STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365344	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luxe Rehabilitation and Care Center	957 Becks Knob Road Lancaster, OH 43130

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on record review, staff interview and policy review, the facility failed to notify resident representatives when there was a significant change in resident condition. This affected two (Resident #86 and #145) of 17 sampled residents. The facility census was 139. Findings include: 1. Review of the closed medical record for Resident #145 revealed the resident was admitted to the facility from the hospital on [DATE]. The resident had been in the hospital from [DATE] to [DATE] and was treated for systolic heart failure with coronary artery bypass graft surgery (heart surgery) and permanent pacemaker (arrested during surgery twice), right pneumothorax (a collapsed lung) , left pleural effusion (a build-up of fluid between the tissues that line the lungs and the chest), pulmonary edema (build up of fluid in the lungs), periodontal abscess (bacterial infection that occurs alongside a tooth), diabetes, dysphagia with gastrostomy tube placement, acute pulmonary embolism (blood clot), and anemia. Review of physician's orders on admission revealed the resident received nothing by mouth and had a continuous tube feeding. On [DATE] a physician progress note documented that Resident #145 was seen due to having complaints of feeling tired of fighting and was ready to die. The facility staff discussed prognosis with family and patient/family desired comfort care only. Will consult hospice and change code status to Do Not Resuscitate (DNR) (no life saving measures when the resident's heart stops beating) per patient wishes. Review of physician's orders revealed a hospice consult was ordered and code status changed to DNR on [DATE]. On [DATE] at 9:59 P.M. LPN #123 documented in the nursing progress notes a temperature of 97.1 (taken at that time), a pulse of 54 (taken at 8:38 P.M. on [DATE]), respirations 14 (taken at that time). The most recent previous respirations were noted to be 20 on [DATE]. A blood pressure of ,d+[DATE] millimeters of Mercury (mmHg) was documented in the nursing progress notes but was noted to be carried forward into the notes from [DATE] at 10:19 A.M. (no new blood pressure taken). It stated the resident was alert and easily arousable. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:00 P.M. nursing progress notes by LPN #123 stated the nurse contacted hospice but was informed that the resident was no longer under their care. The nurse then contacted another hospice company who confirmed they had consulted on the resident's case on [DATE] but had not yet admitted her. The notes did not indicate why the nurse was contacting hospice. On [DATE] at 11:39 P.M. nursing progress notes by LPN #123 stated resident's last known time was 10:30 P. M. The nurse conducted rounds at 11:30 P.M. and found the resident did not have a pulse. Called a second nurse to confirm. Notified Nurse Practitioner who pronounced the resident dead at 11:30 P.M. Interview with LPN #123 on [DATE] at 12:18 P.M. revealed she worked from 7:00 P.M. until 7:00 A.M. on [DATE] into [DATE]. She stated that she had attempted to take Resident #145's blood pressure on [DATE] at 8:38 P.M. when she got a pulse of 54, but was unable to get a blood pressure. She stated the blood pressure machine read error. She stated she intended to get a manual blood pressure machine to check the resident's blood pressure but was busy with other residents. She stated that she called hospice later in the evening (around 11:00 P.M.) because of the low pulse and being unable to obtain a blood pressure. However, hospice had been discontinued with one agency and had not started with the next agency. She stated that when she went back to the resident's room at 11:30 P.M. the resident had passed away. She confirmed she had not contacted the resident's family to notify them of the changes in vital signs (beginning around 8:30 P. M.) until after the resident had expired. 43064 2. Review of Resident #86's medical record revealed an admitted [DATE] with diagnoses including hypertension, major depressive disorder, dementia, and chronic obstructive pulmonary disease. Review of Resident #86's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognition. Review of Resident #86's contacts revealed her sister was power of attorney (POA) (able to make decisions on behalf of the resident) Review of Resident #86's progress note dated [DATE] revealed after breakfast the resident was noted to be pocketing her food (storing her food in her cheeks). Attempts were made several times for her to chew and swallow, but she just smiled and laughed. The speech therapist was consulted regarding her pocketing. There was no evidence the POA was notified of this change. Review of Resident #86 ' s physician order dated [DATE] revealed she was on a regular diet with a puree texture due to pocketing food. There was no evidence the POA was notified of this change. Interview on [DATE] at 2:09 P.M. and 4:26 P.M with the Director of Nursing (DON) verified there was no evidence the POA was notified of the resident's swallowing problems or diet change. Review of the facility policy titled Change in a Resident's Condition or Status dated 2001 and revised [DATE] revealed a nurse will notify the resident's representative when there is a significant change in the resident's physical, mental, or psychosocial status. This deficiency represents noncompliance investigated under Complaint Number OH00161321.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on facility personnel and criminal background check records review, medical record review, review of the new hire application form, interview, and facility policy review, the facility failed to complete criminal background checks as required for all new employees. This had the potential to affect all 139 residents residing in the facility. Additionally, the facility failed to implement their abuse policy regarding reporting, ensuring resident safety, and thoroughly investigating alleged incidents as required. This affected one resident (Resident #8) of three residents reviewed for abuse. Findings Include: 1. Review of facility bureau of criminal investigation (BCI) log, dated 09/01/24 to 01/15/25, revealed no indication whether federal background checks had been completed for any new hires that had not lived in this state for the last five years prior to hire at the facility. Review of facility personnel records of all new staff hired, dated 09/01/24 to 01/15/25, revealed a total of nine new hires (Certified Nursing Assistant (CNA) #619, CNA #620, CNA #621, and Registered Nurse (RN) #622, Nursing Staff #623, Licensed Practical Nurse (LPN) #624, CNA #625, LPN #626, and Dietary Aide (DA) #627) had not lived in this state for the last five years, and the facility did not complete a federal background check. Also, there was a total of 19 additional staff (LPN #600, LPN #601, CNA #602, LPN #603, RN #604, RN #605, Housekeeping Staff #606, CNA #607, LPN #608, CNA #609, DA #610, Dietary Coordinator #611, Medical Records Staff #612, DA #613, CNA #614, [NAME] Records Staff #615, CNA #616, CNA #617, and DA #618) who the facility could not contact (they no longer worked for the facility) to confirm whether they had lived in this state for the last five years prior to hire. Interview with Human Resources Director #107 on 01/13/25 at 1:25 P.M. and 1:35 P.M. confirmed they do not have a place on their new hire application to ask if the prospective employee has lived in this state for the last five years. Also, she confirmed they have not checked any federal background checks for any new hires that had not lived in the state in the five years prior to hire. Interview with Administrator on 01/13/25 at 2:15 P.M. confirmed they have not been checking federal background checks for anyone that has not lived in the state for at least five years. She confirmed they do not know if any new staff fits that description because there is nothing on the application that identified that. She confirmed they do not have a specific policy for checking federal criminal background checks. Review of facility current new hire application form, un-dated, revealed there was no place for applicants to report how long they had lived in the state. Review of facility Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property policy, dated March 2024, revealed it is the facility's policy to undertake background checks of all employees and to retain on file applicable records of current employees regarding such as background checks and to screen prospective residents for appropriateness if admission. The facility will, conduct a criminal background check in accordance with state law and the Facility's policy. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Resident #8 was admitted to the facility on [DATE]. Her diagnoses included acute and subacute hepatic failure, type II diabetes, major depressive disorder, cirrhosis of liver, morbid obesity, heart failure, chronic hepatic failure, history of falling, toxic liver disease, altered mental status, hepatic encephalopathy, and unspecified severe protein calorie malnutrition. Review of her minimum data set (MDS) assessment, dated 11/07/24, revealed she was cognitively intact. Review of Resident #8's medical records found she changed rooms on 12/23/24. There was no documentation to support as to why this change occurred. Review of facility Concern form, dated 12/23/24, revealed a concern given to the nursing staff, stating that multiple residents complain about two aides that work on their hallway, regarding lack of respect and proper care being provided. The resident reporting this concern stated they wanted to remain anonymous due to fear of retaliation from the staff. Review of facility investigative documents for the alleged intimidation incident, dated 12/23/24, revealed the facility completed observation assessments for all residents on the same hallway as Resident #8, an interview question of Does the staff treat you with dignity and respect to each of the same residents, an interview statement written by the DON from Resident #8, and an interview statement written by the DON from the two aides (CNA #211 and CNA #179) who were alleged to have been disrespectful and potentially intimidating to Resident #8. There were no interview statements written by any residents or staff, and there were no other residents/staff questioned about the incident or other potential incidents. Review of the time sheets for CNA #211 and #179 from 12/23/24 to 01/01/25, revealed both alleged perpetrators worked during this time. Interview with the Administrator on 01/14/25 at 4:35 P.M. confirmed the information provided for the investigation was all that was completed. She confirmed the aides were not placed on leave during the incident investigation but it was the facility's policy to complete a thorough investigation and place any staff who have been identified as alleged perpetrators in an abuse allegation, on administrative leave during the investigation. She confirmed that when a resident states they feel intimidated or fear of retaliation for reporting an incident, that would be deemed as an allegation of abuse. She confirmed this allegation was not reported to the state department of health as directed in the facility abuse policy. Interview with Resident #8 on 01/16/25 at 11:10 A.M. confirmed that she felt intimidated and verbally abused by three different staff in the facility (Licensed Practical Nurse #248, CNA #179 and #211). She stated they would intimidate and make fun of her for continuing to ask for assistance with incontinence care but this has not happened since being moved from her previous room; primarily because the three staff that did this to her do not work on her new floor. She confirmed she was never interviewed about the incident by any staff in the facility. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property policy, dated March 2024, revealed abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, punishment with resulting physical harm, pain or mental anguish. If a staff member is accused or suspected, the facility should immediately remove that staff member from the facility and the schedule pending the outcome of the investigation. Once the administrator and the state department of health are notified, an investigation of the alleged violation will be conducted. This deficiency represents non-compliance investigated under Complaint Number OH00161464

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review, interview, facility investigation review, and policy review, the facility failed to report an allegation of abuse to the state survey agency. This affected one (Resident #8) of three residents reviewed for abuse. The census was 139. Findings Include: Resident #8 was admitted to the facility on [DATE]. Her diagnoses included acute and subacute hepatic failure, type II diabetes, major depressive disorder, cirrhosis of liver, morbid obesity, heart failure, chronic hepatic failure, history of falling, toxic liver disease, altered mental status, hepatic encephalopathy, and unspecified severe protein calorie malnutrition. Review of her minimum data set (MDS) assessment, dated 11/07/24, revealed she was cognitively intact. Review of Resident #8 medical records found she changed rooms on 12/23/24. There was no documentation to support as to why this change occurred. Review of facility Concern form, dated 12/23/24, revealed a concern given to the nursing staff stating that multiple residents complained about two aides that worked on their hallway, regarding lack of respect and proper care being provided. The resident reporting this concern stated they wanted to remain anonymous due to fear of retaliation from the staff. Review of facility investigative documents for the alleged intimidation incident, dated 12/23/24, revealed no evidence that this incident was reported to the state survey agency. Review of the facility self-reported incidents revealed this allegation was not reported to the state survey agency on 12/23/24 or 12/24/24. Interview with Administrator on 01/14/25 at 4:35 P.M. confirmed this allegation of abuse was not reported to the state survey agency as required. Interview with Resident #8 on 01/16/25 at 11:10 A.M. confirmed that she felt intimidated and verbally abused by three different staff in the facility (Licensed Practical Nurse #248, CNA #179 and #211). She stated they would intimidate and make fun of her for continuing to ask for assistance with incontinence care but this has not happened since being moved from her previous room; primarily because the three staff that did this to her do not work on her new floor. She confirmed she was never interviewed about the incident by any staff in the facility. Review of facility Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property policy, dated March 2024, revealed if any form of abuse is alleged, the administrator of his/her designee will notify the state department of health immediately, but no later than two hours after the allegation is made. This deficiency represents non-compliance investigated under Complaint Number OH00161464.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on facility medical record review, resident interview, staff interview, facility investigative documents review, and facility policy review, the facility failed to complete a thorough investigation of an abuse allegation. This affected one (Resident #8) of three residents reviewed for abuse. The census was 139. Findings Include: Resident #8 was admitted to the facility on [DATE]. Her diagnoses included acute and subacute hepatic failure, type II diabetes, major depressive disorder, cirrhosis of liver, morbid obesity, heart failure, chronic hepatic failure, history of falling, toxic liver disease, altered mental status, hepatic encephalopathy, and unspecified severe protein calorie malnutrition. Review of her minimum data set (MDS) assessment, dated 11/07/24, revealed she was cognitively intact. Review of Resident #8 medical records found she changed rooms on 12/23/24. There was no documentation to support as to why this change occurred. Review of facility Concern form, dated 12/23/24, revealed a concern given to the nursing staff, stating that multiple residents complain about two aides that work on their hallway, regarding lack of respect and proper care being provided. The resident reporting this concern stated they wanted to remain anonymous due to fear of retaliation from the staff. Review of facility investigative documents for the alleged intimidation incident, dated 12/23/24, revealed the facility completed observation assessments for all residents on the same hallway as Resident #8, an interview question of Does the staff treat you with dignity and respect to each of the same residents, an interview statement written by the DON from Resident #8, and an interview statement written by the DON from the two aides (CNA #211 and CNA #179) who were alleged to have been disrespectful and potentially intimidating to Resident #8. There were no interview statements written by any residents or staff, and there were no other residents/staff questioned about the incident or other potential incidents. Review of the time sheets for CNA #211 and #179 from 12/23/24 to 01/01/25, revealed both alleged perpetrators worked during this time. Interview with the Administrator on 01/14/25 at 4:35 P.M. confirmed the information provided for the investigation was all that was completed. The DON verified it was the facility's policy to complete a thorough investigation and place any staff who have been identified as alleged perpetrators in an abuse investigation, on administrative leave during the investigation. She confirmed that when a resident states they feel intimidated or fear of retaliation for reporting an incident, that would be deemed as an allegation of abuse. Interview with DON on 01/15/25 at 11:40 A.M. and 1:00 P.M. confirmed she did interviews with the two aides and Resident #8 about the alleged abuse incident. She confirmed she did not document the statements, but she would do that today. Also, she stated other nurses and managers interviewed other people about this incident, but she doesn't know who and there was no record of it being completed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #8 on 01/16/25 at 11:10 A.M. confirmed that she felt intimidated and verbally abused by three different staff in the facility (Licensed Practical Nurse #248, CNA #179 and #211). She stated they would intimidate and make fun of her for continuing to ask for assistance with incontinence care but this has not happened since being moved from her previous room; primarily because the three staff that did this to her do not work on her new floor. She confirmed she was never interviewed about the incident by any staff in the facility. Review of facility Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property policy, dated March 2024, revealed abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, punishment with resulting physical harm, pain or mental anguish. If a staff member is accused or suspected, the facility should immediately remove that staff member from the facility and the schedule pending the outcome of the investigation. Once the administrator and the state department of health are notified, an investigation of the alleged violation will be conducted. This deficiency represents non-compliance investigated under Complaint Number OH00161464.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 37100 Based on observations, medical record review, interview, and facility activity calendar review, the facility failed to schedule activities to meet the needs of the residents on the memory care unit. This affected 21 of 21 memory care residents (Residents #9, #13, #27, #30, #32, #40, #41, #46, #49, #76, #78, #84, #86, #92, #96, #98, #129, #136, #139, #141) and Resident #107 who was not in the memory care unit. The facility census was 139. Findings Include: Review of Memory Care Activity Calendars, dated November 2024 to January 2025, revealed there were no activities scheduled for the weekends. Observations on 01/15/25 from 9:10 A.M. to 9:30 A.M. found no activities occurring in the memory care unit. Staff were assisting residents with their breakfast and morning hygiene routines; there were no activity staff in the memory care unit. Review of Memory Care Unit January Activity Calendar revealed the activity starting at 9:00 A.M. was to be AM Chats. Observations on 01/15/25 from 9:30 A.M. to 9:50 A.M. found no activities were occurring in the non-memory care unit areas. Staff were assisting with clearing from breakfast and assisting with resident care needs. Activity staff was not found during this time. Review of non-Memory Care Unit January Activity Calendar revealed the activity starting at 9:00 A.M. was to be AM Chats. for 01/15/25. Observations on 01/15/25 from 12:10 P.M. to 12:35 P.M. and 1:10 P.M. to 1:30 P.M. revealed no activities occurring in the memory care unit. At 1:30 P.M., activities staff brought a container of brownies into the memory care unit for an activity. Review of Memory Care Unit January Activity Calendar revealed Nail Time was to be completed at 12:00 P. M. and Snack and Chat was to start at 1:00 P.M. Observations on 01/15/25 from 12:50 P.M. to 1:05 P.M. and 1:30 to 1:40 P.M. in the non-memory care unit areas found no activities occurring. There were approximately seven residents sitting in the common areas, waiting for activities to start. Lunch was still being passed in the dining room during this time. Review of non-Memory Care Unit January Activity Calendar revealed an activity involving slot machines was to be occurring at 1:00 P.M. Interview with Activity Assistant #156 and Activity Assistant #174 on 01/15/25 at 1:30 P.M. confirmed they were delayed in doing their snack activity due to lunch duties. Also, they confirmed they did not do the nail time activities at 12:00 P.M. because they did it a different day. They confirmed they fit in the activities when they can. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident #107 on 01/15/25 at 1:40 P.M. confirmed she was told after she was wheeled to the other building for activities, that the 1:00 P.M. activity would be delayed until 3:00 P.M. due to lunch running late. The resident said she was frustrated because she would have sit in her wheelchair another two hours, not in her building, which may hurt her back. She stated this happens occasionally, that all activities are pushed back, due to a delay with staff, meals, or other reasons. Interview with Activities Director #221 on 01/14/25 at 2:05 P.M. and 01/16/25 at 2:00 P.M. revealed they don't have activities on the weekends in memory care because they only have four total activities staff, so they prioritize activities in the other portions of the building. She confirmed activities are late (based on the time they are scheduled) due to her being overwhelmed with doing the duties of dietary manager and activities director. She stated activities are late because of how long it takes them to serve meals, so they push activities around to fit them in. She is hoping when the second kitchen is functional, that will help with the activity times. This deficiency represents non-compliance investigated under Complaint Number OH00161522.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 07316 Based on record review, policy review, and staff interview, the facility failed to ensure a resident received adequate treatment and care and the physician was notified at the time of a change in condition. This affected one of 17 sampled residents (Resident #145). The facility census was 139. Findings include: Review of the closed medical record for Resident #145 revealed the resident was admitted from the hospital on 12/09/24. The resident had been in the hospital from 11/09/24 to 12/09/24 and was treated for systolic heart failure with coronary artery bypass graft surgery and permanent pacemaker (arrested during surgery twice), right pneumothorax, left pleural effusion, pulmonary edema, periodontal abscess, diabetes, dysphagia with gastrostomy tube placement, acute pulmonary embolism, and anemia. Review of physician's orders on admission revealed the resident received nothing by mouth and had a continuous tube feeding. She had physician's orders on admission for two types of insulin: Glargine (long acting insulin) five units once daily at 6:00 P.M. and Humulin R (short acting insulin) 12 units (subcutaneous) (sq) every six hours at 12:00 A.M., 6:00 A.M., 12:00 P.M., and 6:00 P.M. There were no physician's orders for parameters of when to notify the physician regarding low or high blood sugars. The blood sugar was being monitored four times daily (via fingerstick at bedside). Review of nursing progress notes revealed on 12/17/24 at 6:10 P.M. Resident #145's blood pressure was noted to be 145/76 millimeters of Mercury (mmHg) (normal blood pressure is 120/60 mmHg). However, this blood pressure had been carried over into the nursing progress notes from 12/15/24 at 7:46 P.M. (not a new blood pressure reading on 12/17/24 at 6:10 P.M.). Review of vital sign records revealed on 12/17/24 at 6:46 P.M. Resident #145's blood pressure was noted to be 92/60 mmHg (considered low). On 12/17/24 at 9:20 P.M. it was noted to be 93/54 mmHg. These blood pressures were significantly lower than the most recent blood pressure obtained on 12/15/24 at 7:46 P.M. of 145/76 mmHg. On 12/17/24 at 11:06 P.M. Licensed Practical Nurse (LPN) #123 documented a blood pressure of 93/54 mmHg taken at 9:20 P.M. in the nursing progress notes. There was no evidence the physician was notified or that any further action was taken related to the low blood pressures. There was no evidence the resident's blood pressure was rechecked until 12/18/24 at 10:19 A.M. when it was 105/65 mmHg. (No pulse or respirations done on 12/18/24). On 12/18/24 a physician progress note documented that Resident #145 was seen due to having complaints of feeling tired of fighting and is ready to die. The facility staff discussed prognosis with family and patient/family desires comfort care only. Will consult hospice and change code status to Do Not Resuscitate (DNR) per patient wishes. Review of physician's orders revealed a hospice consult was ordered and code status changed to DNR on 12/18/24. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luxe Rehabilitation and Care Center	957 Becks Knob Road Lancaster, OH 43130

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/19/24 at 5:04 A.M. the resident's blood sugar was noted to be 380 milligrams per deciliter (mg/dl) (normal fasting blood sugar is 60-90 mg/dl). The previous day on 12/18/24 the blood sugar was 212, 280, 200, and 180. There was no evidence the physician was notified of the blood sugar of 380 or that any further action was taken regarding the high blood sugar. The resident received Morphine for pain at 7:49 A.M. on 12/19/24. There was no evidence of any vital signs being taken on 12/19/24 until 8:38 P.M. The vital signs documented in the nursing progress notes on 12/19/24 at 11:41 A.M. were carried forward from 12/17/24 (temperature, pulse, and respirations) and 12/18/24 (blood pressure). No new vital signs documented at that time. The residents blood sugar at 6:42 P.M. on 12/19/24 was documented as 300. The resident received Morphine for pain at 8:38 P.M. On 12/19/24 at 8:38 P.M. the resident's pulse was documented as 54 (in vital sign records). No other vital signs were documented at that time. The most previous pulse on 12/17/24 was 85. There was no evidence the pulse was rechecked. On 12/19/24 at 9:21 P.M. LPN #123 documented that she collaborated with a colleague to change the dressings on the residents gastrostomy tube and chest incisions. The resident was alert and oriented to person, place, and time. She requested ice, which nurse provided. Throughout the process the resident showed no signs or distress or pain. On 12/19/24 at 9:59 P.M. LPN #123 documented in the nursing progress notes a temperature of 97.1 (taken at that time), a pulse of 54 (taken at 8:38 P.M. on 12/19/24), respirations 14 (taken at that time) The most recent previous respirations were noted to be 20 on 12/17/24. A blood pressure of 105/65 was documented in the nursing progress notes but was noted to be carried forward into the notes from 12/18/24 at 10:19 A.M. (no new blood pressure taken). On 12/19/24 at 11:00 P.M. nursing progress notes by LPN #123 stated the nurse contacted hospice but was informed that the resident was no longer under their care. The nurse then contacted another hospice company who confirmed they had consulted on the resident's case on 12/19/24 but had not yet admitted her. The notes did not indicate why the nurse was contacting hospice. There was no evidence the physician was contacted. On 12/19/24 at 11:39 P.M. nursing progress notes by LPN #123 stated resident's last known time was 10:30 P.M. The nurse conducted rounds at 11:30 P.M. and found the resident did not have a pulse. Called a second nurse to confirm. Notified Nurse Practitioner who pronounced the resident dead at 11:30 P.M. Interview with LPN #123 on 01/15/25 at 12:18 P.M. revealed she worked from 7:00 P.M. until 7:00 A.M. on 12/18/24 into 12/19/24. She stated that she had attempted to take Resident #145's blood pressure on 12/19/24 at 8:38 P.M. when she got a pulse of 54, but was unable to get a blood pressure. She stated the blood pressure machine read error. She stated she intended to get a manual blood pressure machine to check the resident's blood pressure but was busy with other residents. She stated that she called hospice later in the evening (around 11:00 P.M.) because of the low pulse and being unable to obtain a blood pressure. However, hospice had been discontinued with one agency and had not started with the next agency. She confirmed she did not contact the physician with the resident's change in condition (low pulse and unable to get blood pressure). She also stated the physician should be notified of a blood sugar above 300 (per her nursing judgement). She stated that when she went back to the resident's room at 11:30 P.M. the resident had passed away. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing on 01/15/25 at 3:45 P.M. revealed the facility did not have a policy on vital sign monitoring. However, she stated the facility procedure was to do vital signs every shift for residents who are skilled for Medicare. She confirmed Resident #145 was skilled during her stay. She stated the nurses should not be carrying vital signs forward into the nurses progess notes from previous shifts/days. They should be doing a new set of vital signs each shift. She further confirmed Resident #145 did not have parameters in place for when to notify the physician for elevated blood sugars. Review of the facility policy titled Diabetes Mellitus dated January 2023 revealed the physician will order the frequency of glucose monitoring and high and low parameters as applicable. The policy stated normal ranges are defined as 80-130 before meals and less than 180 after meals. Hyperglycemia is considered anything above target reference ranges. This deficiency represent non-compliance investigated under Master Complaint Number OH00161522 and Complaint Number OH00161114.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37100 Based on observation, medical record review, interview, and facility policy review, the facility failed to ensure all residents followed safe smoking provisions and failed to assess residents for safe smoking prior to smoking while residing in the facility. This affected five (Residents #4, #5, #6, #11, and #94) of five residents reviewed for smoking. The facility identified Resident #4, #5, #6, #11 and #94 as the only residents who smoked. The census was 139. Findings Include: 1. Observations on 01/14/25 at 1:30 P.M. and 1:40 P.M., there were used cigarette butts found in the trash can of each building's front porch. The trash cans were not safe for smoking materials to be disposed in. Also, the trash cans were lined with plastic trash bags. This was confirmed by Licensed Practical Nurse (LPN) #131 and the Administrator. Observation on 01/14/25 at 1:40 P.M. found Resident #4 on the front porch, smoking a cigarette. There were no ash trays or proper cigarette disposal devices on the front porch. The front porch was not a designated smoking area for the facility. Interview (via email) with Administrator on 01/14/25 at 12:28 P.M. confirmed the facility does allow smoking, but the residents have to sign out and go off property to smoke. She confirmed they do not allow any smoking on the facility property. There was no documented discussions or signed documents that the smoking residents understood the policy of the facility. Interview with Resident #94 and Certified Nursing Assistant (CNA) #134 on 01/14/25 at 1:38 P.M. confirmed the residents will smoke on the front porches and do not have to go off property to smoke. When they are done smoking, they dispose of the cigarette butts in the trash can on the porch Review of facility Smoking Policy, dated November 2024, revealed the facility will respect each resident's right to smoke tobacco products or vape while a resident and will maintain a safe environment for all residing in the facility. The administrator/designee will review the smoking policy with residents who desire to smoke on admission and annually. A copy of the smoking policy will be provided to the resident, and a signed copy maintained in the facility. 2. Resident #4 was admitted to the facility on [DATE]. His diagnoses were cellulitis of right lower limb, morbid obesity, heart failure, COPD, hypertension, benign prostatic hyperplasia, hyperlipemia, lymphedema, chronic pain syndrome, muscle weakness, and personal history of other venous thrombosis and embolism. Review of his minimum data set (MDS) assessment, dated 01/01/25, revealed he was cognitively intact. Review of Resident #4 smoking assessments revealed a smoking assessment had not been completed since admission. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #5 was admitted to the facility on [DATE]. Her diagnoses were pneumocystosis, insomnia, shortness of breath, acute kidney failure, type II diabetes, fluid overload, hyperkalemia, anemia, chronic metabolic acidosis, chronic kidney disease, anxiety disorder, muscle weakness, COPD, acute and chronic respiratory failure with hypoxia, hyperlipidemia, pleural effusion, and hypertension. Review of her MDS assessment, dated 12/03/24, revealed she was cognitively intact. Review of Resident #5 smoking assessments revealed no smoking assessment had been completed since admission. 4. Resident #6 was admitted to the facility on [DATE]. His diagnoses were hyperlipidemia, other chronic pain, osteoarthritis, GERD, and obesity. Review of his MDS assessment, dated 10/31/24, revealed he was cognitively intact. Review of Resident #6 smoking assessments revealed a smoking assessment was not completed since admission to the facility. 5. Resident #94 was admitted to the facility on [DATE]. His diagnoses were personal history of nicotine dependence, anxiety disorder, dependence on renal dialysis, cardiac arrhythmia, limitation of activities due to disability, COPD, repeated falls, personal history of pulmonary embolism, history of falling, anemia, pleural effusion, hypertensive chronic kidney disease, morbid obesity, end stage renal disease, vitamin D deficiency, lymphedema, anemia, emphysema, shortness of breath, acute and chronic respiratory failure, hypertensive chronic kidney disease, pain, hyperlipidemia, type II diabetes, acute posthemorrhagic anemia, gas gangrene hypotension, atrial fibrillation, obstructive sleep apnea, acute kidney failure, and major depressive disorder. Review of his MDS assessment, dated 12/15/24, revealed he was cognitively intact. Review of Resident #94 smoking assessments revealed no smoking assessment had been completed Interview with Director of Nursing (DON) on 01/15/25 at 11:40 A.M. confirmed there were no smoking assessments done upon admission and quarterly thereafter for the above four residents. She confirmed they should have been done and they have no evidence to support they were completed prior to 01/13/25. Review of facility Smoking Policy, dated November 2024, revealed on admission, quarterly, and as needed, the resident will be assessed to determine if they are a smoker or non-smoker. Residents who smoke will be assessed to determine if they are safe to smoke independently or if they need supervision and adaptive equipment while smoking. This deficiency represents non-compliance investigated under Master Complaint Number OH00161522.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on observations, record review, and interview, the facility failed to provide pharmacy services to ensure medications were available to be administered per physician orders. This affected two (Residents #39 and #71) of five residents observed for medication administration The facility census was 139. Findings include: 1. Review of the medical record for Resident #39 revealed an admitted [DATE]. There was a physician's order dated 08/01/24 for ergocalciferol (Vitamin D2) 1.25 milligrams one tablet once daily every Monday related to Vitamin D deficiency. Observations on 01/13/25 at 8:05 A.M. revealed Licensed Practical Nurse (LPN) #127 prepare medications to administer to Resident #39. LPN #127 stated that Vitamin D that was ordered to be given at that time was not available. She stated she did not know why it was not available. Interview with the Director of Nursing on 01/13/25 at 8:20 A.M. revealed the ergocalciferol comes from the pharmacy but was not available for administration. 2. Review of the medical record for Resident #71 revealed an admitted [DATE]. There was a physician's order dated 01/22/24 for Mucinex DM ER 12 hour 30-600 milligrams one twice daily for cough/congestion. There was a physician's order dated 07/26/24 for fexofenadine 180 milligrams one half tablet daily for seasonal allergies. Observations on 01/13/25 at 9:35 A.M. revealed Agency LPN #301 prepare medications to administer to Resident #71. LPN #301 stated that Mucinex (expectorant to thin mucus) and fexofenadine (antihistamine) that were ordered to be given at that time were not available. Interview with Assistant Director of Nursing #129 on 01/13/25 at 10:20 A.M. confirmed both were stock medications but neither medication was available for administration to Resident #71 at that time. This deficiency represents non-compliance investigated under Complaint Number OH00161227.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on observations, record review, and staff interview, the facility failed to ensure a resident's drug regimen was free from unnecessary medications when his blood pressure was not adequately monitored. This affected one (Resident #7) of five residents observed during medication administration. The facility census was 139. Findings include: Review of the medical record for Resident #7 revealed an admitted [DATE] and a readmitted [DATE] with diagnoses including hypertension (high blood pressure), syncope (fainting), hypotension (low blood pressure) due to drugs, and dementia. A Minimum Data Set assessment completed 01/06/25 indicated the resident had severe cognitive impairment. Resident #7 had a physician's order dated 12/29/24 for Midodrine 2.5 milligrams one tablet twice daily for hypotension (low pressure). The physician's order stated to hold the medication if the systolic blood pressure was greater than 140 millimeters of Mercury (mmHg) or the diastolic blood pressure was greater than 80 mmHg. Observations on 01/13/25 at 9:07 A.M. revealed Licensed Practical Nurse (LPN) #152 prepared medications to administer to Resident #7. The medications included Midodrine 2.5 milligrams. LPN #152 entered the room and placed an automatic blood pressure cuff on the resident's wrist and started the machine. She left the blood pressure cuff on the wrist after it was done. The surveyor could see that the blood pressure was 160/93 mmHg on the screen of the blood pressure machine. The surveyor asked LPN #152 what the blood pressure was and she stated she did not remember but the resident had flashed her the results and it was ok. The blood pressure cuff remained on the resident's wrist. LPN #152 administered the medications to Resident #7, including the Midodrine. Upon returning to the medication cart, LPN #152 stated the resident had a physician's order not to give the medication if the systolic blood pressure was greater than 140 (also had order not to give if diastolic is greater that 80). She then looked at the blood pressure cuff, which still read 160/93. LPN #152 stated that this was not the blood pressure for Resident #7 but was the blood pressure of another resident. However, she confirmed that she had already given the Midodrine. LPN #152 then returned to Resident #7's room and took the blood pressure again with the same wrist blood pressure monitor. Resident #7's blood pressure registered 132/93 mmHg (still exceeding the administration parameters ordered by the physician). Review of vital sign records revealed there was no evidence Resident #7's blood pressure was checked again after receiving the Midodrine when it should have not been until 10:49 P.M. on 01/13/25 and was noted to be 107/67 mmHg. Interview with Assistant Director of Nursing #129 on 01/15/25 at 11:15 A.M. confirmed LPN #152 should not have given Resident #7 the Midodrine on 01/13/25 without adequately checking the resident's blood pressure. She confirmed the Midodrine should not have been given for a systolic blood pressure greater than 140 mmHg or a diastolic blood pressure greater than 80 mmHg. She confirmed his blood pressure should have been rechecked within an hour after receiving the Midodrine inappropriately on 01/13/25 at 9:07 A.M. but there was no evidence the resident's blood pressure was rechecked until 10:49 P.M. on 01/13/25. This deficiency represents non-compliance investigated under Complaint Number OH00161227.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on observations, record review, and interview, the facility failed to ensure medications were properly stored. This affected one (Resident #71) of five residents observed for medication administration. The facility census was 139. Findings include: Review of the medical record for Resident #71 revealed an admitted [DATE]. A Minimum Data Set assessment on 12/20/24 indicated the resident had intact cognition. There was a physician's order dated 07/26/24 for Breo Ellipta inhalation 100-25 micrograms one puff daily and a physician's order dated 04/17/23 for Flonase nasal spray 50 micrograms two sprays in each nostril daily. Review of the medication administration record for January 2025 revealed the nurses were documenting that the Breo Ellipta inhaler and Flonase nasal spray were administered daily. There was no evidence of a physician's order to self administer medications. Observations on 01/13/25 at 9:35 A.M. revealed Agency Licensed Practical Nurse (LPN) #301 prepared medications to administer to Resident #71. LPN #301 stated she was unable to find a Breo Ellipta inhaler (a corticosteriod medication used to treat Chronic Obstructive Pulmonary Disease (COPD) or Flonase nasal spray (a corticosteriod medication used for seasonal allergies) in the medication cart that were due to be administered to the resident at that time. LPN #301 entered the resident's room. Resident #71 then stated that she had the Breo Ellipta inhaler and the Flonase nasal spray in her room and had already used the medications. The medications were observed in an open basket on her bed (not locked). Interview with Assistant Director of Nursing #129 on 01/13/25 at 9:45 A.M. revealed Resident #71 should not have the medications (Breo Ellipta or Flonase) in her room. She stated the resident did not have a physician's order to self administer the medications. Interview with Resident #71 on 01/14/25 at 9:00 A.M. revealed she had the medications in her room for two years and the nurses did not watch her take the medications. This deficiency is an incidental finding discovered during the complaint investigation.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on observations, resident interview, review of training records, review of meal monitoring records, and staff interview, the facility failed to ensure there was sufficient staff with the appropriate competencies and skills to carry out the functions of the food and nutrition services. This could affect 137 of 139 residents in the facility (Residents #61 and #122 receive nothing by mouth). Findings include: The facility consisted of two buildings ([NAME] and [NAME]) connected by a therapy wing in the center. [NAME] had 92 beds on four hallways and [NAME] had 83 beds on four hallways. Observations on 01/09/25 at 9:20 A.M. revealed the breakfast meal cart sitting in the hallway on 400 hall [NAME] Wing. Interview with Licensed Practical Nurse (LPN) #254 on 01/09/25 at 9:20 A.M. revealed they had received the meal cart to the hallway at 9:10 A.M. The last tray was served at 9:55 A.M. LPN #254 stated there was not a real set schedule for meal delivery and it could be anywhere from 8:15 A.M. to 8:45 A. M. Interview with Dietary Manager #221 on 01/09/25 at 10:15 A.M. revealed she had been assigned as dietary manager at the end of September 2024. She also currently served as the Activity Director for the 172 bed facility. She stated the facility had two kitchens but they were currently only using one of the kitchens (in [NAME] building) to serve all of the residents from. The trays had to be transported to the [NAME] building for all meals. She stated there were no specific meals times assigned for each hallway. She stated breakfast was to be served between 7:00 A.M. to 9:00 A.M. (15 minutes per cart for eight carts), lunch between 11:00 A.M. to 1:00 P.M. and supper between 4:30 P.M. to 6:30 P. M, or 5:00 P.M. to 7:00 P.M. She stated breakfast service in the kitchen had started at 7:05 A.M. and ended at 9:05 A.M. (trays delivered at 9:10 A.M. to 400 [NAME] per LPN #254). She confirmed there was one evening recently (3 weeks ago) where supper was served to the last hall at 8:00 P.M. Observations in the kitchen on 01/09/25 at 11:30 A.M. revealed the lunch tray line had not yet started (to start at 11:00 A.M. per Dietary Manager). Interview with [NAME] #145 revealed he had just started about one month prior and had not cooked in a nursing home before. There were two other staff in the kitchen. Interview with [NAME] #109 revealed this was her fifth day working at the facility. She stated there were usually four staff to help with meal service plus one for doing dishes. She stated there was a call off so there were only three staff to prepare and serve lunch to all the residents. This included her, [NAME] #145, and one other staff. She stated they were late starting tray line due to being short staffed due to the call off. She stated she was having to do jobs she was not familiar with. Staff were not observed to puree food for eight residents receiving pureed diets until after the tray line had started. The staff stopped the tray line and pureed food to add to the trays. The staff also did not have copies of the menu/spread sheets to know how much of each food item to put on the different diet meal trays. The first meal cart left the kitchen at 12:05 P. M. (approximately 50 minutes after scheduled to leave). The Dietary Manager nor Dietician were observed in the kitchen during the preparation of the first meal cart. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with Resident #63 on 01/09/25 at 3:15 P.M. revealed sometimes supper is not served until 8:00-8:30 P.M. She stated the food is cold and she would rather eat earlier. Interview with Resident #8 on 01/09/25 at 3:30 P.M. revealed the meals are late and supper was served one night at 7:30 P.M. Interview with the Administrator on 01/09/25 at 10:45 A.M. and 1:50 P.M. revealed the facility had multiple resident concerns regarding the meals being late on 12/29/24 (that weekend). She stated the doors to the kitchen were locked and no staff could get in until a cook went home and got a spare key, causing the meal to be late. She stated there was also a leak in the kitchen ceiling that delayed meals. She stated also the dishwasher stopped working and was still not working in the kitchen being used ([NAME]), so the staff have to take all the dirty dishes to the [NAME] kitchen to be washed and bring them back to the [NAME] kitchen. She stated the goal was to have both kitchens open to cut down on meal service time but the facility did not have enough dietary staff to do this currently. She stated because of transporting dishes and the lack of sufficient dietary staff, meals can not be started sooner and can not be completed sooner than a two hour time frame. She stated resident preferences on meal times had not been determined by the facility. She stated the facility had been monitoring meal service times beginning 01/01/25. Review of the meal service monitoring times from 01/01/25 to 01/09/25 revealed breakfast started between 6:50 A.M.-7:10 A.M. and ended between 8:50 A.M. and 9:10 A.M. Lunch started between 10:45 A.M. and 11:00 A.M. and ended between 1:00 P.M. and 1:10 P.M. Supper started between 4:45 P.M. and 5:00 P.M. and ended between 6:40 P.M. and 7:10 P.M. Review of training records for [NAME] #145 (hired 12/11/24) and [NAME] #109 (hired 12/30/24) revealed no evidence they were trained on diet types, including puree, or the use of spread sheets/menus. Interview with Dietician #300 on 01/13/25 at 10:55 A.M. revealed she had visited the facility two days per week since April 2024. She stated that during her visits, she conducted test trays once a month to test the food for temperature and palatability. She confirmed that when she conducts the test trays, the hot foods are cold. She stated she does not observe meal tray preparation while visiting the facility. She stated the facility does not have enough staff to have both kitchens open. She stated ideally all trays should be served within one hour of the start of tray line (not two hours as currently). She confirmed dietary staff should be trained adequately to perform their job duties. Interview with Dietary Manager #221 on 01/16/24 at 1:50 P.M. revealed it was very overwhelming to be in the position of Dietary Manager and Activity Director for the whole facility. She stated she was not able to spend the time with staff in both departments to provide the support they need to do their jobs properly. This deficiency represents non-compliance investigated under Complaint Number OH00161227.

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	365344	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luxe Rehabilitation and Care Center	957 Becks Knob Road Lancaster, OH 43130

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on observations, review of menus/spread sheets, and staff interview, the facility failed to ensure menus were followed. This affected 11 of 137 residents (Residents #9, #25, #27, #30, #40, #49, #86, #92, #98, #129, and #136) residing in the facility and receive nutrition from the kitchen. The facility identified two residents (Resident #61 and #122) who received nothing by mouth. Findings include: 1. On 01/09/25 at 9:00 A.M. the surveyor requested to review menus with serving sizes for the week (spread sheets). The facility provided copies of recipes for the food items being prepared for the lunch meal. The recipes did not include the specific food items or serving sizes for the various diets provided by the facility including mechanical soft, pureed, and finger foods. The recipes stated to provide one, three ounce steak patty, four ounces of mashed potatoes, and four ounces of peas and carrots. Interview with [NAME] #145 on 01/09/25 at 11:31 A.M. revealed he had only worked at the facility for one month and had never seen any menus that included specific food items or serving sizes for the various diets (spread sheets). He stated he used the box the food items came in to determine the serving size to give each resident. As an example, he showed the surveyor the instant mashed potato box which stated a serving size was a quarter cup (two ounces) of potatoes. Observations of the lunch meal tray line on 01/09/25 at 11:40 A.M. revealed the meal to be served consisted of Salisbury steak, mashed potatoes, peas and carrots, a slice of bread, and pineapple tidbits. [NAME] #145 stated he was providing one meat patty (which he did not know how much it weighed), a gray scoop of mashed potatoes (four ounces), one slice of bread, and three ounces of peas and carrots. The pineapple was already portioned out in bowls. Observations between 11:40 A.M. and 12:05 P.M. revealed Residents #30, #40, #92, #98, and #129, who are all on regular diets, received three ounces of peas and carrots. Resident #136, who was on a mechanical soft diet, received three ounces of peas and carrots, and Residents #27, #9, and #49, who are on finger foods diets, received three ounces of peas and carrots. Review of the menu with serving sizes (once provided) revealed the regular, mechanical soft, and finger foods diets should have received four ounces of peas and carrots. Interview with Dietary Manager #221 on 01/09/25 at 12:09 P.M. confirmed the residents should have received four ounces of peas and carrots (per the recipe). In addition, observations of the lunch meal on 01/09/25 at 11:40 A.M. revealed Residents #27, #9, and #49, who are on finger foods diets, did not receive mashed potatoes. They did not receive a food item to substitute for the mashed potatoes. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 01/09/25 between 11:40 A.M. and 12:05 P.M. revealed [NAME] #145 to prepare a pureed meal tray for Resident #86. He did not have any set serving sizes available to know how much food to provide for the pureed food items. He was observed to use a small gravy ladle (no size listed on it) to dip the pureed meat. [NAME] #145 confirmed he did not know how much pureed meat he was providing. He did not provide any pureed peas and carrots but instead provided a bowl of tomato soup. Once provided on 01/13/25, review of the menus with serving sizes (spread sheets) revealed the lunch meal on 01/09/25 was to include four ounces of peas and carrots for regular, mechanical soft, and finger food diets. The finger food diets were to receive four ounces of potato wedges instead of the mashed potatoes. The pureed diets were to receive three ounces of pureed Salisbury steak and 4 ounces of pureed peas and carrots. Interview with Dietary Manager #221 on 01/09/25 at 10:15 A.M. revealed she was not aware of any menus with serving sizes. She stated the staff followed the recipes for serving sizes. Interview with Dietician #300 on 01/13/25 at 10:55 A.M. revealed there was a change to a new menu system on 12/01/24 and the menus with serving sizes (spread sheets) should have been printed for staff to use and were not. She confirmed that using the recipe would not tell staff what specific foods items or how much of each food item to provide for the various diets including mechanical soft, puree, and finger foods. She stated Dietary Manager #221 had just started in that role mid November 2024. She stated that she visits twice weekly but was not aware that staff did not have the menus/portion sizes available for use at all of the meals. She stated she did not watch meal tray preparation during her visits. She confirmed potato wedges were to be given in place of mashed potatoes for the residents on finger food diets and the cook should have provided three ounces of pureed meat and four ounces of pureed peas and carrots (not tomato soup). 43064 2. Review of Resident #86's medical record revealed an admitted [DATE] with diagnoses including hypertension, major depressive disorder, dementia, and chronic obstructive pulmonary disease. Review of Resident #86's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognition. Review of Resident #86's physician order dated 01/01/25 revealed she was on a regular diet with a puree texture due to pocketing food. Observation on 01/15/25 at 12:02 P.M. revealed the only vegetables Resident #86 received was tomato soup. There were no green beans Review of Resident #86's tray ticket revealed no dislikes were listed. Review of the lunch menu for 01/15/25 revealed residents, including those on a puree diet, were to receive chicken a la king with a biscuit, green beans, and a cookie bar. Interview on 01/15/25 at 12:02 P.M. with Certified Nursing Assistant (CNA) #227 verified Resident #86 had not received green beans. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the medical record for Resident #25 revealed an admitted [DATE] with diagnoses including dementia, mood disorder, anxiety disorder, Alzheimer ' s disease, and dysphagia. Review of Resident #25's quarterly MDS assessment dated [DATE] revealed she had severely impaired cognition Review of Resident #25 physician order dated 05/24/24 revealed an order for a puree diet with pudding thick liquids. Observation on 01/15/24 at 12:30 P.M. revealed Resident #25 did not receive pureed green beans for lunch and had not received a replacement Review of Resident #25's tray ticket revealed no dislikes were listed. Review of the lunch menu for 01/15/25 revealed residents, including those on a puree diet, were to receive chicken a la king with a biscuit, green beans, and a cookie bar. Interview on 01/15/25 at 12:30 P.M. with CNA #179 verified Resident #25 was not given green beans and had not been given a replacement. This deficiency represents noncompliance investigated under Master Complaint Number OH00161522 and Complaint Number OH00161227.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on observations, meal test tray, staff interview, policy review, and resident interview, the facility failed to ensure meals were palatable, appetizing and served at appropriate temperatures. This affected six of six residents interviewed regarding food temperatures/palatability (Residents #1, #8, #63, #67, #70, and #116). The facility census was 139. Findings include: Observations on 01/09/25 at 9:20 A.M. revealed the breakfast meal cart sitting in the hallway on 400 hall [NAME] Wing. Interview with Licensed Practical Nurse (LPN) #254 on 01/09/25 at 9:20 A.M. revealed they had received the meal cart to the hallway at 9:10 A.M. The meal cart was a closed, unheated cart. Observations revealed LPN #254 and one nursing assistant were delivering the meal trays to the 24 residents on the 400 hall on [NAME] Wing. Another nursing assistant was observed on the hallway during breakfast but she was assisting residents with getting weighed and she was not observed to deliver any meal trays. Further observation revealed at 9:50 A.M. (40 minutes after the breakfast trays were delivered to the unit) there were still four breakfast trays remaining to be served from the cart, including Resident #67 and #74's trays. Resident #67's tray was delivered to him in his room at 9:54 A.M. (44 minutes after the meal cart was delivered to the unit). A replacement tray was requested so that a test tray could be completed. Resident #74's breakfast tray was removed from the cart at 9:53 A.M. (43 minutes after the meal cart was delivered to the unit) and the food was tasted and the temperatures were taken. The slice of toast tasted cold and very chewy (difficult to swallow). The hash brown patty tasted cold and hard and measured 86 degrees Fahrenheit (F). The scrambled eggs tasted cold and measured 90 degrees F. The milk tasted warm and measured 54 degrees F. The last breakfast tray was delivered to a resident on 400 hall at 9:55 A.M. (45 minutes after the meal cart was delivered to the unit). Interview with Resident #67 on 01/09/25 at 10:00 A.M. revealed his breakfast meal was cold when he received it. He stated the food was always cold. Interview with LPN #254 on 01/09/25 at 10:03 A.M. revealed there is usually one nurse and one to two nursing assistants to pass the meal trays on the 400 hall [NAME] wing for breakfast and lunch. She stated there was her and one nursing assistant passing breakfast trays on 010/9/25 as the float nursing assistant was in the shower room. She stated she had not kept track of the time and did not know how long the trays had sat on the cart once they were delivered to the hallway. She stated she could ask for help from other staff to pass trays but did not. Interview with Residents #1, #8, #63, #70, and #116 on 01/09/25 between 2:45 P.M. and 3:30 P.M. revealed the food is cold most of the time. Interview with Dietician #300 on 01/13/25 at 10:55 A.M. revealed she visits the facility two days per week. She stated that during her visits, she conducted test trays to test the food for temperature and palatability. She confirmed that when she conducts the test trays, the hot foods are cold. (continued on next page)

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator on 01/13/25 at 1:50 P.M. revealed the facility had multiple complaints from residents regarding cold food and the trays coming out late on 12/29/24. Interview with LPN #108 on 01/16/25 at 10:53 A.M. revealed there had been frequent complaints from residents about the quality and temperature of the meals. Review of the facility policy titled food temperatures and dated 2021 revealed foods sent to the units for distribution (such as meals) will be transported and delivered to unit storage areas to maintain temperatures at or below 41 degrees F for cold foods and at or above 135 degrees F for hot foods. This deficiency represents noncompliance investigated under Master Complaint Number OH00161522 and Complaint Numbers OH00161464 and OH00161227.

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on observations, record review, and staff interview, the facility failed to ensure a resident received food prepared in a form to meet their individual needs. This affected one (Resident #86) of ten residents observed during the lunch meal service. The facility census was 139. Findings include: Review of the medical record for Resident #86 revealed an admitted [DATE] with diagnoses including hypertension, major depressive disorder, dementia, and chronic obstructive pulmonary disease. Review of a quarterly Minimum Data Set assessment dated [DATE] revealed the resident had severely impaired cognition. Review of physician's orders revealed on 01/01/05 the resident was changed to a pureed texture diet due to pocketing food. The plan of care dated 09/17/24 stated to serve diet as ordered. Observations on 01/09/25 between 11:40 A.M. and 12:05 P.M. revealed [NAME] #145 to prepare Resident #86's lunch tray. He placed pureed meat, mashed potatoes, and a bowl of tomato soup on the tray. A bowl of regular texture pineapple was also added to the tray before it was placed on the meal tray cart. At 12:05 P.M. the meal tray cart was delivered to the unit where Resident #86 resided (secured dementia unit). The meal tray was delivered to Resident #86, including the regular texture pineapple. The meal card on the tray stated the resident was on a pureed texture diet. The meal tray remained in front of the resident for five minutes. On 01/09/25 at 12:13 P.M. interview with Licensed Practical Nurse (LPN) #101 confirmed Resident #86 was on a pureed texture diet. She further confirmed the resident received regular texture pineapple and should not have. She removed the pineapple from Resident #86's meal tray. Observations on 01/09/25 at 12:26 P.M. revealed Resident #86 remained with her meal tray in front of her and had another bowl of regular texture pineapple on her meal tray. LPN #101 confirmed, at that time, that Resident #86 had regular texture pineapple again and should not have. She stated another resident must have given it to her. Resident #86 did not eat any of her food during the time observed from 12:05 P.M. to 12:26 P.M. This deficiency represents noncompliance investigated under Complaint Numbers OH00161321 and OH00161227.

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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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on observations, resident interview, staff interview, and review of meal monitoring records, the facility failed to ensure meals were served at regular times and in accordance with resident needs and preferences. This could affect 137 of 139 residents in the facility (Residents #61 and #122 do not receive nutrition by mouth). Findings include: The facility consisted of two buildings ([NAME] and [NAME]) connected by a therapy wing in the center. [NAME] had 92 beds on four hallways and [NAME] had 83 beds on four hallways. Observations on 01/09/25 at 9:20 A.M. revealed the breakfast meal cart sitting in the hallway on 400 hall [NAME] Wing. Interview with Licensed Practical Nurse (LPN) #254 on 01/09/25 at 9:20 A.M. revealed they had received the meal cart to the hallway at 9:10 A.M. The last tray was served at 9:55 A.M. LPN #254 stated there was not a real set schedule for meal delivery and it could be anywhere from 8:15 A.M. to 8:45 A. M. Interview with Dietary Manager #221 on 01/09/25 at 10:15 A.M. revealed she had been assigned as dietary manager at the end of September 2024. She also currently served as the Activity Director for the 172 bed facility. She stated the facility had two kitchens but they were currently only using one of the kitchens (in [NAME] building) to serve all of the residents from. The trays had to be transported to the [NAME] building for all meals. She stated there were no specific meals times assigned for each hallway. She stated breakfast was to be served between 7:00 A.M. to 9:00 A.M. (15 minutes per cart for 8 carts), lunch between 11:00 A.M. to 1:00 P.M. and supper between 4:30 P.M. to 6:30 P. M, then she said or 5:00 P.M. to 7:00 P.M. She stated breakfast service in the kitchen had started at 7:05 A.M. and ended at 9:05 A.M. (trays delivered at 9:10 A.M. to 400 [NAME] per LPN #254). She confirmed there was one evening recently (3 weeks ago) where supper was served to the last hall at 8:00 P.M. Observations in the kitchen on 01/09/25 at 11:30 A.M. revealed the lunch tray line had not yet started (to start at 11:00 A.M. per Dietary Manager). Interview with [NAME] #145 revealed he had just started about one month prior and had not cooked in a nursing home before. There were two other staff in the kitchen. Interview with [NAME] #109 revealed this was her fifth day working at the facility. She stated there were usually four staff to help with meal service plus one for doing dishes. She stated there was a call off so there were only three staff to prepare and serve lunch to all the residents. This included her, [NAME] #145, and one other staff. She stated they were late starting tray line due to being short staffed due to the call off. She stated she was having to do jobs she was not familiar with. Staff were not observed to puree food for eight residents receiving pureed diets until after the tray line had started. The staff stopped the tray line and pureed food to add to the trays. The staff also did not have copies of the menu/spread sheets to know how much of each food item to put on the different diet meal trays. The first meal cart left the kitchen at 12:05 P. M. (approximately 50 minutes after scheduled to leave). The Dietary Manager nor Dietician were observed in the kitchen during the preparation of the first meal cart. (continued on next page)

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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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with Resident #63 on 01/09/25 at 3:15 P.M. revealed sometimes supper is not served until 8:00-8:30 P.M. She stated the food is cold and she would rather eat earlier. Interview with Resident #8 on 01/09/25 at 3:30 P.M. revealed the meals are late and supper was served one night at 7:30 P.M. Interview with the Administrator on 01/09/25 at 10:45 A.M. and 1:50 P.M. revealed the facility had multiple resident concerns regarding the meals being late on 12/29/24 (that weekend). She stated the doors to the kitchen were locked and no staff could get in until a cook went home and got a spare key, causing the meal to be late. She stated there was also a leak in the kitchen ceiling that delayed meals. She stated also the dishwasher stopped working. She stated the dishwasher was still not working in the kitchen being used ([NAME]), so the staff have to take all the dirty dishes to the [NAME] kitchen to be washed and bring them back to the [NAME] kitchen. She stated the goal was to have both kitchens open to cut down on meal service time but the facility did not have enough dietary staff to do this. She stated because of transporting dishes and the lack of sufficient dietary staff, meals can not be started sooner and can not be completed sooner than a two hour time frame. She stated resident preferences on meal times had not been determined by the facility. She stated the facility had been monitoring meal service times beginning 01/01/25. Review of the meal service monitoring times from 01/01/25 to 01/09/25 revealed breakfast started between 6:50 A.M.-7:10 A.M. and ended between 8:50 A.M. and 9:10 A.M. Lunch started between 10:45 A.M. and 11:00 A.M. and ended between 1:00 P.M. and 1:10 P.M. Supper started between 4:45 P.M. and 5:00 P.M. and ended between 6:40 P.M. and 7:10 P.M. Interview with Dietician #300 on 01/13/25 at 10:55 A.M. revealed she had visited the facility two days per week since April 2024. She stated that during her visits, she conducted test trays once a month to test the food for temperature and palatability. She confirmed that when she conducts the test trays, the hot foods are cold. She stated she does not observe meal tray preparation while visiting the facility. She stated the facility does not have enough staff to have both kitchens open. She stated ideally all trays should be served within one hour of the start of tray line (not two hours as currently). Interview with LPN #108 on 01/16/25 at 10:53 A.M. revealed she was aware of frequent complaints from residents that meals did not consistently arrive on time. This deficiency represents noncompliance investigated under Complaint Numbers OH00161464 and OH00161227.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Hire a qualified full-time social worker in a facility with more than 120 beds. 43064 Based on interview and personnel file review the facility failed to ensure employment of a full-time, qualified social worker. This had the potential to affect all 139 residents residing in the facility. Findings include: Review of Social Service Director #146's personnel file revealed she was hired on 07/22/22 as the social service director. She had a bachelor's degree in business administration dated 07/01/22. There was no evidence of a required bachelor's degree in social work or a human services field. Review of the termination form undated, revealed the last licensed social worker had been employed from 09/23/24 to 12/06/24. Interview on 01/16/25 at 1:17 P.M. with Social Service Director #146 verified she did not have a required degree. She reported the facility had previously employed a licensed social worker but she was no longer employed at the facility. Interview on 01/16/25 at 1:30 P.M. with the Administrator verified the facility did not currently have a licensed social worker employed. This deficiency is an incidental finding discovered during the complaint investigation.