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	08/29/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review, interview, and facility policy review, the facility failed to ensure one resident (#126) was dressed in personal clothing daily to maintain the resident's dignity. This affected one (Resident #126) of three residents reviewed for dignity. The facility census was 140. Findings Include: Review of the medical record for Resident #126 revealed an initial admitted [DATE] with the diagnoses including but not limited to cerebrovascular accident with left sided hemiplegia, dysphagia, dysarthria and anarthria, generalized muscle weakness, hyperlipidemia, gastro-esophageal reflux disease, anemia, Rhabdomyolysis, and duodenal ulcer. Review of the plan of care dated 07/02/24 revealed the resident had a self-care deficit related to cognitive impairment, generalized weakness and pain. Interventions included allow time for resident to express feelings of frustration regarding the need for assistance in activities of daily living (ADL) tasks, assist with ADL as needed, encourage resident to use call light when assistance is needed and monitor for pain during ADL tasks and provide medication per physician orders. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. Review of the resident's monthly physician orders for August 2024 identified no orders indicating the resident was unable to be dressed in her personal clothing. On 08/21/24 at 9:43 A.M., observation of Resident #126 revealed she was quiet at bedrest and remained dressed in a hospital gown. On 08/21/24 at 9:52 A.M., interview with Licensed Practical Nurse (LPN) #239 verified the facility staff did not dress the resident in personal clothing. LPN #239 revealed due to the resident's incontinence it was easier to keep her in a hospital gown. On 08/21/24 at 10:08 A.M. observation of Resident #126 revealed the resident remained dressed in a hospital gown. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/21/24 at 3:38 P.M., observation of Resident #126 revealed the resident continues to remain dressed in a hospital gown. On 08/22/24 at 11:04 A.M., observation of Resident #126 revealed the resident remained dressed in a hospital gown. Review of the facility policy titled, Dignity, dated 02/11 revealed each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life and feelings of self-worth or self-esteem. Residents are treated with respect and dignity at all times. When assisting with care, residents are supported in exercising their rights. For example encourage to dress in clothing they prefer. This deficiency represents noncompliance investigated under Complaint Number OH00157155.

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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** 47985 Based on observations and interviews, the facility failed to ensure resident rooms had sufficient space. This affected one (Resident #66) of one resident reviewed for accommodations of physical needs. The facility census was 140. Findings included: Record review revealed Resident #66 admitted to the facility on [DATE] with diagnoses including type II diabetes, heart failure, dementia, and muscle weakness. Review of a care plan dated 06/27/24 revealed Resident #66 required assistance for activities of daily living (ADLs) due to cognitive impairment and immobility with interventions including but not limited to providing assistive devices to increase ADL self-care as needed. Observation and interview on 08/20/24 at 10:18 A.M. revealed Resident #66's bed and dresser near the foot of the bed were approximately two feet between them, not leaving enough space for Resident #66 to use her rollator to move through her room easily. Interview on 08/26/24 at 12:51 P.M. with Licensed Practical Nurse (LPN) #320 confirmed Resident #66 did not have sufficient space between the foot of her bed and dressed to move with her rollator. A policy regarding accommodation of physical needs was requested on 08/26/24 at 2:02 P.M. but was not received.

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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** 47985 Based on record review and interviews, the facility failed to assist residents in locating missing items. This affected one (#4) of one resident reviewed for missing items. The facility census was 140. Findings include: 1. Record review revealed Resident #4 admitted to the facility on [DATE] with diagnoses including moderate intellectual disabilities, major depression, and hypertension. Review of a quarterly minimum data set completed on 07/24/24 revealed Resident #4's cognition remained intact. Interview on 08/20/24 at 9:44 A.M. with Resident #4 revealed she was missing three stuffed animals including a new teddy bear she had received recently. Interview on 08/22/24 at 9:01 A.M. with State tested Nursing Assistants (STNAs) #182 and #257 revealed Resident #4 had a certain teddy bear with her at all times but it went missing about three weeks ago. STNA #182 stated Resident #4 had reported the missing teddy bear to a nurse on a different shift so she did not look for it or report it missing again. STNA #182 stated the process for missing items is to let the nurse know an item is missing who relays the information to the unit manager, then look for the item, tell the social worker, look through the lost and found, write a concern, and check the inventory sheet. Review of the missing items logs for July and August 2024 revealed no record of Resident #4 having a missing teddy bear. Review of a statement from STNA #257 dated a month ago provided on 08/26/24 revealed Resident #4 threw her brown teddy bear up in the air while having an apparent anxiety attack which was passed on in report from the previous shift. Review of a statement provided by the Administrator dated 08/26/24 revealed just because one individual reported the last time he saw the bear was a few weeks ago doesn't mean it has been missing that long. Resident has a history of throwing all her belongings in the room, in the hallway, and anywhere in throwing distance. A policy for missing items was requested on 08/26/24 at 2:02 P.M. but a policy was not provided.

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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** 47985 Based on interview ,record review, and facility policy review, the facility failed to investigate an allegation of abuse. This affected one (Resident #4) of one resident reviewed for abuse. The facility census was 140. Findings included: Record review revealed Resident #4 admitted to the facility on [DATE] with diagnoses including moderate intellectual disabilities, major depression, and hypertension. Review of a quarterly minimum data set completed on 07/24/24 revealed Resident #4's cognition remained intact. Interview on 08/20/24 at 9:38 A.M. with Resident #4 revealed an aide hit her on her left arm on night shift. Resident #4 stated it was a hard, open-handed hit. Interview on 08/21/24 at 9:35 A.M. with Licensed Practical Nurse (LPN) #239 revealed an aide had been removed from Resident #4's hallway after resident had reported the aide had tapping her arm and would not stop until Resident #4 yelled at her. LPN #239 stated Resident #4 complained her arm was hurting the following day and had been on the phone with her family having a meltdown regarding the incident. LPN #239 stated the aide instigated the situation by saying you don't like me so I'm just working with roommate. LPN #239 stated she reported the incident and allegations to the nurse unit manager (UM) as well as human resources (HR). Interview on 08/22/24 at 8:31 A.M. with Nurse UM #110 revealed she had no concerns of abuse reported to her. Nurse UM #110 stated she did have to provide education to an aide because she and Resident #4 were playing back and forth and the aide patted her arm which could be misinterpreted as abuse. Interview on 08/22/24 at 8:56 A.M. with HR revealed she had been told she would be sitting in on education with a nurse because concerns were brought forward about an interaction between them and Resident #4. HR stated she believed the situation was more of a joking relationship and Resident #4 was just not in the mood to play, got upset with the aide, and felt like the aide was instigating the situation by continuously asking Resident #4 what was wrong. HR stated there was a language barrier between Resident #4 and the aide in question. HR stated she forwarded the information on to the Director of Nursing (DON) and Nurse UM #110. HR revealed she did not directly speak with the aide. Interview on 08/22/24 at 9:36 A.M. with Administrator revealed she had heard no allegations of abuse against Resident #4. Review of a statement provided by LPN #239 to DON revealed when she went to administer Resident #4's medications, Resident #4 stated the aide who was French-speaking was tapping her arm and continued to do so despite being asked to stop. The aide continued to tap Resident #4's arm until resident yelled at her to stop, told her not to touch her again. Resident #4 then reported the next day the same aide came to her room to care for her roommate and instigated the situation by continuously saying you don't like me. Resident #4 stated she was upset and did not want the aide to care for her. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a statement by DON dated 08/13/24 revealed an unnamed nurse had interviewed Resident #4 and did not feel abuse occurred because resident did not feel the aide was trying to hurt her just annoying her. The nurse felt Resident #4 was more upset her roommate was getting attention from the aide and she was not. The statement continued by stating Resident #4 began complaining a few days later but was interviewed with no concerns. DON stated the STNA and other residents were interviewed. Interview on 08/26/24 at 3:29 P.M. with Administrator revealed Resident #4 has behaviors when her roommate gets more attention than her. Administrator did confirm just because Resident #4 was having behaviors did not mean abuse did not occur. Administrator stated an investigation was not completed because no one felt abuse had occurred. Administrator stated LPN #239 was not a witness to the alleged incident so how would she know if abuse occurred? Administrator did confirm all allegations of abuse should be investigated and should have a self-reported incident completed. Review of a policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property dated 03/2024 revealed facility staff should immediately report all allegations of abuse to the administrator and to the Ohio Department of Health in accordance with the procedures in this policy.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on record review and interview, the facility failed to accurately complete a level one Pre-Admission Screening/Resident Review (PASARR) and did not list psychosis disorder on the serious mental illness section to be reviewed for a level two. This affected one resident (#86) of two reviewed for PASARR. The facility census was 140. Findings include: Review of the medical record for Resident #86, revealed an admitted [DATE]. Diagnoses included but were not cerebral infarction, major depressive disorder, anxiety disorder and as of 03/12/24 psychotic disorder. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 09 out of 15 suggesting severe cognitive impairment. The resident was assessed to have a psychotic disorder. Review of a PASARR completed on 03/05/24 by the Business Office Manager (BOM) #249 revealed psychosis disorder was not indicated under the level one review for serious mental illness. Interview on 08/21/24 at 3:02 P.M. with the BOM #249 confirmed psychosis disorder was not included on the level one screen for the PASARR.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review and interview, the facility failed to screen a resident for serious mental illness and intellectual disabilities on a resident review (PASRR). This affected one (Resident #66) of two residents reviewed for PASRRs. The facility census was 140. Findings included: Record review revealed Resident #66 admitted to the facility on [DATE] with diagnoses including dementia, bipolar disorder, major depression, mood disorder, and epilepsy. Review of a PASRR completed on 06/10/24 revealed the section of serious mental illness was not completed accurately and did not include the diagnoses of bipolar disorder, major depression, and mood disorder. In the section of intellectual disabilities, epilepsy was not listed. Interview on 08/21/24 at 2:31 P.M. with Business Office Manager (BOM) #249 revealed PASRRs are completed upon admission, medication changes, a new diagnosis, and admission to hospice. BOM #249 stated she completed the PASRR by using the information on the Hospital Exemption completed by the hospital so she likely missed the diagnoses due to that. Review of a policy titled PASARR dated 04/2023 revealed all new admissions should be screened for mental disorders and intellectual disabilities through the PASRR process. A level I should be completed to determine if there are mental disorder or intellectual disabilities that would qualify for a level II. Any changes in psychiatric diagnoses require a new PASRR.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, observation, and staff interview, the facility failed to ensure care plans were complete and comprehensive for residents with existing pressure ulcers to include appropriate interventions for offloading pressure and turning/ repositioning to promote healing of the pressure ulcers. This affected two (Resident #49 and #107) of five residents reviewed for pressure ulcers. The facility census was 140. Findings include: 1. Review of Resident #49's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included paraplegia, reduced mobility, muscle weakness, need for assistance with personal care, adult onset diabetes mellitus, anemia, chronic pain, paranoid schizophrenia, severe intellectual disabilities, protein calorie malnutrition, and major depressive disorder. Review of Resident #49's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognition was moderately impaired. He was not known to have displayed any behaviors, nor was he known to reject care during the seven days of the assessment period. He was indicated to have had a functional limitation in range of motion in his bilateral lower extremities. He was identified as being at risk for pressure ulcers and had unhealed pressure ulcers that was a stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle) and an unstageable pressure ulcer (full thickness pressure injuries in which the base was obscured by slough and/ or eschar) that was not present upon admission. Review of Resident #49's care plans revealed he had a care plan in place for the potential for and the presence of an actual pressure ulcer related to reduced mobility. The care plan reflected the resident was known to have pressure ulcers to his left upper hip and his right heel. The goal was for the pressure ulcers to decrease in size or heal. The interventions indicated the resident required assistance with activities of daily living and mobility needs. The care plan did not include the need to turn and reposition the resident or the need to offload his heels as skin prevention interventions. Review of Resident #49's physician's orders revealed treatment orders were in place for the treatment of pressure ulcers to his left hip and right heel. The physician's orders did not include the need to turn and reposition the resident or the need to offload pressure for his heels as part of his plan of care. Review of Resident #49's wound assessments on a skin grid pressure form revealed he was known to have a stage III pressure ulcer (full thickness tissue loss where subcutaneous fat may be visible, but bone, tendon, or muscle was not exposed) to his left hip. He was also known to have an unstageable pressure ulcer to the right heel. Review of Resident #49's treatment administration record for August 2024 revealed there was no documented evidence of the resident being turned/ repositioned. There was also no evidence of his heels being elevated on a pillow or other devices used to offload the pressure off his heels. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations of Resident #49 on 08/20/24 at 3:30 P.M. and on 08/21/24 at 8:45 A.M. noted the resident to be lying in bed on his left side. He was not noted to have his right heel offloaded to alleviate any pressure from his heel to promote wound healing. His right heel was noted to be in direct contact with the mattress. There were no pillows under his heels, nor did he have any heel protectors or other boots on to alleviate pressure to his right heel. He was noted to have two pillows under his head and a third pillow was noted sitting on top of his nightstand at the time the observation was made. Findings were verified by Licensed Practical Nurse (LPN) #231. On 08/21/24 at 10:06 A.M., an interview with State tested Nursing Assistant (STNA) #168 revealed she had only worked at the facility for about five days now. She was aware of the resident having a dressing on his left hip, but was not aware he had anything on his right heel. She stated they tried to keep him turned side to side, used pillows, and changed him every couple of hours. They also placed a pillow between his knees and under his arm. She was asked what they were doing to offload his heels. She denied the resident had anything on his right heel that she was aware of. She further denied they used any pillows or other devices to offload his heels. On 08/21/24 at 10:12 A.M., an interview with LPN #231 confirmed Resident #49 did not have his heels offloaded, while in bed, when she went in to do his dressing changes that morning. She further confirmed the resident's care plans did not include the need to turn and reposition him or the need to offload his heels as part of his skin prevention interventions. She stated resident care plans were the responsibility of all nursing management team members and was not the sole responsibility of the MDS nurse. 47987 2. Review of the medical record for Resident #107, revealed an admitted [DATE]. Diagnoses included but not limited to muscle weakness, reduced mobility, weakness, need for assistance with personal care, repeated falls, unsteady on feet, unspecified dementia, and anxiety disorder. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 03 out of 15 suggested severe cognitive impairment. The resident was assessed to require substantial/maximal assistance with toilet hygiene and shower/bathe self, bed mobility, and all transfers. The resident was also assessed to have no pressure ulcers and was at risk. Review of the active care plan for Resident #107 revealed the resident had the potential impairment to skin integrity and risk for pressure ulcer related to dementia, weakness, self-care deficit, activity intolerance, decreased mobility and Resident #107 has a pressure wound to right buttock with no interventions including turning and repositioning to off load the pressure to the right buttock wound. Review of Resident #107's skin grid assessment dated [DATE] revealed a stage three right buttock 5 centimeters (cm) X 1 cm X.1cm. Review of Resident #107's record dated 07/25/24 to 08/23/24 revealed the assistance of at least one to two people to turn as well as no documentation of the resident being turned and repositioned. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes for Resident #107 dated 07/25/24 to 08/23/24 revealed the notes did not include any documented of refusals of turning and repositioning per the resident. Observations on 08/21/24 at 8:14 A.M., 10:13 A.M., 11:58 A.M., and 2:12 P.M. of Resident #107 revealed the resident to be on his back in bed. Interview on 08/21/24 at 2:14 P.M. with State tested Nursing Assistant #162 verified he was unsure if Resident #162 needed turned every two hours or not as the intervention is not on his Kardex. Review of facility policy titled Prevention of Pressure Ulcers/Injuries revised October 2018 revealed to reposition residents as indicated on the care plan and reposition residents who are dependent on staff for repositioning. This deficiency represents non compliance investigated under Complaint Number OH00157155.

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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** 31404 Based on staff and resident interview, record review, and facility policy review, the facility failed to develop comprehensive care plans with the resident in attendance with an interdisciplinary team for Resident #105, and revise a nutritional care plan to include gastrostomy tube placement for Resident #115. This affected one (Resident #105) of four residents reviewed for care planning and one (Resident #115) of three residents reviewed for tube feeding. The facility census was 140. Findings include: 1. Record review of Resident #105 revealed an admitted [DATE] with pertinent diagnoses of: unspecified severe protein calorie malnutrition, type two diabetes mellitus with diabetic nephropathy, osteomyelitis, diarrhea, malignant neoplasm of prostate, peripheral vascular disease, pressure ulcer of right heel, muscle weakness, hyperlipidemia, pain, chronic embolism and thrombosis of deep veins of upper extremity, allergic rhinitis, obstructive and reflux uropathy, hypertension, acute kidney failure, neuromuscular dysfunction of the bladder, long term use of anticoagulants, and cellulitis of limb. Review of the 08/07/24 quarterly Minimum Data Set (MDS) revealed the resident was cognitively intact and used a wheelchair to aid in mobility. The resident was dependent for toileting, shower/bathing , lower body dressing, and putting on taking off footwear. The resident is always incontinent of bowel and bladder. Interview with Resident #105 on 08/20/24 at 1:07 P.M. revealed he does not get invited to care planning conferences. Review of Resident #105 medical record on 08/21/24 revealed no evidence of interdisciplinary care conference in the last year. Interview with Social Services Worker #187 on 08/21/24 2:38 P. M. verified Resident #105 did not have any care conferences in the last year. Review of 09/01/13 facility Care Planning Interdisciplinary Team policy revealed a comprehensive care plan for each Resident is developed within seven days of completion of the Resident assessment (MDS). The Resident, the Resident family, and/or legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the Residents care plan. 28923 2. Review of Resident #115's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included severe protein calorie malnutrition, Parkinson's disease, Barrett's esophagus without dysplasia, and gastrostomy status (surgical procedure that creates an opening through the abdomen into the stomach for the placement of a feeding tube for nutritional purposes). (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 Resident #115's progress notes revealed he was transferred to the hospital on that date for a planned procedure in which a Percutaneous Endoscopic Gastrostomy (PEG) tube was placed. A new order had been put in place on 07/17/24, upon his return, for enteral nutrition feedings to begin at 6:00 P.M. Review of Resident #115's physician's orders revealed the resident had an order for Osmolite 1.5 cal at 60 milliliters (ml) per hour x 12 hours from 6:00 P.M. to 6:00 A.M. for total of 720 ml/ hour. That current order had been active since 07/30/24. He had other enteral feeding orders that had been in place beginning on 07/17/24, after the PEG tube had been placed. He was also receiving a consistent carbohydrate diet with pureed texture and nectar thick liquids. Review of Resident #115's care plans revealed he had a care plan in place for being at risk for nutrition related to Parkinson's disease, Barrett's esophagus, other chronic health problems, being underweight, and use of a diuretic. The care plan identified his diet as a consistent carbohydrate diet with a pureed texture and nectar thick liquids. The nutrition at risk care plan was not revised to reflect the resident had a PEG tube placed on 07/17/24 or that he was receiving enteral nutrition via his PEG tube. On 08/20/24 at 3:25 P.M., an observation of Resident #115 noted him to be lying in bed. He was noted to have an enteral feeding pole next to his bed with a pump. His enteral feeding bottle of Osmolite 1.5 cal was still hanging on the pole, but was not running at that time, as the physician's orders was for it to be infused x 12 hours between 6:00 P.M. and 6:00 A.M. daily. On 08/22/24 at 1:12 P.M., an interview with Registered Nurse (RN) #140 revealed Resident #115's nutrition care plan was not revised to reflect the placement of a PEG tube on 07/17/24 to be used for enteral nutrition. She reported it was all of the management's team's responsibility to ensure care plans were revised and updated as needed.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on interviews, observations, record reviews, and facility policy review, the facility failed to complete vital signs and a transfer form when change of condition was required for Resident #115. This affected one resident (#115) for change of condition and the facility also failed to order daily weights for Resident #442 after surgery upon readmission affecting one resident (#443) reviewed. The facility census was 140. Findings include: 1. Review of Resident #115's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included a chronic or unspecified gastric ulcer with hemorrhage, long term (current) use of aspirin, acute post hemorrhagic anemia, Barrett's Esophagus without dysplasia, gastrostomy status, hematemesis, and unspecified dementia. Review of Resident #115's progress notes revealed a nurses note dated 07/23/24 at 6:08 A.M. that indicated the resident was throwing up black stuffs and was given Zofran (anti-emetic). The resident continued throwing up and the nurse notified an on call nurse practitioner. Directive was given to send the resident to the emergency department (ED). There was no documented evidence of the nurse obtaining vital signs on the resident upon his change in condition. Further review of Resident #115's progress note revealed a nurse's note dated 07/23/24 at 1:47 P.M. that indicated an update was received from the hospital and the facility was informed the resident had been admitted to the hospital for a gastrointestinal (GI) bleed and blockage. Review of Resident #115's transfer records from the facility that was provided to the receiving hospital revealed the only forms sent with the resident to the hospital was a copy of his admission record (face sheet) that included the resident's personal information, contacts, code status, and diagnoses and a copy of the resident's active physician's orders. There was no evidence of a transfer form being sent with the resident that included vital signs or other relevant information needed for purposes of continuity of care. Review of Resident #115's vital signs recorded under the vital sign tab of the electronic medical record (EMR) revealed there was no evidence of the resident's vital signs being obtained at the time of his change in condition on 07/23/24 around 6:00 A.M. The last vital signs that had been recorded (prior to the resident's hospital transfer) was on 07/22/24 at 11:23 P.M. as recorded by the night shift nurse that sent the resident out the morning of 07/23/24. Review of Resident #115's hospital records for his transfer to the ED on 07/23/24 revealed the resident was found to have a low blood pressure when he arrived at the ED on 07/23/24 at 7:05 A.M. His blood pressure was recorded as being 90/57 mm/hg and he had been given a liter of intravenous fluid in the ER raising his blood pressure to 120 systolic (top number of a blood pressure reading). He was admitted to the hospital with a GI bleed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 08/22/24 at 11:05 A.M., an interview with Registered Nurse (RN) #140 revealed she could not find any evidence of a transfer form (eINTERACT Transfer Form) being completed for Resident #115's transfer to the hospital on 07/23/24. She stated their transfer paperwork should have included the eINTERACT Transfer Form, in addition to the face sheet and active physician's orders, for continuity of care purposes. She was asked what should be included as part of an assessment when a resident had a change in condition. She confirmed the assessment should have included obtaining the resident's vital signs. She verified there was no evidence the nurse, that assessed the resident and transferred him to the hospital, obtained vital signs as part of the assessment. She acknowledged the hospital records indicated the resident was found to be hypotensive, while at the hospital, and was given intravenous fluids. She initially indicated the nurse may not have obtained vital signs due to the resident having hematemesis and the nurse already knew he needed to be transferred to the hospital. She then acknowledged that vital signs should have been part of an assessment with a change in condition and the nurse would have had time to obtain them prior to EMS services arriving for transport. Review of the facility's policy on Change in a Resident's Condition or Status revised May 2017 revealed the nurse would record in the resident's medical record information relative to the changes in the resident's medical condition or status. The facility denied having a policy specific to hospital transfers and provided an Acute Care Transfer Document Checklist in it's place. Documents recommended to accompany the resident to the receiving acute care facility included a resident transfer form. 2. Review of Resident #443's medical record revealed the resident was admitted to the facility on [DATE]. His diagnosis included surgical aftercare following surgery on the circulatory system (Coronary Artery Bypass Graft x 5). Review of Resident #443's Patient Discharge Instructions dated 07/26/24 from the transferring acute care facility revealed the resident was to have a daily weight obtained. The cardio-thoracic surgery discharge instructions provided in addition to the patient discharge instructions indicated the resident was to be weighed daily. It further indicated they were to call the cardio-thoracic surgeon's office to report any sudden weight gains of three or more pounds in one day or five pounds over one week. Review of Resident #443's physician's orders from his date of admission on 07/26/24 until his discharge on 08/20/24 revealed the resident did not have an order for obtaining a daily weight until 08/01/24. The order added on 08/01/24 included the need to notify the provider if there was a two pound weight gain over night or a five pound weight gain in one week. Review of Resident #443's weights recorded under the vital sign tab of the electronic medical record (EMR) revealed the resident was not being weighed daily as per the patient discharge instructions provided to the facility on [DATE], at the time of his admission. He had a weight of 269.8 pounds on 07/26/24 and a weight of 267.8 pounds on 07/27/24. He was then not weighed again until 07/30/24, when he weighed 269.4 pounds. Weights recorded after that were sporadic and were not obtained daily as ordered, even after the daily weight was ordered on 08/01/24. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #443's medication administration record (MAR) revealed there was no daily weights recorded between 07/26/24 and 07/31/24. The August 2024 MAR did add the order to obtain daily weights beginning on 08/01/24, after another order was given to obtain daily weights. There was no weights recorded for 08/05/24 or 08/11/24, even after another order for daily weights was obtained on 08/01/24. Review of Resident #443's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. He was not known to display any behaviors nor was he indicated to reject care. On 08/19/24 at 2:28 P.M., an interview with Resident #443 revealed he was told by his heart doctor that his weight should be monitored daily. He denied the facility staff were checking his weights daily and indicated he had to do it on his own. On 08/22/24 at 4:25 P.M., an interview with RN #140 confirmed Resident #443's order for him to be weighed daily that was included on his patient discharge instructions from the hospital was not carried over when the resident was admitted to the facility on [DATE]. She stated it was not until 08/01/24 that they noted the order for the daily weight was missed. They obtained an order for the daily weight on 08/02/24 and the order also included parameters on when to notify the physician if a weight gain of 2 or more pounds were noted in a day or five pounds were noted in a week. She further confirmed, even after the daily weight was ordered, there were two days in which a daily weight had still not been obtained and recorded. She acknowledged the importance of monitoring a resident's daily weight following cardio-thoracic surgery in which a quintuple bypass procedure was done.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review, staff interviews, review of wound notes, and facility policy review, the facility failed to accurately assess an identified pressure area and implement interventions to prevent a stage III (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling pressure ulcer to the interdigit of the left fourth and fifth toe and the left fifth toe) for Resident #38. In addition, the facility failed to accurately assess an identified pressure area and implement interventions to prevent worsening of a right heel pressure ulcer for Resident #49. Actual harm occurred on 06/06/24 when Resident #38 who required extensive assistance from two staff and was incontinent, had a Stage III pressure ulcer interdigit of the left fourth and fifth toe and the outer fifth toe was not comprehensively assessed, not providing implementation of appropriate prevention interventions, and treatment or adequate assessments of the wound area. Actual harm occurred on 08/19/24 when Resident #49 who required assistance with mobility, had a suspected deep tissue injury (SDTI), (purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/ or shear) to his right heel that deteriorate to an unstageable (full thickness tissue loss in which the base of the ulcer was covered by slough and/ or eschar in the wound bed) pressure ulcer and was not being accurately assessed, not providing implementation of appropriate prevention interventions, and treatment or adequate assessments of the wound area. This affected two (Resident #38 and Resident #49) of five reviewed for pressure ulcers. The facility census was 140. Findings Included: 1. Review of the medical record for Resident #38 revealed an initial admitted [DATE] with the latest readmission of 04/08/24 with diagnoses including but not limited to retention of urine, acute kidney failure, severe sepsis, speech disturbances, dysphagia, urinary tract infection, cerebral infarction, psychotic disorder with hallucinations, chronic coronary microvascular dysfunction, Parkinson's disease, anxiety disorder, hypothyroidism, diabetes mellitus, major depressive disorder, severe morbid obesity, Rheumatoid arthritis, congestive heart failure, lymphedema, metabolic encephalopathy, hypertension, osteoarthritis, chronic kidney disease, obstructive sleep apnea, hyperlipidemia, peripheral vascular disease, right above the knee amputation, chronic obstructive pulmonary disease, dementia, anemia, gastro-esophageal reflux disease, chronic pain, obstructive and reflux neuropathy, neuromuscular dysfunction of bladder and benign prostatic hyperplasia. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the plan of care dated 07/28/23 revealed the resident had a potential for pressure ulcer development related to reduced mobility and activity intolerance. Interventions included administer medications as ordered, dietary supplements as ordered, labs as ordered, observe for changes in skin status, observe nutritional status for adequate intake, skin assessment as indicated, the resident required assistance with activities of daily living (ADL) and mobility needs, the resident requires pressure relieving/reducing device on bed and/or chair and treatments as ordered and observe for effectiveness. Review of the resident's readmission assessment with baseline care plan dated 04/09/24 revealed the resident was not admitted to the facility with any pressure ulcers to his left foot. Review of the resident's Braden scale dated 04/09/24 revealed a score of 12 indicating the resident was at high risk for skin breakdown. Review of the plan of care dated 04/09/24 and last revised on 07/30/24 revealed the resident had an actual area of skin impairment, skin tear to left buttocks and deep tissue pressure injury (DTPI) to left fifth toe. Interventions included evaluate for pain and provide pain relieving interventions as ordered, initiate wound treatment, continue treatment as ordered by the physician, nursing to observe the wound dressing daily to ensure the dressing remains intact and there are no signs/symptoms of infection or increased drainage, observe for clinical changes such as infection and/or worsening of wound, refer to dietician to determine need/no need for dietary intervention and skin observation and document on bath/shower days, charge nurse to notify the wound nurse, physician and family of any new areas. Review of the weekly non-pressure skin grid dated 06/06/24 revealed the facility identified the resident had a wound to the left third toe measuring 1.5 centimeters (cm) by 0.8 cm with 70% granulation and 30% eschar. The facility also identified a wound to the left great toe measuring 1.8 cm by 1.0 cm with 100% eschar. The wounds had no staging or presence of exudate. Review of the weekly non-pressure skin grid dated 06/13/24 revealed the facility corrected the locations of the left interdigit between toes fourth and fifth and the left fifth toe. The left interdigit between the fourth and fifth toes measured 1 cm by 0.5 cm and was 100% granulation tissue. The left fifth toe measured 1.5 cm by 1. 0 cm and was 100% eschar. The assessment contained no staging, presence of exudate or determination if the wound had improved, deteriorated or remained unchanged. Review of the weekly non-pressure skin grid dated 06/20/24 revealed the left interdigit between the fourth and fifth toes measured 0.3 cm by 0.5 cm by less than 0.1 cm with 100% granulation. The left fifth toe measured 1.5 cm by 1.0 cm and was 100% eschar. The assessment contained no staging, presence of exudate or determination if the wound had improved, deteriorated or remained unchanged. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors including rejection of care. The assessment indicated the resident has an indwelling urinary catheter and was always incontinent of bowel. The assessment indicated the resident was at risk for skin breakdown and had one stage III pressure ulcer and one deep tissue injury (DTI) [purple or maroon localized area of discolored intact skin or blood filled blister] that were not present on admission. The facility implemented pressure reducing device to bed/chair, nutrition or hydration intervention to manage skin problems, pressure ulcer/injury care, application of non-surgical dressing other than to feet, application of ointments/medications other than to feet and application of dressing to feet. Review of the state optional MDS assessment dated [DATE] reveled the resident was dependent on two staff for bed mobility, transfers, and toilet use. Review of the weekly non-pressure skin grid dated 06/27/24 revealed the left interdigit between the fourth and fifth toes measured 0.3 cm by 0.5 cm by less than 0.1 cm with 100% granulation. The left fifth toe measured 1.5 cm by 1.0 cm and was 100% eschar. The assessment contained no staging, presence of exudate or determination if the wound had improved, deteriorated or remained unchanged. Review of the weekly non-pressure skin grid dated 07/02/24 revealed the left interdigit between the fourth and fifth toes measured 0.3 cm by 0.3 cm by less than 0.1 cm with 100% granulation. The left fifth toe measured 1.5 cm by 0.8 cm and was 100% eschar. The assessment contained no staging, presence of exudate or determination if the wound had improved, deteriorated or remained unchanged. Review of the weekly non-pressure skin grid dated 07/08/24 revealed the left interdigit between the fourth and fifth toes and left fifth toe was not measured due to the resident refused to lay down. Review of the medical record revealed no documented evidence the facility attempted to assess the wound at a later time and/or date. Review of the weekly non-pressure skin grid dated 07/15/24 revealed the left interdigit between the fourth and fifth toes measured 0.3 cm by 0.3 cm by less than 0.1 cm with 100% granulation. The left fifth toe measured 0.8 cm by 0.8 cm and was 100% eschar. The assessment contained no staging, presence of exudate or determination if the wound had improved, deteriorated or remained unchanged. Review of the weekly pressure skin grid dated 07/22/24 revealed the facility staged the wound as a stage III pressure ulcer to the left interdigit of the fourth and fifth toes measuring 0.2 centimeters (cm) by 0.3 cm by less than 0.1 cm with 100% granulation tissue. The wound had a moderate amount of drainage. The facility determined the wound had improved. Review of the medical record revealed no documented evidence the facility assessed the wound to the resident's left fifth toe on 07/22/24. Review of the weekly pressure skin grid dated 07/29/24 revealed the Stage III pressure ulcer to the left interdigit of fourth and fifth left toes was healed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the weekly pressure skin grid dated 07/29/24 revealed the stage III pressure ulcer to the left fifth metatarsal was identified on 06/06/24. The wound measured 1.5 cm by 0.8 cm by 0.1 cm with 80% granulation tissue and 20% slough. The wound had no drainage. The facility determined the wound had improved. Review of the weekly pressure skin grid dated 08/05/24 revealed the stage III pressure ulcer to the left fifth metatarsal measured 1.0 cm by 0.5 cm by 0.1 cm and was 80% granulation and 20% eschar. The wound had no drainage. The facility determined the wound had improved. Review of the weekly pressure skin grid dated 08/12/24 revealed the stage III pressure ulcer to the left fifth metatarsal measured 0.5 cm by 0.5 cm by and was 80% granulation and 20% eschar. The wound had no drainage. The facility determined the wound had improved. Review of the weekly pressure skin grid dated 08/19/24 revealed the stage III pressure ulcer to the left fifth metatarsal measured 0.3 cm by 0.5 cm by and was 80% granulation and 20% eschar. The wound had no drainage. The facility determined the wound had improved. Review of the resident's monthly physician orders for August 2024 identified orders dated 04/12/24 Barrier cream to buttocks, 07/26/24 monitor wounds for signs/symptoms of infection or decline, notify physician of if noted, 08/05/24 cleanse left fifth toe, pat dry, apply skin prep to wound bed and leave open to air daily and as needed, 08/15/24 cleanse right buttocks skin tear with wound spray, pat dry, apply zinc ointment to wound and leave open to air every shift and as needed. On 08/21/24 at 10:04 A.M., observation of Resident #38 revealed the resident's left foot was externally rotated outward allowing the fifth digit to resident directly on the bed. On 08/21/24 at 2:58 P.M., interview with Licensed Practical Nurse (LPN) #231 revealed the stage III pressure ulcer to the left interdigit fourth and fifth toes and the stage III pressure ulcer to the left fifth digit was caused by a boot being applied to tight to his left foot. LPN #231 verified the lack of off-loading to the left foot. On 08/21/24 at 3:05 P.M., observation of Resident #38 revealed he was being transferred from the shower room to his room via two assists on a shower chair. The resident was noted to have no dressing to the left foot and the foot was dragging the carpet while being pushed down the hallway. On 08/21/24 at 3:28 P.M., interview with LPN #231 verified the wounds were not comprehensively assessed, no evidence comprehensive, effective and individualized interventions were implemented to prevent the development of the pressure ulcers. On 08/21/24 at 3:37 P.M., observation of the resident's wound revealed the wound was covered with a light tan scab. The left foot had no off-loading to the pressure ulcer. On 08/22/24 at 9:32 A.M., observation of Resident #38 revealed the resident's left foot was laying directly on the bed with no off-loading observed. 28923 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	2. Review of Resident #49's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included paraplegia, severe intellectual disabilities, reduced mobility, muscle weakness, protein-calorie malnutrition, adult onset diabetes mellitus, anemia, osteomyelitis, chronic pain, and need for assistance with personal care. He was hospitalized between 01/26/24 and 02/02/24. Review of Resident #49's re-admission assessment dated [DATE] revealed he was noted to have stage IV pressure ulcers to his coccyx and right buttock and a suspected deep tissue injury to the right heel. Review of Resident #49's skin grid pressure assessment completed on 02/08/24 revealed the suspected deep tissue injury (SDTI) to the right heel originated on 02/02/24. The area measured 3 centimeters (cm) x 2. 5 cm. No description of the general appearance of the area was provided. Review of a subsequent skin grid pressure assessment of Resident #49's pressure ulcer to the right heel revealed it deteriorated from a SDTI to an unstageable (full thickness tissue loss in which the base of the ulcer was covered by slough and/ or eschar in the wound bed. The description of the general appearance of the area indicated it had 100% eschar. Review of Resident #49's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognition was moderately impaired. He was not known to have displayed any behaviors, nor was he known to reject care during the seven day assessment period. He had a functional limitation in his range of motion of his bilateral lower extremities. He was identified as having been at risk for pressure ulcers and was also identified as having an unhealed pressure ulcer. The MDS indicated that he was known to have one stage IV pressure ulcer and one unstageable pressure ulcer that was not present upon admission. Review of Resident #49's care plans revealed he had a care plan in place for having the potential for and having an actual pressure ulcer development related to reduced mobility and activity intolerance. The care plan was revised on 02/02/24 to reflect the presence of a pressure ulcer to the right heel. The goal was for the resident's pressure ulcer to decrease or heal through the review date. The interventions included the need to perform treatments as ordered. The interventions also included the use of pressure reduction devices to the chair/ bed and placing a pillow between the resident and his mobility bars when turned to that side. The interventions did not include the need to elevate his heels on pillows or to use some other off-loading device despite the resident being known to have an existing pressure ulcer to his right heel. Review of Resident #49's physician's orders revealed he had treatment orders in place for the right heel to cleanse the pressure ulcer with normal saline solution and pat dry. They were then to apply skin prep covering with an ABD dressing and secure by wrapping it with Kerlix (gauze wrap). The dressing was to be changed every two days and as needed (prn). That order was last updated on 08/05/24. Review of Resident #49's weekly wound assessments revealed the resident's pressure ulcer to the right heel was last assessed on 08/19/24. The pressure ulcer to the right heel was assessed and staged as a SDTI measuring 0.5 cm x 0.8 cm with a depth that was not able to be determined. A description of the general appearance of the area was provided and indicated the wound bed had 100% eschar, which should have resulted in the pressure ulcer being staged as an unstageable pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #49's treatment administration record (TAR) for August 2024 revealed the resident's treatment to his pressure ulcer on the right heel was last documented as having been completed on 08/19/24 on day shift (7:00 A.M. to 7:00 P.M.). There was no documentation showing the treatment to the right heel had been provided on a prn basis that month as ordered. The TAR's did not include documentation of any skin prevention interventions being implemented that involved off-loading the resident's heels. On 08/20/24 at 3:30 P.M. and again on 08/21/24 at 8:45 A.M., observations of Resident #49 noted him to be lying in bed. His right heel, where he was known to have an existing pressure ulcer, was noted to be in direct contact with the mattress on the bed. On 08/21/24 at 9:29 A.M., an observation was made of State tested Nursing Assistant (STNA) #168 noted her to bring in Resident #49's breakfast tray and provided him with set up help. He was noted by the STNA to be down in his bed. She asked the resident if he wanted pulled up in bed and assisted him in doing so by grabbing his draw sheet that was under him pulling him up in bed. The resident's right heel was noted to still be in contact with the mattress and the movement of the resident while pulling him up in bed caused friction against his right heel as it was dragged along the mattress on the bed. She did not offer to off-load his heels for him and left them in direct contact with the mattress. On 08/21/24 at 9:42 A.M., a treatment observation was made of Resident #49's pressure ulcer to his right heel. His treatment was provided by LPN #231, who was the facility's wound/ treatment nurse, and she was assisted by RN #108. The right heel was not noted to have a dressing on it as ordered. The treatment completed in accordance with the physician's orders. The right heel was observed and noted to be covered with an area of eschar that measured 2.2 cm x 2.5 cm. The scabbed area (eschar) was lifting at the edges. The resident tolerated the procedure with no complaints of pain. On 08/21/24 at 10:06 A.M., an interview with STNA #168 revealed she had only worked at the facility for about five days now. She was aware of the resident having a dressing on his left hip, but was not aware of the resident having any wounds on his right heel. She was asked what skin prevention interventions they were implementing for the resident to help existing pressure ulcers heal and to prevent new ones from developing. She stated they tried to keep him turned every couple of hours when they changed him and also placed a pillow between his knees and under his arm. She was asked what they were doing to offload heels. She again denied knowledge of the resident having anything on his right heel that she was aware of. She further denied they used any pillows or other off-loading devices to elevate his heels off the mattress when in bed. She acknowledged she had been observed pulling the resident up in bed when she positioned him for breakfast earlier that morning. She further acknowledged the resident's heel was not off-loaded and when she pulled him up in bed his heel was dragged against the mattress of the bed resulting in a friction force to his right heel. She denied that she had left the resident with his heels elevated, after she pulled him up in bed. (continued on next page)

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	365344	A. Building B. Wing	08/29/2024

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 0686 Level of Harm - Actual harm Residents Affected - Few	On 08/21/24 at 10:12 A.M., an interview with LPN #231 confirmed Resident #49 did not have a dressing intact to his right heel that she had to remove when doing his dressing change. She suspected the dressing may have gotten loose and was taken off, but denied she had been informed that was the case. She acknowledged the resident had an order for the dressing to his right heel to be changed on a prn basis and if it had come off someone should have put a new one on him. She further acknowledged the staff should be informing the nurse when the dressing to the right heel was off so a new dressing could be applied. She also confirmed the resident did not have his heels offloaded while in bed, when she went to do his dressing changes. She was informed STNA #168 was not aware the resident had a pressure ulcer to his right heel and observed pulling him up in bed dragging his right heel against the mattress. She indicated they should be off-loading his heels and not to cause any shearing or friction forces to his skin when pulling him up in bed. On 08/21/24 at 11:53 A.M., a follow up interview LPN #231 was conducted to see why Resident #49's pressure ulcer to his right heel was staged as a SDTI, when the latest assessment and observations of the wound during the dressing change clearly showed it was an unstageable pressure ulcer. She reported the wound physician that followed the resident and assessed him weekly did not allow the nurses to stage pressure ulcers. The wound physician would not change a wound's staging from what it was when first noted, until it had been resolved. She was informed a pressure ulcer that was a stage IV pressure ulcer would remain a stage IV until it was healed. A stage III pressure ulcer would remain a stage III until it was healed, unless it deteriorated into a stage IV pressure ulcer and then should be classified as such. A SDTI could resolve or it could deteriorate into a stage III or IV pressure ulcer. She acknowledged, if a SDTI deteriorated to a stage III or IV, it should be reclassified as such as that was a deterioration in the wound. She confirmed the resident's SDTI did present as an unstageable pressure ulcer, as the wound bed was covered with 100% eschar. Review of the facility's policy on Prevention of Pressure Ulcers/ Injuries revised October 2018 revealed the facility was to review the resident's care plan and identify risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Prevention included mobility/ repositioning of the resident. They were to provide support devices and assistance as needed. They were also to select appropriate support surfaces based on the resident's mobility and overall risk factors. The purpose of the procedure was to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors.

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F 0689 Level of Harm - 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** 32654 Based on observation, record review, fall investigation review, staff interview and safety belt installation instructions, the facility failed to properly secure one resident (Resident #38) during a transport in the facility's bus. Actual harm occurred on 05/06/24 when Resident #38 who was in a manual wheelchair was placed in the facility bus for transport. The wheelchair was secured with the wheelchair tie down and belts, however, the resident was not secured as recommended with both a torso and pelvic seat belt. The resident slid out of the wheelchair onto the floor of the bus and sustained a left femoral shaft fracture and left great toe fracture. This affected one (Resident #38) of six residents reviewed for falls. The facility census was 140. Findings Include: Review of the medical record for Resident #38 revealed an initial admitted [DATE] with the latest readmission of 04/08/24 with diagnoses including but not limited to retention of urine, acute kidney failure, severe sepsis, speech disturbances, dysphagia, urinary tract infection, cerebral infarction, psychotic disorder with hallucinations, chronic coronary microvascular dysfunction, Parkinson's disease, anxiety disorder, hypothyroidism, diabetes mellitus, major depressive disorder, severe morbid obesity, Rheumatoid arthritis, congestive heart failure, lymphedema, metabolic encephalopathy, hypertension, osteoarthritis, chronic kidney disease, obstructive sleep apnea, hyperlipidemia, peripheral vascular disease, right above the knee amputation, chronic obstructive pulmonary disease, dementia, anemia, gastro-esophageal reflux disease, chronic pain, obstructive and reflux neuropathy, neuromuscular dysfunction of bladder and benign prostatic hyperplasia. Review of the plan of care dated 08/31/19 revealed the resident was at risk for falls related to deconditioning, unaware of safety needs, Parkinson's disease, decreased mobility, activity tolerance, muscle weakness, CHF and COPD with shortness of breath. Interventions included bed against wall per resident preference, bilateral mobility bars to bed, encourage the resident to attend activities that minimize the potential for falls while providing diversion and distraction, encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility, keep the resident's call light within reach and encourage the resident to use it for assistance as needed, mechanical lift required for transfers due to advanced Parkinson's disease, provide resident with a safe environment, therapy to evaluate and treat as ordered and as needed and resident/family/legal representative has been educated to call for assistance by using call light for mobility needs to reduce risk for falls. Review of the resident's falls risk evaluation dated 04/12/24 revealed a score of 10 indicating the resident was at risk for falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the progress note dated 05/06/24 at 4:00 P.M. revealed the resident was returning from transport at an area hospital when the facility Former Transport Driver (FTD) #274 turned the corner, the resident slid from his wheelchair and landed on the floor of the transport vehicle. The transport driver and State tested Nursing Assistant (STNA) #179 were unable to get the resident up so 911 was called. The medics arrived on scene and were able to get the resident from the bus to their cot and suggested the resident be transported to the local emergency department (ED) for an evaluation. At the ED the resident was found to have a left broken great toe. The resident was discharged and transported back to the facility. Review of the discharge summary from the ED visit dated 05/06/24 revealed the resident was treated for fall from wheelchair, laceration and hematuria. Review of the facility fall investigation dated 05/06/24 at 1:40 P.M. revealed the facility was notified the resident sustained a fall while being transported back from an appointment in the facility bus. The incident revealed the resident slid from his wheelchair onto the floor of the facility bus. The resident stated he slid from his wheelchair when FTD #273 turned a corner. The resident was transported to a local ED by 911 and found to have a broken left great toe. Review of the medical record revealed no documented evidence the resident was assessed following the fall including the broken left great toe. Review of the resident's progress note dated 05/08/24 at 12:42 P.M. a new order was obtained for X-ray of left hip, knee, tibia and fibula. The facility's contracted X-ray company was made aware of the need for the X-ray. Review of the progress note dated 05/09/24 at 8:40 A.M. revealed the resident was complaining of pain to his left knee and the pain was getting worse after the Certified Nurse Practitioner (CNP) had prescribed him the medication Prednisone for swelling. The resident's knee was swollen and painful to touch. The resident stated nothing really made the pain better and medication helps a little bit, but it's still quite painful. The resident stated being mobile increased the pain. The physician was notified and an order for X-ray was obtained. Review of the resident's May 2024 Medication Administration Record (MAR) revealed no documented evidence the resident was given an analgesic for the reports of pain to the left knee. Review of the X-ray results dated 05/09/24 revealed the results of the X-ray were reported on 05/09/24 at 1:15 P.M. Further review revealed the resident had a supracondylar knee fracture (also called distal femur fracture). Review of the resident's progress note dated 05/10/24 at 10:20 P.M. revealed the resident returned from the local ED with diagnosis of left femoral shaft fracture and was treated with immobilization, Hydrocodone-acetaminophen 5-325 milligrams (mg) with the special instructions to administer two tablets by mouth every for hours as needed for pain and follow up appointment with ortho scheduled for 05/17/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the acute care hospital discharge summary dated 05/10/24 revealed the resident was treated for a left femoral shaft fracture (a break in the long straight part of the thigh bone.). The resident was treated with an immobilizer to the left leg, pain medication and a follow up appointment with orthopedics on 05/17/24. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors including rejection of care. The assessment indicated the resident has an indwelling urinary catheter and was always incontinent of bowel. The assessment indicated the resident has not had any falls since the prior assessment. The resident's weight was 255 pounds and had no know weight loss. Review of the state optional MDS assessment dated [DATE] reveled the resident was dependent on two staff for bed mobility, transfers, and toilet use. On 08/21/24 at 10:04 A.M., observation of Resident #38 revealed his left leg was externally rotated outward causing the outer part of the left foot to rest on the bed. 08/21/24 12:28 PM interview with STNA #179 revealed she was riding in the back of the bus with Resident #38. STNA #179 revealed FTD #179 failed to ensure the resident was secured with the pelvic and chest belts. She said when they pulled out of the parking lot the resident slid from his wheelchair onto his buttocks. STNA #179 revealed she was not trained in securing a resident in the bus. She revealed it was a new facility bus and it was her first time on the bus. STNA #179 revealed transport staff received training on the bus seat belt following the incident. On 08/22/24 at 3:53 P.M., interview with Regional Director of Operations (RDO) #274 verified the resident's manual wheelchair was tied down with the four-point system, however the resident was not secured as recommended with the chest and pelvic belts. RDO #274 revealed FTD #273 received training on the securing a resident on the bus prior the incident. RDO #273 revealed FTD #273 was terminated from employment with the facility due to not securing a resident properly following the additional training. Review of the statement dated 05/07/24 revealed FTD #273 received training and provided a return demonstration regarding safety protocol that must be followed when transporting residents in facility vehicles or bus. The training included how to properly secure safety belts to the wheels of the wheelchair, how to properly secure the safety belt that is positioned across the resident. Review of the four-point wheelchair securement system instructions revealed the four point wheelchair and occupant securement systems, when used as recommended, provide the safest means of transportation for wheelchair passengers unable to transfer from their wheelchairs when traveling in motor vehicles. Each component has been designed, engineered and tested to work as one comprehensive system.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on observations, interviews, record reviews and facility policy review, the facility failed to ensure residents received oral fluids between meals. This affected three residents (#10, #33, and #41) out of three residents reviewed for hydration. The facility also failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range when Resident #130's weekly weight were not completed as ordered after having weight loss. This affected one (Resident #130) of eight residents reviewed for nutrition The facility census was 140. Findings include: 1.Review of the medical record for Resident #10, revealed an admitted [DATE]. Diagnoses included but were not limited to chronic obstructive pulmonary disease, altered mental status, unspecified dementia and other reduced mobility. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of the resident is rarely/never understood. The resident was assessed to require total dependence on all aspects of care which includes eating, toilet hygiene, shower/bathe self, transfers and bed mobility. Review of the active care plan for Resident #10 revealed the intervention to encourage and provide fluids and encourage good hydration to promote healthier skin related to at risk for electrolyte imbalance and at risk for skin alterations. Review of the nutritional assessment for Resident #10 dated 05/14/24 completed by the Dietician revealed the resident required 1675-2010 milliliters (ml) of fluids per day. Review of the intake record dated 07/25/24 to 08/23/24 for Resident #10 revealed the resident was not documented as having consumed 1675-2010mls of fluids on all the days. Review of the progress notes for Resident #10 dated 07/25/24 to 08/23/24 revealed the notes did not include any documented of refusals of fluids per the resident. Observation on 08/19/24 at 11:04 A.M. revealed Resident #10 did not have any oral fluids at bedside. Observation 08/21/24 at 8:05 A.M., 10:18 A.M., and 12:00 P.M. did not have any oral fluids at bedside. Interview on 08/21/24 at 12:03 P.M. with State tested Nursing Assistant (STNA) #156 confirmed documentation of fluids in between meals are documented in the residents' charts and confirmed Resident #10 's record showed Resident #10 only had two documentations each day of fluid intake for the dates of 07/25/24 to 08/23/24 did not equal 1675-2010 mls per day. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/21/24 at 12:06 P.M. with Licensed Practical Nurse (LPN) #158 confirmed Resident #10 did not have any oral fluids at the bedside, could not ask for fluids and needed assistance with oral intake. 2.Review of the medical record for Resident #33, revealed an admitted [DATE]. Diagnoses included but not limited to need for assistance with personal care, chronic kidney disease stage 3, unspecified dementia, and muscle weakness. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 07 out of 15 indicated severe cognitive impairment. The resident was assessed to require partial to moderate assistance with eating. Review of the active care plan for Resident #33 revealed the intervention to maintain adequate hydration due to at risk for infection related to a history of recurrent urinary tract infections. Review of the nutritional assessment for Resident #33 dated 07/31/24 completed by the Dietician revealed the resident required 1550-1860 milliliters (ml) of fluids per day. Review of the intake record dated 07/25/24 to 08/23/24 for Resident #33 revealed the resident was not documented as having consumed 1550-1860mls of fluids on all the days. Review of the progress notes for Resident #33 dated 07/25/24 to 08/23/24 revealed the notes did not include any documented of refusals of fluids per the resident. Observation on 08/19/24 at 10:59 A.M. revealed Resident #33 did not have any oral fluids at bedside. Observation 08/21/24 at 8:06 A.M., 10:17 A.M., and 11:59 A.M. did not have any oral fluids at bedside. Interview on 08/21/24 at 12:02 P.M. with STNA #156 confirmed documentation of fluids in between meals are documented in the residents' charts and confirmed Resident #33 's record showed Resident #33 only had two documentations each day of fluid intake for the dates of 07/25/24 to 08/23/24 did not equal 1550-2860mls per day. Interview on 08/21/24 at 12:06 P.M. with LPN #158 confirmed Resident #33 did not have any oral fluids at the bedside, could not ask for fluids and needed assistance with oral intake. 3. Review of the medical record for Resident #41, revealed an admitted [DATE]. Diagnoses included but not limited to dementia, anxiety disorder, other reduced mobility, need for assistance with personal care and Alzheimer's disease. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 03 out of 15 indicating severe cognitive impairment. The resident was assessed to require total dependence on all aspects of care which included eating, toilet hygiene, shower/bathe self, transfers, and bed mobility. Review of the active care plan for Resident #41 revealed the intervention to maintain adequate hydration due to at risk for infection related to a history of recurrent urinary tract infections. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the intake record dated 07/25/24 to 08/23/24 for Resident #41 revealed the resident was not documented as having consumed between 300mls-740mls of fluids on all the days. Review of the progress notes for Resident #41 dated 07/25/24 to 08/23/24 revealed the notes did not include any documented of refusals of fluids per the resident. Observation on 08/19/24 at 9:59 A.M. revealed Resident #41 did not have any oral fluids at bedside. Observation 08/21/24 at 8:08 A.M., 10:18 A.M., and 12:01 P.M. did not have any oral fluids at bedside. Interview on 08/21/24 at 12:01 P.M. with STNA #156 confirmed documentation of fluids in between meals are documented in the residents' charts and confirmed Resident #33 's record showed Resident #41 only had two documentations each day of fluid intake for the dates of 07/25/24 to 08/23/24 was between 300mls-740mls per day only. Interview on 08/21/24 at 12:06 P.M. with LPN #158 confirmed Resident #41 did not have any oral fluids at the bedside, could not ask for fluids and needed assistance with oral intake. Interview on 08/26/24 at 7:33 A.M. with the [NAME] Nurse #140 confirmed the facility passed water in the morning and before lunch and before dinner and as needed. If a resident was unable to ask, the staff were still required to provide water to residents and assist them with drinking the water if that was needed and the staff are to document the intake of residents on the intake oral area in their records for meals and in between meals. Review of the facility policy titled Fresh Ice Water revised October 2010 revealed the facility staff are to provide fresh cold water for residents each shift. 31404 4. Record review of Resident #130 revealed an admitted [DATE] with pertinent diagnoses of: seizures, mixed anxiety disorder, major depressive disorder, and dementia without behaviors. Review of the 05/18/24 admission Minimum Data Set (MDS) assessment revealed the resident was severely cognitively impaired and required partial to moderate assist for eating and personal hygiene. Resident #130 did not use any devices to aid in mobility and was frequently insentient of bladder and always incontinent of bladder. Review of Physicians Orders date 05/28/24 revealed an order for weekly weights times four weeks with an end date of 07/16/24. Review of Resident #130's medical record revealed no weekly weights for the weeks of 05/28/24, and 6/26/24. There were weights for 05/15/24 of 137.2 pounds (lbs), 06/05/24 of 132.0 lbs, 06/11/24 of 126.3 lbs, 06/19/24 of 132.4 lbs, and 07/08/24 of 131.4 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Dietician #300 on 08/21/24 at 3:00 P.M. verified Resident #130 had a significant weight loss of 11 pounds from 05/15/24 to 06/11/24. Dietician #300 verified they did not get weekly weights for Resident #130 for the weeks of 05/28/24, and 6/26/24. She stated there was a problem getting weekly weights and that now they have someone specifically who does weights. This deficiency represents noncompliance investigated under Complaint Number OH00157155.

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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** 28923 Based on record review, observation, and staff interview, the facility failed to ensure enteral tube feeding bottles were dated and timed when they were hung during administration for a resident receiving nightly nocturnal tube feedings. This affected one (Resident #115) of three residents reviewed for tube feedings. The facility census was 140. Findings include: Review of Resident #115's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included Parkinson's disease, unspecified dementia, Barrett's esophagus, severe protein- calorie malnutrition, and gastrostomy status (surgical procedure that creates an opening through the abdomen into the stomach for the placement of a feeding tube for nutritional purposes). Review of Resident #115's physician's orders revealed the resident had an order in place to receive Osmolite 1.5 cal at 60 milliliters (ml)/ hour x 12 hours for a total of 720 ml/ day via his Percutaneous Endoscopic Gastrostomy (PEG) tube via pump. The enteral feeding was scheduled to be hung every day at 6:00 P.M. and disconnected at 6:00 A.M. the following day, after 720 ml had been infused over 12 hours. The order was last updated on [DATE]. On [DATE] at 2:45 P.M., [DATE] at 3:25 P.M., [DATE] at 8:43 A.M., and again on [DATE] at 8:30 A.M., observations of Resident #115 noted the resident to be lying in bed. His enteral feeding bottle of Osmolite 1. 5 cal was still hanging in his room on the enteral feeding pole, after it had been disconnected from the resident. The enteral feeding bottles were checked and were noted not to include a date or time to indicate when the bottles of the enteral nutrition feeding had been hung up for administration. On [DATE] at 1:17 P.M., an interview with Licensed Practical Nurse (LPN) #121 revealed Resident #115 received enteral tube feedings via pump every night between the hours of 6:00 P.M. and 6:00 A.M. The enteral tube feeding bottle would be hung by the day shift nurse and would then be disconnected by the night shift nurse at 6:00 A.M., after it had infused 720 ml over a 12 hour period. She confirmed the nurse that initiated the enteral tube feeding was supposed to date and time when the enteral feeding bottle was hung. She acknowledged the resident's enteral tube feeding bottles had been observed still hanging on the pole (after it had been disconnected) and were without a date and time on it to reflect when they were hung. She stated she would have to provide education to the nurses to make sure they were doing that. She indicated those enteral tube feeding bottles were only good for 24 hours, after they had been spiked. The night shift nurse would not be able to confirm it was a new (not expired) enteral tube feeding bottle since they were hung on the prior shift.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404 Based on observation, staff interview, policy review, and record review the facility failed to ensure that a resident who needs respiratory care is provided such care consistent with professional standards of practice when they did not have an order for oxygen for Resident #54 and did not provide oxygen at the ordered rate for Resident #78. This affected two (Resident #54, and #78) of two residents reviewed for respiratory care. The facility census was 140. Findings include: 1. Record review of Resident # 54 revealed an admitted [DATE] with pertinent diagnoses of: hypotension, right bundle branch block, cardiomegaly, hypoxemia, gout, allergic rhinitis, glaucoma, muscle weakness, urinary tract infection, heart failure, peripheral vascular disease, anemia, anorexia, end stage renal disease, dependence on wheelchair, spinal stenosis, peripheral vascular disease, hypertension, major depressive disorder, chronic respiratory failure with hypoxia, anxiety disorder, and chronic obstructive pulmonary disease. Review of the 08/01/24 Minimum Data Set (MDS) assessment revealed the resident was cognitively intact and used a wheelchair to aid in mobility. The resident was dependent for personal hygiene, putting on/taking off footwear, lower body dressing, upper body dressing, shower/bathe, toileting, and oral hygiene. Review of the medical record on 08/22/24 at 2:00 P.M. revealed there was not an order for Resident #54 to be on oxygen. Observation on 08/22/24 at 2:20 P.M. revealed Resident #54 was receiving humidified oxygen through a nasal cannula at two liters per minute. Interview on 08/22/24 at 2:24 P.M. with Licensed Practical Nurse (LPN) #310 verified Resident #54 was on oxygen. Interview with LPN #110 on 08/22/24 at 2:28 P.M. verified there is not an order for Resident #54 oxygen and she is on two liters per minute right now with a humidifier. 50538 2. Review of the medical record for Resident #78 , revealed an admitted [DATE] . Diagnoses included: acute kidney failure, Chronic obstructive pulmonary disease, diabetes, chronic kidney disease stage four with hemodialysis, history of a urinary tract infection with a code status of full code and erythromycin, nicotine, invokana, januvia, and sulfa antibiotics allergies. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent Minimum Data Set (MDS) 3.0 assessment for Resident #78, dated 07/31/24, revealed a Brief Interview for Mental Status (BIMS) of 15 out of 15 indicating resident was cognitively intact. The resident was assessed to require substantial assist with upper body dressing and personal hygiene and is dependent with all other activities of daily living, except for eating which was assessed as set up and oral care which was assessed as supervision or touching assistance. Further review of the MDS 3.0 assessment dated [DATE] revealed oxygen use was indicated. Review of physician orders revealed an order for oxygen via nasal cannula/mask at four liters per minute continuously. Observation on 08/20/24 at 8:57 A.M. revealed Resident #78 was having rapid labored breathing and was receiving oxygen at five liters per minute via nasal cannula. Interview with Resident #78 on 08/20/24 at 8:57 A.M. revealed that she felt short of breath but was feeling better since the nurse had been in and increased her oxygen and given her a breathing treatment. Further observation on 08/20/24 at 3:27 P.M. revealed Resident #78 was resting in bed with calm, even respirations and oxygen remains in place at five liters per minute via nasal cannula. Interview on 08/20/24 at 3:49 P.M. with Registered Nurse (RN) #266 revealed he had assessed Resident #78 in the morning, given her a breathing treatment and increased her oxygen to five liters per minute via nasal cannula. RN #266 verified the oxygen order was for four liters per minute. RN# 266 stated that he thought there was an order to titrate the oxygen flow between four and five liters per minute. RN #266 further stated he believed that order was from before Resident #78 went to the hospital on 08/06/24. RN #266 verified the oxygen flow rate was at five liters per minute and readjusted the flow rate to four liters per minute. Review of the policy titled Oxygen Administration copyedited 2001 by Med-Pass, Inc. revised October 2010, revealed the purpose of the policy was to provide guidelines for safe oxygen administration. Further review revealed that facility staff were to verify there is a physician's order for the procedure and to review the physician's orders. Facility staff is to adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow rate is being administered.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404 Based on staff interview, and record review the facility failed to provide or obtain laboratory services only when ordered by a physician when they did not draw a hemoglobin A1C, complete blood count, comprehensive metabolic panel, and Depakote level quarterly in June for Resident #85 and when a basic metabolic panel was not drawn as ordered for Resident #443. This affected two (Resident #85, and #443) of six Residents reviewed for laboratory values. The facility census was 140. Findings include: 1. Record review of Resident #85 revealed an admitted [DATE] with pertinent diagnoses of: disorientation, delusional disorders, insomnia, anorexia, pulmonary embolism, Parkinson's disease, anxiety disorder, mood disorder, unspecified dementia with mood disturbance, fracture of first lumbar vertebrae, spondylosis, adjustment disorder with depressed mood, fracture of sacrum, cervical disc degeneration,fall, solitary pulmonary nodule, type two diabetes mellitus, intestinal malabsorption, obesity, shortness of breath, atrial fibrillation, dementia with behavioral disturbance, vitamin D deficiency, atherosclerotic heart disease of native coronary, mild cognitive impairment, type two diabetes mellitus, anemia, overactive bladder, wheezing, hypokalemia, major depressive disorder, hyperlipidemia, long term use of aspirin, pain, dementia with psychotic disturbance, chronic obstructive pulmonary disease, and edema. Record review of 05/08/24 quarterly Minimum Data Set (MDS) assessment revealed the resident was moderately cognitively impaired and used a walker to aid in mobility and required supervision or touching assistance for personal hygiene, putting on taking off footwear, lower and upper body dressing, showering, and toileting. The resident was always continent of bowel and bladder. Review of a Physician Order dated 03/15/24 revealed orders for hemoglobin A1C (a lab test to determine blood glucose control), complete blood count (a blood cell test), comprehensive metabolic panel (a test that measures proteins, enzymes, electrolytes, and minerals) and Depakote level (test to measure effectiveness of seizure medication) quarterly (March, June, Sept, Dec) on the 15th every three months starting on the 15th for one day. The order was discontinued on 07/31/24. Review of the medical record on 08/21/24 revealed no hemoglobin A1C, complete blood count, comprehensive metabolic panel, and Depakote level lab test in the medical record for June of 2024 Interview with The Director of Nursing (DON) on 08/22/24 at 12:19 P.M. verified there was no hemoglobin A1C, complete blood count, comprehensive metabolic panel, and Depakote level lab test in the medical record for June 2024. 28923 2. Review of Resident #443's medical record revealed he had admitted to the facility on [DATE]. His diagnoses included surgical aftercare following surgery on the circulatory system (quintuple coronary artery bypass graft), hypertension, and acute kidney failure. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #443's patient discharge instructions from the transferring acute care facility (hospital) revealed he was to have a basic metabolic panel (BMP) done within seven days of his admission to the receiving facility (skilled nursing/ long term care). The order indicated it was ordered for a future visit to follow up on an acute kidney injury. Resident #443's medical record was absent for evidence a BMP was obtained within seven days of his admission into the facility. Further review of Resident #443's medical record revealed a BMP had not been ordered to be obtained until 08/08/24 (13 days after his admission into the facility). The order date was indicated to have been 07/26/24 (day of admission). The reason for the order was indicated to be for the diagnosis of acute kidney failure. On 08/19/24 at 2:28 P.M., an interview with Resident #443 revealed he was supposed to have a blood test done to check his kidney function, after he was admitted to the facility from the hospital. He was told that a blood test would be done, but the facility did not do it. He had to intervene to get it ordered and it was still 11 days after that before it was collected. On 08/26/24 at 8:55 A.M. an interview with Licensed Practical Nurse (LPN) #121 was conducted to determine why a BMP had not been obtained within seven days of the resident's admission, as was noted on his patient discharge instruction orders. She was informed of Resident #443 concerns about his kidney function test not being completed timely as ordered. She acknowledged the resident's patient discharge instructions from the hospital did specify to obtain the BMP within seven days of his admission. She provided a complete metabolic panel that had been collected on 08/12/24. When asked why a BMP had not been done within seven days of his admission, she stated it was missed when he was admitted and the patient discharge instructions was used to write his admission orders. They wrote an order to obtain the BMP and specified the need to obtain it once within seven days back dating the order for 07/26/24 (date of his admission). It was around 08/08/24 when it was brought to their attention, which is why the lab was ordered to be done on 08/08/24 (outside the seven day window it was ordered to be done within).

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 47985 Based on observation, interview, and facility policy review, the facility failed to ensure pureed foods were prepared to the correct texture. This had the potential to affect nine (#7, #10, #18, #23, #40, #41, #94, #115, and #391) of nine residents who received pureed texture diets. The facility census was 140. Findings included: Observations made continuously on 08/21/24 at 9:59 A.M. to 10:45 A.M. during the preparation of pureed foods revealed [NAME] #166 was preparing pureed hotdogs. She added 11 hotdogs to the blender, 11 buns, and beef broth before blending. Once the items had blended approximately one minute, [NAME] #166 stated it was ready to serve. Attempted to get a spoon full to check the texture, and one third of a hotdog bun came up out of the mixture. [NAME] #166 began to pureed again without scraping the sides. After about 30 seconds, she stopped and stated the mixture was ready again. Chunks of hotdog were visible on the sides of the blender. The mixture was tasted and maintained flavor. [NAME] #166 required encouragement to scrape the sides and continue blending the mixture until it was smooth. [NAME] #166 added a bit more broth and pureed the mixture again for approximately 30 seconds. She stated it was ready and began emptying the contents of the blender into a bin to place in the hot-well. The mixture was thin and runny, and surveyor intervened to ask if the texture was correct. Dietary Manager and Kitchen Consultant intervened and encouraged [NAME] #166 to add thickener. Half of a #6 scoop was added to the mixture and took about one minute before the mixture was ready. Once the blender was clean and dry, fiesta blend veggies were added to the blender. [NAME] #166 used eight four-ounce scoops and two ounces of butter. After about one minute of mixing, [NAME] #166 stated the veggies were ready. Mixture was tasted and chunks were noted. [NAME] #166 continued to puree for another minute until the texture was smooth. Sweet potato fries were pureed next. 11 portions of fries were added to the blender once clean and dry, with two and three-quarter cups of milk. After thirty seconds, the mixture was chunky and thick to taste. Unmeasured amount of milk was added to the mixture and pureed for about thirty seconds and the texture was smooth. [NAME] #166 confirmed findings throughout the observations. Review of a policy titled Therapeutic Diets dated 10/2017 revealed a therapeutic diet is considered a diet ordered by a physician, practitioner or dietitian as part of treatment for a disease or clinical condition to modify specific nutrients in the diet or to alter the texture of a diet. If a mechanically altered diet is ordered the provider will specify the texture modification.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47985 Based on observations, interviews, and facility policy reviews, the facility failed to ensure the kitchen was maintained in a clean manner, garbage cans were clean and the kitchen was pest free. This had the potential to affect 139 of 140 residents who received meals in the facility. The facility census was 140. Findings include: Observations were continuously made of the kitchen on [DATE] starting at 9:00 A.M. and ending at 9:38 A.M. Observations included a large amount of flies and gnats in the back of the pantry, one uncovered garbage can next to the back door, one dirty garbage can near walk-in refrigerator covered in splatters and grime, and another garbage covered in splatters and grime near the hand-washing sink. The walk-in refrigerator held a five pound tub of sour cream which expired on [DATE], there was an open bag of spaghetti noodles which was not resealed in the pantry, a partially filled 22-quart tub of sugar with a use by [DATE] sticker was in the pantry, the standing refrigerator did not have a thermometer inside it, shelves throughout the kitchen had grime and dust on them as well as the stainless steel backsplashes, there was a large amount of debris under the standing refrigerator and shelving, the bucket of sanitizer fluid which was being used to clean the food prep area was 150 parts per million instead of the required 200 parts per million, there was a large amount of black debris and grime behind the steamer and stove area, and the dish washing area contained grime throughout. Interview with Dietary Manager (DM) on [DATE] at 9:38 A.M. confirmed findings. Observation on [DATE] at 9:59 A.M. revealed four hot-wells with dirty water and debris floating, including two dead flies. Additionally, there were five flies flying throughout the kitchen prep area and landing on clean utensils which were being used for food preparation without being cleaned first. Interview on [DATE] at 10:42 A.M. with DM confirmed there were two dead flies in the dirty hot-well water, as well as five flies in the food prep area. DM stated the dishes are not cleaned prior to use because they are clean when they are hung up. Interview on [DATE] at 11:02 A.M. with Kitchen Consultant revealed the kitchen is filthy, equipment needs to be pulled out so the kitchen can be deep cleaned, and the flies are a huge problem. She stated each time she visits the facility, she completes a survey and the facility is improving. Review of a policy titled Dry Storage Areas dated 2021 revealed floors, walls, shelves and other storage areas will be kept clean, spoiled foods should be disposed of promptly and the storeroom will be cleaned on a regular basis. Review of a policy titled Pest Control dated ,d+[DATE] revealed the facility should have a pest control contract to provide frequent treatment of the environment for pests with an emphasis on the pest control program in the kitchens and cafeterias. Monitoring of pest control will be completed by facility staff and problems should be reported promptly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a policy titled Sanitization dated ,d+[DATE] revealed all kitchen areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects. All utensils, counters, shelves and equipment shall be kept clean and maintained in good repair. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions. Sanitizing of surfaces must be performed using one of the following solutions: ,d+[DATE] PPM chlorine solution, , d+[DATE] PPM quaternary ammonium compound, or a 12.5 PPM iodine solution. Kitchen wastes that are not disposed of by mechanical means shall be kept in clean, leakproof, nonabsorbent, tightly closed containers, and the Dietary Manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 47985 Based on observations, interviews, and facility policy review, the facility failed to ensure garbage cans were clean and the kitchen was pest free. This had the potential to affect 139 of 140 residents who received meals in the facility. The facility census was 140. Findings include: Observations were continuously made of the kitchen on 08/19/24 starting at 9:00 A.M. and ending at 9:38 A.M. Observations included a large amount of flies and gnats in the back of the pantry, one uncovered garbage can next to the back door, one dirty garbage can near walk-in refrigerator covered in splatters and grime, and another garbage covered in splatters and grime near the hand-washing sink. Interview with Dietary Manager (DM) on 08/19/24 at 9:38 A.M. confirmed findings. Observation on 08/21/24 at 9:59 A.M. revealed four hot-wells with dirty water and debris floating, including two dead flies. Additionally, there were five flies flying throughout the kitchen prep area and landing on clean utensils which were being used for food preparation without being cleaned first. Interview on 08/21/24 at 10:42 A.M. with DM confirmed there were two dead flies in the dirty hot-well water, as well as five flies in the food prep area. DM stated the dishes are not cleaned prior to use because they are clean when they are hung up. Review of a policy titled Pest Control dated 07/2016 revealed the facility should have a pest control contract to provide frequent treatment of the environment for pests with an emphasis on the pest control program in the kitchens and cafeterias. Monitoring of pest control will be completed by facility staff and problems should be reported promptly. This deficiency represents noncompliance investigated under Complaint Number OH00157155.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, observation, staff interview, and policy review, the facility failed to ensure a resident's indwelling urinary catheter's collection bag was maintained off the floor and did not increase his risk for infection. This affected one (Resident #115) of one residents reviewed for indwelling urinary catheters. The facility census was 140. Findings include: Review of Resident #115's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included unspecified dementia, chronic kidney disease, history of urinary tract infections, congestive heart failure, hydronephrosis, acute kidney failure with tubular necrosis, and obstructive and reflux uropathy. Review of Resident #115's physician's orders revealed he had an order to maintain an indwelling urinary catheter every shift to straight drain due to benign prostate hypertrophy with urinary tract symptoms. The orders also included the need to change the catheter bag monthly and as needed (prn). Review of Resident #115's care plans revealed he had a care plan in place for being at risk for complications related to the use of an indwelling urinary catheter. The goal was for the resident to remain free from signs/ symptoms of a urinary tract infection. The interventions included the need to position the resident's catheter bag and tubing below the level of the bladder and ensure the tubing was not under the resident's leg. On 08/22/24 at 1:31 P.M., an observation of Resident #115 noted him to be sitting up in his recliner in his room. His indwelling urinary catheter bag was noted to be sitting on the floor next to his recliner between the recliner and the wall and on the opposite side away from his bed. Findings were verified by Licensed Practical Nurse (LPN) #121. On 08/22/24 at 1:33 P.M., LPN #121 was noted to call the aide in that was working on Resident #115's hall. She instructed the aide that the indwelling urinary catheter's collection bag could not be placed in direct contact with the floor. The aide told her the resident must have moved it and claimed to have secured it to the side of the bed, after putting him in his recliner. Further review of Resident #115's medical record revealed there was no documented evidence to support he was known to move his indwelling urinary catheter's collection bag or was known to place it on the floor. The resident's care plan for the use of an indwelling urinary catheter was not revised to include an intervention to encourage the resident to leave his catheter hanging on the bed frame and not to put it on the floor until after it was brought to LPN #121's attention. The care plan was reflected to have been revised on 08/22/24, after being discussed with the facility staff. Observations of Resident #115, prior to and after the noted incident of the catheter bag being on the floor, revealed no evidence of him moving or handling the indwelling urinary catheter's collection bag. Further observations were made of Resident #115 on 08/26/24 being up in his recliner chair at the bedside. He was noted to leave his catheter's collection bag properly secured to the side of his bed and off the floor. He was not observed to be restless when either in bed or up in his chair. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy on Urinary Catheter's revised 03/10/19 revealed they were to use standard precautions when handling or manipulating the drainage system. They were to ensure the catheter tubing and the drainage bag were kept off the floor.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on record review, staff interview and facility policy review, the facility failed to provide justification for the use of antibiotic therapy for one resident (#38). This affected one (Resident #38) of five reviewed for unnecessary medications. The facility census was 140. Findings Include: Review of the medical record for Resident #38 revealed an initial admitted [DATE] with the latest readmission of 04/08/24 with diagnoses including but not limited to retention of urine, acute kidney failure, severe sepsis, speech disturbances, dysphagia, urinary tract infection, cerebral infarction, psychotic disorder with hallucinations, chronic coronary microvascular dysfunction, Parkinson's disease, anxiety disorder, hypothyroidism, diabetes mellitus, major depressive disorder, severe morbid obesity, Rheumatoid arthritis, congestive heart failure, lymphedema, metabolic encephalopathy, hypertension, osteoarthritis, chronic kidney disease, obstructive sleep apnea, hyperlipidemia, peripheral vascular disease, right above the knee amputation, chronic obstructive pulmonary disease, dementia, anemia, gastro-esophageal reflux disease, chronic pain, obstructive and reflux neuropathy, neuromuscular dysfunction of bladder and benign prostatic hyperplasia. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the progress note dated 07/12/24 at 9:12 A.M. revealed a urine specimen was collected to be sent to the lab. Review of the progress note dated 07/16/24 at 9:44 A.M. revealed the a new order was obtained for Keflex 500 milligrams (mg) by mouth twice daily for seven days for a urinary tract infection (UTI). Review of the resident's July 2024 Medication Administration Record (MAR) revealed the resident received a dose of Keflex 500 mg on 07/16/24 at 8:00 P.M. and on 07/17/24 at 8:00 A.M. Review of the progress note dated 07/17/24 at 4:36 P.M. revealed the physician seen the resident and discontinued the antibiotic Keflex 500 mg and started Macrobid 100 mg by mouth twice daily for five days for UTI. On 08/22/24 at 9:24 A.M., interview with Licensed Practical Nurse (LPN) #121 verified the antibiotic was started before the culture and sensitivity (C&S) returned. Review of the facility policy titled, Antibiotic Stewardship, dated 08/24 revealed antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 28923 Based on observation, resident interview, and staff interview, the facility failed to ensure residents' rooms and mobility devices were properly maintained and not in a state of disrepair. This affected four (Resident #15, #68, #70, and #115's) of the 34 residents sampled. The facility census was 140. Findings include: 1. On 08/20/24 at 8:44 A.M., an observation of Resident #70's room revealed the overbed light above his bed was not working. The short chain that was on the side of the fluorescent light did not activate a light to come on when it was pulled. Resident #70 also complained of not having a string attached to the short chain that he could reach in order to be able to use the light when he desired. On 08/26/24 at 10:00 A.M., a follow up observation of Resident #70's room revealed his light over the bed still did not work and was still missing a longer string to allow the resident to use it to turn the light on and off. Findings were verified by Maintenance Director #172 on 08/26/24 at 10:18 A.M. 2. On 08/20/24 at 9:55 A.M., an observation of Resident #105's room revealed there was some sort of dried substances on his ceiling above his bed. It was not able to be determined if the substance observed was some kind of food or what. On 08/26/24 at 10:05 A.M., a follow up observation of Resident #105's room revealed his ceiling above his bed continued to have dried substances on it and was in need of being cleaned. Findings were verified by Maintenance Director #145. He stated he would have someone from housekeeping clean the dried substances off the wall. He was not able to determine what the substance was. 3. On 08/20/24 at 8:54 A.M., an observation of Resident #68's room revealed it was not maintained in a clean manner. There were some debris on the floor and was in need of being swept and mopped. The walls in the room were also in disrepair with gouges, scuff marks, and paint spots from the resident's canvas paintings smeared on the walls. His wheelchair's armrest was also noted to have it's padding cracked with the foam exposed. On 08/26/24 at 10:08 A.M., a follow up of Resident #68's room revealed the floor and the walls to be in the same shape they were on 08/20/24. His wheelchair's armrest also remained in disrepair. Findings were verified by Maintenance Director #145. He confirmed the walls were in disrepair and stated he would have to try to get in there to repair it. He also indicated he had some extra armrests for wheelchairs that he could replace the cracked one with. 4. On 08/19/24 at 2:41 P.M., an observation of Resident #115's room revealed the wall by the door was noted to have dried drip lines on it. The wall behind the headboard of his bed was noted to have gouge marks in it. His wheelchair's arm rest on the left side was also noted to have the padded armrest cracked in multiple areas causing a rough surface. (continued on next page)

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	08/29/2024

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/26/24 at 10:09 A.M., a follow up observation of Resident #115's room revealed his wall remained dirty and in disrepair as was noted on 08/19/24. The wheelchair the resident used was sitting in the hall outside his room and continued to have an armrest that had cracking in the padding. Findings were verified by Maintenance Director #145. On 08/26/24 at 10:15 A.M., an interview with Maintenance Director #145 revealed the facility had a binder that was kept at the receptionist's desks on each of the facility's two buildings that included maintenance reports that should be filled out when a repair was necessary in a resident's room or with any resident care equipment. He reviewed the maintenance reports he had in the book for August 2024 and denied any of the above environmental concerns were mentioned in it. He stated the maintenance department checked that binder daily and made repairs accordingly. They would sign off in the book with the work had been completed. This deficiency represents noncompliance investigated under Complaint Number OH00157155.