STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365354	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longmeadow Care Center	565 Bryn Mawr Ravenna, OH 44266

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on record review, interview and review of the facility policy, the facility failed to ensure there was a signed advance directive/Do Not Resuscitate (DNR) form in Resident #17's medical record. This affected one resident (#17) out of one resident reviewed for advance directives. The facility census was 73. Findings include: 1. Review of the medical record for Resident #17 revealed an admitted [DATE] with diagnoses including paraplegia, diabetes, pressure ulcer to sacral region, and congestive heart failure. Review of the [DATE] physician's orders revealed Resident #17 had an order dated [DATE] for a code status of DNR Comfort Care-Arrest. Review of the undated DNR Comfort Care form in the medical record revealed it was unsigned by a physician, Physician Assistant (PA) and/or Nurse Practitioner (NP). The form revealed the box next to DNR Comfort Care Arrest was marked. The form indicated that the signature of a physician, PA, and NP was required. Observation on [DATE] at 10:03 A.M. of Resident #17's hard medical record/chart and electronic medical record with Assistant Director of Nursing (ADON)/Licensed Practical Nurse (LPN) #323 revealed he was not able to find a signed DNR Comfort Care- Arrest form. He verified Resident #17's DNR form in the medical record was undated and not signed by a physician, PA or NP. Interview and observation on [DATE] at 11:30 A.M. revealed ADON/LPN #323 brought in a DNR Comfort Care form dated [DATE] that was signed by Nurse Practitioner (NP) #950 that indicated Resident #17 was a DNR Comfort Care- Arrest. ADON/ LPN #323 revealed he had found the form in Resident #17's admission paperwork that was not part of his hard medical record/or electronic medical record. He verified the nurses had not had access to the DNR form to provide when the resident went to appointments, Emergency Rescue Services (EMS), and/or hospital especially during an emergency situation requiring cardiopulmonary resuscitation (CPR). (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy labeled, Resident's Rights Regarding Treatment and Advance Directives dated [DATE] revealed the facility would support and facilitate a resident's right to request, refuse, and/or discontinue medical or surgical treatment and to formulate an advance directive. The policy revealed upon admission, if the resident had an advance directive, copies of the advance directive would be made and placed on the chart and communicated to the staff. The policy did not include ensuring the DNR form was signed and dated by the physician, PA and/ or NP.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on record review, interview and review of the facility policy, the facility failed to report two incidents of resident elopement to the state agency. This affected two residents (#16 and #56) of two residents reviewed for neglect. The facility census was 73. Findings include: 1. Review of the medical record for Resident #16 revealed an admitted [DATE]. Diagnoses included colon cancer, diabetes, epilepsy, depression, muscle weakness and macular degeneration. Review of the care plan dated 09/23/21 revealed Resident #16 was a high risk for elopement and had exited the facility on 07/01/19. Interventions included applying and maintaining a Wander Guard (a wander management system to alert staff when a resident attempts to exit a designated area), checking the device for proper function, developing an activity program to divert Resident #16's attention and meet his individual needs and redirecting the resident to a safer area if he began wandering. The care plan was resolved on 08/18/21, and reimplemented 09/05/22. Review of the elopement assessment dated [DATE] revealed Resident #16 was not at risk for elopement. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 was rarely or never understood. He required set up for eating, partial to moderate assistance for oral hygiene, substantial to maximum assistance for personal hygiene and was dependent on staff for toileting and showering. He used a manual wheelchair to ambulate. Review of the nursing progress note dated 03/04/24 at 7:00 P.M. revealed the nurse was notified by another staff member Resident #16 was down the road in a wheelchair. The nurse walked to the resident who was sitting in his wheelchair on the sidewalk three blocks from the facility. The resident was agitated and initially refused to return to the facility. Emergency services was called to assist with transport back to the facility. Resident #16 could not explain what he was doing. Upon return to the facility, the resident was placed on one-to-one supervision and a Wander Guard was implemented. Review of the undated facility investigation revealed the Administrator, Director of Nursing (DON), Regional Director of Operations (RDO) and the Regional Director of Clinical Services (RDSO) were notified of the elopement on 03/04/24 at 6:30 P.M. At approximately 6:29 P.M., the nurse on duty was notified by Human Resources Manager (HRM) #300 that Resident #16 was down the street from the facility in a wheelchair. Two nurses attempted to get Resident #16 to return to the facility and ultimately called emergency services to assist in doing so. The resident could not explain why he had left the facility, and one-to-one staff as well as a Wander Guard were implemented upon return to the facility. 2. Review of the medical record for Resident #56 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included respiratory failure, prostate cancer and lung cancer. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the elopement assessment dated [DATE] revealed Resident #16 was not at risk for elopement. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #56 was severely cognitively impaired. He required supervision for eating and oral care and partial to moderate assistance for showering and hygiene. He used a manual wheelchair as needed. Review of the nursing progress note dated 11/16/24 at 1:02 P.M. revealed Resident #56 could not be located in the facility. The elopement protocol was initiated, and the DON and Nurse Practitioner (NP) were made aware. Resident #56's responsible party (RP) was notified and reported she had Resident #56 in the car with her after she found him walking down the sidewalk at 12:10 P.M. A Wander Guard was applied to Resident #56 upon his return to the facility. Review of the undated facility investigation revealed on 11/16/24 at approximately 11:40 A.M., Resident #56 could not be located in the facility. A code was called, and Resident #56 was found outside the facility with his Power of Attorney (POA)/RP. The weather was described as 46 degrees Fahrenheit (F) and cloudy. There was no description of what Resident #56 was wearing at the time of the elopement and no evidence of how Resident #56 exited the building without staff noticing. The investigation revealed Resident #56's POA had reported the resident attempted to leave a prior facility and was confused. Review of the physician's orders for November 2024 revealed an order for a Wander Guard. The order began on 11/16/24. Review of the care plan dated 11/16/24 revealed Resident #56 was at a high risk for elopement due to cognitive loss. Interventions included a Wander Guard, activity program to divert attention and meet individual needs, redirection if wandering to a potentially unsafe area and observing and reporting risk actors to the physician. Interview on 03/25/25 at 3:18 P.M. with Licensed Practical Nurse (LPN) #341 revealed Resident #56 was out of the building for approximately 15 minutes when they called his POA and were told he was in the car with her. He was assessed on return for injuries, and none were found. She could not recall any indicators of Resident #56 seeking to exit the facility. Interview on 03/26/25 at 9:22 A.M. with Resident #56's POA revealed she was on her way to the facility to see Resident #56 when she saw him walking outside, away from the facility, about one half mile from the facility. Resident #56 got into her vehicle and came back to the facility with her; she revealed it was approximately 15-20 minutes before anyone came out of the facility to look for him. Resident #56 was a little confused and may have been telling the facility he wanted out. She could not confirm if she told anyone at the facility he wanted to leave prior to the elopement. He could not tell her where he was going when she picked him up. She revealed it was chilly outside, and the temperature was approximately 40 degrees F. Interview on 03/26/25 at 9:55 A.M. with the Assistant Director of Nursing (ADON)/ LPN #323 revealed the Wander Guard system was active on all exterior doors except for the front door. There is a receptionist Monday through Friday from 8:00 A.M. until anywhere between 4:00 P.M. and 6:00 P.M. Staff were expected to watch the front door when there is no receptionist. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/26/25 at 1:34 P.M. with the Administrator verified both elopements (Residents #16 and #56) occurred. She revealed she did not have any evidence a self-reported incident (SRI) had been completed, and stated she was not aware it was required. Review of the facility policy titled Elopement and Wandering Residents dated 01/14/25 revealed in the event of a resident elopement, the appropriate reporting requirements to the state survey agency would be conducted.

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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 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** 45441 Based on record review, interview and review of the facility policy, the facility failed to thoroughly investigate two incidents of resident elopement. This affected two residents (#16 and #56) of two residents reviewed for neglect. The facility census was 73. Findings include: 1. Review of the medical record for Resident #16 revealed an admitted [DATE]. Diagnoses included colon cancer, diabetes, epilepsy, depression, muscle weakness and macular degeneration. Review of the care plan dated 09/23/21 revealed Resident #16 was a high risk for elopement and had exited the facility on 07/01/19. Interventions included applying and maintaining a Wander Guard (a wander management system to alert staff when a resident attempts to exit a designated area), checking the device for proper function, developing an activity program to divert Resident #16's attention and meet his individual needs and redirecting the resident to a safer area if he began wandering. The care plan was resolved on 08/18/21, and reimplemented 09/05/22. Review of the elopement assessment dated [DATE] revealed Resident #16 was not at risk for elopement. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 was rarely or never understood. He required set up for eating, partial to moderate assistance for oral hygiene, substantial to maximum assistance for personal hygiene and was dependent on staff for toileting and showering. He used a manual wheelchair to ambulate. Review of the nursing progress note dated 03/04/24 at 7:00 P.M. revealed the nurse was notified by another staff member Resident #16 was down the road in a wheelchair. The nurse walked to the resident who was sitting in his wheelchair on the sidewalk three blocks from the facility. The resident was agitated and initially refused to return to the facility. Emergency services was called to assist with transport back to the facility. Resident #16 could not explain what he was doing. Upon return to the facility, the resident was placed on one-to-one supervision and a Wander Guard was implemented. Review of the undated facility investigation revealed the Administrator, Director of Nursing (DON), Regional Director of Operations (RDO) and the Regional Director of Clinical Services (RDSO) were notified of the elopement on 03/04/24 at 6:30 P.M. At approximately 6:29 P.M., the nurse on duty was notified by Human Resources Manager (HRM) #300 that Resident #16 was down the street from the facility in a wheelchair. Two nurses attempted to get Resident #16 to return to the facility and ultimately called emergency services to assist in doing so. The resident could not explain why he had left the facility, and one-to-one staff as well as a Wander Guard were implemented upon return to the facility. 2. Review of the medical record for Resident #56 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included respiratory failure, prostate cancer and lung cancer. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the elopement assessment dated [DATE] revealed Resident #16 was not at risk for elopement. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #56 was severely cognitively impaired. He required supervision for eating and oral care and partial to moderate assistance for showering and hygiene. He used a manual wheelchair as needed. Review of the nursing progress note dated 11/16/24 at 1:02 P.M. revealed Resident #56 could not be located in the facility. The elopement protocol was initiated, and the DON and Nurse Practitioner (NP) were made aware. Resident #56's responsible party (RP) was notified and reported she had Resident #56 in the car with her after she found him walking down the sidewalk at 12:10 P.M. A Wander Guard was applied to Resident #56 upon his return to the facility. Review of the undated facility investigation revealed on 11/16/24 at approximately 11:40 A.M., Resident #56 could not be located in the facility. A code was called, and Resident #56 was found outside the facility with his Power of Attorney (POA)/RP. The weather was described as 46 degrees Fahrenheit (F) and cloudy. There was no description of what Resident #56 was wearing at the time of the elopement and no evidence of how Resident #56 exited the building without staff noticing. The investigation revealed Resident #56's POA had reported the resident attempted to leave a prior facility and was confused. Review of the physician's orders for November 2024 revealed an order for a Wander Guard. The order began on 11/16/24. Review of the care plan dated 11/16/24 revealed Resident #56 was at a high risk for elopement due to cognitive loss. Interventions included a Wander Guard, activity program to divert attention and meet individual needs, redirection if wandering to a potentially unsafe area and observing and reporting risk actors to the physician. Interview on 03/25/25 at 3:18 P.M. with Licensed Practical Nurse (LPN) #341 revealed Resident #56 was out of the building for approximately 15 minutes when they called his POA and were told he was in the car with her. He was assessed on return for injuries, and none were found. She could not recall any indicators of Resident #56 seeking to exit the facility. Interview on 03/26/25 at 9:22 A.M. with Resident #56's POA revealed she was on her way to the facility to see Resident #56 when she saw him walking outside, away from the facility, about one half mile from the facility. Resident #56 got into her vehicle and came back to the facility with her; she revealed it was approximately 15-20 minutes before anyone came out of the facility to look for him. Resident #56 was a little confused and may have been telling the facility he wanted out. She could not confirm if she told anyone at the facility he wanted to leave prior to the elopement. He could not tell her where he was going when she picked him up. She revealed it was chilly outside, and the temperature was approximately 40 degrees F. Interview on 03/26/25 at 9:55 A.M. with the Assistant Director of Nursing (ADON)/ LPN #323 revealed the Wander Guard system was active on all exterior doors except for the front door. There is a receptionist Monday through Friday from 8:00 A.M. until anywhere between 4:00 P.M. and 6:00 P.M. Staff were expected to watch the front door when there is no receptionist. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/26/25 at 2:10 P.M. with ADON/LPN #323 further revealed the facility could not determine exactly how Residents #16 and #56 left the facility without staff knowledge, as the facility investigations did not conduct a root cause analysis. He also could not confirm if care planned interventions such as engaging the residents in person centered activities, were in progress at the time of the elopements. Review of the facility policy titled Abuse, Neglect and Exploitation dated 01/01/24 revealed neglect was defined as failure of the facility to provide goods and services to a resident that aided in avoiding unnecessary harm, mental or physical anguish or emotional distress. An investigation was warranted when neglect was suspected and included providing complete and thorough documentation of the investigation.

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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 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** 45441 Based on record review and interview, the facility failed to ensure care plans were comprehensive. This affected two residents (Residents #12 and #229) of 24 residents reviewed for care plans and had the potential to affect all 73 residents in the facility. Findings include: 1. Review of the medical record for Resident #12 revealed and admitted [DATE]. Diagnoses included respiratory failure, congestive heart failure, chronic obstructive pulmonary disease (COPD), kidney disease, sleep apnea, glaucoma and depression. Review the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 was cognitively intact. She required setup help for eating, oral and personal hygiene, supervision for toileting and partial to moderate assistance for showering. Review of the physicians' orders from March 2025 revealed an order for Acetaminophen 1000 milligrams (mg) (analgesic) three times a day for pain, and 325 mg every four hours as needed for pain. There was also in order for oxycodone 7.5 mg (opioid pain medication) every four hours as needed for pain. Interview on 03/27/25 at 1:53 P.M. with Licensed Practical Nurse (LPN) #341 revealed Resident #12 had hip surgery years ago and was told she would always be in pain. The facility was aware of her pain and managing it through therapy, nonpharmacological interventions and medications. Interview on 03/31/25 at 7:57 A.M. with LPN #302 confirmed she was aware Resident #12 had issues with pain. She also confirmed there was no evidence the residents care plan addressed her pain needs. 2. Review of the medical record for Resident #229 revealed an admitted [DATE]. Diagnoses included bladder cancer and kidney failure. Review of the smoking assessment dated [DATE] revealed Resident #229 was a supervised smoker. Review of the baseline care plan dated 03/05/25 revealed no evidence smoking had been addressed for Resident #229. Interview on 03/31/25 at 7:57 A.M. with LPN #302 confirmed smoking had not been addressed in Resident #229's care plan. Review of the facility policy titled Comprehensive Care Plans dated 06/01/24 revealed the facility would develop and implement a comprehensive, person-centered care plan which addressed the medical, mental, and psychosocial needs of the resident.

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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 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** 39973 Based on record review, observation, interview and facility policy review, the facility failed to ensure treatment orders were implemented in a timely manner and/or completed as ordered. Actual Harm occurred on 02/04/25 when Resident #17, who was a paraplegic and was dependent on staff assistance for most activities of daily living (ADL) including transfers, and rolling left and right in bed, was found to have an in-house acquired Stage II pressure ulcer (partial- thickness skin loss appearing as a shallow area with a red or pink wound bed) to his sacrum (located at the base of the spine) that measured 3.5 centimeters (cm) in length by 1.9 cm in width by 0.2 cm in depth. The facility failed to implement the treatment as ordered on 02/04/25 of Medi Honey (a brand of medical-grade honey-based product used for wound management) and silicone bordered foam dressing daily until 02/07/25. Wound Nurse Practitioner (NP) #900 consulted on 02/11/25 and noted a significant decline to Resident #17's sacrum pressure ulcer as the wound increased in size to 11.0 cm in length by 5.2 cm in width by unable to determine the depth as the wound had 10 percent slough (dead tissue that accumulated on the surface of a wound) and 60 percent purple/ maroon discoloration. Wound NP #900 classified the pressure wound as unstageable (full thickness tissue loss in which the actual depth of the ulcer was obscured by slough/ dead skin). The facility did not ensure ongoing treatments were completed as ordered and on 03/18/25, Resident #17's sacrum pressure ulcer was classified as a Stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle) as the wound had bone that was palpable. In addition, Resident #17 had pressure ulcers to his right and left ankles and the treatments were not completed as ordered. This affected one (#17) of two residents reviewed for pressure ulcers. The facility census was 73. Findings include: 1. Review of the medical record for Resident #17 revealed an admitted [DATE] with diagnoses including paraplegia, diabetes, pressure ulcer to sacral region, and congestive heart failure. Resident #17 was on hospice when admitted with senile degeneration of the brain listed as his end stage diagnosis; however, hospice was discontinued on 01/08/25, and he had no other terminal/end stage diagnosis. Review of the care plan dated 11/04/24 revealed Resident #17 had actual skin impairment related to diabetic, arterial, and pressure ulcers. He preferred to be out of bed and lie on his back despite education. Interventions included initiating wound treatment and continuing treatment as ordered, limiting time out of bed, nursing to observe the wound dressing daily to ensure that the dressing remains intact and that there were no signs of infection, pressure reducing cushion to chair and pressure reducing mattress to bed. Review of the Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 had intact cognition. He had impairment on both his lower extremities and required substantial to maximum assistance with toileting hygiene and showers. He was completely dependent on staff with rolling left and right and transfers. He was at risk for the development of pressure ulcers and had two unhealed Stage 3 (full-thickness skin loss extending to the subcutaneous tissue layer) pressure ulcers that were present on admission and one vascular ulcer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the February 2025 treatment administration record (TAR) revealed Resident #17 had an order to his sacrum area to apply zinc barrier cream topically every shift and as needed dated from 10/31/24 to 02/06/25. The TAR was blank, indicating the treatment was not completed on dayshift 02/01/25, 02/02/25 and 02/06/25. The treatment order to his sacrum pressure ulcer was changed on 02/07/25, three days after Wound NP #900 had ordered to clean the wound with normal saline, pat dry, apply Medi Honey and cover with silicone foam dressing daily and as needed. The treatment order for Resident #17's sacrum pressure ulcer was changed on 02/12/25 to clean the wound with normal saline, pat dry, apply calcium alginate (absorbent sterile wound dressing used to manage moderate to heavy drainage from a wound), cover with silicone foam dressing daily and as needed. The TAR was blank, indicating the treatment was not completed on 02/18/25. The treatment order for Resident #17's sacrum pressure ulcer was changed on 02/19/25 to clean the wound with normal saline, pat dry, apply one fourth strength Dakin's (a solution for wound management for cleaning and debriding wounds) moistened gauze, and cover with silicone foam dressing daily and as needed. The TAR was blank, indicating that the treatment was not completed on 02/26/25 and 02/28/25. Review of the nursing note dated 02/03/25 and completed by Assistant Director of Nursing (ADON)/Licensed Practical Nurse (LPN) #323 revealed Resident #17 had a new open area to his sacrum area. Wound NP #900 was notified and stated she would see Resident #17 in the morning (02/04/25). Review of the Skin Grid Pressure assessment dated [DATE] and completed by ADON/LPN #323 revealed Resident #17 had a new Stage 2 pressure ulcer to his sacrum that measured 3.5 cm in length by 1.9 cm in width by 0.2 cm in depth. The wound was described as a shallow open area with pink moist tissue with a thin biofilm (protective slimy layer on the wound surface) partially wiped away. The assessment noted adding Medi Honey for autolytic debridement (a wound care technique that used the patient's enzymes to break down and remove dead tissue). Review of Wound NP #900's progress note dated 02/04/25 revealed Resident #17 had a new in-house acquired Stage 2 partial thickness pressure ulcer to his sacrum that measured 3.5 cm in length by 1.9 cm in width by 0.2 cm in depth. The area was described as a shallow open area with pink moist tissue with thin biofilm that partially wiped away. A new order was received to cleanse the wound with normal saline, apply Medi Honey and silicone bordered foam dressing daily. She revealed the treatment was chosen for autolytic debridement, antimicrobial activity (substances ability to kill or inhibit the growth of microorganisms), and epithelization promotion (the process of repairing a wound). The progress note stated that Resident #17 and the nursing staff were educated on the importance of adhering to prescribed treatments and dressing changes to prevent infection. Review of the Skin Grid Pressure assessment dated [DATE] and completed by ADON/LPN #323 revealed Resident #17's pressure ulcer to his sacrum had a rapid decline with larger measurements, and the wound had dark purple tissue extending across the sacrum towards the rectal area. The wound was classified as an unstageable pressure ulcer and measured 11 cm in length by 5.2 cm in width and the depth was unable to be determined. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Wound NP #900's progress note dated 02/11/25 revealed nursing reported a decline to Resident #17's sacral pressure ulcer which was previously thought may be related to moisture, but upon assessment Wound NP #900 felt the wound was pressure. Wound NP #900 revealed the wound may be related to end-of-life skin failure such as Kennedy terminal ulcer (Resident #17 did not have a terminal diagnosis, and Wound NP #900 felt the wound had a high likelihood of healing). She described the wound as unstageable and measured 11.0 cm in length by 5.2 cm in width and unable to determine the depth. The wound bed contained 30 percent granulation, 10 percent slough, and 60 percent purple/maroon discoloration with moderate serosanguinous (drainage from the wound with a mixture of clear watery fluid and blood) drainage. She recommended changing the treatment to cleanse the wound with normal saline, apply calcium alginate and cover with silicone bordered foam dressing daily. She revealed the treatment was chosen for autolytic debridement and drainage management. Review of the March 2025 TAR revealed Resident #17 continued to have a treatment to his sacrum to clean with normal saline, pat dry, apply one fourth Dakin's moistened gauze and cover with silicone foam dressing daily and as needed from 03/01/25 to 03/11/25. The TAR was blank 03/07/25, 03/10/25, and 03/11/25, indicating the treatment was not completed as ordered. The treatment was changed to twice a day from 03/11/25 until 03/18/25, and the TAR was blank on dayshift 03/14/25, 03/15/25, 03/16/25, and 03/18/25, indicating the treatment was not completed as ordered. The treatment was changed on 03/18/25 to continue the same treatment (clean with normal saline, pat dry, apply one forth strength Dakin's moistened gauze, and cover with silicone foam dressing twice daily) except add zinc oxide cream to peri-rectum twice a day. The TAR was blank 03/20/25, 03/21/25, and 03/24/25, indicating the treatment was not completed as ordered. Review of Wound NP #900's progress note dated 03/18/25 revealed Resident #17's pressure ulcer was classified as a Stage 4 pressure ulcer that measured 12.5 cm in length by 8.5 cm in width by 4.0 cm in depth. The wound had undermining between ten o'clock and two o'clock that measured 5.1 cm and had ten percent slough. There was heavy thick green drainage with palpable bone in the center of the wound. Review of Wound NP #900's progress note dated 03/25/25 revealed Resident #17 had a Stage 4 pressure ulcer to his sacrum area that measured 12.2 cm in length by 6.4 cm in width by 4.0 cm in depth. The note revealed there was undermining between ten o'clock and two o'clock that measured 5.1 cm. The wound bed had 90 percent granulation and 10 percent slough. Wound NP #900 noted that the wound had improved as there was healing beefy red granulating tissue with minimal slough and that the wound was being evaluated for graft placement. She recommended the same treatment to continue cleansing with normal saline, pat dry, apply one fourth strength Dakin's moistened gauze, and cover with silicone foam dressing twice daily. Nursing to topically apply zinc oxide cream to peri-rectum twice a day. Observation of wound care on 03/26/25 at 8:33 A.M. completed by ADON/LPN #323 and Certified Nursing Assistant (CNA) #344 revealed a Stage 4 pressure ulcer to Resident #17's sacrum. ADON/LPN #323 described the wound as granulating tissue covering the wound bed with bone exposed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 03/26/25 at 11:58 A.M. with ADON/LPN #323 verified Resident #17's sacrum treatments per the February and March 2025 TARs: 02/01/25, 02/02/25, 02/06/25, 02/18/25, 02/26/25, 02/28/25, 03/07/25, 03/10/25, 03/11/25, dayshift 03/14/25, 03/15/25, 03/16/25, 03/18/25, 03/20/25, 03/21/25, and 03/24/25 were blank, indicating the treatment was not completed as ordered. ADON/LPN #323 verified Wound NP #900 evaluated Resident #17's new facility acquired pressure ulcer to his sacrum on 02/04/25 and classified the wound as a Stage 2, and that he received a treatment order to cleanse the wound with normal saline, apply Medi Honey and cover with silicone bordered foam dressing daily. He verified the treatment was not transcribed and implemented until 02/07/25 per the physician orders/TAR. He verified from 02/04/25 to 02/11/25 Resident #17's wound significantly declined from a Stage 2 that measured 3.5 cm in length by 1.9 cm in width by 0.2 cm in depth to an unstageable pressure wound that measured 11 cm in length by 5.2 cm in width and unable to determine the depth as it contained ten percent slough, and 60 percent purple/maroon discoloration. He verified the wound then became a Stage 4 with bone exposed. Interview on 03/17/25 at 1:32 P.M. with Wound NP #900 revealed she was not aware that the treatment that she had ordered on 02/04/25 for Resident #17 was not initiated until 02/07/25. She verified the wound had declined rapidly from 02/04/25 to 02/11/25 from a Stage 2 to an unstageable pressure ulcer. She also verified she was not aware that the treatments were not being documented as completed as ordered. She verified the wound as of 03/25/25 was a Stage 4. 2. Review of medical record for Resident #17 revealed an admitted [DATE] with diagnoses including paraplegia, diabetes, pressure ulcer to sacral region, and congestive heart failure. Review of Wound NP #900's progress note dated 11/05/24 revealed Resident #17 had a right lateral ankle Stage 3 pressure ulcer present on admission that measured 3.0 cm in length by 2.5 cm in width by 0.3cm in depth. The wound bed contained 90 percent granulation and 10 percent slough. Resident #17 had a Stage 3 pressure ulcer to his left lateral ankle that measured 1.2 cm in length by 0.5 cm in width by 0.3 cm in depth and the wound bed had 100 percent granulated tissue. Review of February 2025 TAR revealed Resident #17 had an order from 12/25/24 to 02/18/25 to cleanse his left lateral ankle with normal saline, pat dry, apply calcium silver alginate, cover with bordered foam dressing daily and as needed. The TAR was blank 02/01/25, 02/02/25 and 02/18/25, indicating the treatment was not completed as ordered. The treatment to his left lateral ankle was changed on 02/19/25 to cleanse with normal saline, pat dry, apply Skin Prep and leave open to air daily and as needed. The TAR was blank 02/20/25, 02/24/25, and 02/25/25, indicating the treatment was not completed as ordered. The TAR revealed Resident #17 had an order dated 12/25/24 till 02/11/25 to his right lateral ankle to cleanse with normal saline, pat dry, apply calcium alginate silver, ABD, and wrap with Kerlix gauze daily and as needed. The TAR was blank 02/01/25, 02/02/25, and 02/11/25, indicating the treatment was not completed as ordered. The treatment was changed on 02/19/25 to cleanse his right lateral ankle with normal saline, pat dry, apply moistened collagen, abdominal (ABD), wrap with Kerlix gauze daily and as needed. The TAR was blank 02/20/25, 02/24/25, and 02/25/25, indicating the treatment was not completed as ordered. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of March 2025 TAR revealed Resident #17 had an order from 02/27/25 till 03/04/25 for his left lateral ankle pressure ulcer to cleanse with normal saline, pat dry, apply Skin Prep and leave open to air and as needed every Tuesday, Thursday and Saturday. The TAR was blank 03/01/25, indicating the treatment was not completed as ordered. The treatment to his right lateral ankle dated from 02/27/25 to 03/04/25 to cleanse with normal saline, pat dry, apply moistened collagen, ABD, wrap with Kerlix gauze every Tuesday, Thursday, Saturday, and as needed. The TAR was blank on 03/01/25 and 03/04/25, indicating the treatment was not completed as ordered. The treatment to his right lateral ankle was changed on 03/05/25 to cleanse with normal saline, pat dry, apply calcium silver alginate, ABD, wrap with Kerlix gauze daily and as needed. The TAR was blank on 03/07/25, 03/10/25, 03/11/25, 03/14/25, 03/15/25, 03/16/25, and 03/18/25, indicating the treatment was not completed as ordered. The treatment to his right lateral ankle was changed on 03/19/25 to cleanse the wound with normal saline, pat dry, apply Skin Prep daily and as needed. The TAR was blank on 03/21/25 and 03/24/25, indicating the treatment was not completed as ordered. Review of Wound NP #900's progress note dated 03/04/25 revealed the left lateral ankle was healed. Wound NP #900's progress note dated 03/25/25 revealed Resident #17's right lateral Stage 3 pressure ulcer was healed. Interview on 03/26/25 at 11:58 A.M. with ADON/LPN #323 verified all the above times the treatment on February 2025 and March 2025 TAR the treatment was not documented as completed as the TAR was blank. Review of the facility policy labeled, Pressure Injury Prevention and Management, dated 01/08/25, revealed the facility was committed to the prevention of avoidable pressure injuries and would provide treatment and services to heal pressure ulcers, prevent infection and prevent the development of additional pressure ulcers. The policy revealed treatments would be provided for all residents who have a pressure ulcer present. The policy revealed interventions would be documented in the care plan and communicated to all relevant staff. This deficiency represents non-compliance investigated under Master Complaint Number OH00163991, Complaint Numbers OH00162697 and OH00161917.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, interview, record review and review of facility policy, the facility failed to ensure splints were applied as ordered and per therapy recommendations. This affected two residents (#1 and #47) out of two residents reviewed for splints. This had the potential to affect seven residents (#1, #34, #37, #47, #49, #54, and #72) that were identified by the facility with an order for a splint. The facility census was 73. Findings include: 1. Review of the medical record for Resident #47 revealed an admitted [DATE] with diagnoses including cerebral infarction due to embolism of right middle cerebral artery, hemiplegia and hemiparesis following intracranial hemorrhage affecting left non-dominant side, and hypertension. Review of the care plan dated 07/18/24 revealed Resident #47 had the potential for complications related to cerebral vascular accident as evidence by cognitive impairment, decline in activities of daily living (ADL) abilities and left non-dominant side hemiparesis. Interventions included therapy per order, providing adaptive equipment as needed, and reporting to the physician any decline. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #47 had impaired cognition. She had impairment on one side to both her upper and lower extremities and was dependent on staff for most of all her ADL, including dressing. Review of the Treatment Administration Record (TAR) for February 2025 and March 2025 revealed no documentation regarding Resident #47's splint application. Review of Occupational Therapy (OT) Discharge Summary dated 02/17/25 and completed by Occupational Therapist (OT) #951 revealed Resident #47 tolerated the application of the splint to her left hand greater than four hours to decrease risk of further contracture. Review of March 2025 Physician Orders revealed Resident #47 had an order dated 01/29/25 for a left-hand splint on in the A.M. and off in the P.M. Review of undated task bar for Resident #47 revealed no documentation regarding Resident #47's application of her splint in the last 30 days. Interview on 3/24/25 at 12:11 P.M. with Resident #47's father revealed he was concerned as Resident #47 had a splint for her left hand and that he always seen it in the same spot on her dresser and did not feel the staff was applying the splint as ordered. Observation on 03/25/25 at 2:19 P.M., 03/26/25 at 8:28 A.M., 03/26/25 at 10:42 A.M. and 03/26/25 at 1:28 P.M. revealed Resident #47 was not wearing a splint to her left hand. The left-hand splint remained on the dresser in the same spot it was observed 03/24/25. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/26/25 at 1:31 P.M. with Certified Nursing Assistant (CNA) #344 revealed she worked on Resident #47's unit frequently and stated Resident #47 did not have an order to apply a splint to her left hand. She revealed the splint that was lying on her dresser was old and stated, she does not need it anymore and that she did not apply a splint to Resident #47's left hand. Interview on 03/26/25 at 2:06 P.M. with Licensed Practical Nurse (LPN) #328 revealed she worked on Resident #47's unit frequently over the past two years and to her knowledge Resident #47 did not have an order for a left-hand splint and/or had she ever seen her with a splint on while she was working (dayshift). LPN #328 verified after checking the electronic medical record physician orders, Resident #47 did have an order for left hand splint to be on in the A.M. and off in the P.M. She revealed that she and CNA #344 frequently worked on Resident #47's unit, and the splint order was not showing up on the TAR and/or the task bar which would notify them that Resident #47 had an order for the splint. She was unsure why it was not showing up on the TAR and/or task bar. Interview on 03/26/25 at 2:15 P.M. and 2:35 P.M. with Rehabilitation Director #902 revealed per the OT discharge summary dated 02/17/25, Resident #47 was to have a left-hand splint on in the A.M. and off in the P.M. greater than four hours. Rehabilitation Director #902 revealed OT #951 put the order into the electronic medical record, but she verified she put it in incorrectly as it did not show up on the TAR and/or tasks preventing the nurses and aides of knowing that there was an order for Resident #47 to wear a left-hand splint daily. Interview on 03/26/25 at 2:30 P.M. with Assistant Director of Nursing (ADON)/ LPN #323 verified Resident #47 had a physician order to wear a left-hand splint in the A.M. and remove in the P.M. He revealed OT #951 had put the order into the electronic record incorrectly, and the order only showed up in the order section of the record, not on the TAR and/or task bar. He stated the way the order was put in did not trigger the nurses and/or aides to know there was an order for Resident #47 to have a splint. Review of the facility policy labeled, Prevent of Decline in Range of Motion dated 01/01/24 revealed the facility would establish and utilize a systematic approach for prevention of decline in range of motion including assessment, appropriate care planning, and preventative care. The facility would provide treatment and care in accordance with professional standards of practice that included appropriate services such as therapy, appropriate equipment such as braces or splints, and assistance as needed including active and passive assistance. 45441 2. Review of the medical record for Resident #1 revealed an admitted [DATE] with diagnoses including history of stroke, diabetes, muscle weakness and heart failure. Review of the care plan dated 02/17/25 revealed Resident #1 required assistance with ADL. Interventions included assisting in oral care, encouraging self-care as able, providing assistive devices as needed, and encouraging use of the spica (a splint used for treating bony and soft-tissue injuries of the lateral hand's thumb, carpal, and metacarpal) to the right thumb. Review of the TAR for February 2025 revealed no evidence Resident #'1's spica was applied in the morning on the following dates: 02/01/25, 02/02/25, 02/17/25, 02/18/25, 02/24/25, 02/26/25 and 02/28/25. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS assessment dated [DATE] revealed Resident #1 was severely cognitively impaired. He required setup help for eating and was dependent on staff for oral hygiene, toileting, showering and personal hygiene. He was not actively receiving therapy services. Review of the physician's orders for March 2025 revealed an order for a right-hand thumb spica to be on in the morning with care and off in the evening. The order began on 08/08/23. Review of the TAR for March 2025 revealed Resident #1's spica was not applied in the morning on the following dates: 03/02/25, 03/10/25, 03/13/25, 03/21/25 and 03/22/25. Observation on 03/31/24 at 8:09 A.M. revealed Resident #1 was in his room in his wheelchair coloring a picture. No spica was in use. Interview at the time of the observation with CNA #375 confirmed she had assisted Resident #1 in getting up for the day, and he should have had a spica in use. She could not locate the device and confirmed it should have been placed on Resident #1's hand when she assisted him with morning care. Interview on 04/01/25 at 8:35 A.M. with Rehab Director #902 confirmed Resident #1 had used a spica to his left thumb since at least 2023. She confirmed she had seen him with it and felt it was effective in maintaining his current level of functioning, it was not meant to increase his ability to use his right hand. She was unaware the spica was not being used on a consistent basis. Review of the facility policy titled Prevention of Decline in Range of Motion dated 01/01/24 revealed facility staff would be educated on basic, restorative nursing care which included maintaining proper positioning, appropriate exercises and the use of assistive devices. This deficiency represents noncompliance investigated under Complaint Number OH00162697.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on record review, interview and review of the facility policy, the facility failed to prevent elopements for Residents #16 and #56. This affected two residents (#16 and #56) of six residents reviewed for accidents. The facility census was 73. Findings include: 1. Review of the medical record for Resident #16 revealed an admitted [DATE]. Diagnoses included colon cancer, diabetes, epilepsy, depression, muscle weakness and macular degeneration. Review of the care plan dated 09/23/21 revealed Resident #16 was a high risk for elopement and had exited the facility on 07/01/19. Interventions included applying and maintaining a Wander Guard (a wander management system to alert staff when a resident attempts to exit a designated area), checking the device for proper function, developing an activity program to divert Resident #16's attention and meet his individual needs and redirecting the resident to a safer area if he began wandering. The care plan was resolved on 08/18/21, and reimplemented 09/05/22. Review of the elopement assessment dated [DATE] revealed Resident #16 was not at risk for elopement. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 was rarely or never understood. He required set up for eating, partial to moderate assistance for oral hygiene, substantial to maximum assistance for personal hygiene and was dependent on staff for toileting and showering. He used a manual wheelchair to ambulate. Review of the nursing progress note dated 03/04/24 at 7:00 P.M. revealed the nurse was notified by another staff member Resident #16 was down the road in a wheelchair. The nurse walked to the resident who was sitting in his wheelchair on the sidewalk three blocks from the facility. The resident was agitated and initially refused to return to the facility. Emergency services was called to assist with transport back to the facility. Resident #16 could not explain what he was doing. Upon return to the facility, the resident was placed on one-to-one supervision and a Wander Guard was implemented. Review of the undated facility investigation revealed the Administrator, Director of Nursing (DON), Regional Director of Operations (RDO) and the Regional Director of Clinical Services (RDSO) were notified of the elopement on 03/04/25 at 6:30 P.M. At approximately 6:29 P.M., the nurse on duty was notified by Human Resources Manager (HRM) #300 that Resident #16 was down the street from the facility in a wheelchair. Two nurses attempted to get Resident #16 to return to the facility and ultimately called emergency services to assist in doing so. The resident could not explain why he had left the facility, and one-to-one staff as well as a Wander Guard were implemented upon return to the facility. 2. Review of the medical record for Resident #56 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included respiratory failure, prostate cancer and lung cancer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the elopement assessment dated [DATE] revealed Resident #16 was not at risk for elopement. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #56 was severely cognitively impaired. He required supervision for eating and oral care and partial to moderate assistance for showering and hygiene. He used a manual wheelchair as needed. Review of the nursing progress note dated 11/16/24 at 1:02 P.M. revealed Resident #56 could not be located in the facility. The elopement protocol was initiated, and the DON and Nurse Practitioner (NP) were made aware. Resident #56's responsible party (RP) was notified and reported she had Resident #56 in the car with her after she found him walking down the sidewalk at 12:10 P.M. A Wander Guard was applied to Resident #56 upon his return to the facility. Review of the undated facility investigation revealed on 11/16/24 at approximately 11:40 A.M., Resident #56 could not be located in the facility. A code was called, and Resident #56 was found outside the facility with his Power of Attorney (POA)/RP. The weather was described as 46 degrees Fahrenheit (F) and cloudy. There was no description of what Resident #56 was wearing at the time of the elopement and no evidence of how Resident #56 exited the building without staff noticing. The investigation revealed Resident #56's POA had reported the resident attempted to leave a prior facility and was confused. Review of the physician's orders for November 2024 revealed an order for a Wander Guard. The order began on 11/16/24. Review of the care plan dated 11/16/24 revealed Resident #56 was at a high risk for elopement due to cognitive loss. Interventions included a Wander Guard, activity program to divert attention and meet individual needs, redirection if wandering to a potentially unsafe area and observing and reporting risk actors to the physician. Interview on 03/25/25 at 3:18 P.M. with Licensed Practical Nurse (LPN) #341 revealed Resident #56 was out of the building for approximately 15 minutes when they called his POA and were told he was in the car with her. He was assessed on return for injuries, and none were found. She could not recall any indicators of Resident #56 seeking to exit the facility. Interview on 03/26/25 at 9:22 A.M. with Resident #56's POA revealed she was on her way to the facility to see Resident #56 when she saw him walking outside, away from the facility, about one half mile from the facility. Resident #56 got into her vehicle and came back to the facility with her; she revealed it was approximately 15-20 minutes before anyone came out of the facility to look for him. Resident #56 was a little confused and may have been telling the facility he wanted out. She could not confirm if she told anyone at the facility he wanted to leave prior to the elopement. He could not tell her where he was going when she picked him up. She revealed it was chilly outside, and the temperature was approximately 40 degrees F. Interview on 03/26/25 at 9:55 A.M. with the Assistant Director of Nursing (ADON)/ LPN #323 revealed the Wander Guard system was active on all exterior doors except for the front door. There is a receptionist Monday through Friday from 8:00 A.M. until anywhere between 4:00 P.M. and 6:00 P.M. Staff were expected to watch the front door when there is no receptionist. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/26/25 at 1:34 P.M. with the Administrator verified both elopements (Residents #16 and #56) occurred. She revealed she did not have any evidence a self-reported incident (SRI) had been completed, and stated she was not aware it was required. Review of the facility policy titled Abuse, Neglect and Exploitation dated 01/01/24 revealed neglect was defined as failure of the facility to provide goods and services to a resident that aided in avoiding unnecessary harm, mental or physical anguish or emotional distress. The facility would establish a safe environment which prohibited and prevented all types of abuse, neglect and misappropriation and would identify and correct situation when abuse and neglect was likely to occur.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on interview, record review, and review of facility policy the facility failed to obtain weights according to Dietician recommendations for Resident #47. This affected one Resident (#47) out of three residents reviewed for nutrition. The facility census was 73. Findings included: Review of the medical record for Resident #47 revealed an admitted [DATE] and her diagnoses included cerebral infarction due to embolism of right middle cerebral artery, diabetes, hypertension and presence of gastrostomy tube (tube inserted into the stomach to provide means of feeding and medication). Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #47 had impaired cognition, and she had a feeding tube with weight loss that was not prescribed. Review of the care plan last revised 02/13/25 revealed Resident #47 was at risk for malnutrition related to underweight, dysphagia, nothing by mouth, feeding tube, pressure wounds, and significant weight change. Interventions included monitor weight every month and as needed, nothing by mouth, and provide prescribed tube feeding. There was nothing in the care plan regarding following dietician recommendations of weekly weights. Review of the weight records per electronic medical record from 09/01/24 to 03/27/25 revealed on 09/01/24 Resident #47's weight was 139 pounds. Her weight 09/02/24 was 133.1 pounds, 09/09/24 130.4 pounds, 10/02/24 was 122.8 pounds, 10/16/24 was 121.9 pounds, 10/17/24 was 121.5 pounds, 10/24/24 was 122 pounds, 11/26/24 was 125.2 pounds, 12/10/24 was 120 pounds, 01/02/25 was 118 pounds, 01/23/25 was 118.8 pounds, 02/05/25 was 112 pounds, and 03/16/25 was 112 pounds. Review of Medical Nutrition Therapy Recommendation Log completed 12/05/24 by Dietician #903 revealed Resident #47 had a significant weight change as well as a wound. Dietician #903 recommended to increase her Diabetasource Advanced Control (AC) (type of tube feeding formula) one carton six times a day and complete weekly weights. Review of Medical Nutrition Therapy Recommendation Log completed 12/20/24 by Dietician #903 revealed Resident #47 had weight loss and she was not tolerating her Diabetasource AC tube feeding that had been increased to six times a day. Dietician #903 recommended decreasing down to five cartons per day and continue weekly weights. Dietician #903 noted that if weight loss continued, she would switch to Two Cal formula (type of tube feeding formula). Review of Medical Nutrition Therapy Recommendation Log completed 01/09/25 by Dietician #903 revealed Resident #47 had significant weight loss as she had a six percent weight loss in one month. Dietician #903 recommended Two Cal five cartons per day and continue weekly weight. There were no further Medical Nutrition Therapy Recommendation Log provided after 01/09/25. Review of the March 2025 physician orders revealed Resident #47 had an order for an enteral feed of Two Cal 250 milliliters (ML) bolus five times a day. There was no order regarding weights. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Dietician #903's progress note dated 01/27/25 at 11:22 A.M. revealed Resident #47 had significant weight loss as her weight on return from the hospital was 118. She had a 22 percent weight loss over the last six months. She continued to be nothing by mouth as she failed her modified barium swallow (MBS) (imaging test that uses barium designed to evaluate how foods and liquids move through gastrointestinal tract) on 12/20/24. While in the hospital it was noted she had a mass to her oropharynx (part of the throat) which was removed and may have contributed to her swallowing issues. She recommended changing the enteral feed to Two Cal 250 milliliters (ML) bolus five times a day and monitor weekly weights. Review of Weekly Weight/ Admission Tracker dated from 01/30/25 to 03/20/25 revealed Dietician #903 tracked residents' weights on a form and the tracker revealed Resident #47 had the following weights: 01/30/25 her weight was 112 pounds, 02/06/25 her weight was 112 pounds, and 03/13/25 her weight was 112 pounds. The tracker revealed on 02/13/25, 02/20/25, 02/27/25, 03/06/25, and 03/13/25 there was no weight listed. Review of Dietician #903's progress note dated 02/13/25 at 10:27 A.M. revealed Resident #47 had significant weight changes as her most recent weight was 112 pounds and she was classified as underweight. She had five percent weight loss in one month, eight percent weight loss in three months, and 26 percent weight loss in six months (all were undesired). The note revealed Resident #47 remained nothing by mouth and received feeding through her feeding tube. Resident #47 was unable to tolerate total calorie need as she does not tolerate changes to the volume of tube feeding and at this time Dietician #903 did not recommend any changes except to consider possible hospice and continue weekly weights. Review of Dietician #903 progress note dated 03/20/25 at 11:24 A.M. revealed Resident #47 had significant weight changes as her most recent weight was 112 pounds and she was classified as underweight. The note revealed she had a 14 percent wight loss in the last six months but had been stable over the last month. The note revealed Resident #47 remains nothing by mouth and received feeding through her feeding tube. Resident #47 was unable to tolerate total calorie need as she does not tolerate changes to the volume of tube feeding and at this time Dietician #903 did not recommend any changes except to consider possible hospice and continue weekly weights. Interview on 03/27/25 at 8:24 A.M. and 9:50 A.M. with Dietician #903 revealed she had recommended Resident #47 to receive weekly weights due to her weight loss since at least 12/05/24. She revealed she tracked the weights on a Weekly Weight/ Admission Tracker form and verified she only had the following weights for Resident #47 from 01/30/25 to 03/20/25: 01/30/25 her weight was 112 pounds, 02/06/25 her weight was 112 pounds, and 03/13/25 her weight was 112 pounds. She verified she was missing the following weekly weights: 02/13/25, 02/20/25, 02/27/25, 03/06/25, and 03/13/25. She revealed she communicated to the Director of Nursing (DON) by use of Medical Nutrition Therapy Recommendation Log of any dietary recommendations including frequency of weight. She verified the weights were not completed weekly per her recommendation and was not sure why. Dietician #903 revealed they discussed weekly in a Risk meeting any residents at risk, who had weight loss, and any residents on the Medical Nutrition Therapy Recommendation Log. She revealed that it had never been brought up in the risk meeting regarding the concern of weights not being completed per her recommendation stating, and stated I really am not sure why. She left the interview and came back with Assistant Director of Nursing (ADON)/ Licensed Practical Nurse (LPN) #323. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/27/25 at 8:30 A.M. with ADON/ LPN #323 verified Resident #47's weekly weight had not been completed per Dietician #903 recommendations and he also stated, not sure as well as to why. He verified the facility had weekly Risk meetings and discussed residents at nutritional risk but also revealed it had not been discussed regarding not getting weekly weights as recommended per Dietician #903's progress notes and what was on Medical Nutrition Therapy Recommendation Log. Review of facility policy labeled, Weight Policy dated 03/01/22 revealed weights would be obtained in a timely and accurate manner, documented and responded to appropriately. Residents would be weighed every week on admission for three weeks and then monthly unless ordered otherwise per the physician or dietician. The dietician would track the weights and work with the facility during the routine weight meeting to review resident's weight trends and determine if additional interventions were needed. This deficiency represents non-compliance investigated under Complaint Number OH00162697.

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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** 39973 Based on observation, interview, record review and review of facility policy the facility did not ensure there was proper signage indicating oxygen was in use. This affected three Residents (#2, #18, and #26) out of four residents reviewed for oxygen use. This had the potential to affect 21 Residents (#6, #7, #12, #13, #17, #20 #26, #27, #29, #35, #44, #45, #51, #53, #54, #59, #62, #63, #229, #232, and #237) that were identified by the facility as having oxygen. The facility census was 73. Findings included: 1. Review of the medical records for Resident #2 revealed an admitted [DATE] and diagnoses included bipolar disorder, diabetes, and hypertension. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #2 had intact cognition and was not on oxygen. Review of the March 2025 physician orders for Resident #2 revealed he had no orders for oxygen. Observation on 03/24/25 at 11:30 A.M. revealed in Resident #2's room there was a Broda chair (a chair that reclines back) and on the back of the chair it had Resident #44's name on it and a green portable oxygen e-cylinder (a cylinder that contains compressed oxygen that was combustible). There was no signage on the entry to the room indicating there was oxygen in the room. There also was another wheelchair belonging to Resident #14. (Both Resident #14 and Resident #44 do not reside in Resident #2's room) Interview on 03/24/25 at 11:30 A.M. with Resident #2 revealed he did not use oxygen. He revealed the facility frequently used his room for storage as they often placed other residents' wheelchairs in his room and he did not feel it was right. He revealed the oxygen in his room on the back of Resident #44's was not his. Interview and observation on 03/24/25 at 3:18 P.M. with Register Nurse (RN)/ Regional #901 verified the oxygen e-cylinder continued to be in Resident #2's room on the back of Resident #44's Broda chair as well as Resident #14's wheelchair. She verified that both Resident #14 and Resident #44 do not reside in Resident #2's room. She verified all rooms with oxygen should have signage on the outside of the door prior to entering and that other residents oxygen should not be in another resident's room. 2. Review of the medical record for Resident #18 revealed an admitted [DATE] and diagnoses included diabetes, panic disorder and acute respiratory failure with hypoxia. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #18 had intact cognition and was not on oxygen. Review of March 2025 physician orders revealed Resident #18 did not have an order for oxygen. (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 care plan dated 03/14/25 revealed Resident #18 was at high risk for aspiration and complications due to dysphagia. Interventions included observe and report to physician of aspiration and complications: choking on liquids, coughing on liquids, coughing during or after meals, and respiratory difficulty. There was nothing in the comprehensive care plan regarding oxygen. Interview and observation on 03/24/25 at 3:18 P.M. with RN/ Regional Nurse #901 verified there was one e-cylinder oxygen tank in a holder sitting in his room by the window. She verified there was no oxygen signage on the outside of Resident #18's room. 3. Review of medical record for Resident #26 revealed an admitted [DATE] and diagnoses included renal disease requiring dialysis, spinal stenosis, hypertension, and diabetes. Review of the undated comprehensive care plan revealed nothing in the care plan regarding oxygen use. Review of the Medicare Five- Day MDS 3.0 assessment dated [DATE] revealed Resident #26 had intact cognition and was not on oxygen. Review of the March 2025 physician orders revealed Resident #26 had an order dated 03/10/25 for oxygen at two liters per nasal cannula as needed for oxygen saturation rates below 88 percent. Interview and observation on 03/24/25 at 3:18 P.M. with RN/ Regional Nurse #901 verified Resident #26 had one e-cylinder oxygen tank in a holder and one oxygen concentrator sitting in her room. She verified there was no oxygen signage on the outside of the doorway. Review of undated facility policy labeled, Oxygen Administration revealed oxygen was administered to residents who need it, and consistent with professional standards of practice. The policy revealed oxygen was administered under the orders of a physician except in case of an emergency. The policy revealed oxygen warning signs must be placed on the door of the resident's room.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on interview, record review and facility policy review, the facility failed to ensure non-pharmacological interventions were attempted prior to administering as needed pain medication and failed to ensure parameters were in place for when to administer of Acetaminophen versus opioid pain medication. This affected two residents (#12 and #21) of five residents reviewed for unnecessary medications. The facility census was 73. Findings include: 1. Review of the medical record for Resident #12 revealed and admitted [DATE]. Diagnoses included respiratory failure, congestive heart failure, chronic obstructive pulmonary disease (COPD), kidney disease, sleep apnea, glaucoma and depression. Review the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 was cognitively intact. She required setup help for eating, oral and personal hygiene, supervision for toileting and partial to moderate assistance for showering. Review of the physicians' orders from March 2025 revealed an order for Acetaminophen 1000 milligrams (mg) three times a day routinely for pain which began on 01/26/25 and Acetaminophen 325 mg two tablets every four hours as needed for pain which began on 08/03/24. There was also an order for Oxycodone 7.5 mg (opioid pain medication) every four hours as needed for pain which began on 01/20/25. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) for February 2025 revealed Resident #12 received Oxycodone once on 02/01/25 for a pain level of eight on a pain scale of zero to ten, ten being the worst, and two times on 02/01/25 for a pain level of seven, once on 02/02/25 for a pain level of five, once on 02/02/25 for a pain level of seven and once on 02/02/25 for a pain level of six, once on 02/03/25 for a pain level five, once on 02/03/25 for a pain level of seven and once on the 02/03/25 for a pain level of nine, once on 02/04/25 for a pain level of ten, twice on 02/04/25 for a pain level of five, once on 02/05/25 for a pain level of eight, once on 02/05/25 for a pain level of seven and once on 02/05/25 for a pain level of five, once on 02/06/25 for a pain level of six and once on 02/06/25 for a pain level of eight, once on 02/07/25 for a pain level five, once on 02/07/25 for a pain level of seven and once on 02/07/25 for a pain level of six, three times on 02/08/25 for a pain level of five, once on 02/09/25 for a pain level of nine and twice on 02/09/25 for a pain level of five, once on 02/10/25 for a pain level of eight and twice on 02/10/25 for a pain level of seven, once on 02/11/25 for a pain level of five, twice on 02/12/25 for a pain level of five and once on 02/12/25 for a pain level of seven, twice on 02/13/25 for a pain level of eight and once on 02/13/25 for a pain level of seven, once on 02/14/25 for a pain level of 10 and twice on 02/14/25 for a pain level of five, once on 02/15/25 for a pain level of five and twice on 02/15/25 for a pain level of seven, three times on 02/16/25 for pain level of five, once on 02/17/25 for a pain level of seven, once on 02/17/25 for a pain level of five and once on 02/17/25 for a pain level of eight, once on 02/18/25 for a pain level of eight, once on 02/18/15 for a pain level of five and once on 02/18/25 for a pain level of seven, once on 02/19/25 for a pain level of seven and twice on 02/19/25 for a pain level of eight, three times on 02/20/25 for a pain level of seven, once on 02/21/25 for a pain level of five, once on 02/21/25 for a pain level of eight, once on 02/21/25 for a pain level of seven, once on 02/22/25 for a pain level of seven and twice on 02/22/25 for a pain level of five, once on 02/23/25 for a pain level of two and twice on a 02/23/25 for a pain level of seven, once 02/24/25 for a pain level of three, twice on 02/25/25 for a pain level of five, twice on 02/26/25 for a pain level of eight, once on 02/26/25 for a pain level of seven, 02/27/25 for a pain level of five, once on 02/28/25 for a pain level of seven and twice on 02/28/25 for a pain level of eight. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR for March 2025 revealed Resident #12 received the as needed Acetaminophen once on 03/10/25 for a pain level of five and Oxycodone twice on 03/01/25 for a pain level of eight, once on 03/01/25 for pain level of seven, once on 03/02/25 for a pain level of five, twice on 03/02/25 for a pain level of seven, once on 03/03/25 for a pain level of seven, twice on 03/03/25 for a pain level of eight, once on 03/04/25 for a pain level of eight, once on 03/04/25 for a pain level of six, once on 03/04/25 for a pain level of seven, once on 03/05/25 for pain a level of five, twice on 03/05/25 for a pain level of eight, once on 03/06/25 for a pain level of five, twice on 03/06/25 for a pain level of six, once on 03/07/25 for a pain level of five, once on 03/07/25 for a pain level of seven, once one 03/07/25 for a pain level of eight, three times on 03/08/25 for a pain level of five, once on 03/09/25 for a pain level of seven, two times on 03/09/25 for a pain level of eight, once on 03/10/25 for a pain level of eight, once on 03/10/25 for pain level of six, once on 03/10/25 for a pain level of five, two times on 03/11/25 for a pain level of five, once on 03/12/25 for a pain level of five, once on 03/12/25 for a pain level of two, once on 03/12/25 for a pain level of seven, three times on 03/13/25 for a pain level of seven, once on 03/14/25 for a pain level of eight, two times on 03/14/25 for a pain level of seven, once on 03/15/25 for a pain level of nine, two times on 03/15/25 for a pain level of eight, once on 03/16/25 for a pain level of five, once on 03/16/25 for a pain level of eight, once on 03/16/25 for a pain level of seven, once on 03/17/25 for a pain level of five, once on 03/17/25 for a pain level of seven, once on 03/17/25 for a pain level of eight, two times on 03/18/25 for a pain level of eight, once on 03/19/25 for a pain level of eight, two times on 03/19/25 for a pain level of seven, two times on 03/20/25 for pain level of seven, once on 03/20/25 for a pain level of seven, once on 03/21/25 for a pain level of five, two times on 03/21/25 for a pain level of seven, three times on 03/22/25 for a pain level of five, three times on 03/23/25 for a pain level of five, once on 03/24/25 for a pain level of three, once on 03/24/25 for a pain level of two, once on 03/24/25 for a pain level of five, once on 03/25/25 for a pain level of eight and two times on 03/25/25 for a pain level of five. Interview on 03/27/25 at 10:31 A.M. with Licensed Practical Nurse (LPN) #341 confirmed there was no documented evidence nonpharmacological interventions were attempted prior to the administration of as needed pain medications for Resident #12, and there were no parameters for which as needed pain medication to administer when a resident experienced pain. 2. Review of the medical record for Resident #21 revealed and admitted [DATE]. Diagnoses included schizophrenia, emphysema, heart disease, depression, anemia, history of stroke and epilepsy. Review of the quarterly MDS assessment dated [DATE] revealed Resident #21 was moderately cognitively impaired. She required setup help for eating, substantial or maximum assistance for orally and personal hygiene and was dependent on staff for toileting and showering. Review of the physician's orders for March 2025 revealed an order for Acetaminophen 325 mg as needed for pain which began on 10/09/19 and Dilaudid 4 mg (opioid pain medication) every four hours as needed for pain which began on 03/21/25. Review of the MAR for March 2025 Review Resident #21 received one dose of Acetaminophen on 03/08/25 for a pain level of three. She also received one dose of Dilaudid on 03/22/25 for a pain level of seven, two doses on 03/22/25 for a pain level of eight, one dose on 03/23/25 for a pain level of eight, one dose on 03/23/25 for a pain level of seven, one dose on 03/24/25 for a pain level of three, one dose on 03/24/25 for a pain level of four and two doses on 03/25/25 for a pain level of four. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/27/25 at 10:31 A.M. with LPN #341 confirmed there was no documented evidence nonpharmacological interventions were attempted prior to the administration of as needed pain medications for Resident #21, and there were no parameters for which as needed pain medication to administer when a resident experienced pain. Review of the facility policy titled Pain Management dated 08/22/22 revealed the facility would attempt nonpharmacological approaches in an attempt to relieve pain which included but was not limited to environmental comfort measures such as adjusting room temperatures, repositioning hand smoothing linens and lower doses of medication would initially be administered, slowly titrating up until comfort was achieved.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, interview, record review and review of facility policy, the facility failed to ensure insulin was dated when opened and medications were not left unattended at bedside. This affected three Residents (#2, #44, and #52) out of eight residents who resided on the Blue unit with insulin orders, and one resident (Resident #32) of one resident observed for unsecured medications. Findings included: 1. Review of medical record for Resident #52 revealed an admitted [DATE] and diagnoses included diabetes, chronic obstructive pulmonary disease, and heart failure. Review of care plan dated 10/27/23 revealed Resident #52 had a potential risk for hyperglycemia and hypoglycemia due to diabetes. Interventions included administer medications as ordered, obtain blood sugar levels as orders and be alert to signs of hypoglycemia and hyperglycemia. There was nothing in the care plan regarding properly labeling and dating insulin when opened. Review of Medicare Five-Day Minimum Data Set (MDS) dated [DATE] revealed Resident #52 had intact cognition and received three days of insulin during the assessment period. Review of March 2025 physician orders for Resident #52 revealed she had an order for Humalog Kwik pen solution pen-injector 100 units per milliliter (ml) per sliding scale subcutaneously (SQ). A blood sugar from 151 to 200 the order was to administer four units of insulin. Observation of medication administration on 03/25/25 at 8:26 A.M. revealed Licensed Practical Nurse (LPN) #371 obtained Resident #52's blood sugar and it was 153. She proceeded to administer Resident #52 four units of Humalog per the pen-injector SQ as ordered. Observation revealed the Humalog Kwik injector pen was not dated as to when it had been opened. Interview on 03/25/25 at 8:30 A.M. with LPN #371 verified the Humalog Kwik injector pen had been previously opened and had no date as to when it was opened. She verified she had not checked prior to administration that the insulin was dated. 2. Review of medical record for Resident #2 revealed an admitted [DATE] and diagnoses included diabetes and hypertension. Review of care plan dated 12/03/17 revealed Resident #2 was at risk for hyperglycemia and hypoglycemia related to diabetes. Interventions included administer medications as ordered, obtain blood sugar levels as orders and be alert to signs of hypoglycemia and hyperglycemia. There was nothing in the care plan regarding properly labeling and dating insulin when opened. Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #2 was cognitively intact and used insulin seven days during the assessment period. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of March 2025 physician orders for Resident #2 revealed a physician order dated 04/04/24 for Lantus (insulin) Solostar SQ solution pen-injector 100 units per milliliter to inject 22 units SQ at bedtime due to diabetes. Observation of the medication cart on the Blue Unit on 03/25/25 at 8:30 A.M. revealed Resident #2 had two open Lantus pen-injectors that were not dated as to when they were opened. Interview on 03/25/25 at 8:35 A.M. with LPN #371 verified that Resident #2 had two opened Lantus insulin pen injectors that were not dated as to when they were opened. 3. Review of medical record for Resident #44 revealed an admitted [DATE] and diagnoses included diabetes and hypertension. Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #44 had impaired cognition and used insulin seven days during the assessment period. Review of March 2025 physician orders for Resident #44 revealed a physician order dated 11/14/24 for Insulin Glargine Solostar subcutaneous solution pen injector 100 units per ml to inject 20 units SQ at bedtime due to diabetes. Observation of the medication cart on the Blue Unit on 03/25/25 at 8:30 A.M. revealed Resident #44 had two Insulin Glargine pen injectors that were opened but not dated. Interview on 03/25/25 at 8:35 A.M. with LPN #371 verified Resident #44 had two opened Glargine insulin pen injectors that were not dated as to when they were opened. Review of facility policy labeled, Medication Administration dated 06/21/17 revealed insulin was a high-risk drug and warranted additional precautions for the safe and effective administration. The policy revealed the nurse was to check the expiration date prior to administration to ensure it was within the usage date. Vials and pens without an open date recorded should be discarded. 45441 4. Review of the medical record for Resident #32 revealed an admitted [DATE]. Diagnoses included hypertension, hyperlipidemia, kidney disease, insomnia, legal blindness, Gastro Esophageal Reflux Disease (GERD) chronic migraines and diabetes. Review of the quarterly MDS assessment dated [DATE] revealed Resident #32 was cognitively intact. She was independent in eating, oral hygiene and toileting and required set up help for showering, dressing and personal hygiene. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician's orders for March 2025 revealed orders for Allopurinol (used to treat gout and kidney stones) 100 milligrams (mg) by mouth (PO) once per day (QD), Aspirin 81 mg PO QD, Famotidine (used to treat ulcers and GERD) 40 mg PO QD, Fenofibrate (used to treat hyperlipidemia) 145 mg PO QD, Furosemide (used to treat kidney disease) 40 mg PO QD, Januvia (used to treat diabetes) 100 mg PO QD, Levothyroxine (used to treat hypothyroidism) 50 micrograms (mcg) PO 30 minutes before breakfast and 50 mcg PO QD, Liothyronine (used to treat hypothyroidism) 5 mcg PO QD, Montelukast (used for allergies) 10 mg PO QD, multivitamin PO QD, Omega three 1200 mg PO QD, Acetazolamide (used to treat glaucoma) 500 mg PO twice per day (BID), Metformin (used to treat diabetes) 1000mg PO BID, Potassium Chloride 20 milliequivalent (meq) PO BID, Tylenol 1000mg BID and Lyrica (used to treat nerve pain) 75 mg PO three times a day (TID). Observation and interview on 03/25/25 at 8:27 A.M. revealed a medicine cup with approximately 16 pills sitting on the bedside table next to Resident #32's bed. Resident #32 verified staff usually watch her take her medicine, but she was asleep this morning, so the medicine was left on her beside table. Interview at the time of the observation with Certified Nurse Aide (CNA) #904 confirmed medications should not be left at bedside, and confirmed the medications on the bedside table for Resident #32. Review of the facility policy titled Medication Storage dated 07/23/19 revealed only licensed nurses were allowed to access medications, and medications would be locked or attended by people with authorized access.

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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** 45441 Based on record review, interview and facility policy review, the facility failed to ensure the physician was notified of laboratory results for Resident #12. This affected one resident (#12) of three residents reviewed for laboratory results. The facility census was 73. Findings include: Review of the medical record for Resident #12 revealed and admitted [DATE]. Diagnoses included respiratory failure, congestive heart failure, chronic obstructive pulmonary disease (COPD), kidney disease, sleep apnea, glaucoma and depression. Review of Resident #12's medical record revealed a urinalysis was obtained on 08/27/24 which showed evidence of nitrites, epithelial cells, bacteria, hyaline casts, mucous and white blood cell clumps. There was no evidence that the physician was notified of the results of the urinalysis. Interview on 03/26/25 at 9:21 A.M. with Licensed Practical Nurse (LPN) #322 confirmed there was no documented evidence the laboratory results were reported to the physician for Resident #12. Review of the facility policy titled Notification of Changes dated 01/01/25 revealed the facility would consult the resident's physician when there was a change in treatment including new treatment, acute conditions or exacerbation of chronic conditions.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 37097 Based on observation and staff interview, the facility failed to maintain its garbage disposal area in a clean and sanitary condition. This had the potential to affect all 73 residents. Findings include: On 03/31/25 at 3:05 PM observation of the facility's garbage disposal area with Dietary Manager (DM) #305 revealed the top lids and side doors to both dumpsters were open and garbage was overflowing. This was confirmed by DM #305 at the time of the observation.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 37097 Based on observation, record review, job description review, and interview, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This had the potential to affect all 73 residents residing in the facility. Findings include: Review of undated facility Job Description for the Administrator revealed the primary purpose was to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern long-term care facilities to ensure that the highest degree of quality care was always provided to the residents. They were to develop and maintain written job descriptions for each staff position. The description revealed they would ensure that all residents receive care in a manner and in an environment that maintained or enhanced their quality of life and ensure that each resident received the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status, as defined by the comprehensive assessment and care plan. Review of the undated Job Description for the Director of Nursing (DON) revealed the primary purpose of the position was to plan, organize, develop, control and direct the overall operation of our Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern the facility, and as may be directed by the Administrator and the Medical Director, to ensure that the highest level of quality care is maintained at all times. They were to assure that nursing care was provided to all residents in accordance with the Plan of Care and that physician orders and resident rights were maintained During the annual and complaint surveys, observations, record reviews and interviews resulted in concerns related to the overall operation of the facility including but not limited failure to report and thouroughly investigate two incidents of elopement, failure to ensure comprehensive care planning, failure to prevent in-house aquired pressure ulcers, failure to ensure splints were in place as ordered, failure to obtain weights according to Dietician recommendations, and failure to have an effective antibiotic stewardship program. The facility failed to provide evidence that the administrative staff, including the Administrator and/or DON, had effective systems in place to timely identify and correct quality and care concerns. 1. The facility failed to report or thoroughly investigate two incidents of resident elopement. This affected Residents #16 and #56. Interview on 3/26/25 at 1:34 P.M. with the Administrator verified both elopements (Residents #16 and #56) occurred. She revealed she did not have any evidence a self-reported incident (SRI) had been completed, and stated she was not aware it was required. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 3/26/25 at 2:10 P.M. with Assistant Director of Nursing (ADON)/Licensed Practical Nurse (LPN) #323 further revealed the facility could not determine exactly how Residents #16 and #56 left the facility without staff knowledge, as the facility investigations did not conduct a root cause analysis. He also could not confirm if care planned interventions such as engaging the residents in person centered activities, were in progress at the time of the elopements. 2. The facility failed to ensure care plans were comprehensive. This affected Residents #12 and #229 Interview on 04/01/25 at 7:44 A.M. with LPN #302 confirmed she was aware not all care plans had been updated regularly. She had recently been off work for personal issues, and no one else was responsible for the oversight of care plans and ensuring accuracy. 3. The facility failed to ensure treatment orders were implemented in a timely manner and/or completed as ordered. Resident #17, who was a paraplegic and was dependent on staff assistance for most activities of daily living (ADL) including transfers, and rolling left and right in bed, was found to have an in-house acquired Stage II pressure ulcer (partial-thickness skin loss appearing as a shallow area with a red or pink wound bed) to his sacrum (located at the base of the spine) that measured 3.5 centimeters (cm) in length by 1.9 cm in width by 0.2 cm in depth. The facility failed to implement the treatment as ordered on 02/04/25 of Medi Honey (a brand of medical-grade honey-based product used for wound management) and silicone bordered foam dressing daily until 02/07/25. Wound Nurse Practitioner (NP) #900 consulted on 02/11/25 and noted a significant decline to Resident #17's sacrum pressure ulcer as the wound increased in size to 11.0 cm in length by 5.2 cm in width by unable to determine the depth as the wound had 10 percent slough (dead tissue that accumulated on the surface of a wound) and 60 percent purple/ maroon discoloration. Wound NP #900 classified the pressure wound as unstageable (full thickness tissue loss in which the actual depth of the ulcer was obscured by slough/ dead skin). The facility did not ensure ongoing treatments were completed as ordered and on 03/18/25, Resident #17's sacrum pressure ulcer was classified as a Stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle) as the wound had bone that was palpable. In addition, Resident #17 had pressure ulcers to his right and left ankles and the treatments were not completed as ordered. Interview on 03/26/25 at 11:58 A.M. with ADON/LPN #323 verified Resident #17's sacrum treatments per the February and March 2025 TARs: 02/01/25, 02/02/25, 02/06/25, 02/18/25, 02/26/25, 02/28/25, 03/07/25, 03/10/25, 03/11/25, dayshift 03/14/25, 03/15/25, 03/16/25, 03/18/25, 03/20/25, 03/21/25, and 03/24/25 were blank, indicating the treatment was not completed as ordered. 4. The facility did not ensure splints were applied as ordered and per therapy recommendations. This affected Residents #1 and #47. Interview on 03/26/25 at 1:31 P.M. with Certified Nursing Assistant (CNA) #344 revealed she worked on Resident #47's unit frequently and stated Resident #47 did not have an order to apply a splint to her left hand. She revealed the splint that was lying on her dresser was old and stated, she does not need it anymore and that she did not apply a splint to Resident #47's left hand. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 03/26/25 at 2:06 P.M. with Licensed Practical Nurse (LPN) #328 revealed she worked on Resident #47's unit frequently over the past two years and to her knowledge Resident #47 did not have an order for a left-hand splint and/or had she ever seen her with a splint on while she was working (dayshift). LPN #328 verified after checking the electronic medical record physician orders, Resident #47 did have an order for left hand splint to be on in the A.M. and off in the P.M. She revealed that she and CNA #344 frequently worked on Resident #47's unit, and the splint order was not showing up on the TAR and/or the task bar which would notify them that Resident #47 had an order for the splint. She was unsure why it was not showing up on the TAR and/or task bar. Interview on 03/26/25 at 2:15 P.M. and 2:35 P.M. with Rehabilitation Director #902 revealed per the OT discharge summary dated 02/17/25, Resident #47 was to have a left-hand splint on in the A.M. and off in the P.M. greater than four hours. Rehabilitation Director #902 revealed OT #951 put the order into the electronic medical record, but she verified she put it in incorrectly as it did not show up on the TAR and/or tasks preventing the nurses and aides of knowing that there was an order for Resident #47 to wear a left-hand splint daily. Observation on 03/31/24 at 8:09 A.M. revealed Resident #1 was in his room in his wheelchair coloring a picture. No spica was in use. Interview at the time of the observation with CNA #375 confirmed she had assisted Resident #1 in getting up for the day, and he should have had a spica in use. She could not locate the device and confirmed it should have been placed on Resident #1's hand when she assisted him with morning care. Interview on 04/01/25 at 8:35 A.M. with Rehab Director #902 confirmed Resident #1 had used a spica to his left thumb since at least 2023. She confirmed she had seen him with it and felt it was effective in maintaining his current level of functioning, it was not meant to increase his ability to use his right hand. She was unaware the spica was not being used on a consistent basis. 5. the facility failed to obtain weights according to Dietician recommendations for Resident #47. Interview on 03/27/25 at 8:24 A.M. and 9:50 A.M. with Dietician #903 revealed she had recommended Resident #47 to receive weekly weights due to her weight loss since at least 12/05/24. She revealed she tracked the weights on a Weekly Weight/ Admission Tracker form and verified she only had the following weights for Resident #47 from 01/30/25 to 03/20/25: 01/30/25 her weight was 112 pounds, 02/06/25 her weight was 112 pounds, and 03/13/25 her weight was 112 pounds. She verified she was missing the following weekly weights: 02/13/25, 02/20/25, 02/27/25, 03/06/25, and 03/13/25. She revealed she communicated to the Director of Nursing (DON) by use of Medical Nutrition Therapy Recommendation Log of any dietary recommendations including frequency of weight. She verified the weights were not completed weekly per her recommendation and was not sure why. Dietician #903 revealed they discussed weekly in a Risk meeting any residents at risk, who had weight loss, and any residents on the Medical Nutrition Therapy Recommendation Log. She revealed that it had never been brought up in the risk meeting regarding the concern of weights not being completed per her recommendation stating, and stated I really am not sure why. She left the interview and came back with ADON/LPN #323. Interview on 03/27/25 at 8:30 A.M. with ADON/ LPN #323 verified Resident #47's weekly weight had not been completed per Dietician #903 recommendations and he also stated, not sure as well as to why. He verified the facility had weekly Risk meetings and discussed residents at nutritional risk but also revealed it had not been discussed regarding not getting weekly weights as recommended per Dietician #903's progress notes and what was on Medical Nutrition Therapy Recommendation Log. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6 The facility did not ensure they had an effective antibiotic stewardship program that monitored antibiotic use including reducing the risk of adverse effects of the development of antibiotic-resistant organisms from unnecessary or inappropriate antibiotic use. Review of Infection Control Log (a second log the facility maintained) for February 2025 and March 2025 revealed the facility tracked residents that had received antibiotics including resident, admitted , onset of infection, site of infection, infection diagnosis, if a culture was completed, if an x-ray was completed, organism, antibiotic, isolation, re-culture date and date infection resolved. There was nothing on the log regarding whether the ATB met McGeer's criteria and/ or any other criteria to ensure the ATB was necessary. Interview on 03/26/24 at 7:22 A.M. with LPN/ Infection Control Preventionist #301(who was named as the Infection Control Preventionist upon entrance) revealed she worked night shift three days a week on the floor as well as oversaw the infection control program including completing the infection control logs. She revealed the (above) log Infection Log- ATB (antibiotic) Surveillance presented to this surveyor was completed by the DON and that she completed the Infection Control Log as well. She verified on her log there was no documentation if the ATB met McGeer's criteria or any other criteria to ensure the ATB was appropriate. She revealed she usually wrote true by the antibiotic after she reviewed to ensure the ATB was appropriate, but she had gotten behind the last few months and had not. She verified she was not aware the DON had placed on the other log Infection Log- ATB (antibiotic) Surveillance that 21 ATBs for February 2025 and March 2025 did not meet McGeer's criteria and that she did she did not have any resident specific individual McGeer's forms and/ or criteria that she had completed for the residents on ATBs for the month of February 2025 and March 2025. She verified for the above residents that were marked on the log as not meeting the McGeer's criteria she did not have any documentation the physician or nurse practitioner (NP) was aware that the ATB did not meet the criteria for usage. She revealed she had never attended a Quality Assurance and Performance Improvement (QAPI) meeting, provided her logs at the QAPI meeting and/ or reviewed anything in a QAPI meeting regarding ATB's not meeting criteria for usage. Interview on 03/26/25 at 7:44 A.M. with the DON verified she had completed the infection control logs labeled, Infection Log- ATB (antibiotic) Surveillance dated February 2025 and March 2025 and verified she had documented the above ATB's did not meet the McGeer's criteria and she did not have any documentation the physician and/ or NP was aware these antibiotics did not meet the criteria including discussion in QAPI.

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Longmeadow Care Center	565 Bryn Mawr Ravenna, OH 44266

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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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on observation, interview, review of the Centers for Disease Control (CDC) nursing standard of practice for medication administration, and review of facility policy and procedure, the facility failed to ensure staff administered medications to Resident #7 and Resident #69 according to professional standards of practice. This affected two out of two residents observed for medication administration. The facility census was 72. Findings include: Resident # 7 was admitted on [DATE] with diagnoses including paroxysmal atrial fibrillation, gastroesophageal reflux disease, glaucoma, benign heart neoplasm, chronic obstructive pulmonary disease with pulmonary embolism, high blood pressure, transient ischemic attack (TIA), anemia, kidney disease, osteoarthritis, obesity, vitamin D deficiency, osteoporosis, and neuropathy. Resident #7's physician orders dated [DATE] to [DATE] indicated to administer the following medications upon rising: - Eliquis 2.5 mg tablet - furosemide 40 milligrams (mg) tablet - metoprolol 25 mg tablet - PreserVision multivitamin with minerals 1 tablet - vitamin D 50 microgram (mcg) tablet Resident #69 was admitted on [DATE] with diagnoses including fibromyalgia, gastroesophageal reflux disease, constipation, paroxysmal atrial fibrillation, high blood pressure, cardiac pacemaker, anxiety, depression, obesity, spinal stenosis with low back pain, heart disease, and Alzheimer's disease. Resident #69's physician orders dated [DATE] to [DATE] indicated to administer the following medications upon rising: - Amiodarone hydrochloride 200 milligrams (mg) tablet - Cardizem CD Extended Release 180 mg tablet - Folic acid 1 mg oral tablet - guaifenesin extended release tablet administer one tablet. - Loratadine 10 mg oral tablet (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- multivitamin one tablet - Namenda 10 mg tablet - pantoprazole sodium delayed release 40 mg tablet - pregabalin 100 mg capsule - thiamine 100 mg tablet - vitamin D3 1.25 mg capsule orally - acetaminophen 500 mg tablet An observation of Licensed Practical Nurse (LPN) #77 on [DATE] at 8:45 A.M. revealed LPN #77 had dispensed medications for Resident #7 and Resident #68 into two medication cups. LPN #77 the proceeded to administer the medications to the residents. Interview with LPN #77, at the time of the observation, confirmed she should have dispensed each of the residents' medications separately and administered the medications one-at-a time to each resident according to professional standards of practice. A review of the Centers for Disease Control (CDC) nursing standard of practice for medication administration revealed the recommendation to follow Safe Administration Guidelines dated 2014 ([NAME]) according to the Institute of Medicine's guidelines for Safe Medication Administration including: - Plan medication administration in a quiet area. - Prepare medications for one patient/resident at a time. - Follow the seven rights of medication administration. - Check that the medications was not expired. - Perform hand hygiene. - Check patient's/resident's room for additional precautions. - Introduce yourself to the patient/resident. - Confirm patient/resident identity. - Check patient/resident for allergies. - Complete assessments as necessary. - Provide patient/resident education. - If patient/resident questions or expresses concern regarding a medication, stop and do not administer. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Check the medication administration record against the physician order for accuracy. Review of the facility policy titled Medication Administration revised [DATE] revealed medications were administered by licensed nurses, or other staff who were legally authorized to do so in the state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.

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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** 30809 Based on record review, observation and interview the facility failed to ensure staff donned appropriate personal protective equipment when providing direct care for Resident #60. This affected one out of three residents reviewed for pressure ulcers. The facility census was 72. Findings include: Review of Resident #60's medical record revealed the resident was admitted on [DATE] with diagnoses including stroke, coronary artery disease, cancer, heart failure, high blood pressure, diabetes mellitus, and high cholesterol. Review of Resident #60's plan of care revised 12/13/24 indicated a potential for complications related to the use of an indwelling urinary catheter. Intervention on the plan of care indicated to implement enhanced barrier precautions. Review of Resident #60's Minimum Data Set (MDS) assessment dated [DATE] indicated the presence of a stage three pressure ulcer (Full thickness tissue loss. Subcutaneous visible but bone, tendon or muscle is not fat may be exposed. Slough may be present but does not obscure the depth of tissue loss.). Review of Resident #60's physician orders dated 05/01/25 to 05/31/25 indicated gloves and a gown were to be worn when providing dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting device care, or use of central line, urinary catheter, feeding lube, tracheostomy/ventilator, and during care of chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers every day and night shift related to gastric tube. An observation of Resident #60's pressure ulcer located on the sacrum with Certified Nursing Assistant (CNA) #76 on 05/01/25 at 9:50 A.M. revealed the pressure ulcer had no wound treatment covering the area and a thick layer of white moisture barrier cream was applied the the entire perineal and sacral area. CNA #76 entered Resident #60's room and did not don a gown and assisted Resident #60 on the her left side to view the sacral pressure ulcer. An interview with CNA #76 on 05/01/25 at 9:50 A.M. verified she did not don a gown prior to assisting Resident #60 to roll to her side. CNA #76 stated she was unaware Resident #60 was supposed to have enhanced barrier isolation precautions implemented. CNA #76 confirmed she should have known due to the presence of the sign located on the wall beside Resident #60's doorway opening outside of Resident #60's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled Enhanced Barrier Precautions dated 07/13/22 indicated it was the policy of the facility to implement enhanced barrier precautions for preventing transmission of novel or targeted multidrug-resistant organisms. Enhanced barrier precautions referred to the use of gown and gloves for certain residents during specific high-contact resident care activities that have been found to increase risk for transmission of multidrug-resistant organisms. Initiation of enhanced barrier precautions could be placed by the nursing staff for residents with certain conditions or devices. An order for enhanced barrier precautions would be obtained for residents with any of the following: - Wounds and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO (multidrug-resistant organisms) colonization status. - Infection or colonization with a novel or targeted MDRO when contact precautions did not apply. - Infection or colonization with other epidemiologically-important MDROs.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on interview, record review and review of facility policy, the facility failed to have an effective antibiotic stewardship program that monitored antibiotic use including reducing the risk of adverse effects of the development of antibiotic- resistant organisms from unnecessary or inappropriate antibiotic use. This affected 21 residents (#5, #11, #16, #18, #19, #20, #23, #27, #28, #35, #47, #50, #51, #53, #54, #55, #56, #60, #68, #73, and #233) of 21 residents identified as ordered antibiotics during the months of February 2025 and March 2025 that did not meet McGreer's criteria (infection surveillance definitions for long term facilities for antibiotic use). The facility census was 73. Findings included: Review of Infection Log- ATB (antibiotic) Surveillance dated February 2025 and March 2025 revealed the facility tracked residents that had received antibiotics for these months. The form included room number, resident's name, admitted , in-house onset date, site of infection, diagnostic testing, organism, McGreer's criteria met or not met, anti-microbial agent, route, start date, stop date, and days of therapy. The form revealed for the month of February 2025 there were 30 occurrences of residents requiring ATB use and nine residents did not meet the McGreer criteria for antibiotic use. The form revealed for the month of March 2025 there were 26 occurrences of residents requiring antibiotic use and 12 residents did not meet the McGreer criteria for antibiotic use. The following residents were identified on the log of not meeting the criteria: a. Resident #18 with an admitted [DATE] was ordered on 02/01/25 Doxycycline (ATB) for infection of the scrotum and on the log the ATB did not meet the criteria for ATB use. b. Resident #28 with an admitted [DATE] was ordered on 02/11/25 Cipro (ATB) for urinary tract infection (UTI) and on the log the ATB did not meet the criteria for ATB use. c. Resident #55 with an admitted [DATE] was ordered on 02/17/25 Keflex (ATB) for UTI and on the log the ATB did not meet the criteria for ATB use. d. Resident #73 with an admitted [DATE] was ordered on 02/19/25 Macrobid (ATB) for UTI and on the log the ATB did not meet the criteria for ATB use. e. Resident #54 with an admitted [DATE] was ordered on 02/19/25 Doxycycline for lungs/ chronic obstructive pulmonary disease (COPD) and on the log the ATB did not meet the criteria for ATB use. f. Resident #27 with an admitted [DATE] was ordered on 02/21/25 Cipro for his scrotum and urine and on the log the ATB did not meet the criteria for ATB use. g. Resident #68 with an admitted [DATE] was ordered on 02/27/25 Bactrim (ATB) for UTI and on the log the ATB did not meet the criteria for ATB use. h. Resident #50 with an admitted [DATE] was ordered on 02/27/25 Amoxicillin (ATB) for UTI and on the log the ATB did not meet the criteria for ATB use. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. Resident #16 with an admitted [DATE] was ordered on 02/28/25 Rocephin (ATB) for UTI and on the log the ATB did not meet the criteria for ATB use. j. Resident #47 with an admitted [DATE] was ordered on 03/02/25 Ertapenem (ATB) for UTI and on the log the ATB did not meet the criteria for ATB use. k. Resident #19 with an admitted [DATE] was ordered on 03/04/25 Fosfomycin (ATB) for UTI and on the log the ATB did not meet the criteria for ATB use. She was also ordered on 03/21/25 Ceftriaxone (ATB) for UTI and on the log the ATB did not meet the criteria for ATB use. l. Resident #56 with an admitted [DATE] was ordered on 03/11/25 Bactrim for UTI and on the log the ATB did not meet the criteria for ATB use. m. Resident #51 with an admitted [DATE] was ordered on 03/12/25 Doxycycline (ATB) for UTI and on the log the ATB did not meet the criteria for ATB use. n. Resident #5 with an admitted [DATE] was ordered on 03/13/25 Macrobid for UTI and on the log the ATB did not meet the criteria for ATB use. o. Resident #35 with an admitted [DATE] was ordered on 03/13/25 Macrobid for UTI and on the log the ATB did not meet the criteria for ATB use. p. Resident #53 with an admitted [DATE] was ordered on 03/14/25 Linezolid for UTI and on the log the ATB did not meet the criteria for ATB use. q. Resident #20 with an admitted [DATE] was ordered on 03/16/25 Cipro for UTI and on the log the ATB did not meet the criteria for ATB use. r. Resident #11 with an admitted [DATE] was ordered on 03/17/25 Macrobid for UTI and on the log the ATB did not meet the criteria for ATB use. s. Resident #233 with an admitted [DATE] was ordered on 03/17/25 Omnicef for infection of foot and on the log the ATB did not meet the criteria for ATB use. t. Resident #23 with an admitted [DATE] was ordered on 03/20/25 Cipro for UTI and on the log the ATB did not meet the criteria for ATB use. u. Resident #60 with an admitted [DATE] was ordered on 03/21/25 Ceftriaxone for UTI and on the log the ATB did not meet the criteria for ATB use. Review of Infection Control Log (a second log the facility maintained) for February 2025 and March 2025 revealed the facility tracked residents that had received antibiotics including resident, admitted , onset of infection, site of infection, infection diagnosis, if a culture was completed, if an x-ray was completed, organism, antibiotic, isolation, re-culture date and date infection resolved. There was nothing on the log regarding whether the ATB met McGeer's criteria and/ or any other criteria to ensure the ATB was necessary. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/26/24 at 7:22 A.M. with Licensed Practical Nurse (LPN)/ Infection Control Preventionist #301(who was named as the Infection Control Preventionist upon entrance) revealed she worked night shift three days a week on the floor as well as oversaw the infection control program including completing the infection control logs. She revealed the (above) log Infection Log- ATB (antibiotic) Surveillance presented to this surveyor was completed by the Director of Nursing (DON) and that she completed the Infection Control Log as well. She verified on her log there was no documentation if the ATB met McGeer's criteria or any other criteria to ensure the ATB was appropriate. She revealed she usually wrote true by the antibiotic after she reviewed to ensure the ATB was appropriate, but she had gotten behind the last few months and had not. She verified she was not aware the DON had placed on the other log Infection Log- ATB (antibiotic) Surveillance that 21 ATBs for February 2025 and March 2025 did not meet McGeer's criteria and that she did she did not have any resident specific individual McGeer's forms and/ or criteria that she had completed for the residents on ATBs for the month of February 2025 and March 2025. She verified for the above residents that were marked on the log as not meeting the McGeer's criteria she did not have any documentation the physician or nurse practitioner (NP) was aware that the ATB did not meet the criteria for usage. She revealed she had never attended a Quality Assurance and Performance Improvement (QAPI) meeting, provided her logs at the QAPI meeting and/ or reviewed anything in a QAPI meeting regarding ATB's not meeting criteria for usage. Interview on 03/26/25 at 7:44 A.M. with the DON verified she had completed the infection control logs labeled, Infection Log- ATB (antibiotic) Surveillance dated February 2025 and March 2025 and verified she had documented the above ATB's did not meet the McGeer's criteria and she did not have any documentation the physician and/ or NP was aware these antibiotics did not meet the criteria including discussion in QAPI. Review of facility policy labeled, Antibiotic Stewardship Program dated 08/23/22 revealed the facility would implement an antibiotic stewardship program as part of the facilities overall infection prevention and control program in order to optimize the treatment of infections while reducing the adverse effects associated with ATB use. The program included antibiotic use protocols and a system to monitor antibiotic use (McGreer criteria). The policy revealed documentation related to the program was maintained by the Infection Preventionist including action plans associated with the program, assessment forms, antibiotic protocols, data collection forms for antibiotic use, antibiotic stewardship meeting minutes, feedback reports, records related to education of physicians and data obtained would be discussed in the facilities QAPI meetings.