STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365221	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Manor of Greenfield	850 Nellie Street Greenfield, OH 45123

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 39967 Based on resident and staff interview, review for the facility grievance log, and review of a facility policy, the facility failed to make prompt efforts to resolve dietary grievances. This had the potential to affect all 50 residents residing in the facility. The facility census was 50. Findings include: Review of the October 2024 grievance log revealed the facility received four grievances regarding dietary services and the quality of the food. The resolutions listed included to educate on tray line and availability and will cook the food longer. Review of the November 2024 grievance log revealed the facility received two grievances regarding dietary services, the quantity of food, and the quality of the food. The resolutions listed were the facility offered alternatives and adjusted portions. Review of the December 2024 grievance log revealed the facility received two grievances regarding dietary services and food. The resolution listed was the facility educated staff. Interview with Resident #9 on 01/21/25 at 9:25 A.M. revealed the food did not taste good at the facility. Interview with Resident #27 on 01/21/25 at 9:36 A.M. revealed the food at the facility was not good. Resident #27 stated he believed the issue was with how the food was prepared. Interview with Resident #28 on 01/21/25 at 10:09 A.M. revealed Resident #28 disliked the food at the facility. Interview with Resident #12 on 01/21/25 at 10:30 A.M. revealed the food did not taste good at the facility. Interview with Resident #29 on 01/21/25 at 11:15 A.M. revealed the food did not taste good at the facility, and reported the food was bland. Interview with Resident #21 on 01/21/25 at 2:32 P.M. revealed the food did not taste good at the facility. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the Administrator on 01/23/25 at 11:03 A.M. verified the facility had received a large number of complaints about the food and dietary services. The Administrator reported the dietary department at the facility were contracted staff and the complaints about dietary services continued to occur because the facility could only discuss the residents' concerns with the dietary services contractor. The Administrator reported the facility did not have any proof of the education provided from the October and December 2024 grievances regarding the dietary services grievances was provided to dietary services staff. The Administrator stated she never tested the food at the facility for quality. Interview with Licensed Practical Nurse (LPN) #335 on 01/23/25 at 1:14 P.M. revealed residents complained of the food being too cold or they received small portions. LPN #335 stated the food complaints at the facility had been ongoing and LPN #335 felt the food did not appear appetizing. Review of the facility's undated policy titled, Resident and family concerns and grievances policy and procedure, revealed residents may voice a grievance to the facility staff in person, by phone or by written communication. The facility will follow up with residents within 72 hours of the filing of a grievance. The facility will make reasonable efforts to ensure that all grievances are adequately resolved within thirty calendar days from the day the grievance was received. This deficiency represents non-compliance investigated under Complaint Number OH00161251.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731 Based on medical record review and staff interview, the facility failed to ensure Minimum Data Set (MDS) assessments were encoded and transmitted within required timeframes. This affected five (#17, #5, #30, #27, and #11) of five residents reviewed for resident assessment. The facility census was 50. Findings include: 1. Review of the medical record for Resident #17 revealed an admitted [DATE]. Diagnoses included chronic kidney disease, hyperlipidemia, hypertension, and anemia. Review of Resident #17's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the MDS was completed 08/13/24 but not submitted until 09/24/24. Interview on 01/22/25 at 3:22 P.M., MDS Coordinator (MDSC) #328 verified Resident #17's was submitted on 09/24/24. MDSC #328 stated the MDS assessment should have been submitted within seven days of completion. 2. Review of the medical record for Resident #5 revealed an admitted [DATE]. The resident discharged from the facility on 08/19/24. Diagnoses included metabolic encephalopathy, chronic obstructive pulmonary disease, hypertension, schizophrenia, hyperlipidemia, rheumatoid arthritis, gastro-esophageal reflux disease, epilepsy, and dementia. Review of Resident #5's MDS assessment dated [DATE] revealed the MDS assessment was completed on 09/09/24 and submitted 09/24/24. Interview on 01/22/25 at 3:23 P.M., MDSC #328 verified Resident #5's MDS assessment was not completed or submitted timely. MDSC #328 stated the MDS assessment should have been completed within seven days of the date of assessment and submitted within seven days of completion. 3. Review of the medical record for Resident #30 revealed an admitted [DATE]. The resident discharged from the facility on 08/30/24. Diagnoses included back pain, venous insufficiency, paroxysmal atrial fibrillation, and adult failure to thrive. Review of MDS assessments completed while Resident #30 revealed the most recent assessment completed was a quarterly MDS assessment on 08/20/24. There was no discharge MDS assessment completed for Resident #30. Interview on 01/22/25 at 3:24 P.M., MDSC #328 verified a discharge MDS assessment was not completed for Resident #30's discharge of 08/30/24. 4. Review of the medical record for Resident #27 revealed an admitted [DATE]. The resident discharged from the facility on 09/04/24. Diagnoses included congestive heart failure, Parkinson's disease, hypertension, and major depressive disorder. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #27's admission MDS assessment dated [DATE] revealed the assessment was completed 08/30/24, however the assessment was submitted on 09/24/24. Interview on 01/22/25 at 3:25 P.M., MDSC #328 verified Resident #27's 08/27/24 admission MDS assessment was not submitted until 09/24/24. MDSC #328 stated assessments should be submitted within seven days of completion. 5. Review of the medical record for Resident #11 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, diabetes mellitus with diabetic neuropathy, vascular dementia, congestive heart failure, and major depressive disorder. Review of Resident #11's annual MDS assessment dated [DATE] revealed the MDS assessment was not completed until 09/06/24 and the assessment was submitted on 09/24/24. Interview on 01/22/25 at 3:26 P.M., MDSC #328 verified Resident #11's 08/09/24 MDS assessment was not completed nor submitted timely. MDSC #328 stated the MDS assessment should have been completed within seven days of the assessment date and submitted within seven days of completion.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on medical record review and staff interview, the facility failed notify the state mental health authority with a significant change Preadmission Screening and Resident Review (PASARR) for a resident with a change in their mental health condition. This affected two (#2 and #33) of three residents reviewed for PASARR. The facility census was 50. Findings include: 1. Review of Resident #33's medical record revealed the resident admitted to the facility on [DATE] with diagnoses including major depressive disorder, hypothyroidism, personal history of traumatic brain injury, hypokalemia, other developmental disorders of speech and language, muscle weakness, and xerosis cutis. Review of Resident #33's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was assessed as severely cognitively impaired. Review of Resident #33's PASARR document dated 11/05/21 revealed Resident #33 had no diagnoses of mental disorders. Resident #33 did not have indications of serious mental illness. Resident #33's diagnosis of traumatic brain injury was marked on the PASARR and Resident #33 was noted to have indications of developmental disability. Review of Resident #33's notice of PASARR determination and right to a state hearing letter dated 11/08/21 revealed Resident #33 may require the level of services provided by the nursing facility and may continue to reside in the nursing facility for 180 days from the date of the determination. The nursing facility in conjunction with the local entitles shall initiate and continue discharge planning activities throughout the period of time specified on the determination notice. The last date of the specified period was listed on the letter as 05/07/22 and the deadline for an extension request was listed on the letter as 04/07/22. Review of Resident #33's medical record from 11/08/21 to 01/22/25 revealed there were no additional extensions or PASARRs determinations for Resident #33 past 05/07/22. Review of Resident #33's diagnosis list dated 01/22/25 revealed Resident #33 had a diagnosis of major depressive disorder with an onset date of 10/08/21 and schizoaffective disorder with an onset date of 08/04/23. Interview with Social Services Director (SSD) #322 on 01/22/25 at 1:16 P.M. verified Resident #33 received a new diagnosis of schizoaffective disorder on 08/04/23 and the facility did not complete a significant change PASARR or notification to the state mental health authority of Resident #33's new diagnosis. SSD #322 also verified Resident #33's major depressive disorder diagnosis with an onset date of 10/08/21 was not listed on the 11/05/21 PASARR. 42731 (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #2 revealed an admitted [DATE]. Diagnoses included dementia, irritable bowel syndrome with diarrhea, gastro-esophageal reflux disease, paranoid schizophrenia (added 04/12/22), chronic pain syndrome, constipation, anemia, major depressive disorder, psychotic disorder with delusions, anxiety, and adult failure to thrive. Review of the quarterly MDS assessment dated [DATE] revealed Resident #2 had moderately impaired cognition. Review of Resident #2's PASARR dated 10/21/20 revealed section D, indications of serious mental illness, was coded as the resident did not have any indications of serious mental illness. There were no further PASARRs completed for Resident #2 in the medical record. Interview on 01/22/25 at 3:11 P.M., SSD #322 verified a new PASARR was not completed when Resident #2 received a new diagnosis of paranoid schizophrenia on 04/12/22.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on observation, resident and staff interview, and medical record review, the facility failed to develop care plans to address resident needs and interventions. This affected four (#12, #24, #39, and #42) of 24 residents reviewed for care planning. The facility census was 50. Findings include: 1. Review of Resident #12's medical record revealed the resident admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, type two diabetes mellitus with other specified complications, congestive heart failure, polyneuropathy, personal history of transient ischemic attack and cerebral infarction without residual deficits, congestive obstructive pulmonary disease, constipation, and centrilobular emphysema. Review of Resident #12's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and was assessed to receive an anticoagulant medication. Review of Resident #12's physician order dated 06/06/24 revealed the resident received the anticoagulant Eliquis five (5) milligrams (mg) with instructions to give one tablet by mouth two times a day for atrial fibrillation. Review of Resident #12's comprehensive care plan from 06/06/24 to 01/22/25 revealed Resident #12 did not have a care plan to address the use of an anticoagulant. Interview with MDS Nurse #328 on 01/22/25 at 1:16 P.M. verified Resident #12 received a scheduled anticoagulant medication and did not have a care plan developed to address anticoagulant use. 2. Review of Resident #42's medical record revealed the resident admitted to the facility on [DATE] with diagnoses including a wedge compression fracture of the first lumbar vertebra, atrial fibrillation, depression, presence of other vascular implants and grafts, hyperlipidemia, chronic obstructive pulmonary disease, and old myocardial infarction. Review of Resident #42's quarterly Minimum Data (MDS) assessment dated [DATE] revealed the resident was cognitively intact and was assessed to receive an anticoagulant medication. Review of Resident #42's physician order dated 09/05/24 revealed the resident received Eliquis 5 mg with instructions to give one tablet by mouth every morning and at bedtime for atrial fibrillation. Review of Resident #42's comprehensive care plan from 09/04/24 to 01/22/25 revealed Resident #42 did not have a care plan to address the use of an anticoagulant. Interview with MDS Nurse #328 on 01/22/25 at 1:16 P.M. verified Resident #42 received a scheduled anticoagulant medication and did not have a care plan developed to address anticoagulant use. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #39's medical record revealed the resident admitted to the facility on [DATE] with diagnoses including end stage renal disease, insomnia, chronic kidney disease, chronic obstructive pulmonary disease, vascular dementia, hypertension, chronic respiratory failure and depression. Review of Resident #39's admission MDS assessment dated [DATE] revealed the resident was cognitively intact and was assessed as edentulous with no natural teeth. Interview and observation with Resident #39 on 01/21/25 at 11:30 A.M. confirmed the resident was edentulous and had dentures in place on his upper gums. Interview with MDS Nurse #328 on 01/22/25 at 1:16 P.M. verified Resident #39 did not have a care plan developed to address his dental needs, use of dentures, or edentulous status. 42731 4. Review of the medical record for Resident #24 revealed an admitted [DATE]. Diagnoses included congestive heart failure, hyperlipidemia, chronic respiratory failure, chronic obstructive pulmonary disease, major depressive disorder, hypertension, restless legs syndrome, type two diabetes, and cognitive communication deficit. Review of the comprehensive MDS assessment dated [DATE] revealed the resident had intact cognition. The resident had impaired range of motion on both lower extremities, was dependent on staff for toileting and bathing, and required substantial/maximal assistance for bed mobility. The resident expressed having little interest or pleasure in doing things more than half of the days during the assessment period. Review of the Care Area assessment dated [DATE] revealed Resident #24 triggered activities related to expressing having little interest or pleasure in doing things. The resident was noted to prefer self-initiated activities in her room. The resident was noted with a diagnosis of depression and required daily interaction with staff and other like residents. The resident was noted to be at risk for decline with her psychosocial status and for social isolation. It was noted activities would be addressed in the care plan. Review of Resident #24's medical record revealed there was no care plan developed to address activities. Interview on 01/22/25 at 4:23 P.M. with Activities Director (AD) #325 verified there was no activities care plan developed for Resident #24.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062 Based on medical record review, staff interview, hospital documentation review, and review of a facility policy, the facility failed to ensure non-pressure wounds were properly assessed and treated in a timely manner. This affected one (#37) of one residents reviewed for wounds. The facility census was 50. Findings Include: Record review for Resident #37 revealed she was admitted to the facility on [DATE]. Diagnoses included, rheumatoid arthritis, essential primary hypertension, gastro-esophageal reflux disease (GERD), chronic pain syndrome, anxiety disorder, and major depressive disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 was cognitively intact. Resident #37 was dependent on staff for bathing, toilet use, dressing, and personal hygiene, and required maximum assistance from staff with eating, and oral hygiene. Review of the hospital discharge report titled, Admission Continuity of Care, included in Resident #37's admission paperwork dated 11/30/24 revealed Resident #37 had a wound located on her left anterior ankle. Review of Resident #37's wound evaluation note dated 12/09/24 revealed the resident presented with a trauma injury wound on her left medical ankle. The wound measured 1.5 centimeters (cm) long by 1.0 cm wide by 0.3 cm deep. Further review of the wound evaluation document revealed necrotic tissue was removed from the wound to establish margins of viable tissue. A treatment order was given to apply leptospermum honey once daily for 30 days and apply a boarder gauze once daily for 30 days with replacement of kerlix if the dressing fell off. Review of a wound evaluation dated 01/20/25 revealed Resident #37's left ankle wound showed improvement as measured 0.5 cm long by 0.5 cm wide by 0.1 cm deep. Interview on 01/21/25 at 9:56 A.M. with Resident #37 stated she had the wound on her left ankle at the hospital, however, no one at the facility identified the wound or provided any treatment to the wound on her left ankle until several days after she admitted to the facility. Interview on 01/22/25 at 3:32 P.M. with MDS Nurse #328 confirmed the facility failed to identify the wound located on Resident #37's left ankle. MDS Nurse #328 confirmed the wound located on Resident #37's left ankle was present at the the time of admission and the facility did not provide treatment to the wound from the time of admission on 12/04/24 through the initial wound care assessment on 12/09/24. Interview on 01/22/25 at 4:15 P.M. with Assistant Director of Nursing (ADON) #308 confirmed the facility failed to treat Resident #37's wound to the left ankle until 12/09/24 when the wound physician as the resident. ADON #308 confirmed the facility failed to identify the wound on Resident #37's initial skin assessment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/22/25 at 4:28 P.M. with Licensed Practical Nurse (LPN) #335 confirmed she was the admission nurse for Resident #37 the day the resident was admitted to the facility. LPN #335 stated she was off work for a few days after Resident #37 was admitted to the facility, and when she returned to work, management told her she missed Resident #37's left ankle would on her initial assessment. Interview on 01/23/25 at 2:14 P.M. with Wound Physician (WP) #501 confirmed his first assessment for Resident #37 was on 12/09/24 and confirmed Resident #37's admitted was 12/04/24. WP #501 stated did not feel the delay in treatment caused further damage to Resident #37's left ankle wound. Review of the facility policy titled, Wound Care, dated October 2010, revealed the facility should verify a physician's order for the procedure, and as part of the preparation for wound care, the facility will review the resident's care plan to assess for any special needs of the resident.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 39967 Based on observation, staff interview, review of menu spreadsheets, and review of a facility policy, the facility failed to ensure menus were followed during meal service. This affected all 50 residents residing in the facility. The facility census was 50. Findings include: Review of the menu spreadsheet dated 01/22/25 revealed residents on a regular diet were to receive one country fried steak with mushroom gravy, four ounces of carrots, four ounces of potatoes, and a square of cornbread, and residents on mechanical soft diets were to receive a four ounce scoop of ground country fried steak with mushroom gravy, four ounces of carrots, four ounces of potatoes, and a square of cornbread. Observation of meal service on 01/22/25 at 4:45 P.M. revealed [NAME] #406 served residents on regular diets one country fried steak, three ounces of gravy, four ounces of carrots, three ounces of potatoes, and a square of corn bread. [NAME] #406 served residents on mechanical soft diets three ounces of mechanically altered country fried steak, three ounces of gravy, four ounces of carrots, three ounces of potatoes, and a square of corn bread. Interview with [NAME] #406 on 01/22/25 at 4:45 P.M. verified residents on regular diets were served a three ounce scoop of potatoes and the menu spreadsheet indicated those residents should have received four ounces of potatoes. [NAME] #406 also confirmed residents on mechanical soft diets were served a three ounce scoop of potatoes and a three ounce scoop of mechanically altered country fried steak and the menu spreadsheet indicated those residents should have received four ounces of potatoes and four ounces of country fried steak. Review of the facility menus policy, dated October 2022, revealed menus were to be served as written. This deficiency represents non-compliance investigated under Complaint Number OH00161251.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 39967 Based on observation, staff interview, review of a resident list, and review of a food recipe, revealed the facility failed to prepare food in a palatable and attractive manner. This affected four (#1, #3, #6, and #42) of four residents who received mashed potatoes during meal observations. The facility census was 50. Findings include: Observation of meal service on 01/22/25 at 4:45 P.M. revealed [NAME] #406 served mashed potatoes as an alternate using a four ounce scoop. Further observation revealed [NAME] #406 went to scoop out a portion of mashed potatoes and part of the scoop was the dry potato mix. Interview with [NAME] #406 on 01/22/25 at 4:45 P.M. verified the mashed potatoes were not thoroughly mixed and residents were served dry mashed potato mix in their mashed potatoes. Review of the facility's undated mashed potato recipe revealed to mix the dry potato mix and water together, add margarine, and mix thoroughly. Review of the facility's undated list of residents that received mashed potatoes on 01/22/25 revealed four (#1, #3, #6 and #42) residents received the alternate mashed potatoes. This deficiency represents non-compliance investigated under Complaint Number OH00161251.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 39967 Based on observation, staff interview, review of a resident diet list, the facility failed to ensure mechanically altered meat was prepared in a form to meet resident needs. This affected 11 (#1, #4, #3, #6, #20, #23, #36, #42, #46, #47, and #202) of 11 residents that received mechanically altered diets. The facility census was 50. Findings include: Observation of meal service on 01/22/25 at 4:45 P.M. revealed a pan of mechanically altered country fried steak on the tray line. There were large chucks of the country fried steak in the pan that were larger than the size of a quarter. [NAME] #406 was observed to use a three ounce scoop to serve the mechanically altered country fried steak with chunks in it to residents that received mechanical diets. Interview with [NAME] #406 on 01/22/25 at 4:45 P.M. verified there were large chucks of mechanically altered pieces of country fried steak that were larger than the size of a quarter in the pan on the tray line. [NAME] #406 also verified she served residents that received mechanical soft diets the mechanically altered country fried steak with large chunks in it. [NAME] #406 confirmed the chunks of mechanically altered country fried steak were too large for residents on mechanical soft diets. Review of an undated list of residents that received mechanical soft diets revealed Resident #1, Resident #4, Resident #3, Resident #6, Resident #20, Resident #23, Resident #36, Resident #42, Resident #46, Resident #47, and Resident #202 received mechanical soft diets.

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	365221	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Manor of Greenfield	850 Nellie Street Greenfield, OH 45123

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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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on observation, medical record review, and staff interview, the facility failed to ensure a resident was served food on a divided plate per the physician order. This affected one (#37) of one residents reviewed for assistive eating equipment and utensils. The facility census was 50. Findings include: Review of Resident #37's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included rheumatoid arthritis, essential primary hypertension, gastro-esophageal, chronic pain syndrome, anxiety disorder, and major depressive disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 was cognitively intact. Resident #37 was dependent on staff for medication administration, bathing, toilet use, dressing, and personal hygiene, and required maximum assistance from staff with eating and oral hygiene. Review of Resident #37's diet order dated 12/12/24 revealed the resident was ordered a regular diet with regular texture and regular consistency. Review of Resident #37's physician order dated 01/07/25 revealed Resident #37 was to have a divided plate for all meals. Observation of the meal service on 01/22/25 at 4:45 P.M. revealed [NAME] #406 placed country fried steak, potatoes, corn bread, and carrots on a regular plate for Resident #37. Interview with [NAME] #406 on 01/22/25 at 4:45 P.M. verified Resident #37 was ordered a divided plate and Resident #37's meal was served on a regular plate. Review of the facility's assistive devices policy, dated October 2022, revealed assistive devices and utensils will be provided as identified in the individualized plan of care to maintain or improve a resident's ability to eat and drink independently.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39967 Based on observation, staff interview, review of a dishwasher operation manual, and facility policy review, the facility failed to ensure food was served in a safe and sanitary manner, failed to ensure the kitchen was properly cleaned, and failed to ensure the dishwasher was appropriately functioning. This affected all 50 residents residing in the facility. The census was 50. Findings include: 1. Observation of the kitchen on 01/21/25 at 8:50 A.M. revealed staff were actively using the dishwasher. The dishwasher had a wash temperature of 111 degrees Fahrenheit (F) and a rinse temperature of 146 degrees F. Dietary Manager (DM) #410 was observed testing the chemical sanitizer in the dishwasher and the dishwasher tested at 200 parts per million (ppm). Interview with DM #410 on 01/21/25 at 8:50 P.M. verified the dishwasher had a wash temperature of 111 degrees F and a rinse temperature of 146 degrees F. DM #410 stated the dishwasher was a low temperature dishwasher, and the wash and rinse temperature should be above 120 degrees F. Review of the facility policy titled, Warewashing, revised February 2023, revealed all dishwasher water temperatures will be maintained in accordance with manufacturer recommendations for high or low temperature machines. Review of the dishwasher's operations manual dated May 2024 revealed the minimum wash and rinse temperature was 120 degrees F. 2. Observation of the kitchen on 01/22/25 at 4:45 P.M. revealed the ventilation cover on the ceiling above the facility's sink had a gray fuzzy substance built up on it. Interview with DM #410 on 01/22/25 at 4:45 P.M. verified the vent on the ceiling above the facility's sink had a gray fuzzy substance built up on it. 3. Observation of the meal tray line on 01/22/25 at 4:45 P.M. revealed [NAME] #406 was observed serving dinner to residents while wearing gloves. [NAME] #406 was observed to get gravy on her glove. [NAME] #406 proceeded to go to the dirty side of the dishwasher and use the overhead facet sprayer to spray the gravy off her glove using her other gloved hand to operate the facet. [NAME] #406 then returned to the tray line and continued to serve resident meals on the tray line without changing her gloves or washing her hands. Further observation of the meal tray line revealed [NAME] #406 grabbed a plate from a clean stack of plates that had a piece of lettuce on it from where it did not get completely cleaned in the dishwasher. [NAME] #406 proceeded to take off the piece of lettuce with her gloved hand, wiped the lettuce and her gloved hand on her shirt and continued to serve the meal on the soiled plate. [NAME] #406 also did not change her gloves after taking the lettuce off the plate or wiping it on her shirt. After the surveyor confirmed [NAME] #406 did not change her gloves or wash her hands during the observation, [NAME] #406 took the gloves off, washed her hands, and then proceeded to blow into a new pair of gloves with her mouth before putting them on and continuing to serve resident meals. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with [NAME] #406 on 01/22/25 at 4:45 P.M. verified she did not change her gloves after spraying off her glove using the facet on the dirty side of the dishwasher, and after removing lettuce from a soiled plate. [NAME] #406 verified that she blew into her new pair of gloves when she changed her gloves. [NAME] #406 also confirmed she continued to serve a resident's meal on a soiled plate after removing a piece of lettuce from the plate. Review of the facility policy titled, Warewashing, revised February 2023, revealed all dishware will be cleaned and sanitized after each use. Review of the facility's food preparation policy, revised February 2023, revealed all staff will practice proper hand washing techniques and glove use.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404 Based on observation, medical record review, staff interview, policy review, the facility failed to maintain proper signage and personal protective equipment for a resident with an indwelling medical device placed on enhanced barrier precautions. This affected one (#9) of five residents reviewed for infection control. The facility census was 50. Findings include: Review of Resident #9's medical record revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, mixed hyperlipidemia, tracheostomy status, cognitive communication deficit, disease of the pancreas, acquired absence of the larynx, dysphagia pharyngeal phase, obesity due to excess calories, epilepsy, chronic kidney disease, major depressive disorder, and type two diabetes mellitus with hypoglycemia. Review of the 12/23/24 quarterly Minimum Data Set (MDS) assessment revealed Resident #9 was cognitively intact and require tracheostomy care while a resident. Review of Resident #9's physician orders revealed an order dated 10/03/24 for enhanced barrier precautions related to a tracheostomy. Observation on 01/21/25 at various random times revealed Resident #9 had no sign on or near the door to the resident's room for enhanced barrier precautions and there was no personal protective equipment (PPE) outside the room. Observation on 01/22/25 at 3:20 P.M. revealed Resident #9 continued to have no sign on or near the resident's room door for enhanced barrier precautions. Interview with Licensed Practical Nurse (LPN) #333 on 01/22/25 at 3:25 P.M. verified there was no enhanced barrier precautions sign on or near Resident #9's room and no PPE available for use in Resident #9's room. Review of the 08/01/22 facility enhanced barrier precautions policy revealed enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDRO) to residents. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. PPE is available outside of the resident rooms.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404 Based on medical record review, staff interview, and policy review, the facility failed to timely administer pneumococcal vaccines. This affected two (#11 and #29) of five residents reviewed for vaccinations. The facility census was 50. Findings include: 1. Review of Resident #11's medical record revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, insomnia, hyperlipidemia, diabetes mellitus with diabetic neuropathy, peripheral vascular disease, mild cognitive impairment, vascular dementia, and hypothyroidism. Review of Resident #11's medical record on 01/23/25 revealed no documented evidence of the resident receiving a pneumococcal vaccine. 2. Review of Resident #29's medical record revealed an admitted [DATE]. Diagnoses included encounter for orthopedic aftercare, anxiety disorder, nausea, anemia, psychoactive substance abuse, tobacco use, spinal stenosis, chronic obstructive pulmonary disease, hemiplegia and hemiparesis following cerebral infarction, cord compression, solitary pulmonary nodule, and chronic pain syndrome. Review of Resident #29's medical record on 01/23/25 revealed no documented evidence of the resident receiving a pneumococcal vaccine. Interview with Assistant Director of Nursing (ADON) #308 on 01/23/25 at 1:51 P.M. revealed Resident #11 and Resident #29 had not received a pneumococcal vaccine during either resident's stay in the facility, but they were suppose to receive it that day. ADON #308 verified the pneumococcal vaccine status should be checked on admission and yearly. Review of the facility pneumococcal vaccine policy, dated 10/01/23, revealed all residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within 30 days of admission to the facility unless medically contraindicated or the resident has completed the current recommended vaccine series.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062 Based on observation, medical record review, and staff interview, the facility failed to maintain a clean, sanitary, and homelike environment. This had the potential to affected all 50 residents residing at the facility. The facility census was 50. Findings include: 1. Interview and observation with the Administrator on 01/23/25 at 9:25 A.M. confirmed the light over the nurses' station when walking onto the unit from the front door did not have a cover and had exposed florescent lighting. The light to the left of the main nurses' station when walking onto the unit was missing a light cover and had exposed florescent lighting. The [NAME] Court hallway had four missing light covers with exposed bulbs. The [NAME] hallway had exposed ceiling with no ceiling tiles outside of Resident room [ROOM NUMBER] and damage on the ceiling with no tiles cover outside of Resident room [ROOM NUMBER]. Their was also a light out over the seating areas of the resident living room. The [NAME] Court hallway had a total of four florescent lights out. The Administrator confirmed the findings at the time of the observations. 2. Medical record review for Resident #41 revealed he admitted to the facility on [DATE]. His diagnoses included complete traumatic amputation of one left lesser toe, essential primary hypertension, staphylococcal arthritis, diabetes mellitus (DM), and chronic obstructive pulmonary disease (COPD). Review of the Minimum Data Set (MDS) assessment for Resident #41 dated 12/12/24 revealed he had mildly impaired cognition. Resident #41 was dependent on staff for toilet use, required moderate assistance from staff with bathing, lower body dressing, putting on shoes, and personal hygiene, and required set up assistance from staff with eating and oral hygiene. Observation on 01/21/25 at 12:50 P.M. revealed Resident # 41's room had a strong odor of urine, scattered debris all over the floor, and the floor appeared to be dirty. Interview on 01/21/25 at 1:53 P.M. with Licensed Practical Nurse (LPN) #238 confirmed the strong smell of urine in Resident #41's room, and confirmed the debris scattered all over the floor and appearance of the dirty floor. 3. Medical record review for Resident #28 revealed he admitted to the facility on [DATE]. His diagnoses included, DM, end stage renal disease, essential primary hypertension, peripheral vascular disease, gastro-esophageal reflux disease, heart failure, heart failure, atherosclerotic heart disease, congenital and hereditary, and insomnia. Review of MDS assessment dated [DATE] revealed Resident #28 was cognitively intact. Further review of the MDS assessment revealed he was dependent on staff for bathing, required set up assistance from staff for eating, required moderate assistance from staff with oral hygiene, upper body dressing, and personal hygiene, and required maximum assistance from staff with toile use and lower body dressing. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 01/21/25 at 10:09 A.M. revealed Resident #28 had a brown and reddish substance splattered and scattered along the wall next to the resident's bed. Further observation revealed the floor appeared soiled and unkept. Interview and observation on 01/22/25 at 11:20 A.M. with LPN #238 confirmed the brown and reddish stains and splatters along Resident #28's wall beside his bed, and confirmed the floor appeared soiled and dirty.