STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365256	A. Building B. Wing	11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Worthington, The	1030 High St Worthington, OH 43085

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on observation, interview, and record review, the facility failed to ensure residents had access to call lights. This affected two (#5 and #58) of two residents reviewed for call lights. The facility census was 91. Findings included: 1. Review of medical record for Resident #5 revealed an admitted [DATE]. Diagnoses included congestive heart failure, congestive heart failure, and Alzheimer's disease. Review of the Minimum Date Set quarterly assessment, dated 08/20/24, revealed Resident #5 had a some cognitive impairment. Resident #5 was setup and clean up for meals; supervision and touching for oral care, toileting, bathing; and independent dressing with lower and upper body, placing shoes on and off, and personal hygiene. Review of plan of care dated 08/20/24 revealed Resident #5 was deaf and hard to hear you. Resident #5 was also incontinent and required every two hours incontinence care. Observation on 10/31/24 at 2:00 P.M., with Resident #5 who was lying in bed, and the call light was not in reach. The call light was observed wrapped around the bed post, and the resident was unable to reach call light. Interview on 10/31/24 at 2:05 P.M., with State tested Nurse Aide (STNA) #123 verified Resident #5 did not have her call light in reach. 2. Review of medical record for Resident #58 revealed an admitted [DATE]. Diagnoses included dementia, chronic obstructive pulmonary disease, and idiopathic epileptic. Review of Quarterly Minimum Data Set assessment, dated 06/19/24, revealed Resident #58 was severely cognitively impaired. Review of required assistance revealed Resident #58 was independent with meals; setup and clean up assistance for oral care, toileting hygiene; supervision and touching for bathing, personal hygiene, putting on and off shoes, dressing lower body, and dressing upper body. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of plan of care dated 09/17/24 revealed Resident #58 had functional ability deficit and required assistance with self-care mobility related to having unsteady gait without support, confusion, dementia, chronic pulmonary disease, and periods of shortness of breath. Interventions included allow adequate time for completion of tasks, attempt to use consistent routines as much as possible, break task into smaller subtasks as needed, explain all procedures and tasks before starting, report all refusals, and call light within reach. Observation on 10/31/24 at 2:10 P.M., with Resident #58 who was lying in bed, and the call light was not in reach. The call light was wrapped around the bed post, and the resident was unable to reach call light. Interview on 10/31/24 at 2:10 P.M. ,with STNA #123 verified Resident #58 did not have her call light in reach.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on staff interview and record review, the facility failed to ensure there was verification of receipt for spenddown notifications and a plan to spenddown the accounts for four residents who received Medicaid Benefits. This affected four residents (#25, #43, #48, and #58) of five residents reviewed for personal funds. The facility census was 91. Findings include: 1. Review of the medical record for Resident #48 revealed an admitted [DATE] with diagnoses including Alzheimer's disease and dementia. Review of Resident #48's payer information revealed her primary payor source was Medicaid. Review of Resident #48's resident trust fund authorization revealed the responsible party was to receive statements. Review of Resident #48's quarterly statement dated 03/31/24 revealed her closing balance was $3,423.92. Review of a letter dated 04/19/24 revealed it was notification that Resident #48's account exceeded the Medicaid limit. There was no evidence this was sent to or acknowledged by the responsible party. Review of Resident #48's quarterly statement dated 06/30/24 revealed her closing balance was $3,265.46 Review of the letters dated 06/29/24 and 07/29/24 revealed the letters were notifications that Resident #48's account exceeded the Medicaid limit. There was no evidence this was sent to or acknowledged by the responsible party. Review of Resident #48's quarterly statement dated 09/30/24 revealed her closing balance was $3,270.18. Review of a letter dated 10/15/24 revealed it was notification that Resident #48's account exceeded the Medicaid limit. There was no evidence this was sent to or acknowledged by the responsible party. Review of the current account balance as of 10/28/24 revealed Resident #48 had $3,146.55 in her account. Interview on 10/31/24 at 11:34 A.M. and 11:39 A.M. with Business Office Manager (BOM) #205 verified they had no evidence that spenddown notification was sent or received by the responsible party. BOM #205 reported he had issues getting ahold of Resident #48's family and had no plan to spend her account down. (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #58's medical record revealed an admitted [DATE] with diagnoses including dementia. Review of Resident #58's payor information revealed her primary payor source was Medicaid. Review of Resident #58's resident trust fund authorization revealed the responsible party was to receive statements. Review of Resident #58's quarterly statement dated 03/31/24 revealed her closing balance was $2,951.67. Review of a letter dated 04/19/24 revealed it was notification that Resident #58's account exceeded the Medicaid limit. There was no evidence this was sent to or acknowledged by the responsible party. Review of Resident #58's quarterly statement dated 06/30/24 revealed her closing balance was $3,050.95. Review of a letter dated 06/29/24 and 07/29/24 revealed it was notification that Resident #58's account exceeded the Medicaid limit. There was no evidence this was sent to or acknowledged by the responsible party. Review of Resident #58's quarterly statement dated 09/30/24 revealed her closing balance was $4,159.46. Review of a letter dated 10/15/24 revealed it was notification that Resident #58's account exceeded the Medicaid limit. There was no evidence this was sent to or acknowledged by the responsible party. Review of the current account balance as of 10/28/24 revealed Resident #58 had $4,074.82 in her account. Interview on 10/31/24 at 11:34 A.M. and 11:39 A.M. with Business Office Manager (BOM) #205 verified they had no evidence that spenddown notification was sent or received by the responsible party. BOM #205 reported he knew he had discussed spending down the money with Resident #58's family in the past but he was not sure when. 3. Review of Resident #43's medical record revealed an admitted [DATE] with diagnoses including dementia. Review of Resident #43's payor information revealed her primary payor source was Medicaid. Review of Resident #43's resident trust fund authorization dated 09/29/20 revealed the responsible party was to receive statements. Review of Resident #43's quarterly statement dated 03/31/24 revealed a closing balance of $2,189.11 (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a letter dated 04/19/24 revealed it was notification that Resident #43's account exceeded the Medicaid limit. There was no evidence this was sent to or acknowledged by the responsible party. Review of Resident #43's quarterly statement dated 06/30/24 revealed her closing balance was $2,264.10. Review of a letter dated 06/29/24 and 07/29/24 revealed it was notification that Resident #43's account exceeded the Medicaid limit. There was no evidence this was sent to or acknowledged by the responsible party. Review of Resident #43's quarterly statement dated 09/30/24 revealed a closing balance of $2,441.68. Review of a letter dated 10/15/24 revealed it was notification that Resident #43's account exceeded the Medicaid limit. There was no evidence this was sent to or acknowledged by the responsible party. Review of the current account balance as of 10/28/24 revealed Resident #43 had $2,500.00 in her account. Interview on 10/31/24 at 11:34 A.M. and 11:39 A.M. with Business Office Manager (BOM) #205 verified they had no evidence that spenddown notification was sent or received by the responsible party. BOM #205 reported usually Resident #43's family called him and told him how to spend it down. 4. Review of Resident #25's medical record revealed an admitted [DATE] with diagnoses including neurocognitive disorder with lewy bodies. Review of Resident #25's payor information revealed their primary payor source was Medicaid. Review of Resident #25's trust fund authorization dated 02/13/17 revealed statements were to be sent to her responsible party. Review of Resident #25's quarterly statement dated 06/30/24 revealed her closing balance was less $200 below the Medicaid limit. Review of Resident #25's quarterly statement dated 09/30/24 revealed a closing balance of $2,148,46. Review of a letter dated 10/15/24 revealed it was notification that Resident #25's account exceeded the Medicaid limit. There was no evidence this was sent to or acknowledged by the responsible party. Review of the current account balance as of 10/28/24 revealed Resident #43 had $2,225.34 in her account. (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/31/24 at 11:34 A.M. and 11:39 A.M. with Business Office Manager (BOM) #205 verified they had no evidence that spenddown notification was sent or received by the responsible party. BOM #205 reported usually Resident #25's family called him and told him how to spend it down.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on medical record review, staff interview, and facility policy review, the facility failed to ensure one resident's (#42) guardian was notified of a change in condition and new medication order. This affected one (Resident #42) of 21 residents reviewed for notification of change. The facility census was 91. Findings include: Review of the medical record for Resident #42 revealed an initial admitted [DATE] with the diagnoses including memory deficit following cerebral infarct. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #42 had a moderate cognitive deficit. Review of the Nurse Practitioner (NP) progress note dated 10/10/24 revealed Resident #42 complained of pain with urination for two days. The NP ordered a complete blood count (CBC), urinalysis and culture and sensitivity (UA/C&S) and if leukocytes were positive she would be treated for a urinary tract infection (UTI). Review of the UA/C&S revealed the resident's urine was cloudy, was positive for nitrates and had a large amount of leukocytes. The culture grew 50,000 to 100,000 klebsiella oxytoca. Review of the resident's discontinued physician orders revealed an order dated 10/14/24 for Cipro (a medication used to treat infections) 250 milligrams (mg) by mouth every 12 hours for five days for UTI. There was no documented evidence the resident's guardian was notified of the change in condition and the new medication Cipro 250 mg was ordered. On 10/29/24 at 2:16 P.M., an interview with the Director of Nursing (DON) verified the resident's guardian was not notified of the resident's change in condition or new medication order to treat the UTI. Review of the facility policy titled Notification of Change, last revised on 02/14/24 revealed the facility must inform the resident, consult with the resident's practitioner and notify the resident's representative when there is a change in status. A change in status would include a need to alter treatment significantly and a significant change in the resident's physical, mental or psychosocial status. Changes in the resident's status, including but not limited to those identified above or any unusual occurrence, the licensed nurse will notify the resident attending practitioner. Any new orders or directives will be implemented by the licensed nurse. Changes in the resident status, including but not limited to those identified above or any unusual occurrences the licensed nurse will notify the resident's representative unless otherwise dictated by the resident. The licensed nurse will document in the resident's electronic medical record the notification and the information that was provided including any additional orders from the practitioner.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 43064 Based on observation and interview, the facility failed to ensure a homelike environment for 27 residents (#7, #14, #17, #25, #28, #29, #30, #33, #35, #40, #43, #45, #46, #48, #51, #53, #57, #67, #70, #71, #72, #75, #78, #83, #241, #242, and #291) on the memory care unit when they served meals on trays in the dining room. This affected 27 residents of 49 residents on the memory care unit. The facility census was 91. Findings include: Observation on 10/28/24 at 12:15 P.M. of the lunch meal revealed all residents in the dining room had been served their meals on trays. Interview on 10/28/24 at 12:17 P.M. with Licensed Practical Nurse (LPN) #152 verified the residents were served meals on trays in the dining room. She reported it helped residents recognize what food was theirs. Interview on 10/31/24 at 12:50 P.M. with the Director of Nursing (DON) verified keeping food on trays did not keep residents from taking food of each other's trays. The facility had no relevant policy.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observations, family and staff interview, review of facility policy, and record review, the facility failed to ensure the residents who required assistance from staff with activities of daily living were provided adequate and timely assistance with nail care and eating. This affected four residents (#11, #30, #55, and #61) of seven residents reviewed for activities of daily living. The facility census was 91. Findings include: 1. Review of Resident #30's medical record revealed an admitted [DATE] with diagnoses including dementia, peripheral vascular disease, and muscle weakness. Review of Resident #30's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition and vision. Resident #30 required set up or clean up assistance from staff for personal hygiene and eating. Review of Resident #30's plan of care dated 09/19/24 revealed he had a functional ability deficit and required assistance with self-care related to impaired cognition, unsteady gait, poor trunk control, poor vision, and incontinence. Interventions included setup or clean up assistance with personal hygiene, and partial or moderate assistance with showering bathing, and dressing. Observation on 10/28/24 at 10:16 A.M. revealed Resident #30 had long dirty nails that were curled at the top. Subsequent observation on 10/29/24 at 2:53 P.M. revealed Resident #30's fingernails remained dirty and long, curled at the top. Interview on 10/29/24 at 2:53 P.M. with Assistant Director of Nursing (ADON) #132 verified Resident #30's nails needed cleaned and cut. Interview on 10/29/24 at 3:49 P.M. with State tested Nursing Assistant (STNA) #128 revealed Resident #30 required maximal assistance with personal hygiene. Interview on 10/30/24 at 2:41 P.M. with Unit Manager #210 verified Resident #30's plan of care did not accurately reflect his assistance needs. 2. Review of Resident #55's medical record revealed an admitted [DATE] with diagnoses including Alzheimer's disease. Review of Resident #55's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she was rarely or never understood. She was dependent on staff for eating. Review of Resident #55's plan of care dated 07/23/24 revealed she had a functional ability deficit and required assistance with self-care and mobility related to diagnoses, poor trunk control, and weakness. Interventions included providing a consistent routine, diet as ordered, encouraging the resident to participate in self-care, and the resident was dependent on staff for eating. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/28/24 at 12:00 P.M. revealed lunch carts were brought to the memory care unit. Observations from 12:15 P.M. to 12:49 P.M. revealed Resident #55 had a tray in her room and had not been fed yet. State tested Nursing Assistants (STNA) #170 and STNA #202 were observed assisting other residents and then cleaning up in the dining room. Interview on 10/28/24 at 12:49 P.M. with STNA #202 verified Resident #55 still needed fed her lunch meal. Observation and interview on 10/28/24 at 12:55 P.M. revealed STNA #170 entering the room to feed Resident #55. STNA #170 verified she was just feeding Resident #55 her lunch meal. 3. Review of Resident #11's medical record revealed an admitted [DATE] with diagnoses including severe dementia with psychotic disturbance, type two diabetes mellitus, protein-calorie malnutrition, and dysphagia. Review of Resident #11's comprehensive Minimum Data Set (MDS) 3.0 assessment revealed she was rarely or never understood. She required substantial to maximal assistance from staff with eating. Review of Resident #11's plan of care dated 08/11/24 revealed the resident had a functional ability deficit and required assistance with self-care and mobility related to severely impaired cognition, impaired mobility, and frequent bowel and bladder incontinence. Interventions included allowing adequate time for completion of task, attempting to use consistent routines as much as possible, break task into smaller subtasks, and substantial or maximal assistance with eating. Observation on 10/28/24 at 12:00 P.M. revealed lunch carts were brought to the memory care unit. Observations from 12:00 P.M. to 12:49 P.M. revealed Resident #11 was in her room and had not been fed yet. STNA #170 and STNA #202 were observed assisting other residents and then cleaning up in the dining room. Interview on 10/28/24 at 12:49 P.M. with STNA #202 verified Resident #11 still needed fed she just was not sure where the resident's tray was. Observation on 10/28/24 at 12:52 P.M. revealed STNA #202 began feeding Resident #11. 4. Review of Resident #61's medical record revealed an admitted [DATE] with diagnoses including dementia, osteoarthritis, and muscle weakness. Review of Resident #61's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was rarely or never understood. He needed setup or clean-up assistance from staff with meals. Review of Resident #61's plan of care dated 10/16/24 revealed he had a functional ability deficit and required assistance with self/care related to diagnoses. Interventions included observing and reporting to the nurse any changes in functional ability, supervision or touching assistance with eating, and partial or moderate assistance with personal hygiene. Review of Resident #61's plan of care revealed it was absent for refusals. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #62's activity of daily living documentation from 10/01/24 to 10/29/24 revealed no indication he had refused meal assistance or assistance with personal hygiene. Interview on 10/28/24 at 1:55 P.M. with Resident #61's family revealed the resident needed assistance at meals, but he did not think the facility provided it. Observation on 10/29/24 at 1:45 P.M. revealed Resident #61's fingernails were long and dirty. Observation on 10/30/24 at 12:37 P.M. revealed Resident #61 with his meal tray, staff were not providing assistance. From 12:42 P.M. to 12:49 P.M., Resident #61 was observed chewing a bite of food, he then spit it out on to his plate. Resident #61 was observed attempting to drink water from a cup that was still covered. Interview on 10/30/24 at 12:49 P.M. with Unit Manager #210 verified Resident #61 was unsupervised and required assistance at meals. She additionally verified the cover had not been removed from his drink. She reported he refused assistance at times. Unit Manager #210 reported he had a behavior of chewing and spitting out his food. Observation on 10/30/24 at 12:50 P.M. revealed Unit Manager #210 cueing the resident to swallow his food and she assisted him to take bites, his intake improved. Interview on 10/30/24 at 1:03 P.M. with Unit Manager #210 verified Resident #61 had eaten better with prompting and cueing. She reported he had been at the 'feed' table in the past and did not like it. She additionally verified Resident #61's nails were long and dirty; she reported he often refused nail care. Review of the facility policy 'Standards of CNA[Certified Nursing Assistance]/STNA Practice' revealed STNAs were to assist the resident in activities of daily living such as feeding and nail care.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observations, staff interview, and record review, the facility failed to ensure activities were offered and provided for Residents #11, #30, #55, and #72. This affected four residents (#11, #30, #55, and #72) of six residents reviewed for activities. The facility census as 91. Findings include: 1. Review of Resident #30's medical record revealed an admitted [DATE] with diagnoses including dementia, adult failure to thrive, chronic kidney disease, peripheral vascular disease, depression, and muscle weakness. Review of Resident #30's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition and vision. Review of Resident #30's plan of care dated 11/14/23 revealed he enjoyed playing spades, biz wiz, conversing about the news, listening to music therapy, listening to daily chronicles, audiobooks, and going outdoor when the weather was nice. Interventions included offering outdoor activities when the weather was appropriate, providing an activities calendar and inviting and encouraging resident to attend scheduled activities of interest, providing materials for individual activities as desired, resident needs assistance to attend activities, he prefers independent activities but may show interest in the following types of group activity such as price is right, cards, TV time, music therapy, reading daily chronicles or other stories. Review of Resident #30's activity evaluation dated 05/09/24 revealed it was somewhat important for the resident to listen to music he liked and keep up with the news. He had interest in games, crafts, sports, music, reading, baking, religious activities, spending time outdoors, listening to radio, talking, volunteer work, parties, and news. The resident received check ins twice a week and one on ones if needed, he helped fold clothes, did certain busy hand puzzles and participated in clubs like cooking and men's group occasionally. Review of Resident #30's activities for from 10/01/24 to 10/29/24 revealed he was not documented as having participated in activities. He was offered and refused arts and crafts on 10/02/24, 10/04/24, and 10/13/24, conversing with others on 10/06/24, exercise on 10/20/24, games on 10/13/24, gardening on 10/06/2, and pet visits on 10/20/24. There was no evidence he was offered additional activities. Observation on 10/28/24 at 10:01 A.M., 11:17 A.M. and 1:45 P.M. revealed Resident #30 at a table in the common area there were no activities or entertainment available. The television was on at the far end of the room but could not be heard from Resident #30's location. Observation on 10/29/24 at 10:49 A.M., 1:52 P.M., 2:33 P.M., and 3:38 P.M. revealed Resident #30 at a table in the common area there were no activities or entertainment available. (continued on next page)

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Laurels of Worthington, The	1030 High St Worthington, OH 43085

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/30/24 at 10:03 A.M., 10:53 A.M., 11:55 A.M., 1:56 P.M., and 2:33 P.M. revealed Resident #30 at a table in the common area there were no activities or entertainment available. At 2:33 P.M., Recreation Services Assistant #157 was observed asking five to six residents if they wanted to attend activities. Resident #30 was not asked. Interview on 10/30/24 at 2:10 P.M. with State tested Nursing Aide (STNA) #128 verified residents were sitting in the common area with no entertainment. She reported the residents spent a lot of quiet time in the dining room. She said activities came in the afternoon and did an activity with them. Interview on 10/30/24 at 2:12 P.M. with Licensed Practical Nurse (LPN) #120 stated she was unable to identify activities for residents who could not do independent activities or would not think to request independent activities. She reported activities did popcorn parties at times. Interview on 10/30/24 at 4:22 P.M. with Director of Recreation Service #190 and the Administrator stated they were trying to find staff to work, at this time they did not have sufficient staff to place activities personnel in the memory care unit throughout the day. They reported activities was usually in memory care in the morning, then they did the skilled side, and then they did an activity that involved residents from both sides. They stated all residents should be offered activities every time they were scheduled and nursing staff should be assisting in bringing people down to activities. Director of Recreation Service #190 stated there was an [NAME] (smart home device) on the memory care unit so staff could play music for residents, and there were also activities that could be given to the residents to do throughout the day. Resident #30 was supposed to be receiving more sensory activities and he enjoyed listening to music. The Director of Recreation Service #190 verified Resident #30's activity record did not reflect that he was offered every activity or participating. 2. Review of Resident #55's medical record revealed an admitted [DATE] with diagnoses including Alzheimer's disease, depression, paranoid personality disorder, and adult failure to thrive. Review of Resident #55's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she was rarely or never understood. Review of Resident #55's plan of care revised 04/23/24 revealed the resident may benefit from sensory stimulation and variety of settings that groups or one to one programs provide. She enjoyed family visits, rhythm and blues and jazz music, being out of room around group of people, socializing to the best of her ability, passively observing group or small group activities, one on ones when she does not want to participate in group activity. Interventions included assisting resident to programs that may offer comfort and sensory stimulation, one-on-one staff contact during programs, use touch, call the resident by name to bring program content or program equipment closer to resident. Review of Resident #55's activity evaluation dated 10/09/24 revealed the resident passively watched group activities and expressed some interest and enjoyment. She watched television and movies and liked to listen to music. They were to trial one-on one activities to see if it would boost her participation or moods. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #55's activities from 10/01/24 to 10/29/24 revealed she was not documented as having participated in activities. She was offered and refused arts and crafts on 10/02/24, 10/04/24, and 10/13/24, conversing with others on 10/06/24, games on 10/13/24, gardening on 10/06/24, and pet visits on 10/20/24. She was not available for arts and crafts on 10/20/24, exercise on 10/19/24, and religious services on 10/20/24. There was no evidence she was offered one-on-ones or additional activities. Observation on 10/28/24 at 10:15 A.M., 11:17 A.M., and 1:40 P.M. revealed Resident #55 in bed watching television. Observation on 10/30/24 at 10:04 A.M. and 1:01 P.M. revealed Resident #55 in bed and awake, her television was not on and there was no entertainment. Interview on 10/30/24 at 1:03 P.M. with Unit Manager #210 verified Resident #55 was sitting in silence, she reported the resident did not like the television. Observations on 10/30/24 at 10:03 A.M., 10:53 A.M., 11:55 A.M., 1:56 P.M., and 2:33 P.M. revealed Resident #30 at a table in the common area there were no activities or entertainment available. At 2:33 P.M. Recreation Services Assistant #157 was observed asking five to six residents if they wanted to attend activities. Resident #55 was not asked. Interview on 10/30/24 at 2:10 P.M. with State tested Nursing Aide (STNA) #128 verified residents were sitting in the common area with no entertainment. She reported the residents spent a lot of quiet time in the dining room. She said activities came in the afternoon and did an activity with them. Interview on 10/30/24 at 2:12 P.M. with Licensed Practical Nurse (LPN) #120 stated she was unable to identify activities for residents who could not do independent activities or would not think to request independent activities. She reported activities did popcorn parties at times. Interview on 10/30/24 at 4:22 P.M. with Director of Recreation Service #190 and the Administrator revealed they were trying to find staff to work, at this time they did not have sufficient staff to place activities personnel in the memory care unit throughout the day. They reported activities was usually in memory care in the morning, then they did the skilled side, and then they did an activity that involved residents from both sides. They stated all residents should be offered activities every time they were scheduled and nursing staff should be assisting in bringing people down to activities. Director of Recreation Service #190 revealed there was an [NAME] (smart home device) on the memory care unit so staff could play music for residents, there was also activities that could be given to the residents to do throughout the day. Resident #55 was supposed to receive one-on-ones, and she verified the documentation did not show her receiving activities. 3. Review of Resident #11's medical record revealed an admitted [DATE] with diagnoses including severe dementia with psychotic disturbance, delusional disorders, adult failure to thrive, and anxiety disorder. Review of Resident #11's comprehensive Minimum Data Set (MDS) 3.0 assessment revealed she was rarely or never understood. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #11's plan of care dated 04/19/24 revealed the resident showed little awareness of programing surrounding. She would benefit from small group awareness or sensory stimulation. The focus was to provide independent materials for busy hands during downtime, but to also include her and continuing to attempt having active participation in music and motion, live entertainment, games, and picture books. Resident #11 would be a good candidate for one on ones. Interventions included escorting to socials and special events, providing sensory activities to promote response, resident enjoyed picture books, instrumental music, conversing and guardian, and using name and tactile stimulation to keep the resident engaged in the activity. Review of Resident #11's activity assessment dated [DATE] revealed the resident was confused and trying to be more mobile. She was not able to answer questions well due to loss in focus. The resident would stay with staff and usually sort and shuffle through items and she enjoyed music and motion as well. Review of Resident #11's activities for from 10/01/24 to 10/29/24 revealed she was offered and refused arts and crafts on 10/02/24, 10/13/24, and 10/20/24, conversing with others on 10/13/24, exercise on 10/19/24, games on 10/13/24 and 10/19/24, pet visit on 10/20/24, and religious services on 10/20/24. She was listed as not available for conversing with others and gardening on 10/06/24. Observation on 10/28/24 at 10:18 A.M., 11:19 A.M., and 1:46 P.M. revealed Resident #11 curled up in a ball in her bed. Observation on 10/29/24 at 10:51 A.M. revealed Resident #11 curled up in bed. Observation at 1:52 P.M., 2:33 P.M., and 3:38 P.M. revealed her in the common area with no activities or form of entertainment. The resident went from leaning her head on the table to leaning up against another resident. Observation on 10/30/24 at 10:03 A.M., 10:53 A.M., 11:55 A.M., 1:56 P.M., and 2:33 P.M. revealed Resident #30 at a table in the common area there were no activities or entertainment available. At 2:33 P.M. Recreation Services Assistant #157 was observed asking five to six residents if they wanted to attend activities. Resident #11 was not asked. Interview on 10/30/24 at 2:10 P.M. with State tested Nursing Aide (STNA) #128 verified residents were sitting in the common area with no entertainment. She reported the residents spent a lot of quiet time in the dining room. She said activities came in the afternoon and did an activity with them. Interview on 10/30/24 at 2:12 P.M. with Licensed Practical Nurse (LPN) #120 stated she was unable to identify activities for residents who could not do independent activities or would not think to request independent activities. She reported activities did popcorn parties at times. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/30/24 at 4:22 P.M. with Director of Recreation Service #190 and the Administrator revealed they were trying to find staff to work, at this time they did not have sufficient staff to place activities personnel in the memory care unit throughout the day. They reported activities was usually in memory care in the morning, then they did the skilled side, and then they did an activity that involved residents from both sides. They stated all residents should be offered activities every time they were scheduled and nursing staff should be assisting in bringing people down to activities. Director of Recreation Service #190 stated there was an [NAME] (smart home device) on the memory care unit so staff could play music for residents, there was also activities that could be given to the residents to do throughout the day. Director of Recreation Service #190 verified Resident #11's activity record did not reflect that he was offered every activity or participating in activities. Review of the policy 'activities/recreation program documentation' dated 08/01/24 revealed a resident's daily pattern of activity involvement was to be monitored including documenting attendance or refusal. 44080 4. Review of medical record for Resident #72 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, dementia and generalized anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #72 was severely cognitively impaired. Observations on 10/28/24 at 9:50 A.M. through 12:30 P.M. revealed Resident #72 was sitting at a table in the dining room after breakfast and no activities were offered or provided. A television was present on the other end of the dining room, but it was out of site for Resident #72. Observations on 10/29/24 from 1:40 P.M. through 3:00 P.M. revealed Resident #72 was in his Broda chair and was sleeping on and off. No activities were were offered or provided. Observation on 10/30/24 at 10:10 A.M. with Recreation Service Assistant (RSA) #157 revealed RSA #157 offered an activity to Resident #48, but did not offer the activity to Resident #72 who was sitting next to Resident #48 at the same table. At 10:25 A.M., Resident #72 was sitting in their Broda chair with no activities offered or provided. Interview on 10/30/24 at 3:30 P.M. with Director of Recreation Services (DRS) #190 verified Resident #72 did not have any record that he had received activities for days 10/28/24, 10/29/24, and 10/30/24.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation, family and staff interview, and record review, the facility failed to arrange podiatry services for Resident #61. This affected one (#61) of seven residents reviewed for activities of daily living. The facility census was 91. Findings include: Review of Resident #61's medical record revealed an admitted [DATE] with diagnoses including dementia, chronic kidney disease, schizoaffective disorder, osteoarthritis, muscle weakness. Review of Resident #61's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was rarely or never understood. Review of Resident #61's physician order dated 06/26/24 revealed an order for podiatry evaluation and treatment as indicated. Review of Resident #61's medical record revealed it was absent for ancillary consents or evidence of podiatry consult. Interview on 10/28/24 at 2:01 P.M. with Resident #61's family revealed he had wanted Resident #61 to be seen by the podiatrist. He reported his toenails were long enough that it was rubbing on the sheets. He reported the resident also had corns to his feet that he wanted taken care of. Observation on 10/29/24 at 1:45 P.M. of Resident #61 revealed he had long, dry, and crumbly nails. Interview on 10/30/24 at 10:51 A.M. with the Director of Social Services (DSS) #106 reported usually residents were offered ancillary services upon admission. The son had not previously signed a consent for ancillary services. However, she verified there was no documentation to indicate Resident #61's son had been offered ancillary services. DSS #106 confirmed Resident #61 had not seen the podiatrist.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, medical record review and staff interview, the facility failed to ensure residents with contractures were provided splints and/or palm protectors to prevent worsening of contractures. This affected two (#1 and #55) of two residents reviewed for range of motion. The facility census was 91. Findings include: 1. Review of the medical record for Resident #1 revealed an initial admitted [DATE] with the latest readmission of 10/28/23. Diagnoses included cerebrovascular accident (CVA) with right sided hemiplegia, dysarthria, aphasia, vascular dementia, chronic kidney disease, adult failure to thrive, atopic and schizoaffective disorder. Review of the plan of care dated 10/26/23 revealed Resident #1 had a functional ability deficit and required assistance with self care/mobility related to effects of CVA, dementia, non-ambulatory, right sided weakness, right sided neglect, poor trunk control confusion, bowel and bladder incontinence and can get agitated during care giving. Interventions included attempt to use consistent routines as much as possible, break task into smaller subtasks, encourage resident to use call light to call for assistance, encourage to participate in self-care as much as able, provide positive reinforcement for all activities attempted, praise resident for all efforts and accomplishments, explain all procedures/tasks before starting, keep finger nails trimmed and clean, palm protector to right hand when splint not worn, check skin before and after apply/removing, therapy treatment when ordered, refer to therapy plan of care for additional information as needed, right resting elbow splint to be donned when right resident hand splint is not donned (one to two hours for each splint) check skin before and after applying/removing, provide assistance devices wheelchair and bilateral half side rails for mobility. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had a severe cognitive deficit. Resident #1 displayed verbal behaviors directed towards others. Resident #1 had impaired functional limitation in range of motion (ROM) on one side of the upper extremity. Review of the resident's monthly physician orders for October 2024 identified orders dated 08/02/23 for a splint to right hand and right elbow daily for two hours as tolerated every shift, skin check before and after applying splints daily and palm protector to right hand when splint not on. Observation on 10/28/24 at 9:59 A.M., revealed Resident #1's right hand was contracted with no splint or palm protector to prevent further contracture. Interview on 10/29/24 at 1:24 P.M., with Registered Nurse (RN) #125 revealed the resident refuses to wear the palm protector at times and will yell out when it is in place. RN #125 verified the medical record contained no documented evidence the resident refused the palm protector at the time of the interview. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/29/24 at 1:28 P.M., of Resident#1's room revealed the splint was in the resident's second drawer of the night stand and the resident had no palm protector available in her room. Interview on 10/29/24 at 1:38 P.M., with State tested Nursing Assistant (STNA) #128 and #209 revealed they were assigned to provide the resident's care. STNA #128 and #209 revealed they were unsure if the resident had a splint or palm protector and would have to look in her room. Further interview with STNA #128 and #209 revealed therapy applies and removes all splints in the facility. Interview on 10/29/24 at 1:48 P.M., with Occupational Therapist (TO) #220 revealed once the resident was discharged from therapy services, the nursing staff were educated on the application and removal of splints. TO #220 verified Resident #1 was discharged from therapy with an order for the placement of the splint and palm protector when the splint is not in place. Interview on 10/29/24 with the Director of Nursing revealed the facility does not have a splint/brace policy. 43064 2. Review of Resident #55's medical record revealed an admitted [DATE], with diagnoses: including Alzheimer's disease, depression, paranoid personality disorder, dysphagia, and adult failure to thrive. Review of Resident #55's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was rarely or never understood. She had an upper and lower extremity impairment on both sides. Review of Resident #55's occupational therapy discharge summary dated 10/26/23 revealed the resident had a goal of a resting hand splint on left hand or wrist for four hours a day with staff education provided for carry over to decrease risk of joint issues. She met this goal on 10/23/23. The discharge recommendation included a splint and brace program of a resting hand splint to the left upper extremity for three hours. Review of Resident #55's orders and progress notes from 10/26/23 to 05/14/24 revealed no mention of a resting hand splint. Review of Resident #55's occupational therapy discharge summary dated 05/14/24 revealed the resident had a goal of tolerating left hand and elbow splint two hours per day to decrease risk of further joint stiffness. She met this goal on 05/09/24 wearing them on her left upper extremity. The discharge recommendation revealed staff was educated on elbow and hand splints for two-hour wear schedule for each. Review of Resident #55's orders and progress notes from 05/14/24 to 10/28/24 revealed no mention of a hand or elbow splint. Review of Resident #55's physician's orders from October 2023 to October 2024 revealed no evidence of orders of a splint or hand brace to the left upper extremity. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #55's plan of care on 10/28/24 revealed it did not address contracture's or limited range of motion in her left upper extremity. It did not address the need for splints or braces for her upper extremities. Observation on 10/28/24 at 11:18 A.M. and 1:40 P.M. and on 10/29/24 at 10:50 A.M. and 12:26 P.M., revealed Resident #55's left hand was contracted in a tight fist. She did not have a hand or elbow splint on. Interview and observation on 10/29/24 at 1:46 P.M., with Unit Manager #210 verified Resident #55's left hand was contracted. Resident #55's left hand was bent forward at the wrist and her fingers were clenched tight against her hand. Resident #55 pulled back her hand when Unit Manager #210 asked to open it. Unit Manager #210 reported the resident had a history of being noncompliant with splints but was unsure if therapy was currently implementing splints. Interview on 10/29/24 at 3:14 P.M., with Unit Manager #210 verified Resident #55's contracture was not mentioned in the medical record nor any documentation that the splint had ever been tried. Interview on 10/29/24 at 3:22 P.M., with Therapy Director #226 verified a splint had been recommended for Resident #55 on 05/14/24. She reported the aides had received training for the splints but were uncomfortable using it because of the resident's inability to give feedback. She reported they had agreed to discontinue the splint but verified it was not documented anywhere. When asked what they were doing to prevent the hand contracture from getting worse she reported they were protecting the skin and screening with therapy. Interview on 10/30/24 at 3:34 P.M., with Occupational Therapist (TO) #220, Therapy Director #226, Unit Manager #210, and the Director of Nursing (DON) and observation of Resident #55 revealed with time, stretching, rubbing muscles, TO #220 was able to stretch Resident #55's arm out, extend her elbow, and flex her wrist. She did not extend Resident #55's middle three fingers which she called 'swan-necked'. Resident #55 had been reevaluated by TO #220 on that day and she was going to implement another splint. Staff verified there had never been any documentation nursing followed up on TO #220's recommendations to implement a splint.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on observation, staff interview, medical record,review and policy review, the faciliy failed to have fall interventions in place for a resident who was at risk for falls. This affected one (63) of one resident reviewed for fall interventions. The facility census was 91. Findings include: Review of medical record for Resident #63 revealed an admitted [DATE]. Diagnoses included cerebral aneurysm, dementia, schizoaffective disorder, and epilepsy. Review of Quarterly Minimum Data Set date 07/22/24 revealed Resident #63 revealed the resident was severely cognitively impaired. Resident #63 required substantial maximal assistance oral care, toileting hygiene, personal hygiene, dressing upper and lower body, oral care, and bathing. Review of plan of care dated 10/22/24 revealed Resident #63 was at risk for risk for falls related to confusion, dementia, with poor safety awareness, non-ambulatory, antidepressant medication, restlessness, servers' impulsiveness, and lowers to herself to the floor on purpose. Interventions included administer meds, anticipate all needs, dose reduction will be attempted as appropriate, encourage resident to wear non-skid footwear when out of bed, and as needed. Keep the resident's environment free of clutter and safe, lock wheels on Geri chair, mattress with bolsters to bed to help define bed boundaries, may have one side of bed against the wall, provide clean eyeglasses daily. Observation on 10/29/24 at 2:39 P.M. with State tested Nurse Aide (STNA) #128, revealed Resident #63 was in her chair and did not have non-skid socks on. Interview with STNA #128 at the time of the observation, verified Resident #63 did not have non-skid socks on. Interview at the time of the observation, with Unit Manager #210 verfiied Resident #63 did not have her non skid socks on and and stated she was a fall risk. Observation on 10/30/24 at 12:11 P.M. with Resident #63 who was sitting at the dining room table in her Broda chair. Resident #63 had regular socks on only. Interview on 10/30/24 at 12:25 P.M., with STNA #198 verified Resident #63 only had regular socks on her feet. STNA #198 verified Resident #63 did not have her non-skid socks on her feet. Review of the policy titled Fall Management, dated 09/22/23, revealed the facility was to provide each resident in assisted in attaining and maintain his or her highest practical level of function by providing the resident adequate supervision, assistive devices, and or functional programs as appropriate to minimize the risk for falls.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44080 Based on observation, staff interview, record review, and review of policies, the facility failed to provide timely incontinence care for a resident dependent on staff for care. This affected one (#72) of one resident reviewed for incontinence care. The facility census was 91. Findings include: Review of medical record revealed Resident #72 was admitted [DATE]. Diagnoses included Alzheimer's disease, overactive bladder, and major depressive disorder. Review of Minimum Data Set, dated dated dated [DATE] revealed Resident #72 indicated th resident was severely cognitively impaired. Resident #72 required dependent during meals, oral care, toileting hygiene, bathing, putting on and off shoes, and personal hygiene. Review of plan of care dated 10/16/24 revealed Resident #72 was at risk for impaired skin integrity/pressure injury related to non-ambulatory, frequent bowel and bladder incontinence, confusion to skin needs, poor bed mobility, performance, and weight loss. Interventions included conduct weekly head to toe skin assessments, dietary consult, nutritional supplement per orders, observe skin with showers, and provide diet as ordered. Observation randomly on 10/30/24 from 9:05 A.M. through 1:34 P.M., revealed Resident #72 was not provided any personal care, including incontinence care. At 1:35 P.M., State tested Nurse Aides (STNA) #168 and STNA #123 were observed to provide incontinent care for Resident #72. Interview on 10/3024 at 1:40 P.M., with STNA #123 verified Resident #72 was moderate saturated of urine in his incontinent brief. STNA #123 stated Resident #72 was not checked and changed timely, since she had provided care before 9:00 A.M. this morning. Review of the policy titled Routine Resident Care, dated 03/07/23, revealed residents receive the necessary distance to maintain good grooming and personal/oral hygiene. Incontinence care was provided timely in according to each resident's needs. Review of the policy titled Standards of Certified Nurse Aide/State tested Nurse Aide Practice, dated 08/15/23, revealed the Certified Nurse Aide/State tested Nurse Aide makes routine rounds to check each resident assigned resident's condition and ensure their needs are met.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50536 Based on observation, medical record review, resident interview, and staff interview, the facility failed to ensure a resident had colostomy supplies available for self care. This affected one (#147) of one resident reviewed for colostomy care. The faciliy census was 91. Findings include: Review of Resident #147's medical record revealed an admitted [DATE], with diagnoses including: surgical aftercare following surgery on the digestive system, acute gastric ulcer with hemorrhage, iron deficiency anemia secondary to blood loss (chronic), chronic diastolic (congestive) heart failure, hypertension (HTN), primary pulmonary hypertension, paroxysmal atrial fibrillation (AFIB), atherosclerotic heart disease of native coronary artery without angina pectoris without angina, ischemic cardiomyopathy, chronic kidney disease stage 3, primary general osteoarthritis, osteoporosis, disorders of bone density and structure multiple sites, attention to colostomy, personal history of malignant neoplasm, and rectal prolapse. Review of the care plan for Resident #172 revealed At risk for potential complications related to new colostomy: altered elimination pattern, altered body image, fluid imbalance, skin breakdown and pain. Date initiate: 10/17/24. Resident #172 will have adequate bowel function via ostomy through the review date. Interventions included: Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal finding to the physician. Allow resident to verbalize feelings regarding change in body image. Refer for counseling if needed. Change colostomy bag as needed. Check for proper fit of colostomy bag to stoma. Educate resident/family/care giver regarding ostomy function and care. Educate resident/family/caregiver on how to change colostomy bag as needed and observe return demonstration. Empty colostomy bag every shift and as needed. Observe for air in the colostomy bag frequently and release as needed. Date these interventions initiated: 10/18/24. Observation on 10/28/24 at 3:42 P.M., revealed Resident #147 seated on the bedside attempting to empty her colostomy bag of air and stool. A strong odor of feces was noted in the hallway. Resident #147 was not wearing gloves during the task, and was observed to have feces on her fingers, lap, and shirt. Interview on 10/28/24 at 3:50 P.M., with Resident #147 confirmed she was attempting to perform self-care with her colostomy, staff keep supplies in the drawers of her bedside table, because she preferred to perform colostomy care at the bedside. Resident #147 opened the drawers to reveal no colostomy care supplies were available. Interview on 10/28/24 at 3:56 P.M., with Registered Nurse (RN) #172 confirmed Resident #147 had been educated on how to care for her colostomy, and is caring for her colostomy on her own as much as possible. RN #172 confirmed there were no colostomy care supplies available for Resident #172 at the bedside.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on medical record review, staff interview, and policy review, the facility failed to ensure daily weights were obtained and post dialysis communication forms were returned to the facility following dialysis. This affected one (#18) of one resident reviewed for dialysis. The facility census was 91. Findings include: Review of the medical record for Resident #18 revealed an initial admitted [DATE], with the diagnoses including: surgical aftercare following surgery on the skin and subcutaneous tissue, peripheral venous insufficiency, end stage renal failure (ESRD), dependence on renal dialysis, hypertension, diabetes mellitus, hyperlipidemia, anemia, polyneuropathy, hyperparathyroidism, and depressive disorder. Review of the plan of care dated 04/04/24 revealed the resident was at risk for hypovolemia related to dialysis related to ESRD and calls dialysis center and cancels appointments two to three times a month. Inventions included check bruit/thrill per facility policy, notify physician if not detected, check vital signs post dialysis, do not draw blood or take blood pressure in left arm, encourage her to go to hemodialysis as scheduled, instruct her on the negative outcomes if she continues to cancel sessions, encourage resident to avoid salt substitutes high in potassium as needed, obtain daily weights as ordered, notify physician of weight changes per physician ordered parameters, upon return from the dialysis center observe the resident's access site and obtain vital signs, document findings in the medical record and report abnormal findings to the physician, medications as ordered, Nepro supplement per orders, observe dialysis site for signs/symptoms of infection, observe for fatigue and encourage frequent rest periods as needed, observe for signs/symptoms of infection to access site, observe for signs of anemia or uremia and notify physician for treatment as needed, observe for signs of fluid retention, observe for signs/symptoms of bleeding, observe skin for sings of pruritis or being dry or scaly and apply lotion as needed, labs as ordered, provide diet as ordered, receives dialysis Monday, Wednesday and Friday at 11:00 A.M., refer to dietician as needed, takes bag lunch to dialysis and weight per order as needed. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident received dialysis. Review of the resident's monthly physician orders for October 2024 identified orders dated 04/05/24, to check vital signs post dialysis on Monday, Wednesday, Friday; daily weight at 6 A.M. for dialysis weight; an order dated 04/09/24, to monitor Left AV fistula for positive bruit and thrill every shift for monitoring; no blood pressure in left arm; an order dated 09/23/24, for hemodialysis every Monday, Wednesday, Friday; check bruit and thrill every shift and observe fistula/graft site for thrombosis, bleeding, stenosis, infection, Steal Syndrome, and aneurysm every shift. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's daily weights revealed the facility failed to obtained the physician ordered resident's weight at 6:00 A.M., on the following dates: 04/06/24, 04/10/24, 04/29/24, 05/13/24, 05/14/24, 05/15/24, 05/23/24, 05/29/24, 05/30/24, 07/10/24, 07/16/24, 07/28/24, 07/31/24, 08/07/24, 08/23/24 and 08/28/24. Review of the resident's medical record revealed no post dialysis communication forms for the following dates: 04/05/24, 04/08/24, 04/10/24, 04/12/24, 04/15/24, 04/17/24, 04/19/24, 04/22/24, 04/24/24, 04/26/24, 04/29/24, 05/01/24, 05/03/24, 05/06/24, 05/08/24, 05/10/24, 05/15/24, 05/17/24, 05/20/24, 05/22/24, 05/24/24, 05/27/24, 05/29/24, 05/31/24, 06/03/24, 06/05/24, 06/07/24, 06/10/24, 06/12/24, 06/14/24, 06/17/24, 06/19/24, 06/21/24, 06/24/24, 06/26/24, 06/28/24, 07/01/24, 07/03/24, 07/05/24, 07/08/24, 07/10/24, 07/12/24, 07/15/24, 07/17/24, 07/19/24, 07/22/24, 07/24/24, 07/26/24, 07/29/24, 07/31/24, 08/02/24, 08/05/24, 08/07/24, 08/09/24, 08/12/24, 08/14/24, 08/16/24, 08/19/24, 08/21/24, 08/23/24, 08/26/24, 08/28/24, 09/02/24, 09/04/24, 09/06/24, 09/11/24, 09/13/24, 09/16/24, 09/18/24, 09/20/24, 09/23/24, 09/30/24, 10/04/24, 10/18/24, 10/21/24 and 10/23/24. Interview on 10/31/24 at 12:49 P.M., with the Director of Nursing (DON) verified the daily dialysis physician ordered weights were not obtained on the listed dates and the facility had no documented evidence of the post dialysis communication forms listed. Review of the policy titled, Hemodialysis, last revised on 09/26/23, revealed the facility completes the appropriate section of the hemodialysis communication form prior to the resident receiving each dialysis session and again when the resident returns from hemodialysis.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50536 Based on observation, resident interview, staff interview and record review, the facility failed to ensure residents who are trauma survivors receive culturally competent, trauma-informed care that accounts for the resident's experiences and preferences in order to eliminate or lessen the severity of triggers that lead to retraumatization for the resident. This affected one (#41) of one resident reviewed for trauma-informed care. The facility census was 91. Finding include: Review of Resident #41's medical record revealed an admitted [DATE], with diagnoses including: post traumatic stress disorder (PTSD), type two diabetes mellitus (DM), peripheral vascular disease (PVD), focal traumatic brain injury without loss of consciousness, history of falling, diabetic foot ulcer, non-pressure chronic ulcer of right heel and midfoot with necrosis of muscle, venous insufficiency, chronic kidney disease (CKD), obesity, hyperlipidemia, anemia, hypothyroidism, adjustment disorder with mixed anxiety and depressed mood. Observation on 10/28/24 at 1:42 P.M., revealed Resident #41 became tearful and sad during an interview related to his time spent serving as a medic in the military during the Vietnam war. Interview with Resident #41 on 10/28/24 at 1:42 P.M., confirmed the time spent serving in the Vietnam war was traumatizing for Resident #41 and resulted in treatment by a mental health provider for nightmares, prior to admission to the facility. Resident #41 stated he had a 31 day stay in a mental health facility in 1970 due to nightmares about the Vietnam war and the things he saw there, including loosing four of his friends. Resident #41 stated that the death of his wife in 2023 re-triggered the nightmares and the sadness he had felt in 1970. Review of the discharge paperwork from Ohio Health dated 07/21/24 revealed the diagnosis of PTSD was included in his discharge diagnosis list from the hospital prior to admission to the skilled facility. Review of the physician's progress note dated 10/14/24 at 4:42 A.M., revealed the provider included in her note the diagnosis of PTSD. Review of the nurse practioner's note dated 10/15/24 at 6:15 P.M., revealed the provider included in her note the diagnosis of PTSD. Review of the care plan, orders, diagnosis list, and MDS on 10/28/24 at 1:42 P.M. revealed no evidence of trauma-informed care (monitoring for triggers, re-traumatizing events, psychological consultation) or treatment of PTSD for Resident #41. Interview on 10/29/24 at 2:25 P.M., with the Director of Nursing (DON) confirmed Resident #41 was offered psych services but declined, and the medical record contained no documented evidence of trauma-informed care related to Resident #41's PTSD diagnosis. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/30/24 at 8:51 A.M., with the DON confirmed the PTSD diagnosis was not included on the admission diagnosis list, and that there was no care plan or monitoring orders for Resident #41's PTSD, and no interventions or evaluations regarding triggers and monitoring. The DON stated the social worker was new at the time of Resident #41's admission, and while she completed the PTSD evaluation, she did not follow the correct procedure for documentation. The DON confirmed Resident #41 was admitted on [DATE] and didn't have an initial psych evaluation with Viaquest until 08/12/24, and Resident #41 still has ongoing triggers related to his time spent in Vietnam, and the passing of his wife.

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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** 50536 Based on record review and staff interview, the facility failed to ensure monitoring for adverse reactions/side effects related to the use of anticoagulants, diuretics, and/or insulin. This affected two (#36 and #82) of two residents reviewed for unnecessary medication use. The facility census was 91. Findings include: 1. Review of Resident #36's medical record revealed an admitted [DATE], with diagnoses including: Cerebral vascular accident (CVA), hemiplegia/hemiparesis right dominant side, dysphagia, aortic stenosis, hypertension (HTN), atrial fibrillation (AFIB), type two diabetes mellitus (DM), congestive heart failure (CHF), hyperlipidemia, contracture left ankle, generalized anxiety disorder (GAD), moderate intellectual disabilities, gastroesophageal reflux disease (GERD), recurrent depressive disorder, and contracture of right ankle/foot. Review of the monthly physician's orders for Resident #36 dated October 2024 revealed orders for: apixaban tablet five milligrams (mg), give one tablet by mouth two times a day for CVA; aspirin (ASA) tablet, chewable, 81 mg, give one tablet by mouth one time a day for heart supplement. basaglar Kwikpen 100 units/milliliter (ml), inject 33 units subcutaneously at bedtime for diabetes; lasix 40 mg, give one tablet by mouth one time a day for CHF; and tradjenta five mg, give one tablet by mouth one time a day for DM. The physician's orders contained no direction for monitoring related to adverse reactions/side effects related to the use of anticoagulants, diuretics, and/or insulin for Resident #36. Review of the care plan for Resident #36 revealed at risk for abnormal bleeding/bruising related to anticoagulant medication use for AFIB and ASA use for CVA. Resident #36 will have no signs of active bleeding through next review. Interventions: Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal findings to the physician. Date initiated 03/15/22. Observe and report to physician as needed (PRN) signs/symptoms of complications: Blood tinged/frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe blurred vision, shortness of breath (SOB), loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs, bleeding gums, petechiae (tiny round brown-purple spots due to bleeding under the skin), back or abdominal pain, and nosebleeds. Date initiated: 03/15/22. Review of the care plan for Resident #36 revealed at risk for dehydration due to Lasix (a diuretic, also called a water pill, commonly used to treat swelling by removing excess water from the body) use. Resident #36 will be free of any discomfort or adverse side effects of diuretic therapy through the review date. Interventions: Observe and report to the physician PRN signs/symptoms of dehydration: Decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on sitting/standing, increased pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes. Date initiated: 04/12/24. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan for Resident #36 revealed at risk for fluctuation in blood sugar levels related to insulin dependent diabetes mellitus (IDDM). Resident #36 will have no complications related to diabetes through the review date. Interventions: Observe for signs/symptoms of hyperglycemia: Increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing, acetone breath (smells fruity), stupor, coma. Report abnormal findings to the physician. Observe for signs/symptoms of hypoglycemia: Sweating, tremor, tachycardia (increased heart rate), staggering gait, pallor, nervousness, confusion, slurred speech, lack of coordination. Report abnormal findings to the physician. Date initiated: 05/20/21. Interview on 10/31/24 at 3:51 P.M., with the Director of Nursing confirmed the facility has no documentation of monitoring for side effects related to the use of anticoagulants, diuretics, and/or insulin for Resident #36. 2. Review of Resident #82's medical record revealed an admitted [DATE], with diagnoses including: fracture of fifth lumbar vertebra, spinal stenosis (lumbar), chronic obstructive pulmonary disease (COPD), hypertension (HTN), depression, anxiety disorder, nicotine dependence, dorsalgia, constipation, cervicalgia, and low back pain. Review of the physician's orders for Resident #82 revealed order for Oxycodone Hydrochloride (HCL) oral tablet 10 milligrams (mg), give 1 tablet by mouth every six hours as needed for chronic neck and back pain. Ordered 09/24/24. Tylenol oral tablet 325 mg, give two tablets by mouth every six hours as needed for pain. Ordered 08/15/24. Review of the medication administration records (MARs) for September 2024, and October 2024, revealed nursing staff were administering both Tylenol and Oxycodone for pain, at various pain levels on the 1/10 pain scale with no parameters attached to the orders to designate which medication to administer for Resident #82's reported pain level. Non-pharmalogical interventions were inconsistently used. Review of the care plan for Resident #82 revealed Resident #82 has pain in back and neck which may interfere with her activities of daily living (ADL) performance, mood, and sleep. Acceptable level of pain: 0/10. Date initiated: 05/30/24. Resident #82 will state pain is at an acceptable level of: 0 on a scale of 0-10 daily through next review. Date initiated: 06/11/24. Interventions for pain included: Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal finding to the physician. Anticipate resident's need for pain relief as needed (PRN) and respond immediately to any complaint of pain. Evaluate characteristics of pain on a scale of 0-10. Evaluate the effectiveness of pain interventions as given. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition as needed. Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decreased range of motion (ROM), withdrawal or resistance to care. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe for pain presence every shift. Observe for side effects of pain medication. Observe for constipation, new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria, nausea, vomiting, dizziness and falls. Report occurrences to the physician. Observe/record: Loss of appetite, choice not to eat and weight loss. Report abnormal findings to the physician. Observe/record: Resident complaints of pain or requests for pain treatment. Offer Non-Pharmacological Interventions: 1) Massage; 2) Meditation/Relaxation; 3) Positioning; 4) Ice/cold pack; 5)Diversional Activity; 6) Rest; 7) Social Interaction. Report to Nurse any change in usual activity attendance patterns or refusal to attend activities related to signs/symptoms or complaints of pain or discomfort. Date these interventions initiated: 05/30/24. Interview on 10/30/24 at 9:49 A.M., with Registered Nurse (RN) #125 confirmed that based on the documentation on the MARs for September and October, and the physician's orders for Resident #125, nursing staff were administering both Tylenol and Oxycodone for varying levels of pain on the scale with no direction attached to the order to designate which of the two medications to administer. RN #125 confirmed that non-pharmalogical interventions should be attempted first, and if ineffective, pain medication should be administered. RN #125 also confirmed that if there are two orders for pain medication, and no parameters attached to the orders based on the pain scale, and/or the reported pain level, a pain assessment would need to be completed, and the physician would need to be consulted for further orders.

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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** 32654 Based on record review and staff interview, the facility failed to monitor for potential side effects of antipsychotic medication use. This affected two (#1 and #36) of five residents reviewed for unnecessary medications. The facility census was 91. Findings include: 1. Review of the medical record for Resident #1 revealed an initial admitted [DATE], with the latest readmission of 10/28/23, with the diagnoses including: cerebrovascular accident with right sided hemiplegia, dysarthria, aphasia, dysphagia, vascular dementia, hypertension, chronic kidney disease, hyperlipidemia, diabetes mellitus, anemia, depression, gastro-esophageal reflux disease, adult failure to thrive, atopic dermatitis and schizoaffective disorder. Review of the resident's plan of care dated 07/01/24 revealed the resident was at risk for adverse reactions and side effects related to psychotropic medication used for schizoaffective disorder and antidepressant used for depression. Interventions included administer antidepressant medications as ordered, observe for side effects/ineffectiveness such as dry mouth, dry eyes, constipation, urinary retention, suicidal ideations, nausea, insomnia, anxiety, restlessness, decreased sex drive, diarrhea and headaches, report any abnormal findings to the physician. Administer antipsychotic medication as ordered. Observe for side effects/ineffectiveness such as sedation, headaches, dizziness, diarrhea, anxiety, extrapyramidal side effects which include akathisia, restlessness, dystonia, Parkinsonism tremor, orthostatic hypotension, weight gain, anticholinergic side effects, blurred vision, constipation, tardive dyskinesia, report any abnormal findings to the physician, abnormal involuntary movement scale (AIMS) per facility policy, dose reduction will be attempted as appropriate, observe/record/report to physician as needed adverse reactions of antipsychotic medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person, obtain labs as ordered, report any abnormal findings to the physician, offer non-pharmacological interventions and psychiatric consult as needed. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident has a severe cognitive deficit. Review of the mood and behavior revealed the resident displayed verbal behaviors directed towards others. The assessment indicated the resident received antipsychotic medications, antidepressant and antiplatelet medications. The assessment indicated the resident received antipsychotic medications on a routine basis. Review of the resident's monthly physician orders for October 2024 identified orders dated 10/23/24, for Abilify 5 milligrams (mg) by mouth daily for schizoaffective disorder and 10/29/24 for Mirtazapine 7.5 mg by mouth daily at bedtime. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365256	A. Building B. Wing	11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Worthington, The	1030 High St Worthington, OH 43085

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's medical record revealed no documented evidence the facility is monitoring for possible side effects for the use of an antipsychotic and antidepressant medications. Interview on 10/29/24 at 4:02 P.M., with the Director of Nursing (DON) verified the facility had no documented evidence the facility monitored Resident #1 for side effects of the use of an antipsychotic and antidepressant medication. 50536 2. Review of Resident #36's medical record revealed an admitted [DATE], with diagnoses including: cerebral vascular accident (CVA), hemiplegia/hemiparesis right dominant side, dysphagia, aortic stenosis, hypertension (HTN), atrial fibrilation (AFIB), type two diabetes mellitus (DM), congestive heart failure (CHF), hyperlipidemia, contracture left ankle, generalized anxiety disorder (GAD), moderate intellectual disabilities, gastroesophageal reflux disease (GERD), and contracture of right ankle/foot. Review of the physician's orders for Resident #36 on 10/31/24 at 3:51 P.M. revealed the following psychotropic medication orders: an order dated 07/15/24 for Buspirone Hydrochloride (HCL) tablet five mg, give one tablet by mouth two times a day and order date 02/25/23, for Sertraline HCL 25 mg, give one tablet by mouth one time a day for depression. The physician's orders contained no direction for monitoring related to adverse reactions to psychotropic drugs, nor the implementation of behavioral interventions as needed. Review of the care plan for Resident #36 revealed at risk for adverse reactions and side effects related to receiving anti-anxiety medication for anxiety and anti-depressant medication for depression. Date Initiated: 11/17/21. Resident #36 will be free from adverse reactions/side effects related to anti-depressant, anti-anxiety therapy through the review date. Date initiated: 02/18/22. Interventions: Administer anti-anxiety medications per orders. Observe for side effects/ineffectiveness such as: Drowsiness, lack of energy, decreased coordination, slow reflexes, slurred speech, confusion/disorientation, depression, dizziness, lightheaded, impaired thinking and judgment, memory loss, nausea, stomach upset, blurred or double vision. Paradoxical side effects: Mania, hostility and rage, aggressive or impulsive behavior, hallucination. Report abnormal findings to the physician. Date these interventions were initiated: 11/17/21. Administer anti-depressant medications per orders. Observe for side effects/ineffectiveness such as: Dry mouth, dry eyes, constipation, urinary retention, suicidal ideations, nausea, insomnia, anxiety, restlessness, decreased sex drive, dizziness, weight gain, tremors, sweating, sleepiness or fatigue, dry mouth, diarrhea, constipation, headaches. Report abnormal findings to the physician. Observe/document/report to physician as needed ongoing signs/symptoms of depression, unaltered by anti-depressant medication: Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, negative mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance. Date these interventions were initiated: 11/17/21. Interview on 10/31/24 at 3:51 P.M., with the Director of Nursing confirmed the facility has no documentation of monitoring for side effects and/or behaviors, or implement behavioral interventions related to psychotropic drug use for Resident #36.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365256	A. Building B. Wing	11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Worthington, The	1030 High St Worthington, OH 43085

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on medical record review, and staff interview, the facility failed to obtain a resident's laboratory tests as physician ordered. This affected one (#18) of five residents reviewed for unnecessary medications. The facility census was 91. Findings include: Review of the medical record for Resident #18 revealed an initial admitted [DATE], with the diagnoses including but not limited to surgical aftercare following surgery on the skin and subcutaneous tissue, peripheral venous insufficiency, end stage renal failure, dependence on renal dialysis, hypertension, diabetes mellitus, hyperlipidemia, anemia, polyneuropathy, hyperparathyroidism, and depressive disorder. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident received dialysis. Review of the resident's monthly physician orders for October 2024 identified an order dated 04/05/24 Albumin and Pre-albumin level every other week. Review of the medical record revealed no eveidence of the lanoratory test ebing completed. Interview on 10/31/24 at 10:27 A.M., with the Director of Nursing (DON) revealed she thought the resident's dialysis company was obtaining the Albumin/Pre-albumin every other week. Interview on 10/31/24 at 12:49 P.M., with the DON verified the physician ordered Albumin and Pre-albumin levels were not obtained every other week.