EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of the medical record for Resident #9 revealed an admitted [DATE] with diagnoses including anemia, pressure ulcer of the sacral region, chronic pain, and anxiety. Review of the medical record revealed no physician's orders for TBP or EBP. Review of the medical record for Resident #27 revealed an admitted [DATE] with diagnoses including paraplegia, anxiety, diabetes, chronic obstructive pulmonary disease (COPD), and an open wound to the left buttock. Review of the medical record revealed no physician's orders for TBP or EBP; however, Resident #27 had a sign for EBP and PPE outside of his door. Review of the medical record for Resident #31 revealed an admitted [DATE] with diagnoses including acute kidney failure, hypothyroidism, diabetes, dementia, and cognitive communication deficit. Review of the medical record revealed no physician's orders for TBP or EBP. Review of the medical record for Resident #32 revealed an admitted [DATE] with diagnoses including COPD, anxiety, chronic respiratory failure, and altered mental status. Review of the physician's orders dated 04/09/24 revealed Resident #32 was on TBP for ESBL (an enzyme produced by some bacteria that makes them resistant to certain antibiotics). Resident #32 did not have signage for TBP on the door of the room or a cart outside the door with PPE. Review of the care plan dated 1/25/24 revealed Resident #32 was on contact precautions related to multi drug resistant organisms (MDRO) in the urine. Interventions included remaining in enhanced barrier precautions for prevention. Review of the medical record for Resident #43 revealed an admitted [DATE] with diagnoses including iron deficiency, COPD, depression, and cognitive communication deficit. Review of the physician's orders for April 2024 revealed Resident #43 was on enhanced barrier precautions (EBP) due to chronic wounds, with gloves and gowns needed when in direct contact with the resident. The order was dated 04/10/24. Resident #43 did not have signage for EBP on the door of the room or a cart outside the door with PPE. Review of the medical record for resident #46 revealed an admitted [DATE]. Diagnoses included Hernia, bilateral hearing loss, dementia hypertension and adult failure to thrive. Review of the medical record revealed no physician's orders for TBP or EBP. Review of the medical record for Resident #49 revealed an admitted [DATE] with diagnoses including diabetes, hypertension, depression, and insomnia. Review of the medical record revealed no physician's orders for TBP or EBP. Review of the medical record for Resident #58 revealed an admitted [DATE] with diagnoses including epilepsy, adult failure to thrive, schizoaffective disorder, diabetes, and neuropathy. Review of the medical record revealed no physician's orders for TBP or EBP. Review of the medical record for Resident #79 revealed an admitted [DATE] with diagnoses including lymphedema, epilepsy, morbid obesity, depression, and hypertension. Review of the medical record revealed no physician's orders for TBP or EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of the medical record for resident #195 revealed an admitted [DATE] with diagnoses including diabetes, COPD, chronic kidney disease, history of stroke, and osteoarthritis. Review of the medical record revealed no physician's orders for TBP or EBP. Review of the care plan dated 03/15/24 revealed Resident #195 required EBP per facility policy related to chronic wounds. Interventions included remaining in EBP for prevention and no signs or symptoms of wound infection. Resident #195 did not have signage for EBP on the door of the room or a cart outside the door with PPE. Review of the medical record for Resident #197 revealed an admitted [DATE] with diagnoses including hypertension, stomach cancer, depression, and muscle weakness. Review of the medical record revealed no physician's orders for TBP or EBP. Review of the facility policy titled Infection Control Guidelines for All Nursing Procedures, dated August 2012, revealed staff will have the appropriate training regarding standard and transmission-based precautions prior to direct care responsibilities as well as how to manage infections including MDRO and how to monitor for signs and symptoms of infection. Review of the facility policy titled Isolation - Initiating Transmission-Based Precautions, dated August 2010, revealed the facility would ensure protective equipment was near the residents' room when on transmission-based precautions and post the appropriate notice on the room entrance door to ensure all staff were aware of precautions. 47568 2. Interview on 04/18/24 at 11:12 A.M. with Housekeepers #479 and #484 revealed both clean and dirty laundry entered and exited the laundry room through the same door. Housekeeper #484 revealed she knew dirty laundry should come in one door and once cleaned go out a separate door; however, Housekeeper #479 revealed she did not follow that practice and all laundry, both clean and dirty, went in and out the same door. Review of the facility policy titled Departmental (Environmental) Services, Laundry and Linen, dated January 2014, revealed clean and soiled linen would be separated at all times. 3. Interview on 04/23/24 at 9:50 A.M. with Director of Environmental Services #487 revealed he believed Legionella testing should be performed annually but had only been at the facility three months and had no documented evidence the Legionella water management policy had been implemented. Review of the facility policy titled Legionella Water Management Program, dated July 2017, revealed the water management program would identify areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria and be reviewed at least yearly, sooner if needed. 4. Review of the medical record for Resident #45 revealed an admitted [DATE]. Medical diagnoses included occlusion and stenosis of bilateral carotid arteries, congestive heart failure, ischemic cardiomyopathy, acute ischemic heart disease, chest pain, type two diabetes mellitus, chronic obstructive pulmonary disease, hypertension, post-traumatic stress disorder, major depressive disorder, and anxiety disorder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of quarterly MDS assessment dated [DATE] revealed Resident #45 had mild cognitive impairment, was independent for eating, required supervision or touching assistance for oral hygiene, toileting hygiene, shower/bathing, upper body dressing, lower body dressing and personal hygiene, and required partial to moderate assistance with putting on and taking off footwear. Resident #45 did not show any behaviors of rejection of care. Review of the care plan dated 09/29/21 revealed Resident #45 had and was at risk for respiratory impairment related to chronic obstructive pulmonary disease. Review of the physician orders for Resident #45 revealed an order for an aerosol treatment iprtopium-albuterol solution 0.5 milligrams (mg) per three milliliters (ml) to receive one application daily at bedtime via inhalation. Observation on 04/15/24 at 9:23 A.M. revealed Resident #45's nebulizer mask sitting on bedside table uncovered, and the attached tubing had no date attached to indicate last time the tubing was changed. Interview on 04/15/24 at 11:13 A.M. with Registered Nurse (RN) #435 confirmed the nebulizer tubing was not dated and the nebulizer mask was not covered. RN #435 stated all nebulizer masks should be covered with a bag and the attached tubing should be dated. 48565 5. Record review for Resident #84 revealed an admitted [DATE]. Significant diagnosis included, major depression, Parkinson's disease, adult failure to thrive, and diabetes mellitus type II with hyperglycemia (high blood sugar). Significant orders included Lantus insulin 16 units subcutaneously at bedtime and Humalog insulin inject as per sliding scale: if blood sugar reading is 0 - 150 = 0; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 450 = 12 units greater than 450mg/dL call provider, subcutaneously with meals for diabetes; hold if fasting blood sugar is less than 100. On 04/17/24 at 8:10 A.M. the blood sugar check for Resident #84 by LPN #430 was observed. LPN #430 wiped off the multiuse glucometer (a machine used to check blood sugar levels) with an alcohol pad after completion of the blood sugar check for Resident #84. LPN #430 verified the usage of the alcohol pad at the time of the observation. Record review for Resident #50 revealed an admitted [DATE]. Significant diagnoses included pneumonia, depression, diabetes mellitus type II, and anxiety. Significant orders included blood sugar check one time daily. On 04/17/24 at 8:36 A.M. the blood sugar check for Resident #50 by RN #440 was observed. RN #440 wiped off the glucometer machine with an alcohol pad after completion of the blood sugar check for Resident #50. RN #440 verified the usage of the alcohol pad at the time of the observation. On 04/17/24 at 11:00 A.M. an interview with the Assistant Director of Nursing (ADON) #451 revealed the multiuse glucometer machines should have been wiped with a disposable germicidal cloth. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	A review of the facility policy titled Glucometer Disinfecting, dated March 2013, revealed before after each use of the glucometer, the nurse must clean and wipe this equipment before using it on the next resident. Gloves and a disinfecting germicidal disposable wipe will be utilized to clean the glucometer to ensure possible contaminated body fluids are removed between resident to resident. The treated surface of the glucometer must remain visibly wet for a full two minutes. 6. Review of the medical record for Resident #16 revealed a date of admission of 03/07/24. Significant diagnoses included Alzheimer's disease, anxiety, adult failure to thrive, chronic respiratory failure with hypoxia (low oxygen levels), and major depressive disorder. Significant orders included oxygen three liters per minute per nasal cannula as needed to keep oxygen saturation above 92%, change oxygen tubing weekly and as needed, place in dated bag when not in use, and ipratropium-albuterol solution 0.5-2.5 mg per/3 milliliters (ml), inhale 3 ml via nebulizer every six hours as needed for shortness of breath. On 04/15/24 at 10:35 A.M. an observation in the room of Resident #16 revealed the nebulizer mask on the floor uncovered. The nasal cannula for oxygen delivery was lying on the bed without being bagged. STNA #415 verified the nebulizer mask on the floor and the unbagged nasal cannula at the time of the observation. A review of the undated facility policy titled, Oxygen and Nebulizer Policy revealed no information in regard to the proper storage of oxygen and nebulizer equipment when not in use to prevent contamination and the spread of infection.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation, interviews, and review of the facility policy, the facility failed to ensure it had a functional call light system for Residents #27, #81, and #82. This affected three residents (#27, #81 and #82) out of 32 residents reviewed for call lights. The facility census was 92. Findings Include: 1. Record review for Resident #82 revealed an admitted [DATE]. Diagnoses included encounter for other orthopedic aftercare, presence of left artificial hip joint, bilateral primary osteoarthritis of hip, pain in left and right hip, major depressive disorder, generalized anxiety disorder, type two diabetes mellitus without complications, other abnormalities of gait and mobility, and muscle weakness (generalized). Review of most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #82 was cognitively intact, required partial/moderate assistance for toilet hygiene, and supervision or touch assistance of staff for toilet transfer and walking up to 150 feet. The resident was occasionally incontinent of urine and bowel and no fall history since previous assessment. Review of the care plan initiated on 06/09/23 revealed Resident #82 was at risk for falls due to generalized weakness, bilateral hip pain and osteoarthritis, unsteady gait, diabetes, coronary artery disease (CAD), hypertension (high blood pressure), hypothyroidism, and hyperlipidemia. Interventions included administering medications per physician order, call bell in reach, encourage to transfer and change positions slowly, and provide assistance to transfer and ambulate as needed. Interview and observation on 04/15/24 at 10:44 A.M. with Resident #82 revealed her call light was not working in the bathroom. She stated she had told a couple aides months ago about it not working and she has not brought the issue up again because they heard her and that is where it dropped. Resident #82 stated she now carries her cell phone with her when she needs to go the bathroom to be on the safe side. Observation of call light in the bathroom revealed when the string was pulled there was no light or sound outside the door indicating the call light had been activated. Interview on 04/15/24 at 10:57 A.M. with Licensed Practical Nurse (LPN) #442 verified the bathroom call light wasn't working. Interview on 04/23/24 at 1:30 P.M. with Director of Environmental Services (DES) #487 at 1:30 P.M. revealed the only way a maintenance staff member knew if a call light wasn't functioning was if a work order was made by a staff member. The maintenance department did not conduct routine audits to ensure call lights were functioning. Review of work orders for non-working call lights from 10/09/23 to 04/18/24 revealed there was no work order made for Resident #82's nonfunctioning call light in the bathroom. Review of facility policy Answering the Call Light, revised October 2010, revealed the purpose of this procedure is to respond to the resident's request and staff were to report all defective call lights to the nurse supervisor promptly. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of medical record for Resident #81 revealed an admitted [DATE]. Diagnoses included fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing, unspecified fall, presence of other orthopedic joint implants, chronic obstructive pulmonary disease (COPD), cerebral palsy, bipolar disorder, generalized anxiety, post traumatic disorder, and depressive disorder. Review of most recent MDS 3.0 assessment dated [DATE] indicted Resident #81 was cognitively intact and required supervision or touch assistance for toileting hygiene, showering/bathing self, chair to bed transfer, toileting transfer, and walking up to 150 feet. Resident #81 was always continent of bowel and bladder and had no falls since prior assessment. Interview and observation on 04/15/24 at 4:21 P.M. with Resident #81 revealed his call light on his wall did not work. Observation at the time of interview revealed the call light would not light up or sound when activated. Interview on 04/15/24 at 4:23 P.M. with Maintenance Assistant (MA) #488 confirmed the call light was not working. Review of work orders for non-functioning call lights from 10/0923 to 04/28/24 revealed there had not been a work order for Resident #82's nonfunctioning call light until it had been pointed out by the state surveyor on 04/15/24 at 4:23 P.M. Interview on 04/23/24 at 1:30 P.M. with DES #487 at 1:30 P.M. revealed the only way a maintenance staff member knew if a call light wasn't functioning was if a work order was made by a staff member. The maintenance department did not conduct routine audits to ensure call lights were functioning. Review of facility policy Answering the Call Light, revised October 2010, revealed the purpose of this procedure is to respond to the resident's request and staff were to report all defective call lights to the nurse supervisor promptly. 3. Review of medical record for Resident #27 revealed an admitted [DATE]. Diagnoses included paraplegia (impairment in the motor or sensory function of the extremities) , polyneuropathy (general degeneration of the peripheral nerves that spreads toward the center of th body), anxiety disorder, type two diabetes without complications, chronic obstructive pulmonary disease (COPD), polyosteoarthritis, chronic pain, osteoporosis, peripheral vascular disease (condition in which narrowed arteries reduce blood flow to the extremities) , and muscle weakness. Review of the most recent MDS 3.0 assessment dated [DATE] revealed Resident #27 was cognitively intact. The resident required supervision or touching assistance from staff for oral hygiene, toileting hygiene, shower/bathe self, personal hygiene, sit to stand, chair to bed transfer, toilet transfer, and tub/shower transfer. Resident #27 intermittently catharized himself, was always continent of bowel, and had no falls since previous assessment. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan created on 09/19/23 revealed Resident #27 had an activity of daily living (ADL) care deficit related to paraplegia, polyneuropathy, sciatica, right foot drop, lumbar spinal stenosis with neurogenic claudication, osteoporosis, low back pain, type two diabetes, cervical disc degeneration/displacement, COPD, and artificial bilateral hip joints. Interventions included extensive assist of one for toileting, extensive assistance for dressing, limited assistance for bathing, supervision/verbal cues for transfers and bed mobility. Review of the care plan created on 09/19/23 revealed Resident #27 was at risk for falls due to impaired balance/poor coordination, sensory deficit, paraplegia, polyneuropathy, sciatica, right foot drop, low back pain, type two diabetes, cervical disc degeneration/displacement, artificial bilateral hip joints, and COPD. Interventions include administer medications per physician order, call bell in reach, and reinforce wheelchair safety as needed such as locking brakes. Interview and observation on 04/15/24 at 3:03 P.M. with Resident #27 revealed his call light was not working. Observation at the time of the interview revealed when the call light activated, the light did not turn on at the wall or outside the room. Interview on 04/15/24 at 4:25 P.M. with MA #488 confirmed Resident #27's call light was not working. Review of work orders for non-functioning call lights from 10/0923 to 04/28/24 revealed there had not been a work order for Resident #27's nonfunctioning call light until it had been pointed out by the state surveyor on 04/15/24 at 4:25 P.M. Interview on 04/23/24 at 1:30 P.M. with DES #487 revealed the only way a maintenance staff member knew if a call light wasn't functioning was if a work order was made by a staff member. The maintenance department did not conduct routine audits to ensure call lights were functioning. Review of facility policy Answering the Call Light, revised October 2010, revealed the purpose of this procedure is to respond to the resident's request and staff were to report all defective call lights to the nurse supervisor promptly.