STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365380	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumnwood Care Center	670 E Sr 18 Tiffin, OH 44883

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on review of the medical record, staff interview, and policy review, the facility failed to ensure shower preferences were honored. This affected one (#18) of one resident reviewed for showers. The facility census was 78. Findings include: Review of the medical record for Resident #18 revealed an admitted [DATE]. Diagnoses included bipolar disorder, type two diabetes mellitus, schizoaffective disorder, delusional disorder, and depressive disorder. Review of a significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The resident was dependent on staff for showers and bathing. Review of the plan of care initiated 08/02/24 revealed the resident's personalized care preferences included a shower three times per week. The resident required physical assistance to total dependence for bathing and shower transfers with two staff with the mechanical lift. Review of the shower schedule revealed Resident #18 was scheduled for showers three times per week on Tuesdays, Thursdays, and Saturdays on first shift. Review of the task documentation from 10/12/24 through 12/11/24 for Resident #18 revealed the resident was dependent on staff for bathing/showering. Further review of the task documentation revealed no documentation whether the resident received a shower or a bed bath. Review of shower sheets dated 11/30/24, 12/01/24, 12/03/24, 12/05/24, 12/08/24, and 12/10/24 revealed the resident had received bed baths and no showers. Review of the nurse's progress notes dated 10/12/24 through 12/11/24 revealed no documentation the resident had refused showers. Interview on 12/09/24 at 9:14 A.M., Resident #18 revealed she preferred showers and was not receiving them. Resident #18 revealed the nursing assistants told her she was not stable enough to sit in a shower chair so she had to have bed baths. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/11/24 at 8:35 A.M., Certified Nursing Assistant (CNA) #584 revealed the resident received bed baths and not showers. CNA #584 revealed there was only one shower bed which the resident required because she was a mechanical lift transfer and it was not usually available so the resident received a bed bath instead. Interview on 12/11/24 at 8:39 A.M., CNA #546 revealed Resident #18 received bed baths and not showers. Interview on 12/11/24 at 10:29 A.M., the Director of Nursing (DON) revealed the facility had recently started using shower sheets for the residents. The DON revealed there were no shower sheets for Resident #18 from 10/12/24 through 11/29/24. The DON stated the facility started using shower sheets to identify if the resident received a shower or bath. The DON revealed the nursing assistants should have been giving the resident a shower using the bariatric shower chair. The DON revealed the facility had two shower beds. The DON was unaware the nursing assistants had been giving the resident bed baths instead of showers. Review of the policy, Resident Rights, revised 12/2016, revealed residents had the right to participate in decision-making regarding care.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on review of the medical record, staff and resident interview, and policy review, the facility failed to ensure residents were provided quarterly statements for their personal funds. This affected one (#20) of one resident reviewed for personal funds. The facility identified 54 residents with personal funds accounts. The facility census was 78. Findings include: Review of medical record for Resident #20 revealed an admitted d of 09/11/17. Diagnoses included type two diabetes mellitus, bipolar disorder, Parkinson's disease, and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Review of the personal fund authorization form dated 07/09/18 revealed the resident authorized the facility to manage her personal fund account. Further review of the medical record revealed no documentation the resident was provided with quarterly statements for personal funds. Interview on 12/09/24 at 9:34 A.M., Resident #20 revealed the facility would not let her see her personal funds statement. Further interview with Resident #20 revealed the facility had not provided her a copy of her quarterly statement in the past year. Interview on 12/11/24 at 3:51 P.M., Business Office Manager (BOM) #517 verified there was no documentation Resident #20 had received quarterly statements for personal funds account. Review of the policy, Accounting and Records of Resident Funds, revised 04/2017, revealed individual accounting records were made available to the resident through quarterly statements and upon request.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on review of the medical record, staff interview, and policy review, the facility failed to timely notify the physician and resident representative of a resident change in condition. This affected two (Residents #30 and #20) of two residents reviewed for change in condition. The facility census was 78. Findings include Review of the medical record for Resident #30 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, heart failure, dementia, and anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Review of a nurses note dated 11/17/24 at 1:54 P.M. revealed the resident stated this morning she had gotten up in the middle of the night and moved her right ankle wrong. The resident complained of pain to the right ankle and foot. No swelling or bruising noted. The resident had two elastic bandages wrapping the ankle and the nurse removed one and rewrapped one so it was not too tight. The nurse got a leg pedal for the resident's wheelchair to use for the foot. The nurse rechecked the foot this afternoon with no change noted. There was no documentation the physician or resident's representative were notified. Interview on 12/09/24 at 9:25 A.M., Resident #30 revealed she had pain in her right ankle and foot. Resident #30 revealed she had rolled her ankle a few weeks ago and had asked for an x-ray and had not received one. Resident #30 revealed she also recently hit the same foot on the bed. Resident #30 revealed she was wrapping her own foot with an elastic bandage. Review of a nurse's note dated 12/09/24 revealed the physician was notified the resident had right ankle pain with a small bruise, no swelling, and an elastic bandage. New orders were received for an x-ray of the right ankle. Review of the radiology report dated 12/09/24 at 9:24 P.M., revealed there was no evidence of fracture, dislocation, or acute disease of the right ankle. Interview on 12/11/24 at 9:52 A.M., the Director of Nursing (DON) verified there was no documentation the physician or resident representative were timely notified of the injury on 11/17/24. The DON verified an x-ray of the right ankle had not been completed until 12/09/24. Review of the policy, Change in a Resident's Condition or Status, revised 05/2017 revealed the facility would promptly notify the resident, the attending physician, and representative of changes in the resident's medical/mental condition and/or status.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37451 Based on observation, resident interview, and staff interview the facility failed to maintain comfortable sound levels in the dining room on the secured unit. This affected one resident (#59) and had the potential to affect the 12 residents who resided on the secured unit. The facility census was 78. Finding include: Review of the medical record for Resident #59 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, anxiety disorder, muscle weakness, and dementia. Review of Resident #59's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of nine indicating Resident #59 was moderately cognitively impaired. Resident #59 required maximal assistance with toilet use, dressing and personal hygiene. Resident #59 required moderate assistance with bathing and supervision with eating. Resident #59 displayed rejection of care behaviors one to three days during the review period and wandering behaviors four to six days during the review period. Observation on 12/09/24 at 9:18 A.M. of dining room on the secured unit found the floors appeared to be clean but were very sticky. The stickiness caused staff and residents shoes to make very loud squeaking noises as they walked across the floor. Resident's were observed leaving the dining room with staff after breakfast and the loud squeaking shoes made it difficult to hear and have conversations. Interview on 12/09/24 at 9:21 A.M. with Licensed Practical Nurse (LPN) #520 reported the loud sounds from shoes walking on the dining room floor was a regular occurrence and was disruptive and agitating to the residents at times. LPN #520 reported even after the floors were mopped they continued to be sticky creating loud sounds as they were walked across. Observation on 12/09/24 at 11:20 A.M. of the dining room on the secured unit found the floors continued to be sticky and created loud squeaking noises when walked across. As the more residents and staff entered the dining room the louder the squeaking sound became. Interview on 12/09/24 at 11:27 A.M. with Certified Nursing Assistant (CNA) #593 verified the loud sounds from their shoes sticking to the floor bothered staff and the residents. CNA #593 reported she even went outside in the rain hoping to help reduce the loud sounds from her shoes sticking to the floor but it had not worked. CNA #593 reported the residents on the secured unit were confused and some would get agitated by the loud squeaking when they were in the dining room. Interview on 12/09/24 at 11:37 A.M. with Resident #59 found her to be alert and aware. Resident #59 reported the squeaking shoes were very noisy and it was driving her crazy. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/09/24 at 11:46 A.M. found Physical Therapy Assistant (PTA) #610 entered the dining room. Her shoes stuck to the floor making a loud squeaking sound. Resident #59 was observed looking at PTA #610 with squinted eyes and appeared bothered by the additional squeaking sounds.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638 Based on observation, medical record review, interviews, and review of facility policy, the facility failed to ensure the comprehensive care plan was complete with current resident condition. This affected one (Resident #20) of two residents reviewed for comprehensive care planning. The census was 78. Findings include: Review of Resident #20's medical record revealed an admitted [DATE]. Diagnoses included bipolar disorder, chronic obstructive pulmonary disease, chronic respiratory failure, ataxia, Parkinson's, schizoaffective, and lymphedema. Review of Resident #20's quarterly Minimum Data Set, dated dated dated [DATE] revealed intact cognition. The resident required maximum assistance for lower body dressing and required oxygen therapy. Review of Resident #20's medical record revealed a physician's order for [NAME] hose (compression stockings) to be applied in the morning and removed at bedtime. Size regular medium. Review of Resident #20's care plan revealed no goals or interventions in place for the use of compression stockings. Observation on 12/09/24 at 10:10 A.M. revealed Resident #20 did not have the compression stockings applied. Interview with Resident #20 on 12/09/24 at 10:10 A.M. revealed the compression stocking in size medium were too tight and she refused to wear them. The resident stated she had informed several aides and nurses regarding this issue. Interview with the Director of Nursing (DON) on 12/11/24 at 11:23 A.M. revealed Resident #20's care plan failed to included compression stocking information. Review of the facility policy titled, Care Plans, Comprehensive Person Centered revised December 2016 revealed a comprehensive, person centered care plan that included measurable objection and time tables to meet the psychosocial and functional needs is implemented for each resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638 Based on observation, record review, staff interview, and resident interview, the facility failed to ensure a resident (#20) was provided compression stockings as physician ordered. This affected one (Resident #20) of one resident observed for compression stockings. The facility census was 78. Findings included: Review of Resident #20's medical record revealed an admitted [DATE]. Diagnoses included bipolar disorder, chronic obstructive pulmonary disease, chronic respiratory failure, ataxia, Parkinson's, schizoaffective, and lymphedema. Review of Resident #20's quarterly Minimum Data Set, dated dated dated [DATE] revealed intact cognition. The resident required maximum assistance for lower body dressing and required oxygen therapy. Review of Resident #20's care plan revealed the resident required diuretic therapy. Interventions included to watch for lower extremity swelling. Review of Resident #20's medical record revealed a physician's order for [NAME] hose (compression stockings) to be applied in the morning and removed at bedtime. Size regular. Observation on 12/09/24 at 10:10 A.M. revealed Resident #20 did not have the compression stockings applied. Interview with Resident #20 on 12/09/24 at 10:10 A.M. revealed the compression stocking in size medium were too tight and she refused to wear them. The resident stated she had informed several aides and nurses regarding this issue. Observation on 12/10/24 at 2:10 P.M. revealed Resident #20 did not have compression stockings applied. Interview on 12/10/24 at 2:12 P.M. with Licensed Practical Nurse (LPN) #578 verified Resident #20 had a physician's order for compression stockings but they were not applied. Observation on 12/10/24 at LPN #578 asked Certified Nursing Assistant (CNA) #607 to put on the hose and the CNA went in to do so and the resident refused saying they were too tight. Interview with the Director of Nursing (DON) on 12/11/24 at 11:23 A.M. revealed she was unaware that Resident #20 was unable to wear the physician ordered compression stockings. An email was received from the DON on 12/12/24 at 9:33 A.M. which revealed the physician had been notified regarding Resident #20's refusal to wear the compression stockings and she had been re-measured for a new pair.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37451 Based on observation, medical record review, staff interview, and review of facility policy, the facility failed to ensure residents had their tube feed running at the ordered rate. This affected one resident (#52) of one resident reviewed. The facility identified one resident who received nutrition via tube feeding in the facility. The facility census was 78. Findings include: Review of Resident #52's medical record revealed an admitted [DATE]. Diagnoses included Parkinson's Disease, dysphagia, moderate protein calorie malnutrition, anxiety disorder, bipolar disorder, seizures, and osteoporosis. Review of Resident #52's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of eight indicating Resident #52 was moderately cognitively impaired. Resident #52 required maximal assistance with toilet use, dressing, bathing, and mobility. Resident #52 had a feeding tube and received 51% or more of his total calories through the tube feeding. Resident #52 displayed no behaviors during the review period. Review of Resident #52's care plan revised 11/30/24 revealed supports and interventions for impaired nutrition related to no food by mouth (NPO) status with tube feeding for total nutrition. Review of Resident #52's physician orders revealed an order dated 11/25/24 and reordered 12/09/24 for Nepro Carb Steady oral liquid supplement. Give 55 milliliters (ml) via gastrostomy tube (g-tube) every shift for enteral feeding related to dysphagia. Water flush 240 ml every four hours. Review of Resident #52's progress notes and electronic Medication Administration Record (eMAR) found no justification for Resident #52's tube feeding rate to be adjusted from the rate ordered by the physician. Observation on 12/09/24 at 9:34 A.M. of Resident #52 found him sleeping in bed with his continuous tube feeding running at 59 ml per hour. Observation on 12/09/24 at 10:40 A.M. of Resident #52 found him sleeping in bed with his tube feed running at 59 ml per hour. Observation on 12/10/24 08:02 A.M. of Resident #52 found him sleeping in bed with his continuous tube feeding running at 50 ml. Observation on 12/10/24 at 2:31 P.M. of Resident #52 found him awake with his continuous tube feed running at 50 ml per hour. Interview on 12/10/24 at 2:35 P.M. with Registered Nurse #545 verified Resident #52's tube feeding was to be running at 55 ml per hour and it was set at 50 ml with no justification or change in the order. RN #545 reported Resident #52's tube feeding was connected on night shift and adjusted Resident #52's tube feeding rate to 55 ml per hour flow rate as was ordered. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Enteral Nutrition, revised November 2018 revealed adequate nutritional support through enteral nutrition was provided to residents as ordered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 37451 Based on observation, resident interview, staff interview and review of facility policy, the facility failed to ensure resident medications were kept secured. This affected one resident (#67) of one reviewed for medication storage. The facility census was 78. Findings include: Review of Resident #67's medical record revealed an admitted [DATE]. Diagnoses included type II diabetes, peripheral vascular disease, diverticulosis, osteomyelitis, gangrene, cellulitis of the lower limb, and acquired absence of right leg below the knee. Review of Resident #67's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #67 was cognitively intact. Resident #67 required maximal assistance with toilet use, bathing, dressing, and transfer. Resident #67 displayed no behaviors at the time of the review. Review of Resident #67's physician orders revealed an order dated 11/08/24 for Loperamide HCL 2 milligrams (mg) one capsule every six hours as needed for diarrhea. Observation on 12/10/24 at 9:56 A.M. of Resident #67 found when he opened the drawer in his overbed table he had a blister pack of white pills in a baggie along with loose round large multicolored tablets. Coinciding interview with Resident #67 verified he was keeping Imodium and stomach chews at his bedside so he could taken them when he wanted. Resident #67 said he had issues with diarrhea and needed the medications. Interview on 12/10/24 at 10:02 A.M. with Certified Nursing Assistant (CNA) #521 verified Resident #67 was not permitted to self administer his medication and needed the nurse to administer his medications. Interview on 12/10/24 at 10:05 A.M. with Registered Nurse (RN) #528 also verified Resident #67 was not able to keep any of his medications at his bedside. Observation on 12/09/24 at 10:09 A.M. of RN #528 found she entered Resident #67 room and asked if he had any medications he was keeping with him. Resident #67 confirmed he had stomach medications and stated he was tired of having diarrhea. RN #528 explained he needed to have an order for any medications he was taking and was not able to keep his medications at his bedside. RN #528 was observed removing two baggies of medications from Resident #67's room Interview on 12/09/24 at 10:11 A.M. with RN #528 verified Resident #67 had medications unsecured in his room. RN #528 reported they would be disposed of and an order would be obtained for Imodium if necessary. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility policy titled, Storage of Medications, revised April 2019 revealed the facility was to store all drugs and biologicals in a safe, secured and orderly manner. Drugs and biologicals used in the facility were to be stored in locked compartments under proper temperatures, light and humidity controls.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37451 Based on observation, staff interview, and review of facility policy, the facility failed to maintain the kitchen in a safe and sanitary manner. This had the potential to affect 77 residents in the facility, Resident #52 received no food by mouth and thus received no food from the kitchen. The facility census was 78. Findings include: Observation on 12/09/24 at 8:35 A.M. of the kitchen found Dietary Staff (DS) #534 was running dishes through the dishwasher. Coinciding interview with DS #534 revealed she was not aware if the dishwasher was a high temperature or chemical machine. Review of the dishwasher found it was labeled as a high temperature machine with the final rinse temperature should be 180 degrees Fahrenheit (F). Observation of the temperature gauge as DS #534 ran the dishwasher found it reached 164 degrees F for the wash and the gauge did not move off the 100 degree mark for the rinse. Observation and coinciding interview on 12/09/24 at 8:37 A.M. with Dietary Director (DD) #601 found when the dishwasher was run again the rinse gauge continued to read 100 degrees and did not move. The dishwasher was run a third time along with an internal temperature gauge puck and DD #601 verified the highest temperature the dishwasher reached was 154 degrees F. DD #601 reported he was unaware of how long the dishwasher was not reaching the 180 degrees F for the rinse cycle and directed the staff to use the three sink system for sanitation after the dishes were ran through the dishwasher. Review of Dishwasher Temperature Record for the month of December 2024 revealed the dishwasher wash and rinse temperatures were taken with every meal. Of the 24 rinse temperatures documented there were 20 times the dishwasher did not reach 180 degrees on the rinse cycle. Observation on 12/09/24 at 8:49 A.M. of the dry storage area found a one gallon bottle of soy sauce open and approximately 1/3 used on the dry storage shelf. The bottle was labeled refrigerate after opening. Interview on 12/09/24 at 8:50 A.M. with DM #601 verified the soy sauce was being stored on the dry storage shelf and it should have been in the refrigerator. DM #601 disposed of the soy sauce. Further review of the dry storage area on 12/09/24 at 8:50 A.M. found a scooped contained in the bulk rice puff cereal. Interview on 12/09/24 at 8:51 A.M. with DM #601 verified there was a scoop contained in the bulk rice cereal and the scoop should have been stored outside of the container and not left in the container. Observation on 12/09/24 at 8:56 A.M. of the reach in freezer found an open box containing an open clear plastic bag of cheddar cheese omelets. Approximately five omelets were observed in the open box. Coinciding interview with DM #601 verified the box of omelets were left open and were not currently being use. (continued on next page)

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	365380	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumnwood Care Center	670 E Sr 18 Tiffin, OH 44883

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled, Food Receiving and Storage, revised October 2017 revealed refrigerated food must be stored below 41 degrees unless otherwise specified by law. All foods stored in the refrigerator or freezer would be covered, labeled and dated. Review of the facility policy titled, Dishwasher Machine Use, revised March 2010 revealed the facility's dishwashing machine hot water sanitation rinse temperatures may not be more than 194 degree Fahrenheit (F) or less than 180 degrees F for all other machines. The operator will check temperatures using the machine gauge with each dishwashing machine cycle and would record the results in the facility approved log. Inadequate temperatures would be reported to the supervisor and corrected immediately.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638 Based on observation, medical record review, staff interview, resident interview, and policy review, revealed the facility failed to ensure medical staff completed accurate documentation regarding a resident's compression stocking application. This affected one (Resident #20) of one resident reviewed for documentation. The facility census was 78. Findings included: Review of Resident #20's medical record revealed an admitted [DATE]. Diagnoses included bipolar disorder, chronic obstructive pulmonary disease, chronic respiratory failure, ataxia, Parkinson's, schizoaffective, and lymphedema. Review of Resident #20's quarterly Minimum Data Set, dated dated dated [DATE] revealed an intact cognition. The resident required maximum assistance for lower body dressing. Review of Resident #20's care plan revealed the resident required diuretic therapy. Interventions included to watch for lower extremity swelling. Review of Resident #20's medical record revealed a physician's order for [NAME] hose (compression stockings) to be applied in the morning and removed at bedtime. Size regular medium. Observation on 12/09/24 at 10:10 A.M. revealed Resident #20 did not have the compression stockings applied. Interview with Resident #20 on 12/09/24 at 10:10 A.M. revealed the compression stocking in size medium were too tight and she refused to wear them. The resident revealed she had not worn the stockings in months. The resident stated she had informed several aides and nurses regarding this issue but new stockings were not received. Observation on 12/10/24 at 2:10 P.M. revealed Resident #20 continued to not have the compression stockings in place. Review of Resident #20's electronic Treatment Administration Record (TAR) dated 11/01/24 through 12/13/24 revealed nursing staff documented the resident's compression stockings had been placed on the resident daily and removed at bedtime. Interview on 12/10/24 at 2:12 P.M. with Licensed Practical Nurse (LPN) #578 verified Resident #20 had a physician's order for compression stockings but they were failed to be applied. LPN #578 verified nursing staff had documented the compression stockings were applied daily even though they were not truly placed on the resident. Observation on 12/10/24, LPN #578 asked Certified Nursing Assistant (CNA) #607 to put on the hose and CNA #607 went to do so and Resident #20 refused stating they were too tight. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) on 12/11/24 at 11:23 A.M. revealed she was unaware that Resident #20 was unable to wear the physician ordered compression stockings. She verified staff had falsely documented Resident #20's TAR. Review of the facility policy titled,Charting and Documentation undated, revealed documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742 Based on observation, medical record review, resident interview, staff interview, and review of facility policy, the facility failed to ensure resident's catheter collection bags were maintained off the floor and in a safe and sanitary manner. This affected two residents (#56 and #39) of two residents reviewed with indwelling catheters. In addition, the facility failed to ensure medications were administered in a safe and sanitary manner. This affected two residents (#56 and #69). The facility census was 78. Findings include: 1. Review of Resident #39's medical record revealed an admitted [DATE]. Diagnoses included urethral syndrome, urinary retention, chronic kidney disease, and breast and lung cancer. Review of Resident #39's Minimum Data Set (MDS) revealed she had intact cognitive function and required an indwelling Foley catheter. Review of Resident #39's most recent care plan revealed the resident required enhanced barrier precautions related to increased risk for multidrug-resistant organisms (MDRO) infections due to wound(s) and an indwelling catheter. Review of Resident #39's medical record revealed a physician's order dated 11/19/24 for a Foley catheter #14 French with continuous drainage. Observation on 12/11/24 at 11:04 A.M. revealed Certified Nurse Assistant (CNA) #590 was pushing Resident #39 in her wheelchair down the hallway to the dining room. Resident #39's Foley catheter bag was dragging on the tile floor all the way down the hall into the dining room. Interview with CNA #590 on 12/11/24 at 11:05 A.M. revealed the aide was unaware Resident #39's Foley catheter bag was dragging on the floor and she was aware it was an infection control issue. The CNA then positioned the bag to remove it from the dining room floor. 37451 2. Review of Resident #56's medical record revealed an admitted [DATE]. Diagnoses included cerebrovascular disease, liver transplant status, type II diabetes, depression, diverticulitis, cerebral infarction, anxiety disorder, stroke, and gangrene. Review of Resident #56's MDS dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #56 was cognitively intact. Resident #56 had an indwelling catheter at the time of the review. Resident #56 required supervision or touching assistance with toilet use, and personal hygiene. Resident #56 required moderate assistance with bathing. Resident #56 displayed no behaviors at the time of the review. Review of Resident #56's care plan revised 10/11/24 revealed supports and interventions for self-care deficit, impaired nutrition, catheter, and pain. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #56's physician orders revealed an order dated 11/04/24 for Foley catheter #16 French 5-10 cubic centimeter (cc) to continuous drainage every shift related to obstructive and reflux uropathy. An order dated 11/04/24 for catheter care every shift per policy and an order dated 11/04/24 for privacy bag every shift. Observation on 12/09/24 at 9:30 A.M. of Resident #56 found his catheter bag hanging on the side of Resident #56's trash can. The bottom of the bag was lying on the floor with no barrier between the floor and the catheter bag, and the wheel of Resident #56's bedside table was on top of Resident #56's catheter bag privacy cover. Coinciding interview with Resident #56 revealed the staff had placed the bag on the trash can and the wheel of his bedside table often rolled over the privacy bag cover when he moved the table around. Resident #56 reported he could get himself out of bed and could move his catheter bag but he just hooked it back on the trash can and tried to be careful when moving his bedside table so it was not sitting on the bag. Interview on 12/09/24 at 9:31 A.M. with CNA #521 verified Resident #56's catheter bag was hanging on the side of the trash can, was partially touching the floor, and the wheel of Resident #56's bedside table was on top of the privacy bag cover. CNA #56 removed the bedside table wheel from the catheter bag and showed the wheel had been on the privacy cover and not the catheter bag itself. CNA #521 did not remove the catheter bag from the trash can or off the floor. Observation on 12/10/24 at 8:01 A.M. of Resident #56 found him sleeping in bed. Resident #56's catheter bag continued to be hanging on the side of the trash can and partially touching the floor. The wheel of Resident #56's bedside table was observed on top of the bottom of Resident #56's catheter bag privacy cover. Observation on 12/10/24 at 2:36 P.M. of Resident #56 found him sleeping in bed. His catheter bag continued to be hanging on the side of the trash can and partially touching the floor. Interview on 12/10/24 at 2:38 P.M. with Registered Nurse (RN) #545 verified Resident #56's catheter bag was hanging on the side of his trash can and was partially touching the floor. RN #545 verified Resident #56's catheter bag was not supposed to be hanging on the trash can or touching the floor. RN #545 moved Resident #56's catheter bag from the trash can to the side of Resident #56's bed. The bag was observed to be repositioned below Resident #56's bladder and off the floor. Review of the facility policy titled, Urinary Catheter Care, revised September 2014 revealed the staff were to maintain clean techniques when handling or manipulating the catheter, tubing or drainage bag. The policy was silent to maintaining the catheter bag off the floor. 35033 3. Review of the medical record for Resident #56 revealed an admitted [DATE]. Diagnoses included cerebrovascular disease, type two diabetes mellitus, depression, hypertension, and anxiety. Review of the quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. Review of the physician orders dated 08/09/24 revealed the resident had orders for oxycodone five milligrams (mg) every 12 hours as needed for pain. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/10/24 at 7:10 A.M. during medication administration for Resident #56 revealed Registered Nurse (RN) #545 removed one oxycodone tablet from the medication card and placed the tablet in her ungloved hand. 4. Review of the medical record for Resident #69 revealed an admitted [DATE]. Diagnoses included hypertension, atrial fibrillation, and convulsions. Review of the quarterly MDS dated [DATE] revealed the resident had intact cognition. Review of the physician orders dated 09/28/24 phenobarbital tablet 64.8 mg in the morning for cerebral infarction. Observation on 12/10/24 7:44 A.M. during medication administration for Resident #69 revealed RN #545 removed one phenobarbital tablet from the medication card and placed the medication in her ungloved hand. Interview on 12/10/24 at 7:56 A.M., RN #545 verified she directly touched the medications for Resident #56 and Resident #69 with an ungloved hand. Interview on 12/10/24 04:10 P.M., the Director of Nursing (DON) verified the nurse should not place medications in their bare hand. Review of the policy, Administering Medications, revised 04/2019, revealed staff followed established facility infection control procedures for the administration of medications.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 37451 Based on observation, staff interview, review of the manufactures instructions for the dishwasher, review of dishwasher temperature logs, and review of facility policy, the facility failed to ensure the dishwashing machine was maintained in a safe operating condition. This had the potential to affect 77 residents in the facility, Resident #52 received no food by mouth and no food from the kitchen. The facility census was 78. Findings include: Observation on 12/09/24 at 8:35 A.M. of the kitchen found Dietary Staff (DS) #534 was running dishes through the dishwasher. Coinciding interview with DS #534 revealed she was not aware if the dishwasher was a high temperature or chemical machine. Review of the dishwasher found it was labeled as a high temperature machine with a final rinse temperature noted to be 180 degrees Fahrenheit (F). Observation of the temperature gauge as DS #534 ran the dishwasher found it reached 164 degrees F for the wash and the gauge did not move off the 100 degree mark for the rinse. Observation and coinciding interview on 12/09/24 at 8:37 A.M. with Dietary Director (DD) #601 found when the dishwasher was run again the rinse gauge continued to read 100 degrees and did not move. The dishwasher was run a third time along with an internal temperature gauge puck and DD #601 verified the highest temperature the dishwasher reached was 154 degrees F. DD #601 reported he was unaware of how long the dishwasher was not reaching the 180 degrees F for the rinse cycle and directed the staff to use the three sink system for sanitation after the dishes were ran through the dishwasher. Review of Dishwasher Temperature Record for the month of December 2024 revealed the dishwasher wash and rinse temperatures were taken with every meal. Of the 24 rinse temperatures documented there were 20 times the dishwasher did not reach 180 degrees on the rinse cycle. Interview on 12/10/24 at 9:44 A.M. with DM #601 revealed a couple months prior they had been having an issue with the temperature gauges on the dishwashing machine. They had been using the puck with every wash cycle to ensure the temperature of the water was reaching the required levels. If the dishwasher did not reach the proper levels the kitchen staff would put the dishes through the three sink system to ensure proper sanitation. DM #601 reported the gauges were repaired at the end of November and they stopped using the pucks. DM #601 reported he was not aware the dishwasher was still not working correctly until yesterday when the puck read 154 after the rinse cycle. DM #601 verified the three sink system was not utilized from 12/01/24 to 12/09/24. The temperature log was reviewed and DM #601 verified there were a number of times in December where the dishwasher did not reach proper temperatures for the rinse cycle. Interview on 12/10/24 at 10:28 A.M. with DM #601 revealed the dishwasher had been fixed by Regional Director of Maintenance #605. Coinciding observation found the dishwasher gauge read 164 degrees F for the wash cycle and 190 degrees F for the rinse cycle. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 12/11/24 7:41 A.M. of the dishwasher for internal water temperatures using a thermometer puck with DM #601 found the rinse cycle read 186 degrees F on the gauge but 149 degrees F on the puck. DM #601 reported the dishwasher had not been in use yet this morning and typically took a couple times running to reach temperature. Additional temperatures were as follows: 12/11/24 at 7:42 AM the rinse gauge read 190 degrees F and the puck read 164 degrees F. 12/11/24 at 7:43 AM the rinse gauge read 190 degrees F and the puck read 166 degrees F. 12/11/24 at 7:45 AM the rinse gauge read 188 degrees F and the puck read 172 degrees F. Coinciding interview with DM #601 revealed they would be having a service professional come out again to fix the dishwasher. DM #601 verified the gauge was providing inaccurate readings of the dishwasher temperatures which indicated the dishwasher was reaching the appropriate rinse temperature of 180 degrees F or higher when in fact the actual internal water temperature was much lower. 12/11/24 at 7:47 A.M. the rinse gauge read 188 degrees F and the puck read 173 degrees F. 12/11/24 at 7:48 A.M. the rinse gauge read 198 degrees F and the puck read 176 degrees F. 12/11/24 at 7:50 A.M. the rinse gauge read 200 degrees F and the puck read 179.6 degrees F. 12/11/24 at 7:51 A.M. the rinse gauge read 200 degrees F and the puck read 179.6 degrees F. 12/11/24 at 7:52 A.M. the rinse gauge read 200 degrees F and the puck read 179.7 degrees F. On 12/11/24 at 7:53 A.M. a different thermometer puck was used to ensure the puck in use was accurate. The rinse gauge read 260 degrees F and the new puck read 172 degrees F. 12/11/24 at 7:54 A.M. the rinse gauge read 210 degrees F and the internal temperature on the puck read 176.9 degrees F. 12/11/24 at 7:56 A.M. the rinse gauge read 212 degrees F and the puck read 177.8 degrees F. 12/11/24 at 7:57 A.M. the rinse gauge read 210 degrees F and the puck read 179.9 degrees F. On 12/11/24 at 7:58 A.M. both pucks were ran through the dishwasher cycle along with two high temperature test strips which had indicators which turned black when an internal temperature of 180 degrees F was reached. The rinse gauge read 212 degree F, the two pucks read 179.9 degrees F and 177.2 degrees F, while the two test strip indicators remained white. Coinciding interview with DM #601 verified the dishwasher continued to not reach the proper temperatures and they would use the three sink system to ensure sanitation until the dishwasher was repaired. Interview on 12/12/24 at 1:22 P.M. with DM #601 revealed the dishwasher was still not getting up to temperature. DM #601 reported they had a service order in for the company to come out and repair it. The facility was waiting on the company to contact them back with a date of when they would be coming out to evaluate the machine and complete the repairs. In the mean time, DM #601 reported they would continue running the dishes through the dishwasher and then putting them through the three sink system. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Manufactures Instructions for dishwasher utilized by the facility revealed the water temperature for the wash cycle was to be 160 degrees F and the rinse cycle was to be 180 degrees F. Review of the facility policy titled, Dishwasher Machine Use, revised March 2010 revealed the facility's dishwashing machine hot water sanitation rinse temperatures may not be more than 194 degree Fahrenheit (F) or less than 180 degrees F for all other machines. The operator will check temperatures using the machine gauge with each dishwashing machine cycle and would record the results in the facility approved log. Inadequate temperatures would be reported to the supervisor and corrected immediately.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 49742 Based on observation, resident interviews, staff interviews, and review of facility policy, the facility failed to ensure the dryers in the facility laundry room were cleaned appropriately. This had the potential to affect all residents in the facility. Additionally, the facility failed to ensure a well-maintained environment. This affected two residents (Resident #24 and Resident #68) of two residents reviewed for environment. The facility census was 78. Findings include: 1. Observation on 12/10/24 at 12:02 P.M. revealed the walk-in vent area behind the facility's three industrial dryers were covered in lint. An interview on 12/10/24 at 12:02 P.M. with Laundry #502 verified these findings. An interview on 12/10/24 at 12:02 P.M. with Laundry #502 revealed Maintenance Supervisor #535 cleans the lint once per year. 31638 2. Observation of Residents #24 and #68 room on 12/09/24 at 9:45 A.M. revealed above Resident #24's bed was a large brown stain on the ceiling. Interview with Residents #24 and #68 on 12/09/24 at 10:35 A.M. verified their ceiling had large brown stain. They stated the stain had been there for a long time. When asked if it bothered them they stated they looked at the spots and imagined the different shapes like clouds, but they wished the ceiling could be painted. Interview with Maintenance Supervisor #527 on 12/12/24 at 8:07 A.M. verified there was a large brown stain on the ceiling in Residents #24 and #68's room. He stated he planned to paint the ceiling. When asked if it was a leak he stated the stain was from a leak but it had been repaired sometime ago but was not able to remember the exact timeframe. Review of the facility policy titled, Maintenance Service, undated, revealed the maintenance department was responsible for providing routine scheduled maintenance service to all areas.