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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Vista Nursing & Rehab by McAre Health	1216 5th Ave Youngstown, OH 44504

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 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** 42013 Based on observation, interview, record review and review of the facility policy, the facility failed to ensure Resident's #46 and #98 were transported to their scheduled appointments. This affected two residents (#46 and #98) out of three residents reviewed for transportation to appointments. The facility census was 101. Findings include: 1. Review of Resident #46's medical record revealed an admitted [DATE] with diagnoses including congestive heart failure, chronic obstructive pulmonary disease, dysphagia following cerebral infarction, and anxiety disorder. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #46 was cognitively intact. Resident #46 required partial to moderate assistance rolling left and right, the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed, and the ability to transfer to and from a bed to a chair or wheelchair. Review of the care plan revised 12/20/24 included Resident #46 had an activities of daily living (ADL) self-care performance deficit related to weakness, chronic obstructive pulmonary disease, and endocarditis. Resident #46 would maintain ADL through the next review date. Interventions included Resident #46 required partial to moderate assistance to move between surfaces, from bed to wheelchair, from wheelchair to toilet, and for showers. Review of Resident #46's Transportation Scheduling Request dated 01/08/25 included the transportation company was called on 01/16/25 and transportation was arranged for a pickup time on 02/12/25 at 8:00 A.M. for a physician appointment at 9:00 A.M. Observation on 02/12/25 at 7:45 A.M. revealed Resident #46 was provided incontinence care for a bowel movement at 7:48 A.M. Observation on 02/12/25 at 8:20 A.M. revealed Resident #46 was sitting in a wheelchair by the elevator with her coat on. (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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/12/25 at 8:45 A.M. revealed Resident #46 was sitting in a wheelchair close to the elevator of the nursing unit she resided in. Certified Nursing Assistant (CNA) #804 was talking to other staff members by the nurse's station and pushing a metal cart. After she was done talking to the staff members, CNA #804 told Licensed Practical Nurse (LPN) #963 she was going to take Resident #46 downstairs to the main entrance so she would be ready for transportation to pick her up for her appointment (the pickup time was 8:00 A.M.). CNA #804 used the elevator and transported Resident #46 to the main entrance of the facility. Observation on 02/12/25 at 8:55 A.M. revealed CNA #804 returned to the nursing unit with Resident #46. CNA #804 stated the transportation driver did not take Resident #46 to her appointment. CNA #804 stated the transportation driver said she called the nursing unit to tell them she was at the facility and ready to take Resident #46 to her appointment, but no one answered the phone. LPN #963 stated she did not hear the phone ring. CNA #804 stated she was assisting residents and did not hear the phone ring. LPN #963 confirmed Resident #46's pick up time was at 8:00 A.M., and Resident #46 should have been at the main entrance at that time and ready to go to her appointment. Interview on 02/12/25 at 8:56 A.M. of CNA #919 revealed she was in Resident #46's room at 7:59 A.M. (observation at 7:48 A.M. revealed the incontinence care was completed) providing incontinence care for a bowel movement. CNA #919 stated she did not hear the phone ring at the nurse's station. Interview on 02/12/25 at 8:59 A.M. of LPN #963 revealed the two aides assigned to the nursing unit have a lot of things they are responsible for, and it puts so much on the aides to also have to transport residents to the front entrance of the facility for their appointments. Review of Resident #46's progress notes dated 02/12/25 at 3:19 P.M. revealed Resident #46 missed an orthopedic appointment today, and the appointment was rescheduled for 02/26/25 at 2:40 P.M. The transport paper was sent, and Resident #46 was aware. Interview on 02/18/25 at 2:12 P.M. of Business Office Manager (BOM) #971 and Business Office Assistant (BOA) #935 revealed they scheduled transportation for the residents, and there were issues with some of the transportation companies. BOA #935 stated the drivers were only required to wait five minutes, and if the residents were not ready to go, the transportation drivers leave. BOM #971 stated the drivers would leave even if they knew the resident was on the way to the transportation van. BOM #971 indicated the facility tried to get the residents transported to the main entrance before the scheduled pick-up time just to make sure they do not miss their ride, and the residents sometimes waited a long time before they were picked up. Interview on 02/19/25 at 8:07 A.M. of CNA #919 indicated that depending on the time of day a resident had an appointment, it could be hard for the aides to take residents to the transportation van because the elevators had to be used to take them downstairs to the front entrance to be picked up by the drivers. CNA #919 stated if the aides were passing meal trays, or providing care to another resident, it is hard to take everyone where they need to go at the time they need to go. Interview on 02/19/25 at 8:35 A.M. of the Administrator revealed the nurses' were responsible to tell the aides what time the residents needed to be taken to the main entrance for their pick up when they had an appointment. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Transportation, reviewed 08/2024, included it was the policy of the facility to arrange and ensure transportation was provided for doctors and specialist appointments if the resident did not have family, a friend or responsible party available for transport. The facility staff would schedule transportation to and from the appointment as needed. The facility staff would notify staff involved of the appointment. The resident would be transported to the appointment. 2. Review of Resident #98's medical record revealed an admitted [DATE] with diagnoses including unstable burst fracture of T7-T8 thoracic vertebra, type two diabetes mellitus, morbid obesity, and chronic obstructive pulmonary disease. Review of Resident #98's physician orders dated 01/18/25 revealed an order for oxygen therapy at four liters per minute via nasal cannula, may titrate as needed, every shift. Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #98 was cognitively intact. Resident #98 required substantial to maximal assistance with toileting hygiene, bathing, and was dependent on staff for lower body dressing. Resident #98 required partial to moderate assistance for the ability to transfer to and from a bed to a chair or wheelchair and for the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. Resident #98 used oxygen therapy. Review of Resident #98's Transportation Scheduling Request dated 01/21/25 included transportation was scheduled on 02/03/25 for Resident #98's appointment on 02/12/25 at 9:30 A.M. Resident #98's pick up time for his appointment was at 8:30 A.M. Review of Resident #98's care plan dated 01/24/25 included Resident #98 had an ADL self-care performance deficit related to activity intolerance, disease process, impaired balance, limited mobility, pain fracture T7-T8 vertebrae, and other diagnoses. Resident #98 would improve his current level of function through the review date. Interventions included Resident #98 required supervision or touching assistance for chair-to-bed-to-chair transfers. Observation on 02/12/25 at 8:04 A.M. of Registered Nurse (RN) #815 revealed she was sitting in the back room of the nurse's station, had a concerned look on her face and stated she worked night shift, and the day shift nurse had not shown up yet. RN #815 stated she was really stressed out about it because she had to take her son to school and now, he was late. RN #815 stated she called the Director of Nursing (DON), and he assured her someone would come, but no one did. RN #815 indicated she had been waiting an hour for her relief. Interview on 02/12/25 at 8:11 A.M. of the DON revealed he was not aware RN #815 had not been relieved by a day shift nurse, and he would make sure someone came to relieve her so she could go home. Review of RN #815's timecard revealed she clocked out on 02/12/25 at 8:20 A.M. Observation on 02/12/25 at 9:15 A.M. with Assistant Director of Nursing (ADON) #911 revealed Resident #98 was sitting in a wheelchair and was assisted out of the elevator and to his room by CNA #894. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/12/25 at 9:15 A.M. of ADON #911 revealed he took over for RN #815 around 8:30 A.M. because she said she had to leave. ADON #911 stated Resident #98 missed an appointment. ADON #911 stated Resident #98's pick up time was 8:30 A.M., and he did not make his appointment because ADON #911 had to find an oxygen tank that would fit on a bariatric wheelchair. ADON #911 stated he did not find an oxygen tank to fit on the wheelchair but sent an oxygen tank on wheels with Resident #98. ADON #911 stated the transportation driver called and said he was at the facility, and ADON #911 indicated he told the receptionist to tell the driver to wait because he was getting him ready, but the driver did not wait. ADON #911 stated Resident #98's pick up time was 8:30 A.M. and he was downstairs by 8:55 A.M. ADON #911 indicated the transportation drivers only wait five minutes and then they leave. Review of Resident #98's late entry progress notes dated 02/12/25 at 3:33 P.M. revealed Nurse Practitioner (NP) #1005 was updated regarding Resident #98 missing a pulmonology appointment today related to transportation. The appointment was rescheduled for 02/27/25 at 9:15 A.M. Review of the facility policy titled Transportation, reviewed 08/2024, included it was the policy of the facility to arrange and ensure transportation was provided for doctors and specialist appointments if the resident did not have family, a friend or responsible party available for transport. The facility staff would schedule transportation to and from the appointment as needed. The facility staff would notify staff involved of the appointment. The resident would be transported to the appointment. This deficiency represents noncompliance investigated under Complaint Number OH00161578.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of the facility policy, the facility failed to ensure Residents #57 and #90 and had a clean, sanitary and homelike environment. This affected two residents (#57 and #90) out of three residents reviewed for sanitary homelike environment. The facility census was 101. Findings include: 1. Review of Resident #57's medical record revealed an admitted [DATE] with diagnoses including bipolar disorder, major depressive disorder, and nontraumatic intracranial hemorrhage. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #57 was cognitively intact. Resident #57 had no impairment of the upper and lower extremities. Resident #57 required set-up or clean-up assistance for activity of daily living (ADL). Observation on 02/12/25 at 10:21 A.M. of Resident #57 revealed she walked up to Registered Nurse (RN) #997 and was very upset and told RN #997 her room needed cleaned. Resident #57 stated her trash can was so full that you cannot even put a Q-tip in it and her bathroom was dirty, and she cleaned it herself today. Resident #57 indicated she did not have toilet paper and had to go searching for a new roll. Resident #57 stated her room had not been cleaned for a couple of days. Observation on 02/12/25 at 10:22 A.M. of Resident #57's room with Housekeeping Aide (HA) #955 confirmed the trash receptacle was very full, and it would be hard to fit anything else in it. HA #955 confirmed Resident #57's bathroom floor and toilet needed cleaned. HA #955 confirmed the toilet paper roll was empty, and there was a new roll propped up on the towel rack. HA #955 stated Resident #57's room needed cleaned, and she would clean it right now. Interview on 02/13/25 at 2:31 P.M. of Housekeeping Director (HD) #844 revealed resident rooms should be cleaned daily which included sweeping, mopping, dusting, clean surfaces, sink, toilet, trash and floors. HD #844 reviewed Resident #57's housekeeping record, and it showed her room was cleaned daily. HD #844 stated she would educate the housekeeping staff on the correct way to clean resident rooms. 51525 2. Review of the medical record revealed that Resident #90 was admitted to the facility on [DATE] with diagnosis including alcoholic cirrhosis of the liver and a new diagnosis of alcoholic induced dementia on 11/25/24. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #90 had a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment with long- and short-term memory impairments. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan dated 01/29/25 stated Resident #90 had a behavior problem and preferred to be nude. Resident #90 often had bowel movement (BM) on the floor of his room and painted the walls and floor with feces. He often ate other people's food. The care plan also stated he refused to allow staff to put sheets and pads on his bed, refused to wear clothes or an incontinence brief, he removed his clothing and soiled linen and threw it on the floor and sometimes walked in the hallway nude. Observation of Resident #90 on 02/10/24 at 8:10 P.M. revealed him lying in bed wearing only a continence brief. He was agitated and asked the surveyor to go away. The surveyor observed kernels of corn and breadcrumbs on his floor; Resident #90 was unable to recall how the food ended up on the floor or how long it had been there. Observation on 02/11/25 3:55 P.M. revealed Resident #90 was lying in bed awake and wearing only a shirt. The floor was messy with crumbs of food and various papers. Yesterday's corn was gone. He was agitated and asked the surveyor to leave. The surveyor observed a chair in the corner of the room with a note attached that said, please clean chair: FECES! Observation on 02/12/25 at 9:00 A.M. revealed Resident #90 lying in bed without clothes wearing only a brief. He asked the surveyor to leave his room. The surveyor observed the dirty chair still in the corner. It had not been cleaned, and the sign was still on it. The surveyor also observed feces on Resident #90's toilet seat and bed linens. Interview with CNA #872 on 02/12/25 9:40 A.M. stated Resident #90 routinely took his clothing off shortly after they help him get dressed, and his room needs cleaned after every meal as he throws food everywhere. CNA #872 also stated she asks housekeeping to clean resident's room more often as he gets feces all over himself and his bed and toilet seat. Observation of Resident #90's room on 02/13/25 at 8:31 A.M. revealed the soiled chair in corner still displaying the sign asking for it to be clean as it had feces on it. Crumbs were observed on the floor. Observation on 02/13/25 at 11:07 A.M. revealed Resident #90 lying in bed wearing a hospital gown. Housekeeping was in the process of cleaning his room at the time of surveyor's observation; the room was clean and comfortable. No crumbs or papers were on the floor. The soiled chair was still sitting in the corner displaying the sign asking for it to be cleaned which was confirmed by Housekeeper #926 at the time of the observation. This deficiency represents noncompliance investigated under Master Complaint Number OH00161714.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49774 Based on record review, interview and facility policy review, the facility did not ensure a baseline care plan was completed within 48 hours for Residents #11, #92, and #257. This affected three residents (#11, #92, and #257) of the 30 resident records reviewed. The facility census was 101. Findings include: 1. Record review revealed Resident #11 was admitted [DATE] with diagnoses of acute osteomyelitis of the right ankle and foot, legal blindness, chronic diastolic (congestive) heart failure, and chronic obstructive pulmonary disease. Review of the Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #11's cognition was intact as evidenced by the Brief Interview for Mental Status (BIMS) assessment score of 15 out of 15. The resident required moderate assistance for toileting, dressing, showers and transfers. Review of the care plan revealed a baseline care plan was initiated on 12/28/24. Interview on 02/18/25 at 10:24 A.M. with Unit Manager #859 confirmed a baseline care plan was not completed until 12/28/24 and not within 48 hours of admission. 2. Record review revealed Resident #257 was admitted [DATE] with diagnoses of lobar pneumonia, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, and chronic diastolic (congestive) heart failure. Review of the Medicare 5-Day MDS 3.0 assessment dated [DATE] revealed Resident #257 had mild cognitive impairment as evidenced by the BIMS assessment score of 11 out of 15. Resident #257 was dependent on staff for toileting and dressing and required maximal assistance with showers. Review of the care plan revealed a baseline care plan was initiated 02/02/25. Interview on 02/18/25 at 10:35 A.M. with Unit Manager #859 confirmed a baseline care plan was not completed until 02/02/25 and not within 48 hours of admission. 3. Record review revealed Resident #92 was admitted [DATE] with diagnoses of malignant neoplasm of unspecified part of right bronchus or lung, chronic obstructive pulmonary disease, anxiety, and protein calorie malnutrition. Review of the Admission MDS 3.0 assessment dated [DATE] revealed Resident #92 had mild cognitive impairment as evidenced by the BIMS assessment score of 13 out of 15. Resident #92 required moderate assistance with showers and supervision with dressing. Review of the care plan revealed a baseline care plan was initiated on 01/05/25. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/12/25 at 3:29 P.M. with Unit Manager #861 confirmed a baseline care plan was not completed until 01/05/25 and not within 48 hours of admission. Review of the Care Plan Policy and Procedure, dated 12/01/18, revealed as procedure, a baseline care plan be developed within 48 hours of a resident's admission and must include the minimum healthcare information necessary to properly care for a resident including, but not limited to initial goals based on admission orders, physician orders, dietary orders, therapy services, social services, and Pre-Admission Screening and Resident Review (PASRR) recommendation, if applicable.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 49774 Based on record review, interview and facility policy review, the facility failed to ensure an initial care conference was completed for Resident #11 and failed to ensure the quarterly care conference was completed for Resident #31. This affected two residents (#11 and #31) of the 30 resident records reviewed. The facility census was 101. Findings include: 1. Record review revealed Resident #11 was admitted [DATE] with diagnoses of acute osteomyelitis of the right ankle and foot, legal blindness, chronic diastolic (congestive) heart failure, and chronic obstructive pulmonary disease. Review of the Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #11's cognition was intact as evidenced by the Brief Interview for Mental Status (BIMS) assessment score of 15 out of 15. The resident required moderate assistance for toileting, dressing, showers and transfers. Review of Resident #11's medical record revealed no documented evidence a care conference had occurred. Interview on 02/18/25 at 10:06 A.M. with Social Service Designee (SSD) #883 confirmed no care conference had been conducted since Resident #11 was admitted to the facility on [DATE]. 2. Record review revealed Resident #31 was admitted [DATE] with diagnoses of cerebral infarction, atherosclerotic heart disease of the native coronary artery without angina pectoris, chronic obstructive pulmonary disease, type II diabetes, morbid (severe) obesity due to excess calories, and psychotic disorder with delusions due to known physiological condition. Review of the Annual MDS 3.0 assessment dated [DATE] revealed Resident #31 had mild cognitive impairment as evidenced by the BIMS assessment score of 13 out of 15. Resident #31 had an impairment to one side and was dependent on staff for toileting, showers, and dressing, and required maximal assistance for personal hygiene and transfers. Review of Resident #31's medical record revealed the last quarterly care conference occurred 10/17/24. Interview on 02/18/25 at 10:06 A.M. with SSD #883 confirmed the quarterly care conference for Resident #31 was not completed in January 2025 which was when the next quarterly conference was to have been conducted. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Conferences Policy, dated January 2024, revealed as procedure, care conferences were to be scheduled to include the resident, resident representative, and interdisciplinary team as soon as possible after admission, routinely, and with a change in condition. 51521

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on observation, record review, interview and facility policy review, the facility failed to ensure Resident #29 was provided adequate nail care. This finding affected one resident (#29) of four residents reviewed for activities of daily living (ADL). The facility census was 101. Findings include: Review of Resident #29's medical record revealed the resident was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia affecting the right dominant side, dementia, and cerebral infarction. Review of Resident #29's current ADL care plan revealed an intervention dated 08/05/21 to check the nail length and trim and clean on bath days and as necessary. Report any changes to the nurse. Review of the Annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #29 exhibited severe cognitive impairment and was dependent on staff for ADL care. Telephone interview on 02/11/25 at 10:02 A.M. with Resident #29's power-of-attorney (POA) revealed the POA had concerns of the resident's nail care not being provided, including cutting and cleaning the fingernails. Observation on 02/11/25 at 1:30 P.M. with Certified Nursing Assistant (CNA) #993 of Resident #29's incontinence care did not reveal concerns of infection control. The resident appeared to have brown debris under her fingernails on both the right and left hands. CNA #991 indicated the resident had some type of food items for the lunch meal that was underneath her fingernails. Observation on 02/12/25 at 12:50 P.M. with the Director of Nursing (DON) revealed Resident #29 was lying in bed, and both her right and left hands had brown debris underneath her fingernails. Interview at the time of the observation with the DON verified Resident #29's right and left hands had brown debris underneath her fingernails. Interview on 02/12/25 at 1:56 P.M. with Registered Nurse (RN) #859 confirmed staff were to clean underneath fingernails. RN #859 also verified nursing staff cut fingernails and the podiatrist cut toenails. Review of the Care of Fingernails and Toenails policy, revised 02/2018, revealed the purpose of the procedure was to clean the nail bed, to keep the nails trimmed, and to prevent infections.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on record review, interview and facility policy review, the facility failed to ensure Resident #49 was provided an ongoing activities program to meet the needs of the resident. This finding affected one resident (#49) of one resident reviewed for activities. The facility census was 101. Findings include: Review of the medical record revealed Resident #49 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including rheumatoid arthritis, spinal stenosis, and anxiety disorder. Review of Resident #49's current activity care plans revealed an intervention dated 11/17/23 which revealed the resident needed a variety of activity types and locations to maintain the resident's interests. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #49 had intact cognition. Review of Resident #49's activity logs from 01/07/25 to 02/12/25 revealed the resident received two one-to-one activity visits from the activity staff, including one on 01/07/25 and one on 02/11/25. Interview on 02/10/25 at 8:03 P.M. with Resident #49 revealed she had not received activities as she was unable to get into a wheelchair to go to the activities and was not provided with activities in her room. Interview on 02/12/25 at 11:23 A.M. with Activity Director (AD) #891 revealed Resident #49 did not have one-to-one activities in her room because two activity staff members were terminated in the prior month. AD #891 confirmed Resident #49's documentation revealed the resident was provided two one-to-one activities from 01/01/25 to 02/12/25, including one on 01/07/25 and one on 02/11/25. She confirmed the staff had not documented the activity on 02/11/25 at the time of the interview because the staff were busy with activities. Review of the Activity policy, revised 01/2020, revealed it was the policy of the facility to provide activity programming to promote the physical, mental and psychosocial well-being of each resident. Activity programs were designed to meet the interests of the residents and encourage independence and interaction in the community.

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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** 48565 Based on observation, record review, interview and facility policy review, the facility failed to ensure orthotics/braces were applied as ordered for Resident #86. This affected one resident (#86) of five residents reviewed for limited range of motion (ROM) and had the potential to affect 13 residents (#5, #6, #7, #29, #31, #40, #42, #43, #64, 72, #81 and #86) identified by the facility as requiring application of orthotics/braces. The facility census was 101. Findings include: Review of the medical record for Resident #86 revealed an admitted [DATE] with diagnoses including cerebral infarction, vascular dementia, diabetes type two, and difficulty walking. Review of the physician's orders revealed an order dated 10/08/24 for a right ankle foot orthosis (AFO) brace when out of bed. (An AFO brace is a brace utilized for support and control the ankle and foot. An AFO is typically used to improve mobility, reduce pain, and prevent deformities). In addition, there was an order dated 11/30/24 to consult Western Reserve Orthotics for right AFO as the current AFO is broken. There was no documented evidence in the medical record on 11/30/24 that the facility called the orthotics company to have the AFO fixed. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #86 was cognitively intact. He did not reject care and had no limitation of ROM to upper and lower extremities. He required setup or clean-up help with eating and personal hygiene, partial to moderate staff assistance with upper and lower body dressing, toileting hygiene, putting on and taking off footwear, and sit to stand and chair to bed transfer, and he was dependent on staff for showers. He was able to walk ten feet with supervision or touching assistance. He was independent for wheeling a wheelchair. He was frequently incontinent of bowel and bladder. He received physical therapy (PT) and occupational therapy (OT). Review of the care plan dated 11/29/24 revealed Resident #86 had an alteration in musculoskeletal status and used a right AFO. Review of Resident #86's Medication Administration Records (MARs) dated 12/01/24 through 12/31/24 and 01/01/25 through 01/31/25 revealed the right AFO brace was signed off as applied and removed as ordered. (The right AFO was broken and unavailable from 11/30/24 to 12/30/24 when it was returned according to Director of Rehabilitation (DOR) #839; however, there was no documented evidence in the medical record that the AFO was returned until the physical therapy (PT) evaluation on 02/05/25. Review of the physical therapy (PT) evaluation dated 02/05/25 revealed Resident #86 was referred to therapy due to a functional decline as a result of bilateral lower extremity weakness and atrophy, reduced functional activity tolerance, and is at high risk for falls. The resident has received a new right AFO and requires gait training. (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 #86's physician's orders revealed an order dated 02/06/25, PT eval completed. PT to treat three to five times a week for 30 days to include therapeutic exercise, therapeutic activity, neuro re-education, and gait. Observations on 02/10/25 at 8:00 P.M. and 02/12/25 at 9:30 A.M and 2:10 P.M. of Resident #86 was up in the wheelchair and was not wearing the right AFO. Interview on 02/12/25 at 9:34 A.M. with Certified Nurse Assistant (CNA) #841 revealed they had been trained on brace application. CNA #841 stated the only resident on the 100-nursing unit with leg braces was Resident #81. (Resident #86 was on the 100-hall and had an order for a brace, a right AFO brace when out of bed). Interview on 02/12/25 at 9:40 A.M. with Registered Nurse (RN) #861 verified there was no brace applied to Resident #86. RN #861 checked the orders and revealed the right AFO broke on 11/30/24. Interview on 02/12/25 at 3:22 P.M. with RN #861 revealed the orthotics company was called today regarding the broken AFO for Resident #86. RN #861 stated the company was coming Tuesday [02/18/25] to have it repaired. Review of the PT note dated 02/14/25 revealed Resident #86 was to have the right AFO brace for gait and transfers. Interview on 02/18/25 an interview with DOR #839 revealed Resident #86's right AFO brace broke in November of 2024, was repaired and returned on 12/30/24. DOR #839 stated Resident #86 was currently receiving therapy services for gait training and new right AFO brace. (The PT evaluation for the new right AFO was completed on 02/05/25). Review of the facility policy titled Resident Mobility and Range of Motion, dated July 2017, revealed residents with limited mobility will receive appropriate services, equipment (braces/splints etc.) and assistance to maintain or improve mobility unless reduction in mobility is unavoidable.

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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** 42013 Based on record review, review of the facility incident log, interview and review of the facility post fall investigation, the facility failed to ensure Resident #47 had a comprehensive fall assessment completed after experiencing falls. This affected one resident (#47) out of three residents reviewed for falls. The facility census was 101. Findings include: Review of Resident #47's medical record revealed an admitted [DATE] with diagnoses including cerebral infarction due to unspecified occlusion or stenosis or right anterior cerebral artery, chronic obstructive pulmonary disease, and muscle weakness. Review of Resident #47's Fall Risk Evaluation dated 12/16/24 revealed she was at risk for falls. Review of the care plan dated 12/16/24 revealed Resident #47 was at risk for falls and potential injury related to debilitation, weakness, impaired balance, impaired cognition. Resident #47 was at high risk for falls due to impulsivity. Resident #47 would be free from major injury through the next review date. A fall without major injury such as a fracture or requiring transfer to the Emergency Department would not require a new intervention. Interventions included having commonly used articles within easy reach such as water, call light, remote control, monitor for side effects of psychotropic medications, and notify the physician of any irregularities. Review of the Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #47 was cognitively intact. Resident #47 required substantial to maximal assistance for toileting hygiene and lower body dressing. Resident #47 required partial to moderate assistance for the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed, for toilet transfer, and the ability to transfer to and from a bed to a chair or wheelchair. Review of the facility incident log dated 12/26/24 revealed Resident #47 had unwitnessed falls at 9:00 A.M. and 2:23 P.M. Review of Resident #47's medical record including progress notes dated 12/26/24 did not reveal evidence Resident #47 experienced a fall at 9:00 A.M. Review of Resident #47's progress notes dated 12/26/24 at 2:41 P.M. included Resident #47 activated her call light. An unidentified certified nursing assistant (CNA) found Licensed Practical Nurse (LPN) #1006. Resident #47 was lying on her right side and stated she was fine and did not hit her head. The nurse obtained vital signs and assisted Resident #47 off the floor. Range of motion (ROM) was at baseline, and a call was placed to the resident's responsible party. Review of Resident #47's progress notes dated 12/26/24 at 3:06 P.M. revealed Resident #47 stated she was trying to use the bathroom and slid out of the chair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #47's medical record including progress notes and assessments dated 12/26/24 did not reveal evidence Resident #47's physician was notified of the falls at 9:00 A.M. or 2:23 P.M., or the family was notified of Resident #47's fall at 9:00 A.M. The medical record had no documented evidence a fall assessment or pain assessment was completed, and there was no documentation of events leading up to either fall. Interview on 02/19/25 at 8:34 A.M. of the Administrator and the Director of Nursing (DON) confirmed Resident #47 had falls documented on the incident log on 12/26/24 at 9:00 A.M. and 2:23 P.M. but there was no documentation in Resident #47's medical record including progress notes regarding a fall at 9:00 A.M. The DON and Administrator confirmed on 12/26/24 there was no evidence Resident #47 had fall assessments, a pain assessment, or the physician was notified of the falls. The DON and Administrator did not provide statements regarding the falls from the staff on duty. The DON and Administrator did not provide additional information regarding Resident #47's falls on 12/26/24 at 9:00 A.M. and 2:23 P.M. Interview on 02/18/25 at 12:46 P.M. of CNA #950 revealed she vaguely remembered working on 12/26/24 and could not remember if it was a busy day and could not remember details regarding Resident #47's falls. CNA #950 stated Resident #47 was sometimes confused and often tried to get up without assistance. CNA #950 indicated she tried to keep a close watch on Resident #47 and check on her every hour if possible. CNA #950 stated it was important to have at least two aides working on the nursing unit, and it would be really helpful if there was a float aide who floated between the two nursing rehab units. CNA #950 stated on 12/26/24, she worked with an aide who was in orientation, and he did not count in the numbers, but he was a really good aide and was helpful. CNA #950 stated there should have been a second aide not in orientation also working with both of them. Interview on 02/19/25 at 3:51 P.M. of LPN #1006 revealed she did not remember working on 12/26/24 and did not remember if it was busy that day or if Resident #47 had falls. LPN #1006 stated it was almost two months ago, and she could not remember that far back. LPN #1006 stated she tried not to stay late to finish her work, but it was often unavoidable because she could not finish everything during her shift, and she did not like to leave anything unfinished such as fall documentation or new admissions. LPN #1006 confirmed she worked until 7:50 P.M. on 12/26/24 and should have finished working at 7:30 P.M. Review of the facility Post Fall Investigation revealed when a resident had a fall the resident's name, unit, date, and time of fall should be documented. There should be physician and family notification documented in the electronic record, neuro checks if head injury or unwitnessed fall, progress notes relating to the fall with interventions and vital signs in the electronic record. There should be an order written for immediate intervention related to how the fall occurred. There should be fall assessments and pain assessments documented in the electronic record. Pass on in report to document every shift for three days. Get statements from nurses and CNAs on the unit. Complete incident report in the electronic record.

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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** 42013 Based on observation, interview, record review and review of the facility policy, the facility failed to ensure Residents #34 and #203's incontinence care was provided timely and failed to ensure Resident #203's care planned interventions for reporting changes in skin status were implemented. This affected two residents (#34 and #203) out of three residents reviewed for incontinence care. The facility census was 101. Findings include: 1. Review of Resident #203's medical record revealed an admitted [DATE] with diagnoses including multiple fractures of the ribs, left side, displaced fracture of lateral condyle of right femur, displaced fracture of surgical neck of unspecified humerus, displaced articular fracture of head of left femur, and type II diabetes mellitus without complications. Review of Resident #203's Weekly Wound assessment dated [DATE] included the first observation of Resident #203's left hip revealed it was well approximated with 26 staples, light serosanguinous drainage and no signs and symptoms of infection. Measurements of the left trochanter (hip) included a length 17.0 centimeters (cm), width of 0.1 cm, and the depth was not measured. Review of Resident #203's progress notes dated 02/03/25 through 02/12/25 revealed no documented evidence that Resident #203's left hip staples had reddened skin around them or her entire left buttock was reddened with white scaly open areas mixed in with the redness and no documented evidence that Resident #203's physician was notified of these findings. Review of the Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #203 was cognitively intact. Resident #203 had upper extremity impairment on one side and lower extremity impairment on both sides. Resident #203 was dependent on staff for toileting hygiene and bathing. Review of Resident #203's care plan revised 02/11/25 included Resident #203 had functional bladder, bowel incontinence related to multiple healing fractures, dependence on staff for toileting needs and care. Resident #203 would remain free from skin breakdown due to incontinence and brief use through the review date. Interventions included to clean the resident's peri-area with each incontinence episode; check and change as required for incontinence and wash, rinse and dry perineum. Resident #203 had the potential for pressure ulcer development related to immobility, existing incisions to the left hip, left medial knee, left lateral knee and right lower extremity. Resident #203 would develop intact skin free of redness, blisters, or discoloration through the review date. Interventions included assessing, recording, monitoring wound healing and measuring length, width, and depth where possible, assessing and documenting the status of the wound perimeter, wound bed and healing progress, report improvements and declines to the physician; if Resident #203 refused treatment, confer with the resident, interdisciplinary team, and family to determine why and try alternative methods to gain compliance and document alternative methods. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/11/25 at 9:28 A.M. of Resident #203 revealed she was lying in bed with the head of the bed elevated. Resident #203 stated she wore an incontinence brief and had to clean myself up because no one comes in to do it, or I just pee in the Depend (brand of incontinence brief) which already has pee in it. Resident #203 stated the doctor said she was getting red from laying in pee. Resident #203 indicated she would activate her call light, and no one answered it, or if they did answer it, the aides would tell her two people were needed to change her, and they did not return. Resident #203 stated the aides change me very infrequently. Observation on 02/12/25 at 10:34 A.M. of Resident #203 revealed she was lying in bed; the sheets were half off the bed, and the bare mattress could be seen. Resident #203 stated she had not been changed this morning and just now threw her incontinence brief in the trash can which was next to her bed. Observation of the trash can revealed an incontinence brief was lying on top of the other trash, and it was saturated with urine and had a pungent smell. When asked about her staples, Resident #203 rolled a little to her right side, and the staples on her left hip could be seen. Observation of Resident #203's left hip revealed a long curving line of staples, and the area around the staples was red. Resident #203's entire left buttock had reddening skin and whitish, scaly open areas mixed in with the redness. The sheet under Resident #203 was bunched up and saturated with urine and pinkish colored drainage was noted on the urine-soaked sheet. Resident #203 stated she had an appointment today. Observation on 02/12/25 at 10:35 A.M. revealed Resident #203 activated her call light and at 10:46 A.M. Certified Nursing Assistant (CNA) #872 answered the call light. CNA #872 confirmed Resident #203's staples on the left hip and left buttock had large, reddened areas around them with some whitish scaly open areas. CNA #872 stated Resident #872 told her the area hurt and when she looked, the area was red and inflamed. When asked if she told the nurse about the open, reddened areas, CNA #872 stated the nurse and other aides knew about the reddened areas because they told her about it. CNA #872 confirmed Resident #203's urine saturated incontinence brief was in the trash can. CNA #872 confirmed Resident #203's bed had the sheet half off and the sheet was bunched under Resident #203 and was saturated with urine and a pinkish colored drainage. CNA #872 stated Resident #203 used a bedpan at times, and the urine on the sheets could have been from the bedpan. Resident #203 stated she activated her call light, it was not answered timely, and by the time it was answered she had to pee so bad she asked for a bedpan. Interview on 02/12/25 at 11:01 A.M. of CNA #894 revealed she often worked on the nursing unit that Resident #203 resided on, and there was not enough staff. CNA #894 stated call lights could take a long time to be answered because the aides were in other rooms assisting residents and providing care, and the call light could not be answered until the resident's care was completed. CNA #894 indicated the nursing unit typically had one nurse and one to two aides working on the floor. Interview on 02/12/25 at 11:15 A.M. of Registered Nurse/Wound Nurse (RN/WN) #861 revealed when Resident #203 was admitted to the facility her staples on the left hip looked good, were approximated and had no drainage or redness. RN/WN #861 stated she looked at Resident #203's left hip staples on 02/11/25, but did not look at the entire left hip area, and the staples had redness around them. RN/WN #861 stated today (02/12/25) the left hip area looked much worse, confirmed the left hip had open areas which were draining, and the skin was very red and inflamed. RN/WN #861 indicated Resident #203 did not ask to use the bedpan and urinated on herself. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #203's After Visit Summary from an orthopedic appointment dated 02/12/25 at 1:10 P.M. included staples were removed today, steri-strips placed, continue to monitor for signs and symptoms of infection, and maceration was noted to the left hip. A new order was given for nystatin cream 100,000 unit per gram (treats fungal or yeast infections), apply topically two times daily. Review of Resident #203's progress notes dated 02/12/25 at 4:38 P.M. included surgeon noted maceration to left hip and prescribed Nystatin cream and a portion of staples were removed. Review of the facility policy titled Incontinence Management Standard of Care, dated 01/2024, included it was the policy of the facility to promote intact skin, maintain dryness and respect the resident's standard and individualized interventions. The procedure was to implement standard interventions to promote healthy skin integrity. Interventions included routine rounding every two hours with turning and repositioning, timely response to the needs of the resident, provision of personal hygiene and skin care after each incontinent episode, barrier cream applied after each incontinent episode. 51525 2. Record review revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including irritable bowel syndrome (IBS) and difficulty walking. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #34 was frequently incontinent of bowel and bladder and was dependent upon staff for toileting hygiene. Resident #34 was cognitively intact with a Brief Interview of Mental Status (BIMS) score of 15 out of 15. The care plan dated 01/13/25 revealed that Resident #34 had bowel incontinence due to immobility and IBS, and staff would check the resident every two hours and assist with toileting as needed. Interview with Resident #34 on 02/10/25 at 8:05 P.M. revealed she had to wait too long for incontinence care at times. She stated she was supposed to be on an every two-hour check and change program, but sometimes it was four hours before she received incontinence care. She stated the staff does not check on her every two hours and only checks on her when she presses her call light. Interview on 02/12/25 at 9:40 A.M. with CNA #872 revealed Resident #34 will let staff know when she needs changed, so sometimes more than two hours will pass before incontinence care was provided. CNA #872 further stated staff does not check Resident #34 for incontinence unless she pressed her call button for assistance. A follow-up interview on 02/18/25 9:48 A.M. with Resident #34, she stated, the aides do not check on me; I have to ask. I have not been changed today or checked on by aides. They wait for me to put my light on, and do not ask if I need anything. Observation on 02/18/25 at 10:05 A.M., Resident 34's call light was activated; two aides were in another resident room; the nurse was in the back room of the nurse's station with the door closed, and no one was available to answer call light. Observation on 02/18/25 at 10:30 A.M., Resident #34's call light was answered, and the resident said she needed changed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/18/25 at 10:36 A.M. of CNA's #842 and #1001 revealed they entered Resident #34's room and proceeded to provide incontinence care. Resident #34's incontinence brief was wet with urine, and her sacral area, perineal area, and the inside area of her buttocks were reddened, with no skin breakdown noted. CNA #842 confirmed Resident #34's perineal area, sacral area, and the inside of her buttocks were reddened and stated Resident #34 was admitted to the facility with the reddened areas. Review of the facility Incontinence Management policy, dated 01/2024, stated staff will conduct routine rounding every two hours with turning and repositioning.

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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** 34297 Based on record review, interview and facility policy review, the facility failed to ensure Resident #13 was provided with the diet as ordered and failed to ensure Resident #86 was weighed weekly as ordered. This affected two residents (#13 and #86) of five residents reviewed for nutrition. The facility census was 101. Findings include: 1. Review of the medical record revealed Resident #13 was admitted to the facility on [DATE] with diagnoses including hemiplegia, unspecified protein-calorie malnutrition, and paranoid schizophrenia. Review of Resident #13's current alteration in nutrition and hydration care plans revealed an intervention dated 03/05/24 to provide the diet as ordered. Review of the Nutritional assessment dated [DATE] revealed Resident #13 was on a regular diet, mechanical soft texture, regular/thin liquids with a nighttime snack daily and a divided plate. Review of the dietary progress note dated 02/07/25 at 8:04 P.M. revealed Resident #13 had a weight change, was on a regular diet, regular texture, regular thin liquids diet with a nighttime snack daily and a divided plate at meals. Frozen nutritional supplements were offered twice daily for lunch and dinner with 100% acceptance documented and house protein twice daily with 25% to 50% accepted. Weekly weights were ordered and continue. A recommendation for Personalized Food First (PFF) scrambled eggs with cheese with breakfast daily and will follow acceptance of the recommendation. Review of Resident #13's physician orders revealed an order dated 02/07/25 for a regular diet, regular texture, regular-thin consistency. The resident was ordered the PFF program with scrambled eggs and cheese for breakfast. Interview on 02/13/25 at 10:08 A.M. with Diet Tech #994 revealed Resident #13 would receive a breakfast tray with the main entree in addition to scrambled eggs with cheese (fortified eggs) as indicated in the PFF program. Interview on 02/13/25 at 10:20 A.M. with [NAME] #949 with Diet Tech #994 in attendance confirmed she provided Resident #13 with two ounces of scrambled eggs with cheese and oatmeal for the breakfast meal. [NAME] #994 confirmed she did not provide Resident #13 with double the portion of eggs per the PFF program. Interview on 02/13/25 at 10:25 A.M. with Diet Tech #994 revealed the PFF program was not new, and Resident #13 should have received eggs with cheese in addition to the scheduled eggs for the breakfast meal as indicated in the PFF program. Interview on 02/13/25 at 10:30 A.M. with [NAME] #949 stated she provided Resident #13 one two ounce scoop of cheesy eggs. [NAME] #949 stated she was aware the resident was on PFF but only gave her one serving of cheesy eggs. (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 02/13/25 at 11:18 A.M. with Dietary Director #867 revealed the reason Resident #13 only received one serving of cheesy eggs and not two servings per the PFF program was because it was a miscommunication between Dietary Tech #992 and the kitchen staff. Dietary Director #867 revealed the PFF program would be placed on Resident #13's meal ticket and the staff did not realize the resident was supposed to receive two servings of eggs for the breakfast meal, including the cheesy eggs per the PFF program. Review of the Menus for the breakfast meal on 02/13/25 revealed residents would be provided a choice of cereal, scrambled eggs, blueberry muffin, vanilla yogurt, margarine, juice of choice, 2% milk and coffee/tea. Review of the spreadsheet for 02/13/25 for the breakfast meal revealed one serving of cereal (four ounces), #16 scoop (2 ounces) of scrambled eggs, one blueberry muffin, 1/2 cup (four ounces) of vanilla yogurt, six fluid ounces of juice, eight fluid ounces of milk, and six fluid ounces of coffee/tea. Review of the Personalized Food First Program policy dated 12/2019 revealed individualized nutrition approaches increase acceptance, decrease malnutrition risk and may help improve nutrition status. Providing nutrient dense preferred foods before suing nutritional supplements may benefit residents by increasing calorie and protein intake. 48565 2. Review of the medical record revealed Resident #86 was admitted to the facility on [DATE] with diagnoses including cerebral infarction, vascular dementia, mood disturbance, anxiety, type II diabetes mellitus, difficulty walking, and acute kidney failure. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #86 was cognitively intact. The nutritional assessment on the quarterly MDS revealed no swallowing difficulties, was on a physician prescribed weight gain regimen, and was on a therapeutic and mechanically altered diet. A review of a care plan dated 11/29/24 revealed Resident #86 had the potential for alteration in nutrition and hydration related to chronic disease, acute kidney failure, cerebral infarction, and diabetes mellitus type two. Interventions included to obtain weights as ordered. Review of the February 2025 physician's orders included regular diet mechanical soft texture, cut up foods, regular thin consistency liquids, an order for a health supplement three times a day dated 04/27/24, and a frozen meal supplement daily dated 01/01/25, and an order dated 01/04/25 for weekly weights times four weeks and then monthly. Review of weights for Resident #86 revealed no weight was obtained on 01/04/25 as ordered. On 01/12/25, Resident #86 weighed 146.8 pounds. There was no documented evidence of weights from 01/13/25 through 02/13/25. Interview on 02/13/25 at 10:00 A.M. with Dietary Technician (DT) #994 verified weekly weights were not obtained as ordered for Resident #86. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Weight Policy, dated November 2018, revealed it is the policy of this facility to attain/maintain a resident's weight within the recommended range as appropriate in relation to their medical and physical status. Weights will be obtained in a timely and accurate manner, documented and responded to appropriately. Residents with significant weight loss/weight gains will be brought into the routine weight meetings until stabilization occurs and/or clinical indications warrant a discontinuation of the weight protocol as indicated by a physician's order such as, the end-of-life process.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51521 Based on observation, record review, interview and facility policy review, the facility failed to ensure Resident #66's tube feeding was infusing as ordered by the physician. This affected one resident (#66) of one resident reviewed for tube feedings. The facility census was 101. Findings include: Medical record review revealed Resident #66 was admitted to the facility on [DATE] with diagnoses including cerebral infarction due to occlusion or stenosis of unspecified cerebral artery, dysphagia, oropharyngeal phase, muscle wasting and atrophy, not elsewhere classified, multiple sites, type II diabetes, vascular dementia, moderate without behavioral disturbance psychotic disturbance, mood disturbance and anxiety, moderate protein-calorie malnutrition. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #66 exhibited moderate cognitive impairment, weighed 133 pounds and did not have any oral intake. Resident #66 required a feeding tube for oral intake. Review of Resident #66's weights from 10/15/24 through 01/31/25 revealed on 10/15/24 the resident weighed 136.4 pounds (lbs) and 01/31/25 the resident weighed 131.8 lbs. Review of the medical record revealed Resident #66 was discharged to the hospital on 12/15/24 for percutaneous endoscopic gastrostomy (PEG) tube replacement and returned to the facility on [DATE]. He returned from the hospital with orders for NPO, and speech therapy (ST) to evaluate and treat for diagnosis of dysphagia (difficulty swallowing). Review of the February 2025 physician's orders for Resident #66's revealed an order dated 08/22/24 to change the tube feed piston syringe daily and label with the date every night shift; an order dated 11/25/24 for Diabetisource (nutritional supplement) tube feeding at 55 milliliters (ml) per hour for 12 hours to be implemented at 7:00 P.M. and removed at 7:00 A.M. with a 25 ml per hour water flush; and an order dated 11/26/24 for Diabetisource carton (250 ml) one carton bolus feeding with a 30 ml water flush following the bolus at 9:00 A.M., 12:00 P.M., 2:00 P.M. and 4:00 P.M. Observation on 02/10/25 at 7:03 P.M. revealed that Resident #66 was lying in bed. The resident was not able to be interviewed. The tube feeding solution was hanging on a tube feeding pole and connected to an automatic tube feeding pump which was turned off at the time of the observation. The tubing of the feeding tube was connected to the resident's PEG tube. The tube feed solution was dated 02/09/25 and flush bag was dated 02/08/25. The piston syringe was observed hanging on pole in a plastic bag, and the bag was undated. Observation on 02/10/25 at 8:30 P.M. with Licensed Practical Nurse (LPN) #990 revealed Resident #66's tube feeding solution was turned off and connected to the resident. (The tube feeding solution should have been turned on at 7:00 P.M.). LPN #990 turned tube feed pump on to infuse. She did not know why Resident #66's tube feeding was shut off and indicated it is usually running per order. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Dietitian #995 on 02/18/25 at 1:53 P.M. revealed Resident #66 had a history of weight gain prior to a 08/24 hospitalization at that time he was eating by mouth (PO). He was intubated due to aspiration pneumonia. Resident # 66 had failed two modified swallow studies at the time of hospitalization and a PEG tube was placed, and Resident #66 became dependent on the PEG tube for nutrition. On 09/12/24 reweighs were ordered and a weight loss was identified. Dietitian #995 adjusted the tube feed orders. Resident # 66 was documented as disconnecting the tube feed and refusing weekly weights. Dietitian #995 ordered bolus tube feeding and nocturnal feedings to meet Resident #66's nutritional needs because the tube feeding was Resident #66's source of nutrition and hydration. Review of the Enteral Nutrition policy, revised 11/2018, revealed adequate nutritional support through enteral nutrition is provided to residents as ordered.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview and record review, the facility failed to ensure Resident #206's pain was addressed timely. This affected one resident (#206) out of three residents reviewed for pain. The facility census was 101. Findings include: Review of Resident #206's medical record revealed and admitted [DATE] with diagnoses including encounter for orthopedic aftercare following surgical amputation, type II diabetes mellitus with diabetic chronic kidney disease, acquired absence of the left leg below the knee. Review of Resident #206's physician orders dated 02/06/25 revealed oxycodone HCl oral capsule (opioid pain medication) 5 milligrams (mg), give one capsule by mouth every six hours as needed for pain for five days. The order was discontinued on 02/11/25. Review of Resident #206's physician orders dated 02/07/25 revealed acetaminophen oral tablet (Tylenol) (analgesic), give 1300 mg by mouth three times a day for pain. Review of Resident #206's physician orders dated 02/10/25 revealed acetaminophen oral tablet 325 mg, give two tablets by mouth every six hours as needed for pain. Review of Resident #206's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #206 was cognitively intact. Resident #206 required supervision or touching assistance for activity of daily living (ADL) and mobility. Resident #206 frequently had pain or hurting in the last five days, and the pain made it hard for her to sleep at night. Resident #206 stated in the last five days she frequently limited her participation in rehabilitation therapy sessions due to pain. Resident #206 stated over the past five days her worst pain was rated as severe. Review of Resident #206's progress note dated 02/12/25 at 7:09 A.M. and written by MDS Nurse #961 included Resident #206 rated her pain in the left thigh over the past five days as severe and rated it at an eight on a pain scale of zero to ten, zero being no pain and ten being the worst pain. Observation on 02/12/25 at 10:08 A.M. of Registered Nurse (RN) #997 revealed she was administering medications to the residents on the nursing unit. Certified Nursing Assistant (CNA) #894 told RN #997 that Resident #206 was having pain in her leg. RN #997 walked into Resident #206's room to ask her about the pain she was experiencing, and Resident #206 stated her pain level was an eight out of a ten. RN #997 stated she would check Resident #206's orders for pain medication, and when she checked she found Resident #206's order for oxycodone was discontinued on 02/11/25. RN #997 wanted to clarify Resident #206's Tylenol orders with NP #1005 before administering the Tylenol to Resident #206. RN #997 also wanted to check with NP #1005 about getting a new order for oxycodone. RN #997 stated she wanted to talk to Assistant Director of Nursing (ADON) #911 about the orders. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/12/25 at 10:59 A.M. of ADON #911 revealed he confirmed 1300 mg of Tylenol three times a day was an unusual dose, and he was going to check with NP #1005 to see if she wanted to adjust the dose. ADON #911 stated the Tylenol order was verified when Resident #206 was admitted to the facility. Interview on 02/12/25 at 12:43 P.M. of RN #997 revealed she was waiting to hear back from NP #1005 about Resident #206's oxycodone and Tylenol orders. Observation on 02/12/25 at 1:01 P.M. of Resident #206 revealed her pain level was a six out of ten. Resident #206 stated she thought RN #997 gave her Tylenol earlier, but she had minimal relief. Resident #206 stated she was lying in bed on her side trying to relax and control her pain, but it was hurting pretty bad. Interview on 02/12/25 at 1:20 P.M. of RN #997 revealed she stated no when asked if she administered Tylenol to Resident #206 earlier in the day. RN #997 checked Resident #206's orders and found a Tylenol order for 650 mg by mouth every six hours as needed. Review of Resident #206's Medication Administration Record (MAR) dated 02/12/25 at 1:29 P.M. revealed Resident #206 was administered 650 mg acetaminophen by mouth for a pain rating of six out of ten. Interview on 02/12/25 at 2:12 P.M. of RN #997 revealed NP #1005 changed Resident #206's Tylenol order and ordered oxycodone. Review of Resident #206's progress notes dated 02/12/25 at 2:41 P.M. included Nurse Practitioner (NP) #1005 was in the facility and met with Resident #206 to discuss pain management. Resident #206's Tylenol order was updated, and oxycodone hydrochloride 5 mg capsule was ordered every six hours as needed. Resident #206 was alert and agreeable. Review of Resident #206's care plan dated 02/17/25 included Resident #206 had pain related to a left below the knee amputation (LBKA) and diabetic neuropathy. Resident #206 would not have discomfort related to side effects of analgesia through the review date. Resident #206 would verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. Interventions included administering analgesia as ordered, give a half hour before treatments or care; anticipate Resident #206's need for pain relief and respond immediately to any complaint of pain. Interview on 02/19/25 at 8:13 A.M. of MDS Nurse #961 confirmed when she interviewed Resident #206 on 02/12/25 at 7:09 A.M. Resident #206 stated she had a pain of eight out of ten and it was severe pain. MDS Nurse #961 stated Resident #206's nurse was well aware of her pain, and she did not mention it to the nurse.

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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** 34297 Based on record review, interview and facility policy review, the facility failed to ensure Resident #4's thrill and bruit were assessed every shift per facility policy. This finding affected one resident (#4) of one resident reviewed for dialysis services. The facility census was 101. Findings include: Review of Resident #4's medical record revealed the resident was admitted on [DATE] with diagnoses including end stage renal disease and dependence on renal dialysis. Review of Resident #4's physician's orders revealed an order dated 06/27/24 for vital signs before and after dialysis and an order dated 06/26/24 for hemodialysis every Tuesday, Thursday and Saturday with an arrival time of 10:10 A.M. There was no order to assess Resident #4's thrill and bruit. Review of Resident #4's medication administration records (MARs) and treatment administration records (TARs) from 01/01/25 to 02/13/25 did not reveal evidence the resident's bruit and thrill were assessed every shift per facility policy. Interview on 02/13/25 at 2:39 P.M. with Assistant Director of Nursing (ADON) #911 confirmed Resident #4's medical record and physician orders did not have evidence the resident's bruit and thrill were assessed every shift per facility policy. Review of the Dialysis Care policy, revised 07/2020, revealed it was the policy of the facility to ensure residents that receive dialysis treatments were safe, well assessed and that the facility collaborates with the dialysis center. Bruit and thrill of the fistula were to be assessed every shift for patency and recorded on the medication administration record (MAR).

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of the facility policy, the facility failed to ensure sufficient staffing to meet the needs of Resident's #34, #46, #98, and #203. This affected four residents (#34, #46, #98, and #203) and had the potential to affect 41 additional residents (#2, #7, #9, #10, #12, #14, #18, #22, #28, #30, #38, #40, #41, #42, #43, #49, #53, #55, #56, #57, #61, #64, #65, #66, #68, #70, #72, #73, #75, #76, #77, #82, #83, #88, #90, #96, #102, #103, #204, #205, and #206), residing on the nursing two and rehab two nursing units. The facility census was 101. Findings include: 1. Review of Resident #46's medical record revealed an admitted [DATE] with diagnoses including congestive heart failure, chronic obstructive pulmonary disease, dysphagia following cerebral infarction, and anxiety disorder. Review of the Annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #46 was cognitively intact. Resident #46 required partial to moderate assistance rolling left and right, the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed, and the ability to transfer to and from a bed to a chair or wheelchair. Review of the care plan revised 12/20/24 included Resident #46 had an activities of daily living (ADL) self-care performance deficit related to weakness, chronic obstructive pulmonary disease, and endocarditis. Resident #46 will maintain ADL through the next review date. Interventions included Resident #46 required partial to moderate assistance to move between surfaces, from bed to wheelchair, from wheelchair to toilet and for showers. Review of Resident #46's Transportation Scheduling Request dated 01/08/25 included the transportation company was called on 01/16/25 and transportation was arranged for a pickup time on 02/12/25 at 8:00 A.M. for a physician appointment at 9:00 A.M. Observation on 02/12/25 at 7:45 A.M. revealed Certified Nursing Assistant (CNA) #919 and Licensed Practical Nurse (LPN) #963 were providing Resident #46's incontinence care for a bowel movement, and the incontinence care was completed at 7:48 A.M. Observation on 02/12/25 at 8:24 A.M. revealed Resident #46 was sitting in a wheelchair by the elevator with her coat on. Observation on 02/12/25 at 8:25 A.M. while standing at the medication cart with LPN #963 revealed Resident #73 was heard loudly screaming over and over. No aides were seen in the hall and were not available to check on Resident #73. LPN #963 secured the medications she was preparing for a resident and went to see why Resident #73 was screaming. A hospice aide was in the room changing Resident #73's incontinence brief and needed assistance. LPN #963 stayed in the room and assisted the hospice aide with Resident #73's care. When she was finished, LPN #963 stated Resident #73 had a fractured right hip, and it took two staff to change her incontinence brief. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/12/25 at 8:29 A.M. while standing at the medication cart with LPN #963 revealed Resident #28 was heard loudly screaming in his room. No aides were available to check on Resident #28 and again LPN #963 secured the medication cart and went in Resident #28's room to see why he was screaming. When LPN #963 exited Resident #28's room, she stated he needed his mouth wash, and she got it for him. LPN #963 stated she did not know where the aides were. Observation on 02/12/25 at 8:35 A.M. of LPN #963 revealed she was standing at the medication cart preparing a resident's medication, several resident call lights were activated, and no aides were available to answer the call lights. LPN #963 had a stressed look on her face, slapped her hands against her legs in frustration, secured the medication cart and answered the call lights. Observation on 02/12/25 at 8:45 A.M. revealed Resident #46 was sitting in a wheelchair close to the elevator of the nursing unit she resided in. CNA #804 was talking to other staff members by the nurse's station and pushing a metal cart. After she was done talking to the staff members, CNA #804 told LPN #963 she was going to take Resident #46 downstairs to the main entrance so she would be ready for transportation to pick her up for her appointment (the pickup time was 8:00 A.M.). CNA #804 used the elevator and transported Resident #46 to the main entrance of the facility. Observation on 02/12/25 at 8:55 A.M. revealed CNA #804 returned to the nursing unit with Resident #46. CNA #804 stated the transportation driver did not take Resident #46 to her appointment. CNA #804 stated the transportation driver said she called the nursing unit to tell them she was at the facility and ready to take Resident #46 to her appointment, but no one answered the phone. LPN #963 stated she did not hear the phone ring. CNA #804 stated she was assisting residents and did not hear the phone ring. LPN #963 confirmed Resident #46's pickup time was at 8:00 A.M., and Resident #46 should have been at the main entrance at that time and ready to go to her appointment. Interview on 02/12/25 at 8:56 A.M. of CNA #919 revealed she was in Resident #46's room at 7:59 A.M. (observation at 7:48 A.M. revealed the incontinence care was completed) providing incontinence care for a bowel movement. CNA #919 stated she did not hear the phone ring at the nurse's station because she was in another resident room providing care. Interview on 02/12/25 at 8:59 A.M. of LPN #963 revealed the two aides assigned to the nursing unit have a lot of things they are responsible for, and it puts so much on the aides to also have to transport residents to the front entrance of the facility for their appointments. Interview on 02/12/25 at 9:34 A.M. revealed LPN #963 stated she helped Resident #46 with incontinence care for a bowel movement around 7:45 A.M. Review of Resident #46's progress notes dated 02/12/25 at 3:19 P.M. revealed Resident #46 missed an orthopedic appointment today, and the appointment was rescheduled for 02/26/25 at 2:40 P.M. The transport paper was sent, and Resident #46 was aware. Interview on 02/18/25 at 2:12 P.M. of Business Office Manager (BOM) #971 and Business Office Assistant (BOA) #935 revealed they scheduled transportation for the residents, and there were issues with some of the transportation companies. BOA #935 stated the drivers were only required to wait five minutes and if the residents were not ready to go, the transportation drivers leave. BOM #971 stated the drivers would leave even if they knew the resident was on the way to the transportation van. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Vista Nursing & Rehab by McAre Health	1216 5th Ave Youngstown, OH 44504

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/19/25 at 8:07 A.M. of CNA #919 indicated that depending on the time of day a resident had an appointment, it could be hard for the aides to take residents to the transportation van because the elevators had to be used to take them downstairs to the front entrance to be picked up by the drivers, and that took time. CNA #919 stated if the aides were passing meal trays, or providing care to another resident it is hard to take everyone where they need to go at the time they need to go. CNA #919 stated there were usually only two aides assigned to the nursing unit, and it would be helpful if there was a third aide to help with things taking residents to the front entrance on time, so they did not miss their appointments. Interview on 02/19/25 at 8:35 A.M. of the Administrator revealed the nurses were responsible for telling the aides what time the residents needed to be taken to the main entrance for their pickup when they had an appointment. Review of the facility policy titled Transportation, reviewed 08/2024, included it was the policy of the facility to arrange and ensure transportation was provided for doctors and specialist appointments if the resident did not have family, a friend or responsible party available for transport. The facility staff would schedule transportation to and from the appointment as needed. The facility staff would notify staff involved of the appointment. The resident would be transported to the appointment. 2. Review of Resident #98's medical record revealed an admitted [DATE] with diagnoses including unstable burst fracture of T7-T8 thoracic vertebra, type II diabetes mellitus, morbid obesity, and chronic obstructive pulmonary disease. Review of Resident #98's physician orders dated 01/18/25 revealed oxygen therapy at four liters per minute via nasal cannula, may titrate as needed, every shift. Review of the Admission MDS 3.0 assessment dated [DATE] revealed Resident #98 was cognitively intact. Resident #98 required substantial to maximal assistance with toileting hygiene, bathing, and was dependent on staff for lower body dressing. Resident #98 required partial to moderate assistance for the ability to transfer to and from a bed to a chair or wheelchair and for the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. Resident #98 was on oxygen therapy. Review of Resident #98's Transportation Scheduling Request dated 01/21/25 included transportation was scheduled on 02/03/25 for Resident #98's appointment on 02/12/25 at 9:30 A.M. Resident #98's pickup time for his appointment was at 8:30 A.M. Review of the care plan dated 01/24/25 included Resident #98 had an ADL self-care performance deficit related to activity intolerance, disease process, impaired balance, limited mobility, pain fracture T7-T8 vertebrae, and other diagnoses. Resident #98 would improve the current level of function through the review date. Interventions included Resident #98 required supervision or touching assistance for chair-to-bed-to-chair transfers. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/12/25 at 8:04 A.M. of Registered Nurse (RN) #815 revealed she was sitting in the back room of the nurse's station, had a concerned look on her face and stated she worked night shift, and the day shift nurse had not shown up yet. RN #815 stated she was really stressed out about it because she had to take her son to school and now, he was late. RN #815 stated she called the Director of Nursing (DON), and he assured her someone would come, but no one did. RN #815 stated she kept calling and each time she called she was told different nurses were coming to the nursing unit to relieve her. RN #815 indicated she had been waiting an hour for her relief and had not started the day shift nurse's work because she thought someone was coming to relieve her. Interview on 02/12/25 at 8:11 A.M. of the DON revealed he was not aware RN #815 had not been relieved by a day shift nurse, and he would make sure someone came to relieve her so she could go home. Review of RN #815's timecard revealed she clocked out on 02/12/25 at 8:20 A.M. Observation on 02/12/25 at 9:15 A.M. with Assistant Director of Nursing (ADON) #911 revealed Resident #98 was sitting in a wheelchair and was assisted out of the elevator and to his room by CNA #894. Interview on 02/12/25 at 9:15 A.M. of ADON #911 revealed he took over from RN #815 around 8:30 A.M. because she said she had to leave. ADON #911 stated Resident #98 missed an appointment. ADON #911 stated Resident #98's pickup time was 8:30 A.M. for his appointment, and he did not make his appointment because ADON #911 had to find an oxygen tank that would fit on a bariatric wheelchair. ADON #911 stated he did not find an oxygen tank to fit on the wheelchair but sent an oxygen tank on wheels with Resident #98. ADON #911 stated the transportation driver called and said he was at the facility, and ADON #911 indicated he told the receptionist to tell the driver to wait because he was getting him ready, but the driver did not wait. ADON #911 stated Resident #98's pick up time was 8:30 A.M. and he was downstairs by 8:55 A.M. ADON #911 indicated the transportation drivers only wait five minutes and then they leave. Observation on 02/12/25 at 9:15 A.M. revealed RN #997 arrived at the nursing unit and received report regarding the residents and counted narcotics with ADON #911. RN #997 stated she worked for a staffing agency, and she picked the shift up on 02/12/25 at 7:00 A.M. RN #997 stated the shift was just posted this morning, and she lived an hour away from the facility which was why she just arrived. Review of Resident #98's late entry progress notes dated 02/12/25 at 3:33 P.M. revealed Nurse Practitioner (NP) #1005 was updated regarding Resident #98 missing a pulmonology appointment today related to transportation. The appointment was rescheduled for 02/27/25 at 9:15 A.M. Interview on 02/13/25 at 9:43 A.M. of Staffing Coordinator (SC) #855 revealed when nurse's or aides called off for their work shift, she would check with facility staff to see if they wanted to pick a shift up. If no one picked up the shift, she would call the staffing agency. SC #855 stated the cut off for calling off was two hours before the shift started, and LPN #878 called off in plenty of time. SC #855 stated LPN #878 called off the night before around 9:00 P.M., and her shift was picked up by an agency nurse within hours. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Transportation, reviewed 08/2024, included it was the policy of the facility to arrange and ensure transportation was provided for doctors and specialist appointments if the resident did not have family, a friend or responsible party available for transport. The facility staff would schedule transportation to and from the appointment as needed. The facility staff would notify staff involved of the appointment. The resident would be transported to the appointment. 3. Review of Resident #203's medical record revealed an admitted [DATE] with diagnoses including multiple fractures of the ribs, left side, displaced fracture of lateral condyle of right femur, displaced fracture of surgical neck of unspecified humerus, displaced articular fracture of head of left femur, and type II diabetes mellitus without complications. Review of Resident #203's Weekly Wound assessment dated [DATE] included the first observation of Resident #203's left hip revealed it was well approximated with 26 staples, light serosanguinous drainage and no signs and symptoms of infection. Measurements of the left trochanter (hip) were length 17.0 centimeters (cm), width of 0.1 cm, depth was not measured. Review of Resident #203's progress notes dated 02/03/25 through 02/12/25 did not reveal evidence Resident #203's left hip staples had reddened skin around them or her entire left buttock was reddened with white scaly open areas mixed in with the redness, or evidence that Resident #203's physician was notified of these findings. Review of the Admission MDS 3.0 assessment dated [DATE] revealed Resident #203 was cognitively intact. Resident #203 had upper extremity impairment on one side and lower extremity impairment on both sides. Resident #203 was dependent on staff for toileting hygiene and bathing. Review of the care plan revised 02/11/25 included Resident #203 had functional bladder, bowel incontinence related to multiple healing fractures, dependence on staff for toileting needs and care. Resident #203 would remain free from skin breakdown due to incontinence and brief use through the review date. Interventions included to clean peri-area with each incontinence episode; check and change as required for incontinence and wash, rinse, and dry perineum. Resident #203 had the potential for pressure ulcer development related to immobility, existing incisions to the left hip, left medial knee, left lateral knee and right lower extremity. Resident #203 would develop intact skin free of redness, blisters, or discoloration through the review date. Interventions included assessing, recording, monitoring wound healing and measuring length, width, and depth where possible, assessing and documenting status of wound perimeter, wound bed and healing progress, reporting improvements and declines to the physician; if Resident #203 refused treatment confer with the resident, interdisciplinary team and family to determine why and try alternative methods to gain compliance and document alternative methods. Observation on 02/11/25 at 9:28 A.M. of Resident #203 revealed she was lying in bed with the head of bed elevated. Resident #203 stated she wore an incontinence brief and had to clean myself up because no one comes in to do it, or I just pee in the depends which already has pee in it. Resident #203 stated the doctor said she was getting red from laying in pee. Resident #203 indicated she would activate her call light and no one answered it, or if they did answer it the aides would tell her two people were needed to change her and they did not return. Resident #203 stated the aides change me very infrequently. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/12/25 at 10:34 A.M. of Resident #203 revealed she was lying in bed; the sheets were half off the bed, and the bare mattress could be seen. Resident #203 stated she had not been changed this morning and just now threw her incontinence brief in the trash can which was next to her bed. Observation of the trash can revealed an incontinence brief was lying on top of the other trash, and it was saturated with urine and had a pungent smell. When asked about her staples, Resident #203 rolled a little to her right side, and the staples on her left hip could be seen. Observation of Resident #203's left hip revealed a long curving line of staples, and the area around the staples was red. Resident #203's entire left buttock had reddening skin and whitish, scaly open areas mixed in with the redness. The sheet under Resident #203 was bunched up and saturated with urine and pinkish colored drainage was noted on the urine-soaked sheet. Resident #203 stated she had an appointment today. Observation on 02/12/25 at 10:35 A.M. revealed Resident #203 activated her call light and at 10:46 A.M. Certified Nursing Assistant (CNA) #872 answered the call light. CNA #872 confirmed Resident #203's staples on the left hip and left buttock had large, reddened areas around them with some whitish scaly open areas. CNA #872 stated Resident #872 told her the area hurt and when she looked, the area was red and inflamed. When asked if she told the nurse about the open, reddened areas, CNA #872 stated the nurse and other aides knew about the reddened areas because they told her about it. CNA #872 confirmed Resident #203's urine saturated incontinence brief was in the trash can. CNA #872 confirmed Resident #203's bed had the sheet half off and the sheet was bunched under Resident #203 and was saturated with urine and a pinkish colored drainage. CNA #872 stated Resident #203 used a bedpan at times, and the urine on the sheets could have been from the bedpan. Resident #203 stated she activated her call light, it was not answered timely, and by the time it was answered she had to pee so bad she asked for a bedpan. Interview on 02/12/25 at 11:01 A.M. of CNA #894 revealed she often worked on the nursing unit that Resident #203 resided on, and there was not enough staff. CNA #894 stated call lights could take a long time to be answered because the aides were in other rooms assisting residents and providing care, and the call light could not be answered until the resident's care was completed. CNA #894 indicated the nursing unit typically had one nurse and one to two aides working on the floor. Interview on 02/12/25 at 11:15 A.M. of RN/Wound Nurse (RN/WN) #861 revealed when Resident #203 was admitted to the facility her staples on the left hip looked good, were approximated and had no drainage or redness. RN/WN #861 stated she looked at Resident #203's left hip staples on 02/11/25, but did not look at the entire left hip area, and the staples had redness around them. RN/WN #861 stated today (02/12/25) the left hip area looked much worse, confirmed the left hip had open areas which were draining, and the skin was very red and inflamed. RN/WN #861 indicated Resident #203 did not ask to use the bedpan and urinated on herself. Review of Resident #203's progress notes dated 02/12/25 at 4:38 P.M. included surgeon noted maceration to left hip and prescribed Nystatin cream and a portion of staples removed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Incontinence Management Standard of Care, dated 01/2024, included it was the policy of the facility to promote intact skin, maintain dryness and respect the resident's standard and individualized interventions. The procedure was to implement standard interventions to promote healthy skin integrity. Interventions included routine rounding every two hours with turning and repositioning, timely response to the needs of the resident, provision of personal hygiene and skin care after each incontinent episode, barrier cream applied after each incontinent episode. 4. Review of Resident #34's medical record revealed an admitted [DATE] with diagnoses including acute respiratory failure with hypoxia, congestive heart failure, irritable bowel syndrome and chronic pain syndrome. Review of the Admission MDS 3.0 assessment dated [DATE] revealed Resident #34 was cognitively intact. Resident #34 had upper and lower extremity impairment on both sides. Resident #34 was dependent on staff for toileting hygiene, bathing, and personal hygiene. Resident #34 was dependent for the ability to roll from lying on back to left and right side and return to lying on back on the bed. Lying to sitting on the side of the bed, sit to lying, sit to stand and chair, bed to chair transfer was not attempted due to medical condition or safety concerns. Resident #34 was frequently incontinent of urine and bowel. Review of the care plan dated 01/24/25 included Resident #34 had an ADL self-care performance deficit related to her disease process, limited mobility, limited range of motion and pain. Resident #34 would improve the current level of function through the review date (it did not specify the ADL). Interventions included Resident #34 was dependent on two staff for transferring and required a mechanical lift and two staff for transfers. Observation on 02/18/25 at 10:05 A.M. revealed Resident #34 activated her call light. There were no staff available to answer the call light. LPN #878 was in the back room of the nursing station, and CNA #842 and CNA #1001 were in resident rooms providing care. Observation on 02/18/25 at 10:30 A.M. Resident #34's call light was answered by CNA #842, and Resident #34 told CNA #842 she needed changed. Observation on 02/18/25 at 10:36 A.M. revealed CNA's #842 and #1001 entered Resident #34's room to provide incontinence and morning care. CNA #842 stated after they were done providing Resident #34's care they would assist her up to a chair. Resident #34 stated okay, but she only wanted to be up for an hour because that was all she could tolerate. Observation on 02/18/25 at 10:49 A.M. revealed CNA's #842 and #1001 assisted Resident #34 to a padded chair in her room using a mechanical lift. Observation on 02/18/25 at 12:27 P.M. of Resident #34 revealed she was sitting in the padded chair in her room. Resident #34 stated her knees were really starting to hurt and wanted to go back to bed but was unable to because two aides were needed to assist her back to bed, and one of the aides was on a break. CNA #842 stated CNA #1001 was on a break, and Resident #34 had to wait until after the residents had their lunch meal to go back to bed. Resident #34 stated her pain was a 12 out of a 10 and she was really starting to hurt. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/18/25 at 1:12 P.M. revealed CNA #842 and CNA #1001 assisted Resident #34 back to her bed. Resident #34 stated her pain in the knees was severe and was an 11 out of 10. CNA #842 stated Resident #34 always said she had a lot of pain and it was an 11 or 12. Resident #34 had tears in her eyes and stated she only wanted to be up for an hour. Review of the facility policy titled Resident Rights included federal and state laws guarantee certain basic rights to all residents of the facility and these rights included the right to self-determination.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49774 Based on record reviews, interviews and facility policy review, the facility failed to ensure Resident #31 was free from unnecessary medications and failed to ensure pharmacy recommendations were conducted monthly for Resident #14. This affected two residents (#31 and #14) of six residents reviewed for unnecessary medications. The census was 101. Findings include: 1. Record review revealed Resident #31 was admitted [DATE] with diagnoses of cerebral infarction, atherosclerotic heart disease of native coronary artery without angina pectoris, chronic obstructive pulmonary disease, major depressive disorder, and anxiety. Review of the Vital Signs and Pain Only Evaluation dated 01/22/25 revealed Resident #31's pain was moderate. Review of the Annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #31's cognition was intact, and he had an impairment on one side in the upper and lower extremity. He was dependent on staff for toileting, showers, dressing, and required maximal assistance for personal hygiene and transfers. Pain management section of the MDS noted Resident #31 was not on a scheduled pain regimen and received pain medication as needed for moderate shoulder pain. Review of current physician's orders revealed an order for pain scale every shift, Percocet (opioid pain medication) tablet 10-325 milligrams (mg) one tablet by mouth every six hours as needed for pain, and acetaminophen tablet 325 mg (analgesic) two tablets every four hours as needed for mild pain . Review of the December 2024 MAR revealed on 12/14/24 Percocet was administered when pain level was three; On 12/15/24 Percocet was administered twice when pain levels were two and three; 12/17/24 Percocet was administered when pain level was zero. Review of the January 2025 MAR revealed on 01/09/25 Percocet was administered when pain level was three; On 01/11/25 Percocet was administered when pain level was one. Review of the February 2025 MAR revealed on 02/14/25 Percocet was administered when pain level was two, and on 02/16/25 Percocet was administered when pain level was one. Interview on 02/18/25 at 12:55 P.M. with Resident #31 revealed his pain was adequately managed with pain medication which the nurses administered as requested. Interview on 02/18/25 at 12:56 P.M. with Licensed Practical Nurse (LPN) #1002 revealed there were no parameters in place to indicate when Percocet was to be administered, and it was given when requested. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/18/25 at 2:06 P.M. with Unit Manager #859 revealed a pain level was obtained prior to administering Percocet and confirmed Percocet did not have parameters for administration in place, so it was administered anytime Resident #31 requested it. Unit Manager #859 identified Agency Nurses #997 and #998 as having administered Percocet when pain level was zero and/or one. Interview on 02/18/25 at 2:32 P.M. with Agency Nurse #997 revealed if she documented pain level on 02/16/24 as one, then it was an error because Resident #31's pain was usually six or seven. Review of the Medication Therapy Policy, revised April 2007, revealed upon or shortly after admission, and periodically thereafter, the staff and practitioner will review an individual's current medication regimen to identify whether: there is a clear indication for treating that individual with the medication to avoid unnecessary medications, the dosage was appropriate, the frequency of administration and duration of use was appropriate. 51525 2. Record review revealed Resident #14 was admitted to the facility on [DATE] with diagnoses of major depressive disorder and anxiety disorder. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #14 admitted to feeling down, depressed or hopeless nearly every day, had trouble falling or staying asleep, or sleeping too much nearly every day, feeling tired or having little energy several days per week, had a poor appetite or over-ate nearly every day. Record review reveals Resident #14 was ordered Venlafaxine HCl ER Oral Capsule Extended Release 24 Hour 75 milligrams (mg) (Venlafaxine HCl) (antidepressant) which was discontinued on 12/24/24 then was ordered Desvenlafaxine ER Oral Tablet Extended Release 24 Hour 50 mg (Desvenlafaxine) (antidepressant) on 12/25/24. Review of the care plan dated 12/31/24 stated Resident #14 was on antidepressant medication due to diagnosis of depression and anxiety. The facility would consult with pharmacy, medical doctor (MD) to consider dosage reduction when clinically appropriate at least quarterly. Monthly pharmacy reviews and medication reductions were requested from the facility Administrator #965; the facility was able to produce only one pharmacy review dated 06/20/24 when the pharmacist asked the physician to consider a gradual dose reduction of Resident #14's order of Desvenlafaxine ER 50 milligrams daily. There was no documentation in the clinical record showing the physician's response or action. Interview with the Administrator on 02/18/25 at 5:23 P.M. stated staff had produced everything they could find for this request. Review of the facility's policy titled Psychotropic Medication Use, dated 8/2024, states the attending physician will identify, evaluate and document with input from other disciplines and consultants as needed symptoms that may warrant the use of psychotropic medications. The policy also states the physician, consultant physician, nurse practitioner shall respond appropriately by changing or stopping problematic doses or medications or clearly documenting (based on the assessing situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences. The facility did not provide a policy related to gradual dose reduction.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565 Based on observation, interview and facility policy review, the facility failed to store food in a manner to prevent contamination. The facility also failed to have test strips at the three-sink manual dishwash area to test for proper sanitation levels and failed to maintain clean floors in the kitchen. In addition, the facility failed to ensure refrigerator maintenance on Nursing Unit One. This had the potential to affect 99 residents receiving food from the kitchen. The facility identified two residents (#19 and #66) who received nothing by mouth. The facility census was 101. Findings include: Observation on [DATE] at 8:10 A.M. during the initial tour of the kitchen revealed the drawer with clean utensils at the puree food prep station was dirty. There was visible dirt and a dried green food substance in the drawer. Dietary Director (DD) #867 verified the findings at the time of the observation. There were no test strips to test for proper sanitation levels at the three-sink manual dishwash station. An interview with DD #867 at the time of the observation verified the lack of test strips. When asked how staff were testing the sanitation levels at the three-sink manual dishwash station, DD #867 stated she did not know. There was a heavy amount of water located on the floor between the automatic dishwasher and the three sink manual dishwash station. DD #867 verified the heavy water on the floor at the time of the observation. DD #867 stated the dishwasher was leaking. The initial tour also revealed dried foods stored improperly. There was one half of a five pound bag of ziti pasta opened and undated, a five pound bag of five minute grits one quarter full opened and undated, a 15-ounce container of brown gravy mix one quarter full opened and undated, a 1.9-pound package of instant mashed potatoes one quarter full opened and undated, a five pound package of macaroni half full opened and undated, and chicken flavoring 16-ounces one quarter full opened and undated. DD #867 verified the opened and undated aforementioned food items at the time of the observation. DD #867 stated food items should be sealed and dated after opening. Observation on [DATE] at 9:15 A.M., of the refrigerator on Nursing Unit One revealed a small carton of two percent milk with an expiration date of [DATE]. The temperature sheet on the front of the refrigerator read [DATE]. A large amount of water was on the bottom of the refrigerator with visible floating dirt. Certified Nurse Assistant (CNA) #841 verified the findings at the time of the observation. CNA #841 stated the refrigerator was to be cleaned by housekeeping. On [DATE] at 9:40 A.M. an interview with Licensed Practical Nurse (LPN)/Unit Manager (UM) #859 revealed night shift was to check the refrigerator for cleanliness and expired food items. A review of the policy titled Kitchen Sanitization Policy, dated [DATE], revealed the food service area shall be maintained in a clean and sanitary manner. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosion, open seams, cracks and chipped areas that may affect their use or proper cleaning. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the policy titled Food Storage, dated 2023, revealed food will be stored at appropriate temperatures and by methods designed to prevent contamination or cross contamination. Subpoint eight stated Plastic containers with tight fitting covers or sealable plastic bags must be used for storing grain products, sugar, dried vegetables and broken lots of bulk foods or opened packages. All containers or storage bags must be legible and accurately labeled and dated. A review of the policy titled Cleaning Dishes-Manual Dishwashing, dated 2023, revealed dishes and cookware will be cleaned and sanitized after each meal. Subpoint five revealed to check the sanitation sink frequently using a test strip to assure the level of sanitizing solution is appropriate. A review of the policy titled Refrigerator and Freezers, dated [DATE], revealed the facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. The policy also revealed monthly tracking sheets for all refrigerators and freezers will be posted to record temperatures. Subpoint ten stated refrigerators and freezers will be kept clean, free of debris, and mopped with sanitizing solution on a regularly scheduled basis and more often as necessary.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565 Based on record review, interviews and facility policy review, the facility failed ensure Resident #86's medical record accurately reflected the status of a right lower extremity brace. This affected one resident (#86) of 33 residents who had a review of medical records. The facility census was 101. Findings include: Review of the medical record for Resident #86 revealed an admitted [DATE] with diagnoses including cerebral infarction, vascular dementia, diabetes type two, and difficulty walking. Review of the physician's orders revealed an order dated 10/08/24 for a right ankle foot orthosis (AFO) brace when out of bed. (An AFO brace is a brace utilized for support and control the ankle and foot. An AFO is typically used to improve mobility, reduce pain, and prevent deformities). In addition, there was an order dated 11/30/24 to consult Western Reserve Orthotics for right AFO as the current AFO is broken. There was no documented evidence in the medical record on 11/30/24 that the facility called the orthotics company to have the AFO fixed. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #86 was cognitively intact. He did not reject care and had no limitation of ROM to upper and lower extremities. He required setup or clean-up help with eating and personal hygiene, partial to moderate staff assistance with upper and lower body dressing, toileting hygiene, putting on and taking off footwear, and sit to stand and chair to bed transfer, and he was dependent on staff for showers. He was able to walk ten feet with supervision or touching assistance. He was independent for wheeling a wheelchair. He was frequently incontinent of bowel and bladder. He received physical therapy (PT) and occupational therapy (OT). Review of the care plan dated 11/29/24 revealed Resident #86 had an alteration in musculoskeletal status and used a right AFO. Review of Resident #86's Medication Administration Records (MARs) dated 12/01/24 through 01/31/25 revealed the right AFO brace was signed off as applied and removed as ordered. (The right AFO was broken and unavailable from 11/30/24 to 12/30/24 when it was returned according to Director of Rehabilitation (DOR) #839; however, there was no documented evidence in the medical record that the AFO was returned until the physical therapy (PT) evaluation on 02/05/25. Review of the PT evaluation dated 02/05/25 revealed Resident #86 was referred to therapy for gait training (walking), bilateral lower extremity weakness, and a new right AFO brace. On 02/12/25 at 9:40 A.M. an interview with Registered Nurse (RN) #861 verified Resident #86's right AFO was broken 11/30/24 and there was no documented evidence in the medical record that it was returned on 12/30/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/12/25 at 3:38 P.M. an interview with RN/Unit Manager (UM) #859 verified that Resident #86 did not have a right AFO brace. RN/UM #859 verified the documentation in the MARs from 12/01/24 through 01/31/25 was inaccurate as there was right AFO to apply and remove. A PT note dated 02/14/25 revealed Resident #86 was to have the right AFO brace for gait and transfers. Interview on 02/18/25 an interview with DOR #839 revealed Resident #86's right AFO brace broke in November of 2024, was repaired and returned on 12/30/24. DOR #839 stated Resident #86 was currently receiving therapy services for gait training and new right AFO brace. (The PT evaluation for the new right AFO was completed on 02/05/25). A review of the policy titled Charting and Documentation, dated July 2017, revealed all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on observation, record review, interview, review of the manufacturer recommendations for a glucometer and facility policy review, the facility failed to ensure Residents #1 and #95, with physician ordered isolation precautions, had the appropriate signage on the entrance door to the resident's rooms indicating the type of precautions and type of personal protective equipment (PPE) required when providing care. This finding affected two residents (#1 and #96) of four residents reviewed for isolation precautions and had the potential to affect an additional 35 residents (#5, #11, #12, #16, #24, #26, #30, #33, #34, #38, #40, #43, #47, #53, #55, #57, #58, #61, #63, #64, #65, #82, #83, #84, #89, #90, #94, #98, #99, #102, #203, #205, #206, #253, #256) residing on the 200 and 300 Rehab Units. In addition, the facility failed to ensure the glucometer blood glucose testing machine (BGT) was appropriately cleaned and sanitized after use on Resident #40 to prevent the potential for cross contamination of bloodborne pathogens. This affected one resident (#40) of two residents reviewed for BGT and had the potential to affect five additional residents (#30, #33, #64, #98 and #203) identified by the facility to receive BGT testing on the 200 Rehab Unit that used the same glucometer. The facility census was 101. Findings include: 1. Review of the medical record revealed Resident #1 was readmitted on [DATE] with diagnoses including other acute osteomyelitis, methicillin susceptible staphylococcus aureus (MSSA), and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #1 exhibited intact cognition. Review of Resident #1's physician orders revealed an order dated 01/12/25 for contact isolation precautions for Carbapenem-Resistant Enterobacteriaceae (CRE). (CRE is a group of bacteria that are resistant to certain antibiotics, making them difficult to treat). Review of Resident #1's care plans revealed an intervention dated 01/13/25 for staff to provide enhanced barrier precautions (EBP) and staff to gown and glove with hands on care (the resident was on contact precautions which includes wearing to gown and gloves when coming into contact with the resident or the resident's environment). Observation on 02/12/25 at 3:00 P.M. revealed Resident #1's door signage revealed the resident was in EBP and not contact isolation precautions as ordered. The care plans were not updated to reflect contact isolation precautions. Interview on 02/12/25 at 3:04 P.M. with Registered Nurse (RN) #960 confirmed the signage on Resident #1's door was not correct, and it should have been contact precautions instead of EBP. 2. Review of Resident #96's medical record revealed the resident was admitted on [DATE] with diagnoses including cutaneous abscess of the buttock, local infection of the skin, and subcutaneous tissue and resistance to vancomycin (antibiotic). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #96's Admission MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #96's physician orders revealed an order dated 01/08/25 for contact isolation precautions every shift for vancomycin resistant enterococci (VRE). (VRE is a bacterial infection caused by a strain of enterococci bacteria that have developed resistance to the antibiotic vancomycin). Review of Resident #96's care plans revealed an intervention dated 01/15/25 for contact isolation precautions related to VRE of the coccyx wound. Observation on 02/11/25 at 3:50 P.M. of Resident #96's resident door revealed EBP signage and not contact isolation precautions. Interview on 02/11/25 at 3:56 P.M. with RN #859 confirmed the signage on Resident #96's door was not correct, and it should have been contact precautions instead of EBP. Review of the Standard Precautions policy, revised 08/2022, revealed contact isolation precautions were intended to prevent the transmission of infectious disease that were spread by direct (i.e. person-to-person) or indirect contact with the resident or the environment, and the use of appropriate PPE, including a gown and gloves upon entering (i.e. before making contact with the resident or resident's environment). Prior to leaving the resident's room, the PPE was removed and hand hygiene performed. 42013 3. Review of Resident #40's medical record revealed an admitted [DATE] with diagnoses including acute embolism and thrombosis of unspecified deep veins of lower extremity, bilateral, type II diabetes without complications and chronic obstructive pulmonary disease. Review of Resident #40's physician orders dated 09/28/24 revealed insulin Lispro subcutaneous solution pen-injector 100 units per milliliter (ml), inject per sliding scale, if blood sugar was 151 to 200 inject 2 units, if blood sugar was 201 to 250 inject 4 units, if blood sugar was 251 to 300 inject 6 units, if blood sugar was 301 to 350 inject 8 units, if blood sugar was 351 plus give 10 units and if blood sugar was over 400 contact the Nurse Practitioner or Physician. Observation on 02/12/25 at 9:47 A.M. of RN #997 revealed she checked Resident #40's blood sugar using a glucometer. After checking Resident #40's blood sugar with the glucometer, RN #997 returned to the medication cart, found an isopropyl alcohol swab and proceeded to clean the glucometer with the isopropyl alcohol swab. RN #997 confirmed she did not use an Environmental Protection Agency (EPA) approved, commercially available 1:10 quaternary/alcohol wipe or bleach wipe and thoroughly wipe down the meter. Review of the manufacturer's instructions for the glucometer included using a lint free cloth dampened with isopropyl alcohol (70 to 80 percent) or a pre-moistened isopropyl alcohol wipe to clean the outside of the blood glucose meter. To disinfect the meter, use an EPA approved, commercially available 1:10 quaternary/alcohol wipe or bleach wipe and thoroughly wipe down the meter and follow the manufacturer recommendations for contact time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This deficiency represents noncompliance investigated under Complaint Number OH00161578.

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 48565 Based on observation, interview, laundry work order review and facility policy review, the facility failed to maintain the walk-in refrigerator, walk-in freezer and automatic dishwasher in a safe operating condition. This had the potential to affect 99 residents receiving dietary services. There were two residents (#19 and #66) identified by the facility as receiving nothing by mouth. In addition, the facility failed to ensure the laundry room, washers and dryers were maintained in clean working order. This had the potential to affect all residents residing in the facility. The facility census was 101. Findings include: 1. Observation on 02/11/25 at 8:10 A.M. during an initial tour of the kitchen the first metal panel of the floor of the walk-in refrigerator to be coming up. There was a noticeable gap between the concrete underflooring and the metal panel. The walk-in freezer had heavy ice buildup in the right upper corner of the unit. Dietary Director (DD) #867 verified the findings of the floor coming up in the refrigerator and the heavy ice buildup in the freezer at the time of the observation. The initial tour also revealed a large amount of water on the floor between the automatic dishwasher and the three-sink manual dishwashing area. DD #867 verified the large amount of water on the floor between the automatic dishwasher and the three-sink manual dishwashing area at the time of the observation. DD #867stated the dishwasher was leaking. A review of the facility policy titled Kitchen Sanitization Policy, dated October 2008, revealed the food service area shall be maintained in a clean and sanitary manner. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosion, open seams, cracks and chipped areas that may affect their use or proper cleaning. 2. Review of the dryer lint logs and work orders from 11/01/24 through 02/13/25 revealed on 02/12/25 at 12:02 P.M., dryer lint traps were being signed off as being cleaned on every shift. Observation on 02/11/25 at 1:46 P.M. revealed one large laundry room and on the right side were two industrial washers, two racks of clothing and four industrial dryers. The facility had a household dryer in between the four industrial dryers which appeared to have a screwdriver stuck inside the selection knob. Two household washers were observed by the entrance with signage stating not to use the washers. Interview on 02/11/25 at 1:48 P.M. with Laundry Staff #809 confirmed that dryer #1 and dryer #3 were not in working order. Laundry Staff #809 confirmed that two manual washers were not to be used and not in working order with signage stating they were out of order. Observation on 02/11/25 at 1:53 P.M. revealed large lint buildup behind the dryers, on the ceilings, walls, and floors. Interview on 02/11/25 at 1:55 P.M. Laundry Staff #809 confirmed that the lint was built up behind the dryers and had not been cleaned. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 02/11/25 at 1:56 P.M. revealed a dirty fan covered with dust by the laundry press, not in use at the present time. Interview on 02/11/25 at 1:58 P.M. Laundry Staff #809 confirmed the dirty fan covered in dust, not in use. Observation on 02/11/25 at 2:00 P.M. revealed a metal screwdriver in place of control knob on the manual dryer in between the two commercial dryers. Interview on 02/11/25 at 2:01 P.M. Laundry Staff #986 confirmed that a screwdriver was being used as knob on the manual dryer. Observation on 02/11/25 at 2:02 P.M. a large fan hanging over the laundry table was covered with dust. Interview on 02/11/25 at 2:08 P.M. Laundry Staff #986 confirmed that the large fan hanging over laundry was covered in dust. Interview on 02/12/25 at 9:53 A.M. Regional Environmental Service Manager (RESM) #992 confirmed that the lint buildup behind the dryers could be better. He confirmed that non-working washers and dryers that were awaiting repairs should have been removed but were still present in laundry area. Observation on 02/12/25 at 10:10 A.M. revealed the screwdriver was removed from non-working dryer, and the dryer was noted to be out of service. Interview on 02/12/25 at 9:53 A.M. with RESM #992 revealed nightshift maintenance was to be performed monthly. He confirmed that several washers and dryers were out of service, waiting for repairs and should have been removed. On 02/15/25 at 1:57 P.M. review of the laundry work orders, revealed work order#16540, placed on 08/03/24, for dryer not getting hot, work order #15948, placed on 04/20/24, for need dryer fixed, and work order #14776, placed on 10/24/23, for dryers not getting hot. Review of the Maintenance Service policy, revised December 2009, revealed the maintenance director was responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment were maintained in a safe and operable manner.