STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365222	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Norworth The	6830 North High Street Worthington, OH 43085

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on medical record review and staff interview, the facility failed to ensure the Pre-Admission Screening and Resident Review (PASARR) documents were accurate to the resident's conditions and diagnoses. This affected two (Residents #4 and #75) of three residents reviewed for PASARR assessments. The facility census was 115. Findings include: 1. Review of the medical record for Resident #4 revealed an admitted [DATE] with diagnoses that included cerebral infarction due to embolism in the right middle cerebral artery, schizophrenia, and bipolar disorder. Updated diagnosis on 10/25/24 showed vascular dementia. Review of Resident #4's care plan, dated 01/11/23, noted a risk for impaired skin, pain, and functional ability deficits due to the diagnosis of vascular dementia. Review of the PASARR identification screen dated 02/28/23 revealed that under Section D: Medical diagnosis, question one asked, Does the individual have a diagnosis of dementia? The facility selected no. Interview on 02/13/25 at 2:16 P.M. with Social Services Assistant (SSA) #334 confirmed the PASARR screening completed on 02/28/23 was inaccurate because it did not include the diagnosis of dementia. 2. Review of the medical record for Resident #75 revealed an admitted [DATE] with diagnoses including psychoactive substance abuse, insomnia, and depression. The updated diagnoses on 07/2020 revealed anxiety disorder, and on 07/16/24, post-traumatic stress disorder was added. Review of the significant change in condition PASARR identification screen dated 11/06/24 for Resident #75 revealed Resident #75 had the mental health diagnoses of mood disorders, panic or other severe anxiety disorders, and post-traumatic stress disorder. Insomnia was not marked as a diagnosis that Resident #75 had. Interview on 02/13/25 at 2:16 P.M. with Social Services Assistant (SSA) #334 confirmed the PASARR screening completed for Resident #75 on 11/06/24 was inaccurate because it did not include the diagnosis of insomnia in the mental health disorders section. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of PASARR policy dated 12/15/22 revealed the PASARR process is used to screen all individuals admitted for nursing care to ensure that needs are met to assist the individual in reaching their highest potential, all seriously mentally ill and/or have an intellectual/developmental disability are required to be evaluated. An updated PASARR is required for incorrect review completed, mental status change not related to delirium, acute psychiatric episode, symptoms of new mental health diagnosis, newly evident or possible serious disability or change in need for nursing facility level of care.

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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** 51068 Based on record review, review of the facility policy, and staff interview the facility failed to ensure they timely followed up with state mental health agency for level two evaluation for Resident #22. This affected one (Resident #22) of four residents reviewed for pre-admission screening and resident review (PASARR) identification screenings. The facility census was 115. Findings include: Review of the medical record for Resident #22 revealed an admitted [DATE] with diagnoses including bipolar disorder and schizophrenia. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 02/06/25, revealed Resident #22 was cognitively intact. Review of the pre-admission screening and resident review (PASARR) for Resident #22 revealed a change of condition PASARR was completed on 11/14/24 with a PASARR results letter on 11/14/24 indicating level II evaluation was required. There was no evidence the level II evaluation was coordinated with the state mental health agency from 11/15/24 to to 02/12/25. Review of the progress notes for Resident #22 revealed on 02/13/25 at 10:33 A.M., Social Services Assistant (SSA) #334 wrote she checked for PASSAR results following a level II No results have been uploaded at this time. Will check at a later date. There was no follow up completed to determine if level II services were required until 02/13/25. Interview on 02/13/25 at 2:14 P.M. with SSA #334 confirmed the only coordination for requesting the level II evaluation from the state mental health agency was not completed until on 02/13/25. Review of the Pre-Admission Screening and Guest/Resident Review - PASARR Ohio Policy revealed if the responses to the Level I screening indicate the presence of a mental illness and/or intellectual/developmental disability, the person is referred to the local community mental health program for comprehensive screening, Level 2.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51068 Based on record review, staff interview, resident interview, and policy review, the facility failed to obtain vision services in a timely manner for Resident #60. This affected one (Resident #60) of two residents reviewed for vision. The facility census was 115. Findings include: Review of Resident #60's medical record revealed an admitted [DATE] with diagnoses including localization-related (focal) idiopathic epilepsy and epileptic syndromes with seizures of localized onset. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #60 did not have corrective lenses and was cognitively intact. The MDS did not trigger for visual function. Review of the progress notes revealed on 08/13/24 at 6:18 P.M., a Nurse Practitioner (NP) documented Resident #60 needed an eye exam and new glasses to address vision impairment, which could contribute to fall risks. On 08/15/24 at 4:02 P.M., a nurse contacted Optometry #500 to schedule an appointment. Review of the after-visit summary (AVS) from Resident #60's eye appointment at an Eye Institute on 08/28/24 revealed a glasses prescription were as follows: Right eye: Sphere +1.25, Cylinder +0.25, Axis 010, Add +2.50 Left eye: Sphere +1.50, Cylinder +0.75, Axis 165, Add +2.50. These findings indicated impaired vision. Review of the physician orders for Resident #60 dated 09/25/24 revealed an order to schedule an eyewear appointment at Optometry #500. The physician order was later discontinued on 10/14/24. There was no documentation Resident #60 received eyeglasses from 08/29/24 to 02/10/25 and/or seen at Optometry #500 for eyewear appointment from 09/25/24 to 02/10/25. On 09/28/24, Social Services Assistant (SSA) #279 documented she requested services from Optometry #600 and Optometry #700 but did not conduct any follow-up with either provider. During an interview on 02/11/25 at 7:43 A.M., Resident #60 stated he needed glasses and had not received them since arriving at the facility. He reported informing staff about his vision concerns and expressed worry about signing documents he could not read. He also stated he did not feel able to participate in activities due to his vision impairment. During an interview on 02/12/25 at 12:05 P.M., Social Worker (SW) #291 explained when a resident requires dental or vision services, they assist in setting up appointments through two different optometry companies. SW #291 stated SSA #334 was responsible for coordinating ancillary services and would check why Resident #60 had not yet received glasses. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/12/25 at 3:02 P.M., SSA #279 confirmed Resident #60 was seen in August 2024 for an eye exam and prescription. SSA #279 stated in September 2024, Resident #60 opted to be seen by the in-house eye doctor, but she was unsure why he was not seen sooner. SSA #279 stated transportation was arranged in February 2025 for the resident to go to Optometry #800 for new glasses, but Optometry #800 was unable to fulfill the prescription. She was unsure why transportation was not scheduled until February 2025. During a subsequent interview on 02/12/25 at 4:08 P.M., SSA #279 stated once a resident required ancillary services is admitted , they were added to the Optometry #600 list. She reported Optometry #600 visits the facility once a month and last visited on 02/10/25 and sometime in November. SSA #279 admitted she had not been following up with Optometry #600 to ensure residents received necessary vision services but stated she would begin doing so. She also revealed the Optometry #600 consent form for Resident #60 was signed on 09/28/24 but was not sent to the appropriate parties until 10/08/24. Review of the Social Services Referral to Outside Providers policy revealed the following requirements: A physician's order must be obtained by nursing. Consent to receive services must be sought from the resident or their representative before initiating services. Social services must make the referral to the outside provider and provide demographics and signed consent as needed. Progress notes from the service provider must be obtained and placed in the resident's medical record. The resident's physician, family, and/or representative must be informed of the service results, and any recommendations should be reviewed with the physician. The provider's recommendations must be integrated into the resident's care plan. Recommendations for interventions should be communicated to direct care staff. Follow-up visits should be scheduled as needed.

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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** 51524 Based on record review, staff interview, and facility policy review, the facility failed to appropriately monitor the resident's significant weight loss and timely follow the registered dietitian's recommendations and facility policy. This affected two (Residents #87 and #94) of six residents reviewed for nutrition monitoring. The facility census was 115. Findings include: 1. Review of the medical record revealed Resident #94 was readmitted to the facility on [DATE]. Diagnoses included chronic kidney disease, diverticulosis of small and large intestines and clostridium difficile (C-diff). Review of the Minimum Data Set (MDS) assessment, dated 12/19/24, revealed Resident #94 was cognitively intact. Resident #94's was readmitted to the facility on [DATE], following a hospitalization . Review of the Resident #94's weights, dated 12/07/24 to 02/10/25, revealed the following weights: 12/13/24 at 132.2 pounds (lbs)), 01/09/25 at 119.0 lbs., 02/06/25 at 114.8 lbs., and 02/10/25 at 114.0 lbs. There was no weight obtained on re-admission on 12/07/24 and weekly weights were not completed per facility policy. The weight change from 12/13/24 to 01/09/25 was a 13.2 pound weight loss, a 10% significant weight loss in approximately one month. Review of Resident #94's weight change note, dated 01/09/25, revealed a significant weight loss from 12/13/24 to 01/09/25. The dietitian requested a re-weight on the date this note was written to ensure accuracy. Review of Resident #94's nutritional notes, dated 01/09/25 to 01/21/25, revealed the only attempted re-weight was on 01/21/25, which Resident #94 refused. There were no other documented attempts to obtain the re-weight prior to 01/21/25. Interview with Registered Dietitian (RD) #103 on 02/18/25 at 11:48 A.M. confirmed Resident #94 should have weekly weights obtained following his return from the hospital on 12/07/24. RD #103 also confirmed he should have had a re-weight taken within 72 hours after a significant weight change has been identified, as the case was on 01/09/25. She confirmed the attempted weight check on 01/21/25 was too late. Review of the facilities Weight Management policy, dated 09/22/23, revealed residents will be weighed upon admission/re-admission; each week for the first four weeks after admission/readmission, and then monthly thereafter or as indicated by the physician. Re-weights are initiated for a five-pound variance if the resident is greater than five pounds. Re-weights will be completed within 48 to 72 hours. 49039 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #87 revealed an admitted [DATE], with diagnoses including type II diabetes mellitus, anxiety, gastro-esophageal reflux disease (GERD) without esophagitis, hyperlipidemia, anemia, and major depressive disorder. Review of the care plan dated 07/11/24 revealed Resident #87 was at risk for nutrition and/or dehydration related to diabetes mellitus type II, anxiety, GERD, hyperlipidemia, insomnia, and vitreous hemorrhage. Interventions included obtaining the resident's weight at least monthly and reporting any significant weight change of 5% or more over a month to the physician and dietitian. Review of Resident #87's weights revealed on 11/08/24, the resident weighed 220.4 pounds (lbs). On 12/17/24, the weight decreased to 208.8 lbs, showing a significant weight loss of 5.26% over one month. Review of the dietary progress notes dated 12/17/24 at 2:20 P.M. revealed weight loss was likely due to variable meal intakes. It was noted the resident accepted the boost supplement (high calorie nutritional supplement) well. A recommendation was made to increase the boost supplement to 237 milliliter twice a day for weight gain, with a plan to notify the physician of the weight loss and add the resident to the weekly weight list. Review of the physician order dated 12/17/24 for Resident #87 indicated a prescription for boost supplement twice a day as a supplement. Resident #87 did have weekly weights recorded from 12/18/24 to 01/19/25. Review of the Minimum Data Set (MDS) 3.0 assessment completed 01/15/25 showed Resident #87 had moderate cognitive impairment. Resident #87 had no swallowing disorder, had a weight loss of 5% or more over the last month and was not on a physician-prescribed weight-loss regimen. Review of weekly weight task for Resident #87 from 01/27/25 to 02/17/25 revealed weight and scale information marked as not applicable. Interview on 02/19/25 at 8:58 A.M. with Registered Dietitian (RD) #353 confirmed after Resident #87's significant weight loss was observed on 12/17/24, RD #353 recommended increasing the boost supplement and initiating weekly weight checks. This recommendation was communicated in the progress notes and discussed during the weekly meeting of the same week. RD #353 confirmed facility staff did not begin obtaining weekly weights until 01/19/25, and Resident #87 was removed from the weekly weight list on 02/06/25. Interview on 02/19/25 at 9:12 AM with Restorative Certified Nursing Assistant (RCNA) #278 confirmed her responsibility for obtaining weekly weights, with a list provided weekly by management. RCNA #278 stated Resident #87 was not included on the weight list for the weeks of 12/17/24. RCNA #278 explained she was not working in the facility from mid-December 2024 through part of January 2025 and was unsure whether another staff member was assigned to obtain the weekly weights as requested by the dietitian. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/19/25 at 9:27 AM with the Director of Nursing (DON) confirmed Resident #87 was not added to the weekly weights list on 12/17/24, but was added on 12/26/24. The DON acknowledged weight records for 12/23/24, 12/30/24, 01/05/25, and 01/12/25 had n/a (not applicable) marked. Weekly weights began being obtained on 01/19/25. Review of facilities Weight Management policy dated 09/22/23 revealed residents determined to have significant weight changes will be weighed on a weekly basis examples of those residents include residents with insidious weight loss and are noted with 5% in one month, 7.5% in three months and 10% in six months.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review and staff interview, the facility failed to provide planning, treatment, and oversight to resident behaviors regarding catheter care. This affected one (Resident #62) of one resident reviewed for behavior monitoring. The facility census was 115. Findings include: Review of Resident #62's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included paraplegia, anxiety disorder, insomnia, chronic pain syndrome, bipolar disorder, intermittent explosive disorder, and post traumatic stress disorder. Review of the Minimum Data Set (MDS) assessment, dated 12/22/24, revealed Resident #62 was cognitively intact. Review of the current physician orders for February 2025 revealed Resident #62 had an order to have a straight catheter procedure to be complete every six hours. Review of Resident #62's current behavioral care plan revealed no documentation, interventions, or plans related to Resident #62's behavior of performing his own straight catheter procedures every two hours, refusing for staff to perform his catheter care, and getting verbally aggressive with staff regarding his catheter care. Review of Resident #62's psychiatric notes, dated June 2024 to February 2025, revealed no documentation to support discussion, care planning, or interventions related to Resident #62 performing straight catheter procedures every two hours. Also, there was no discussion, planning, or interventions related to behaviors exhibited when staff tried to assist with the straight catheter process and no discussion or root cause analysis as to why Resident #62 had to perform straight catheter procedures every two hours, as opposed to every six hours as ordered by his physician. Interview with Director of Nursing (DON) on 02/18/25 at 11:00 A.M. and 12:00 P.M. stated Resident #62 attends psychiatric appointments on a routine basis. She confirmed there was no documentation that Resident #62 behavior of performing self straight catheter procedures every two hours instead of every six hours as ordered. She confirmed they have not documented his behaviors of performing self catheterization every two hours. She confirmed he will yell, scream, and get aggressive with staff when they try to monitor or assist with his catheterization process. She confirmed they do not document those behaviors when related to performing his self catheterization. She confirmed they probably should be.

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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** 37100 Based on medical record review, staff interview, and facility policy review, the facility failed to provide parameters for as needed pain medication. This affected one (Resident #62) of five residents reviewed for unnecessary medications. The facility census was 115. Findings include: Review of Resident #62's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included paraplegia and chronic pain syndrome. Review of the Minimum Data Set (MDS) assessment, dated 12/22/24, revealed Resident #62 was cognitively intact. Review of Resident #62's physician orders, dated December 2024 to February 2025, revealed an order for acetaminophen 650 milligrams (mg) every four hours as needed (PRN) for pain or fever. Also, there was an order for Oxycodone (narcotic pain medication) 15 mg every four hours as needed for pain. Neither medication had parameters as to which pain medication should be administered and what pain level each medication should be given at. Review of Resident #62's medication administration record (MAR), dated 01/01/25 to 02/18/25, revealed the following as needed pain medications were administered: in January 2025, acetaminophen was administered twice for pain levels five and eight (from a pain level scale of zero (no pain) to ten (most severe pain), and then Oxycodone was administered a total of 61 times for pain levels between one to seven. Also, review of February 2025 MAR, acetaminophen was not administered and Oxycodone was administered a total of 31 times for pain levels between one to seven. Interview with Registered Nurse (RN) #227 and RN #236 on 02/19/25 at 10:20 A.M. and 10:25 A.M. confirmed there should be parameters for the as needed pain medication. If there were no parameters, they will use nursing judgement and the resident's pain level to determine which pain medication to give. They confirmed if the pain levels were one to five, they will first administered the lower strength pain medication, such as acetaminophen. If the pain level was six to ten, they will administer the higher strength pain medication, such as tramadol or Oxycodone. RN #236 confirmed Resident #62 did not have pain parameters in place and Oxycodone was being administered for pain levels between one to seven and acetaminophen was administered for pain levels of five to eight. Review of facility Pain Management policy, dated 04/11/23, revealed the facility will observe the resident for indicators of pain. They will ask the resident and observe to determine the intensity of pain. Following the pain evaluation, notify the physician if indicated and implement new orders as received. The licensed nurse, when administering PRN pain medications, will record the drug administration on the PRN MAR. Document the date, time, and effectiveness of PRN pain medication on the PRN administration record.

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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** 51068 Based on record review and staff interview, the facility failed to monitor behaviors and did not provide appropriate justification for a psychotropic medication for one (Resident #80) of five residents reviewed for unnecessary medications. The facility census was 115. Findings include: Review of the medical record for Resident #80 revealed an admitted [DATE] with diagnoses including vascular dementia with behavioral disturbances. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #80 had severe cognitive impairment, and documentation of verbal behaviors. Review of the physician orders for Resident #80 revealed the following medication: Seroquel (Quetiapine Fumarate) 50 milligrams (mg) - Administered twice daily for vascular dementia behaviors, ordered on 10/31/24 with no stop date. Ativan (Lorazepam) 0.5 mg - Administered every four hours as needed for anxiety and agitation, with multiple renewal orders from 11/12/24 through 02/12/25. Trazodone HCl 50 mg - Administered nightly for insomnia, ordered on 10/09/24. Review of the treatment administration record (TAR), from 10/07/24 to 11/01/24, revealed Resident #80 had only seven of 25 nights with behaviors. Review of the progress notes for Resident #80 revealed on 12/26/24 at 1:33 P.M., staff documented the Ativan order was renewed due to intermittent yelling and screaming. However, the note stated the resident did not appear to be in distress and smiled simultaneously. On 01/16/25 at 2:46 P.M., a resident-at-risk note indicated the resident continued to display behaviors despite verbal reassurance and staff interventions. It was also noted the resident exhibited increased lethargy when Seroquel was scheduled. Review of the Omnicare Pharmacy consultation report completed for January 2024 for Resident #80 revealed it was recommended to attempt a gradual dose reduction (GDR) of Seroquel 50 mg at bedtime but was declined by the Certified Nurse Practitioner (CNP) due to risk of declines with GDR with no further explanation. Review of the viaquest psychiatric note completed on 01/07/25 for Resident #80 confirmed the psychiatric history was limited to vascular dementia. Review of the psychoactive medication quarterly evaluation completed on 01/17/25 stated the diagnoses pertaining to the psychoactive medications were insomnia, anxiety, vascular dementia behaviors, and agitation indicating there was not an appropriate justification for Seroquel. Additionally, it stated the resident will continue current dosage, no GDR clinically recommended at this time. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/13/25 at 9:51 A.M. with the Director of Nursing (DON) stated Resident #80 was admitted to the facility on Seroquel with the diagnosis of depression but the physician changed the diagnosis justification to dementia with behaviors. The DON stated from 10/07/24 to 11/01/24, the facility attempted a GDR and claimed the behaviors increased during this time. The DON confirmed during this time there was not adequate documentation of increased behaviors due to the reduction of the Seroquel. Interview on 02/13/25 at 11:38 A.M. with Psychiatric Nurse Practitioner (PNP) #400, stated due to Resident #80's age she would not meet the criteria for schizophrenia making Seroquel use difficult to justify. She stated the family was resistant to a GDR and had requested a different medication such as Haldol. She confirmed vascular dementia behaviors was not an appropriate diagnosis for Seroquel but stated Resident #80 seemed happier on Seroquel. PNP #400 also confirmed the staff need to do a better job at monitoring behaviors to determine if a GDR is truly successful and will have a psych all staff to educate on observing behaviors and documenting appropriately.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on record review, resident and staff interview, observation , review of policy, and review of the resident agreement, the facility failed to timely obtain routine dental services for residents. This affected two (Resident #60 and Resident #103) of two residents reviewed for dental services. The facility census was 115. Findings include: 1. Review of the medical record for Resident #103 revealed an admitted [DATE] with diagnoses of epilepsy, type two diabetes mellitus, chronic kidney disease, mild cognitive impairment, and personal history of transient ischemic attack. Review of the Minimum Data Set (MDS) 3.0 assessment completed 12/17/24 revealed Resident #103 had moderate cognitive impairment and Resident #103 has no natural teeth or tooth fragments. Review of the care plan dated 12/12/24 revealed Resident #103 was at risk for infection, pain, or bleeding in the oral cavity. Resident #103 has no teeth present, and dentures were at home. Interventions included dental consult as needed, observation for oral/dental problems, provision of diet as ordered, and referral to dietician as needed. Review of the progress note dated 12/16/24 revealed Resident #103 had complete upper and lower dentures but cannot eat well without them. It was noted they were damaged in a recent motor vehicle crash. The dentures required replacement and follow-up with a dentist for new dentures. Review of physician orders dated 12/17/24 revealed a consistent carbohydrate diet, regular texture/consistency, and resident request for soft foods/mashed potatoes. There was no documentation in the medical record regarding a follow up to a replacement of dentures and/or dentist following the 12/16/24 progress note through 02/11/25. Interview on 02/11/25 at 10:30 A.M. with Resident #103 stated he had concerns about his ability to eat meals. The resident explained that he has to gum most of his food in order to consume it. He reported that his dentures were damaged during his accident and has not received any updates or assistance regarding the replacement. He mentioned that his previous dentist had kept an extra mold to create a new set of dentures, but he was uncertain whether the facility staff have contacted the office for further action. Interview on 02/12/25 at 3:16 P.M. with Social Services Assistant (SSA) #279 confirmed Resident #103 has been in need of dentures since admission, but they were unable to receive coverage for these services until he obtains a new guardian and was approved for Medicaid. SSA #279 stated the guardianship paperwork for Resident #103 has been sent out, and they were in the process of submitting his emergency Medicaid application. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/18/25 at 9:24 A.M. with SSA #279 revealed the ward clerk was responsible for contacting the hospital and Resident #103's previous dentist office to gather additional information regarding the whereabouts of his dentures or explore potential solutions. SSA #279 stated they were working on the emergency Medicaid application, which should soon provide the necessary coverage. Interview on 02/19/25 at 12:34 P.M. with [NAME] Clerk #245 denied any knowledge of Resident #103's missing dentures. She confirmed she had not been instructed to call the hospital for belongings or reach out to the previous dentist office for assistance with the issue. Review of the admission agreement undated revealed the facility will provide services, included in the daily rate, to the resident. In addition to the included services, the facility will provide additional non-routine services and supplies that may incur an extra charge to the resident. The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. 51068 2. Review of Resident #60's medical record revealed an admitted [DATE], with diagnoses including localization-related (focal) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, age-related osteoporosis, and gastroesophageal reflux disease (GERD). Review of Resident #60's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #60 was cognitively intact. Review of the nursing note on 09/23/24 at 10:34 A.M. revealed Resident #60 complained of a sore mouth, especially when eating food. The resident stated he doesn't have teeth and his gums were painful when chewing food. The Medical Director (MD) was made aware, and new orders for a dietician and dentist were set up. A report was given to the in-house dietician and ancillary certified nursing assistant (CNA) to follow up. There was no documentation in the medical record that Resident #60 was seen by a dentist from 09/24/24 to 02/12/25. There was no evidence the facility followed up regarding Resident #60's dentures from 09/24/24 to 02/12/25. During an interview on 02/11/25 at 7:58 A.M. with Resident #60, he stated he needs molds and new dentures made. He reported eating regular food until his gums become sore, at which point the facility places him on a mechanical soft diet until his gums feel better. Resident #60 was observed not to have teeth in at the time of the conversation. During an interview on 02/12/25 at 12:05 P.M., Social Worker (SW) #291 explained when a resident requires dental or vision services, they assist in setting up appointments through Ancillary Company #600 or Ancillary Company #700 . She stated Social Service Assistant (SSA) #279 was responsible for coordinating ancillary services and would check why Resident #60 had not yet received dentures or additional follow-up dental appointments. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/12/25 at 4:08 P.M. with SSA #279, she stated the consent form for Ancillary Company #700 was signed by Resident #60 on 09/28/24 but not sent until 10/08/24. SSA #334 stated she follows up for dentistry services but was unsure why Resident #60 had not been seen by a dentist to obtain new dentures. SSA #279 further explained that once she sends the consent forms to Ancillary Company #700, she does not follow up to determine if the residents have been seen or if the concerns have been addressed. Review of the Social Services Referral to Outside Providers policy revealed the following requirements: A physician's order must be obtained by nursing. Consent to receive services must be sought from the resident or their representative before initiating services. Social services must make the referral to the outside provider and provide demographics and signed consent as needed. Progress notes from the service provider must be obtained and placed in the resident's medical record. The resident's physician, family, and/or representative must be informed of the service results, and any recommendations should be reviewed with the physician. The provider's recommendations must be integrated into the resident's care plan. Recommendations for interventions should be communicated to direct care staff. Follow-up visits should be scheduled as needed.

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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. 37100 Based on observations, staff interview, and facility policy review, the facility failed to serve food in a safe and sanitary manner. This had the potential to affect 115 of 115 residents who receive food from the kitchen. The census was 115. Findings include: Observations on 02/13/25 from 11:46 A.M. to 12:15 P.M. revealed the following: [NAME] #215 was serving food on the serving line from the steam table, wearing disposable gloves. Each time [NAME] #215 scooped pasta into the service ladle, he would use one of his gloved hands to balance the pasta in the spoon prior to serving it on to the plate. He did not change his gloves at all during the observation period. Also, after touching the pasta each time, he touched the following items in between without changing his gloves: meal plate, multiple serving utensils of other food on the tray line, dirty steam table counter, serving trays, warming lids to the plates, soup bowl, aluminum foil covering food that was in the steamer, and a hot dog bun. Observations on 02/13/25 from 11:54 A.M. to 12:00 P.M. revealed Dietary Manager #271 assisting the dietary staff with serving lunch. He had disposable gloves on and touched the following items without changing his gloves: plastic bag holding hot dog buns, hot dog bun, serving plate, aluminum foil, inside of the oven mitt, food pans, serving ladle, door to the steamer, plastic bag holding the hot dog buns, and then one more hot dog bun. At 12:00 P.M., he took his gloves off and put new ones on. Observations on 02/13/25 from 12:03 P.M. to 12:05 P.M. and 12:06 P.M. to 12:12 P.M. revealed Dietary Manager #271 touching multiple hot dog buns and retouching the above items; following the same process. He changed his gloves and put new ones on at 12:05 P.M. and 12:12 P.M., but not prior to touching hot dog buns and then multiple other items prior to changing his gloves. Interview with [NAME] #215 on 02/13/25 at 12:10 P.M. stated they were to change their gloves when they become soiled, ripped, or otherwise contaminated. He also confirmed if he touches a food item, he was to immediately change his gloves before touching anything else. Interview with Dietary Manager #271 on 02/13/25 at 12:24 P.M. confirmed dietary staff were to change their gloves frequently. He confirmed dietary staff were to have clean gloves on if they touch any food item and after they touch the food item, they were to change their gloves as well. Review of the facilities Glove Use policy, dated 11/19/21, revealed it is the facility policy that gloves will be worn when handling food except when washing fresh produce, to ensure bacteria is not transferred from the food handler's hands to the food product being served. Gloves will be changed and hands will be washed after they become soiled or touch a contaminated surface including: after handling anything soiled, after handling boxes, crates, or packages, or anytime you touch a contaminated surface.

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F 0850 Level of Harm - Potential for minimal harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. 51068 Based on personnel record review, staff interview, and policy review, the facility failed to ensure the social worker had the proper qualifications of one year of supervised social work experience in a health care setting for a facility with 126 beds. This had the potential to affect all 115 residents residing in the facility. Findings include: Review of the personnel file for Social Worker (SW) #291 revealed a hire date of 01/09/23. SW #291 has received her Masters in Social Work (MSW) but there was no evidence that she has had one year of supervised healthcare experience. The personnel file included a reference check from Long Term Care (LTC) Facility #1 where LSW #291 held a Social Services Director position. On the reference check, there was no indication of whether or not SW #291 was supervised during this experience. Interview on 02/18/25 at 9:23 A.M. with the Administrator confirmed SW #291 was hired when the previous Administrator was working and they would know if she was hired with supervised experience but were unable to reach them to confirm. She stated there was a Social Service Liaison who was a Licensed Social Worker (LSW) that oversees the social service program. Interview on 02/18/25 at 11:43 A.M. with Social Service Liaison (SSL) #401 confirmed she was not signing off on any work that was being completed by the social service department at the facility. Interview on 02/18/25 at 1:00 P.M. with Director of Nursing (DON) confirmed they do not have any evidence that SW #291 was supervised prior to her employment at the facility or former employment.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review, review of the facilities infection control log, staff interview, and facility policy review, the facility failed to to follow appropriate antibiotic stewardship protocols. This affected two (Residents #39 and #90) of five residents reviewed for unnecessary medications. The facility census was 115. Findings include: 1. Record review revealed Resident #39 was admitted to the facility on [DATE]. Diagnoses included osteomyelitis of vertebra, paraplegia, and neuromuscular dysfunction of bladder. Review of the Minimum Data Set (MDS) assessment, dated 01/27/25, revealed Resident #39 was cognitively intact. Review of Resident #39's physician orders, dated October and November 2024, revealed the following antibiotics were ordered and administered: Hiprex one gram (gm) for prophylaxis, Amoxicillin 875-125 milligrams (mg) twice daily for wound infection for seven days starting on 11/23/24, bactrim 800-160 mg twice daily for prevention for 10 days starting on 11/25/24, and Doxycycline 100 mg twice daily for chronic osteomyelitis/prophylactic. Review of Resident #39's Medication Administration Record (MAR), dated November 2024, revealed from 11/25/24 to 11/27/24, Resident #39 was administered four separate antibiotics at the same time. Three of the medications (Hiprex, Bactrim, and Doxycycline) were documented as being for prophylactic/prevention reasons. Review of Resident #39's progress notes, dated 11/25/24, revealed his white blood cell count increased from the initial order of amoxicillin, so he was ordered Bactrim to cover for possible Methicillin-resistant Staphylococcus aureus (MRSA). Resident #39's medical record did not have any test, culture, or other further examination to confirm he had MRSA to justify the addition of bactrim on 11/24/24. Review of Resident #39 's physician review/report document, dated 11/26/24, revealed the resident was recently managed with new onset of increased C-Reactive Protein (CRP) and sacral wound worsening. Alert and oriented times four. The resident went out to the doctor appointment as well. He denies shortness of breath and chest pain, denies nausea and vomiting, and denies lethargy, dizziness, or headache. Illeus much improved, However given his recent labs, he started bactrim and augmentin (amoxicillin) as prophylaxis. There was no documentation within the report as to a specific justification for the use of bactrim or amoxicillin. Review of Resident #39's physician orders, dated 02/11/25, revealed he was scheduled, ordered, and administered the following antibiotics: Hiprex one gm for prophylaxis and doxycycline 100 mg twice daily for chronic osteomyelitis/prophylactic. Neither antibiotic had proper justification for the prolonged use. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Director of Nursing (DON) on 02/13/25 at 2:15 P.M. and 02/18/25 at 9:30 A.M. and 1:00 P.M. confirmed in November 2024, Resident #39 was ordered four separate antibiotic medications. She confirmed Resident #39 was ordered amoxicillin on 11/23/24 related to signs and symptoms of an infection. She confirmed the nursing staff contacted the on-call physician and amoxicillin was ordered. She also confirmed that two days later, they contacted Resident #39's physician due to increased white blood cell counts, and bactrim was ordered to cover possible MRSA. She confirmed there was no evidence the facility or physician ordered testing to determine if he had MRSA. Also, there was no clear documentation if all four antibiotics were to be administered at the same time from 11/25/24 to 11/27/24. She confirmed three of the antibiotic medications were ordered/had justification as prophylactic. Review of the facility's Antibiotic Stewardship policy, dated 10/14/22, revealed antibiotic stewardship refers to coordinated interventions designed to improve and measure the appropriate use of antimicrobials, by promoting the selection of the optimal anti-microbial drug regimen, dose, duration of therapy, and route of administration. The medical director and director of nursing will use his/her influence as medical and nursing leaders to help ensure antibiotics are prescribed only when appropriate. The use of prophylactic antibiotic treatment, long term antibiotic maintenance use for chronic infections, and treatment with broad spectrum antibiotics while a culture is pending, should be discouraged by the medical director and consultant pharmacist. 51068 2. Review of the medical record for Resident #90 revealed an admitted [DATE], with a re-entry date of 08/10/24. Diagnoses included diffuse large B-cell lymphoma systolic congestive heart failure, and cardiomyopathy. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 11/30/24, revealed Resident #30 had intact cognition. Review of the physician orders for Resident #90 revealed multiple orders for Bactrim DS (800 - 160 milligrams (mg)). On 05/17/24 at 11:15 A.M., the initial justification for prescribing Bactrim was for a urinary tract infection (UTI). It was discontinued on 05/17/24. Subsequent orders for Bactrim DS were 05/29/24 to 06/17/24 and 07/31/24 to 02/18/25 revealed there was for prophylaxis. Review of the medical record revealed no documentation to support the necessity of continued Bactrim prophylaxis after the UTI was treated. Review of the geriatrics follow-up notes, dated 05/20/24 to 02/11/25, consistently referenced Bactrim use without clinical indication or reassessment of necessity. During an interview on 02/18/25 at 9:56 A.M., the Director of Nursing (DON) stated prophylactic antibiotic use was reviewed only during monthly physician visits, with no evidence of routine reassessments based on clinical indicators. Review of the facilities infection control logs from July 2024 to February 2025 revealed the facility failed to document Resident #90's Bactrim use, indicating a lack of systemic monitoring for effectiveness, adverse reactions, or necessity. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's infection control and antibiotic stewardship policy revealed the following expectations: The program will encourage appropriate prescribing and reduce adverse effects, which often include gastrointestinal complications, C. difficile diarrhea, yeast infections, and antibiotic resistance in aging adults. The Medical Director and DON are responsible for ensuring antibiotics are prescribed only when appropriate. The consultant pharmacist is expected to analyze infections, prescribing patterns, antibiotic duration, and patient outcomes monthly through the Medication Management Review (MMR). The use of prophylactic antibiotic treatment, long-term antibiotic maintenance for chronic infections, and broad-spectrum antibiotic treatment while awaiting culture results should be discouraged by the Medical Director and consultant pharmacist.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49793 Based observation and staff interview, the facility failed to maintain a clean and sanitary environment. This affected four resident rooms (room numbers #60, #90, #215, and #226) and the northwest hallway. This had the potential to affect 54 residents residing in these resident rooms and who were near the northwest hallway. Findings include: An environmental tour was conducted on 02/13/25 between 10:15 A.M. and 11:25 A.M. with the Administrator. The following concerns were observed and verified at the time of observation with the Administrator: A. Observation of room [ROOM NUMBER] revealed there was wall tile hanging loose behind toilet pipe right at the flushing component/handle, dead bugs in bathroom light fixture cover, sink faucet with steady leak/drip, and a broken window ledge (made of marble) section fractured in three small pieces that were loose and jagged. B. Observation of ceiling tiles in the northwest hall (outside room [ROOM NUMBER], in front of the egress door) sagging out of the frames near the ceiling vent outlet and discolored with black dry substance affecting seven separate ceiling tiles. C. Observation of room [ROOM NUMBER] revealed the east wall in the room, the sheet rock or dry wall was gouged and ripped open (approximately five feet), and there was wallpaper tearing off the wall in the bathroom and hanging free. D. Observation of room [ROOM NUMBER] revealed the main toilet pipe (water supply) at the lower coupling, was shooting water straight up when flushing the toilet which sprayed onto the toilet and floor. There was a steady drip/leak from the sink faucet.