STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365381	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wickliffe Country Place	1919 Bishop Rd Wickliffe, OH 44092

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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 interview, record review and review of facility policy revealed the facility did not ensure Resident #32's advanced directives were accurate per the physician orders on her electronic medical record. This affected one resident (#32) out of 43 residents reviewed for advanced directives. The facility census was 126. Findings included: Review of the medical record for Resident #32 revealed an admitted [DATE] and diagnoses included schizophrenia, diabetes, moderate protein-calorie malnutrition, and hypertension. Review of the Do Not Resuscitate (DNR) Comfort Care form dated 08/02/23 and completed by Nurse Practitioner (NP) #500 revealed Resident #32 was to be a DNR Comfort Care- Arrest. Review of the care plan dated 08/24/23 revealed Resident #32 and/ or family had chosen to have an advanced directive: DNR Comfort Care- Arrest. Interventions included the facility would review code status when significant change in condition occurred, monitor for appropriateness of a hospice consult, and review advance directive status with plan of care meetings. Review of September 2024 physician orders per Resident #32's electronic medical record revealed under the code status section at the top of the orders Resident #32 was to be a full code. The physician orders also included an order dated 09/06/24 that revealed Resident #32 was to be a full code. Interview on 09/23/24 at 3:56 P.M. with Licensed Practical Nurse (LPN) #78 was asked if a resident was found unresponsive without vitals where would she check to see what the resident's advanced directives were. LPN #78 revealed she would check the physician orders per the electronic medical record. LPN #78 verified Resident #32's advance directives were conflicting as the physician order stated she was a full code but in the hard chart there was a DNR Comfort Care form that identified Resident #32 was a DNR Comfort Care- Arrest. Interview on 09/23/24 at 3:59 P.M. with the Director of Nursing revealed Resident #32's order in her electronic medical record stated that she was to be a full code but the DNR Comfort Care form in her medical record indicated she was to be a DNR Comfort Care- Arrest. She verified the order in the electronic medical record was not accurate. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy labeled; Advanced Care Planning dated 11/30/23 revealed upon admission the attending physician would help identify the prognosis for each resident. The physician and staff would identify individuals who desire or are likely candidates for palliative care. There was nothing identified in the policy regarding ensuring advanced directives were accurate in the electronic medical record and matched what advance directives were per the DNR Comfort Care form. There was also nothing in the policy regarding where a nurse should look if a resident was found unresponsive regarding what code status to utilize in the physician orders per the electronic medical record and/ or the DNR Comfort Care form in the hard medical record.

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on interview, record review, and review of facility policies the facility failed to ensure the resident, physician, legal guardian and/ or responsible party was notified regarding significant weight changes. This affected two residents (#16 and #32) out of seven residents reviewed for proper notifications of significant weight change. The facility census was 126. Findings included: 1. Review of the medical record for Resident #32 revealed an admitted [DATE] and diagnoses included schizophrenia, diabetes, moderate protein-calorie malnutrition, and dysphagia. She had a legal guardian. There was no documentation in the medical record regarding the physician, and legal guardian being notified of Resident #32's significant weight loss of 17.1 percent from 02/01/24 to 05/08/24. Review of the weight record for Resident #32 from 01/08/24 to 09/24/24 revealed she had the following weights: 01/08/24 her weight was 197.6 pounds, 01/30/24 her weight was 202.3 pounds, 02/01/24 her weight was 193 pounds, and 05/08/24 her weight was 160 pounds which indicated a 17.1 percent significant weight loss. The weight record also revealed on 06/05/24 her weight was 171 pounds, 07/22/24 her weight was 173. 1 pounds, 07/24/24 her weight was 166.6 pounds, and on 08/08/24 her weight was 162.4 pounds. There was no recorded weight from 02/01/24 until 05/08/24 (over three months) and there was no recorded weight for September 2024 as of the time of the review (09/24/24). Review of quarterly Nutrition assessment dated [DATE] and completed by Dietician #171 revealed Resident #32's weight was 171 pounds. The assessment revealed Resident #32 had a 10.2 percent weight loss in six months. She continued a regular pureed diet with cup with handles for meals. The dietician recommended to continue to monitor the resident's weight and meal intakes. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #32 was cognitively impaired. She was dependent on staff for eating. Her weight was 167 pounds, and she was identified with weight loss that was not prescribed. Review of care plan last revised 08/06/24 revealed Resident #32 had nutritional needs as she had a significant weight loss in the last 180 days due to dysphagia, schizophrenia, and cerebral vascular accident. Interventions included diet as ordered, monitor and evaluate any significant weight loss, review weights and notify physician and responsible party regarding any significant weight change. Interview on 09/24/24 at 3:37 P.M. with Dietician #169 revealed the facility did not have a dietician at this time and that other dieticians from other facilities had been filling in until a dietician was hired. She verified on review of the medical record that Resident #32's weight on 02/01/24 was 193 pounds, and then there was no weight recorded until 05/08/24 which was 160 pounds indicating a 17.1 percent weight loss. She verified she had gone for three months without a weight completed and upon her review there was no indication of a reason such as being in the hospital and/ or refusal as her weight should have been completed at least monthly. She verified she did not see per her medical record that the physician or legal guardian was notified of her significant weight loss and believed the nurses were to do this but was unsure. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/24/24 at 3:51 P.M. with the Director of Nursing verified Resident #32's weight was not completed for over three months as her weight on 02/01/24 was 193 pounds, and then there was no weight again until 05/08/24 which was 160 pounds indicating a 17.1 percent weight loss. She stated, to be honest the weight did not get done. Interview on 09/24/24 at 2:10 P.M. with the Director of Nursing verified there was no evidence in the medical record the physician and/ or legal guardian was notified of Resident #32's significant weight loss of 17.1 percent. She verified any significant weight loss the nurses were to notify the physician, resident, legal guardian and/ or responsible party. 2. Review of the medical record for Resident #16 revealed an admitted [DATE] and diagnoses included dementia, emphysema, mild protein calorie malnutrition, and dysphagia. There was nothing in the medical record regarding the resident, responsible party and physician being notified of Resident #16's 21 percent significant weight loss. Review of weight record from 01/04/24 to 09/24/24 revealed Resident #16's admission weight was 131.6 pounds. His weight appeared stable until 07/24/24 his weight was 135 pounds and on 08/06/24 his weight was 106.6 indicating a 21 percent significant weight loss. There were no other weights recorded following the 08/06/24 weight. Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #16 had impaired cognition. His weight was 139 pounds indicating no weight loss and he was on a mechanically altered diet. Review of care plan dated 07/16/24 revealed Resident #16 had nutritional needs related to advanced age, significant weight changes, dementia, dysphagia, and mild protein malnutrition. Interventions included diet as ordered, encourage oral intake, monitor weight every week for one month and then monthly thereafter, review weights and notify physician and responsible party of significant weight changes. Review of Nutritional progress note dated 08/07/24 and completed by Dietician #170 revealed Resident #16 had a significant weight loss of 21 percent as his weight was 106.6 pounds indicating he was underweight. Dietician #170 questioned the validity of the weight and requested a reweigh. There was nothing in the progress note the physician and/ or responsible party was notified regarding the significant weight loss. Review of Nutritional progress note dated 08/20/24 and completed by Dietician #170 revealed Resident #16 had a 21 percent significant weight loss over the last two weeks and Dietician #170 questioned the validity of the weight and requested a reweigh. She recommended to liberalize his diet and continue the magic cup supplement twice a day. There was nothing in the progress note the physician and/ or responsible party was notified regarding the significant weight loss. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/24/24 at 4:27 P.M. with Dietician #169 verified the last recorded weight per the electronic medical record was on 08/06/24 and was 106 pounds indicating a significant weight loss of 21 percent in one month. She verified upon review of the medical record the Dietician #170 had requested a re-weight to be completed on 08/07/24 and 08/20/24 as she questioned the validity of the weight. Dietician #169 revealed upon her review it did not appear a re-weight was completed as she goes by what is in the electronic medical record. She revealed she was unsure if the weight was accurate or not without a re-weight. She verified she did not see per his medical record that the resident, responsible party or physician was notified of his significant weight loss and believed the nurses were to do this but was unsure. Interview on 09/25/24 at 9:51 A.M. with the Director of Nursing revealed a re-weight had been completed on 09/05/24 and the weight was 119.2 pounds (11.7 weight loss) but had not been entered into the electronic medical record instead it was in a weight book. She verified she was unsure if the dieticians knew about the weight book instead of just going by what was in the electronic medical record. She verified the nurses were to put the weights in the electronic medical record for the dietician to review. Interview on 09/25/24 at 10:39 A.M. with the Director of Nursing verified there was nothing in the medical record that indicated the resident, responsible party and/ or physician was notified regarding Resident #16's significant weight loss. Review of undated facility policy labeled, Nutrition Intervention for Significant Weight Change revealed the registered dietician would assess monthly and weekly weight changes and recommended interventions intended to reverse the weight loss. The dietician would calculate and assess for significant weight changes: five percent in one month, 7.5 percent over three months and ten percent over six months would be considered significant. The policy revealed based on resident preferences and/ or discussions with the resident and/ or responsible party the dietician may recommended nutritional interventions to attempt to stabilize or reverse weight loss. There was nothing in the policy regarding notification to physician, responsible party and/ or resident of significant weight loss. Review of facility policy labeled, Change in a Resident's Condition dated 11/30/23 revealed the facility shall notify the resident, physician, and representative of changes in the resident's medical condition. The nurse would document in the resident's medical record information relative to changes in the resident's medical condition or status. This deficiency represents non-compliance investigated under Master Complaint Number OH00157866.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442 Based on record review and interview, the facility failed to ensure a resident received bathing as planned and/or as requested. This affected one resident (#180) of five residents reviewed for showers. The facility census was 126. Findings include: Review of the medical record for Resident #180 revealed an admitted [DATE]. Diagnoses included but were not limited to type II diabetes mellitus, stage III chronic kidney disease and history of transient ischemic attacks. Review of the 09/04/24 admission Minimum Data Set (MDS) 3.0 for Resident #180 revealed a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. Review of activities of daily living (ADLs) revealed Resident #180 required set up assistance for bathing. Review of the care plan dated 09/06/24 for Resident #180 revealed under preferences, preferred showers. Review of the facility shower schedule revealed Resident #180 was to receive showers on Wednesdays and Saturdays during the 3:00 P.M. to 11:00 P.M. shift. Review of the facility Recreation Admission assessment dated [DATE] for Resident #180 revealed under other preferences Resident #180 indicated it was very important choose between a shower or bed bath and preferred showers. Review of the shower sheets for Resident #180 revealed refusals on 09/06/24 and 09/13/24 and showers provided on 09/10/24, 09/17/24, and 09/20/24. No noted reattempts for the shower refusals were indicated. No shower sheet was provided after 09/20/24. Review of the nursing progress notes from 09/04/24 to 09/26/24 for Resident #180 did not indicate any shower refusals. Interview on 09/23/24 at 11:05 A.M. with Resident #180 revealed he was admitted three weeks ago and has never been offered a shower and stated staff have just offered him a washcloth to wash up. Interview on 09/25/24 at 11:02 A.M. with Licensed Practical Nurse (LPN #72) revealed Resident #180 is very cooperative and does not refuse care. Interview on 09/26/24 at 8:06 A.M. with Resident #180 confirmed he was offered a washcloth to clean up yesterday but was not offered a shower. Resident #180 confirmed he has never been offered a shower since admission and has not refused bathing. Resident #180 stated he left a previous facility due to not getting consistent showers and had hoped moving to this facility would be better. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/26/24 at 8:11 A.M. with Unit Manager #139 confirmed shower sheets provided by the facility indicated a refusal on 09/06/24 and 09/13/24 and did not indicate if resident had been re-approached more than once. Unit Manager confirmed there was no shower sheet for 09/20/24 and the care plan did not indicate shower refusals. Unit Manager #139 confirmed Resident #180 was being offered a shower today. Review of the revised facility policy (dated 06/30/22) titled; Bed Bath/Shower revealed residents will be scheduled to accommodate their preferences as facility is able and will be scheduled at least weekly. Staff will complete the bath/shower as scheduled or to accommodate resident preference. The staff will document when the bath/shower was completed per facility protocol.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35768 Based on record review, observation, and interview the facility failed to provide assistance to maintain personal hygiene. This affected one (Resident #69) of five residents reviewed for activities of daily living. The census was 126 Findings include: Review of medical record for Resident #69 revealed an admitted [DATE]. Diagnoses included depression, unspecified and type two diabetes. The resident had impaired cognition. Review of the annual Minimum Data Set (MDS) assessment, dated 09/06/24, revealed Resident #69 had intact cognition. The resident required maximum assistance for personal hygiene. Review of the plan of care dated 09/10/24 revealed Resident #69 had a activity of daily living (ADL) self-care performance deficit related to impaired mobility and generalized weakness. Interventions included for staff to provide total oral care, provide extensive assistance with personal hygiene; and encourage to start task and finish if the resident becomes tired or unable to complete. Observation on 09/23/24 at 10:22 A.M., Resident #69 was observed to have facial hair covering her chin measuring approximately an eighth of an inch. Interview during the observation Resident #69 stated she would love to have the hair shaved off. Interview on 09/23/24 at 10:23 A.M., State tested Nurse Assistant (STNA) #39 stated yeah her hair is pretty long, I will shave it. Observation on 09/25/24 at 10:49 A.M., Resident #69 was lying in bed, her chin was still not shaven. Interview and observation on 09/25/24 at 10:56 A.M. Licensed Practical Nurse (LPN) #75 verified the observation and stated she would take of it immediately. Review of the facility policy titled Activities of Daily Living, dated 2023 noted staff were to maintain personal hygiene including combing and/or styling hair, washing hands and face, brushing teeth, and shaving when needed.

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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 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** 39973 Based on interview, observation, record review, and review of facility policy revealed the facility failed to implement fall interventions as identified in the resident's plan of care. This affected one resident (#32) of four residents reviewed for falls and/ or accidents. The facility census was 126. Findings included: Review of medical record for Resident #32 revealed an admitted [DATE] and diagnoses included schizophrenia, diabetes, moderate protein-calorie malnutrition, and hypertension. Review of care plan dated 07/08/24 revealed Resident #32 was at risk for falls due to impaired mobility, generalized weakness, Schizophrenia, and neuropathy. Interventions included assist with transfers, locomotion and mobility, grab bar to bed, commonly used items within easy reach, and protective floor mat next to bed that was added on 08/29/24. Review of the care plan dated 07/08/24 revealed Resident #32 had a self-care performance deficit related to impaired mobility, generalized weakness, and neuropathy. Interventions included grab bar on both sides of bed to assist with turning and repositioning, staff to anticipate needs daily, assist resident in proper body alignment while in bed, and use positioning devices as needed. Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #32 was cognitively impaired. She was dependent on staff assist with rolling left and right, toileting, dressing and showers. The MDS revealed transfers had not been attempted during the assessment period due to medical condition. Review of quarterly fall review dated 08/06/24 and completed by Licensed practical Nurse (LPN) #139 revealed Resident #32 was at high risk for falls as she needed assistance with toileting, was confined to a chair, unable to stand, had diagnoses that placed her at high risk for falls as well as was on medications that increased her risk of falls. Review of Fall Review- V3 dated 08/27/24 and completed by Registered Nurse (RN) #67 revealed Resident #32 continued to be at high risk for falls. The review revealed a certified nursing assistant (CNA) notified RN #67 that Resident #32 was on the floor. The nurse entered the room and Resident #32 was laying on the floor on her left side close to the bed. Resident #32 was unable to provide information regarding the fall. Resident #32 was lying in bed prior to the fall. There was no fall intervention added per the review. Review of nursing note dated 08/27/24 at 11:09 P.M. and completed by RN #67 revealed a CNA had notified him that Resident #32 was on the floor on her left side close to the bed. He completed an assessment including neurological that revealed no injuries. (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 nursing note dated 08/29/24 at 8:35 A.M. and completed by Assistant Director of Nursing (ADON)/ RN #31 revealed the interdisciplinary team met and discussed Resident #32's recent fall on 08/27/24. An intervention was implemented to have a floor mat to the side of her bed and her care plan was updated. Observation on 09/23/24 at 1:25 P.M. revealed Resident #32 did not have a floor mat on either side of her bed. Observation on 09/24/24 at 11:39 A.M. revealed Resident #32 did not have a floor mat on either side of her bed. Interview on 09/24/24 at 12:58 P.M. with CNA #25 revealed she was Resident #32's CNA and that she did not have a floor mat to the side of her bed. CNA #25 revealed she had never seen her with a floor mat as she does not have one in her room and stated, I do not think she is supposed to have any. Interview on 09/24/24 at 1:05 P.M. with LPN #95 revealed this was the first day working on Resident #32's unit but verified in Resident #32's care plan listed as a fall intervention she was to have a floor mat but that there was not a floor mat in her room. He stated, I will make sure she has a floor mat by the end of today. Observation on 09/25/24 at 7:58 A.M. revealed Resident #32 was laying in bed and there was not a floor mat to the side of her bed. Interview on 09/25/24 at 8:02 A.M. with LPN/ Unit Manager #134 verified there was not a floor mat to the side of Resident #32's bed. She also verified there was an intervention listed in the care plan that she was to have a floor mat due to her recent fall out of bed on 08/27/24. She revealed she would contact central supply to get a floor mat and that she was not sure why a mat was not placed yesterday. Review of facility policy labeled, Falls- Clinical Protocol (dated 11/30/23) revealed for a resident that had fallen staff would attempt to define possible causes. A fall assessment would be completed, and the care plan reviewed and revised as appropriate. The policy revealed based on the assessment the staff and physician would identify pertinent interventions to try to prevent subsequent falls and address risks of serious consequences of falling.

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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, observation, record review, and review of facility policies the facility did not ensure weights were obtained and monitored timely. This affected two residents (#16 and #32) of seven residents reviewed for nutrition. The facility census was 126. Findings included: 1. Review of medical record for Resident #32 revealed an admitted [DATE] and diagnoses included Schizophrenia, diabetes, moderate protein-calorie malnutrition, and dysphagia. She had a legal guardian. There was no documentation in the medical record regarding the physician, and legal guardian was notified of Resident #32's significant weight loss of 17.1 percent from 02/01/24 to 05/08/24. Review of weight record for Resident #32 from 01/08/24 to 09/24/24 revealed she had the following weights: 01/08/24 her weight was 197.6 pounds, 01/30/24 her weight was 202.3 pounds, 02/01/24 her weight was 193 pounds, and 05/08/24 her weight was 160 pounds which indicated a 17.1 percent significant weight loss. The weight record also revealed on 06/05/24 her weight was 171 pounds, 07/22/24 her weight was 173.1 pounds, 07/24/24 her weight was 166.6 pounds, and on 08/08/24 her weight was 162.4 pounds. There was no recorded weight from 02/01/24 till 05/08/24 (over three months) and there was no recorded weight for September 2024 as of the time of the review (09/24/24). Review of quarterly Nutrition assessment dated [DATE] and completed by Dietician #171 revealed Resident #32's weight was 171 pounds. The assessment revealed Resident #32 had a 10.2 percent weight loss in six months. She continued a regular pureed diet with cup with handles for meals. She recommended to continue to monitor her weight and meal intakes. Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #32 was cognitively impaired. She was dependent on staff on eating. Her weight was 167 pounds, and she was identified with weight loss that was not prescribed. Review of care plan last revised 08/06/24 revealed Resident #32 had nutritional needs as she had a significant weight loss in the last 180 days due to dysphagia, schizophrenia, and cerebral vascular accident. Interventions included diet as ordered, monitor and evaluate any significant weight loss, review weights and notify physician and responsible party regarding any significant weight change. Review of September 2024 physician orders revealed Resident #32 had an order for a pureed diet with a two-handle spout cup with meals, pro-heal liquid protein 30 milliliters (ml) twice a day to promote wound healing, and weekly weight times four weeks then monthly. Review of readmission Nutritional assessment dated [DATE] at 1:55 P.M. and completed by Dietician #170 revealed Resident #32's weight was 162 pounds. She recommended to liberalize her diet to regular pureed, add liquid pro-heal 30 ml twice a day to promote wound healing and continue to monitor. Observation on 09/24/24 at 1:03 P.M. revealed Occupational Therapy Assistant (OTA) #102 was sitting next to Resident #32 trying to encourage her to eat but she was refusing most all her food. OTA #102 notified LPN #95 of her refusals. (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 09/24/24 at 3:37 P.M. with Dietician #169 revealed the facility did not have a dietician at this time and that other dieticians from other facilities had been filling in until a dietician was hired. She revealed all newly admitted residents were to be weighed weekly times four weeks and if the weight was stable then each resident was to be weighed monthly. She verified on review of the medical record that Resident #32's weight on 02/01/24 was 193 pounds, and then there was no weight recorded until 05/08/24 which was 160 pounds indicating a 17.1 percent weight loss. She verified she had gone for three months without a weight completed and upon her review there was no indication of a reason such as being in the hospital and/ or refusal as her weight should have been completed at least monthly. She revealed so far, her September 2024 weight had not been completed as she goes by what is in the electronic medical record as she believed the unit managers on each unit puts the weights in for the dietician to review but that she was not aware of any other location the weights would be. She revealed at times she had found weights were not completed timely. Interview on 09/24/24 at 3:51 P.M. with the Director of Nursing revealed all new admission were to be weighed weekly for four weeks and then transition to a monthly weight if there were no concerns. She verified there was no full-time dietician at the facility that a dietician had been coming from other facilities to fill in. She verified Resident #32's weight was not completed for over three months as her weight on 02/01/24 was 193 pounds, and then there was no weight again until 05/08/24 which was 160 pounds indicating a 17.1 percent weight loss. She stated, to be honest the weight did not get done. She revealed for September 2024 her weight also had not been completed per the electronic medical record as they try to get the weights done the first week of the month and the nurses input the weights into the medical record. Observation on 09/25/24 at 12:46 P.M. revealed staff took her lunch tray in, and she refused her meal after several attempts. Interview on 09/24/24 at 2:10 P.M. with the Director of Nursing verified there was no evidence in the medical record the physician and/ or legal guardian was notified of Resident #32's significant weight loss of 17.1 percent. She verified any significant weight loss the nurses were to notify the physician, resident and responsible party. 2. Review of medical record for Resident #16 revealed an admitted [DATE] and diagnoses included dementia, emphysema, mild protein calorie malnutrition, and dysphagia. There was nothing in the medical record regarding the resident, responsible party and physician notified of Resident #16's 21 percent significant weight loss. Review of weight record from 01/04/24 to 09/24/24 revealed Resident #16's admission weight was 131.6. His weight appeared stable until 07/24/24 his weight was 135 pounds and on 08/06/24 his weight was 106.6 indicating a 21 percent significant weight loss. There were no other weights recorded following the 08/06/24 weight. Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #16 had impaired cognition. His weight was 139 pounds indicating no weight loss and he was on a mechanically altered diet. (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 care plan dated 07/16/24 revealed Resident #16 had nutritional needs related to advanced age, significant weight changes, dementia, dysphagia, and mild protein malnutrition. Interventions included diet as ordered, encourage oral intake, monitor weight every week for one month and then monthly thereafter, review weights and notify physician and responsible party of significant weight changes. Review of Nutritional progress note dated 08/07/24 and completed by Dietician #170 revealed Resident #16 had a significant weight loss of 21 percent as his weight was 106.6 pounds indicating he was underweight. Dietician #170 questioned the validity of the weight and requested a reweigh. There was nothing in the progress note the physician and/ or responsible party was notified regarding the significant weight loss. Review of Nutritional progress note dated 08/20/24 and completed by Dietician #170 revealed Resident #16 had a 21 percent significant weight loss over the last two weeks and Dietician #170 questioned the validity of the weight and requested a reweigh. She recommended to liberalize his diet and continue the magic cup supplement twice a day. There was nothing in the progress note the physician and/ or responsible party was notified regarding the significant weight loss. Review of September 2024 physician orders revealed Resident #16 had an order for weekly weights times four weeks and then monthly, mechanical soft regular diet, magic cup supplement two times a day, and encourage extra fluids. Observation on 09/24/24 at 1:00 P.M. revealed Resident #16 was sitting in the lounge with his wife eating his lunch independently. He had a good appetite and no issues were noted. Interview on 09/24/24 at 4:27 P.M. with Dietician #169 verified the last recorded weight per the electronic medical record was on 08/06/24 and was 106 indicating a significant weight loss of 21 percent in one month. She verified upon review of the medical record the Dietician #170 had requested a re-weight to be completed on 08/07/24 and 08/20/24 as she questioned the validity of the weight. Dietician #169 revealed upon her review it did not appear a re-weight was completed as she goes by what is in the electronic medical record. She revealed she was unsure if the weight was accurate or not without a re-weight. Interview on 09/25/24 at 9:51 A.M. with the Director of Nursing revealed a re-weight had been completed on 09/05/24 and the weight was 119.2 pounds (11.7 weight loss) but had not been inputted into the electronic medical record instead it was in a weight book. She verified she was unsure if the dieticians knew about the weight book instead of just going by what was in the electronic medical record. She verified the nurses were to put the weights in the electronic medical record for the dietician to review. Interview on 09/25/24 at 10:39 A.M. with the Director of Nursing verified there was nothing the medical record that indicated the responsible party and/ or physician was notified regarding Resident #16's significant weight loss. Observation on 09/25/24 at 12:44 P.M. revealed Resident #16 was sitting in the lounge with his wife eating his lunch independently. He had a good appetite with no issues. (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 undated facility policy labeled, Nutrition Intervention for Significant Weight Change revealed the registered dietician would assess monthly and weekly weight changes and recommended interventions intended to reverse the weight loss. The dietician would calculate and assess for significant weight changes: five percent in one month, 7.5 percent over three months and ten percent over six months would be considered significant. The policy revealed based on resident preferences and/ or discussions with the resident and/ or responsible party the dietician may recommended nutritional interventions to attempt to stabilize or reverse weight loss. There was nothing in the policy regarding notification to physician, responsible party and/ or resident of significant weight loss. Review of facility policy labeled, Change in a Resident's Condition dated 11/30/23 revealed the facility shall notify the resident, physician, and representative of changes in the resident's medical condition. The nurse would document in the resident's medical record information relative to changes in the resident's medical condition or status. This deficiency represents non-compliance investigated under Master Complaint Number OH00157866.

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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** 39973 Based on interview, observation, record review, and review of facility policy the facility failed to ensure Resident #108's enteral tube feeding (a method of providing nutrition to patients who are unable to eat or drink safely by mouth) was infusing at the correct rate per physician order. This affected one resident (#108) of two residents reviewed for tube feeding. Findings included: Review of the medical record for Resident #108 revealed an admitted [DATE] and diagnoses included heart failure, diabetes, cerebral infarction, and protein-calorie malnutrition. Review of care plan dated 12/08/23 revealed Resident #108 had a feeding tube to assist in maintaining or improving nutritional status related to cerebral infarction, and difficulty swallowing. Interventions included tube feeding per dietary recommendation and physician order, check placement of feeding tube, keep head of bed elevated and monitor for complications. Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #108 was rarely or never understood due to impaired cognition. She had a feeding tube. Review of nursing note dated 08/20/24 at 2:05 P.M. and completed by Dietician #172 revealed Resident #108 tolerated her enteral tube feeding at a lower volume at a continues rate than the increased rate at a shorter time. Dietician #172 recommended Diabetisource at 50 milliliter (ml) per hour continuous. Review of September 2024 physician order dated 08/20/24 revealed Resident #108 was to receive Diabetisource 50 ml per hour continuous. Observation on 09/24/24 at 8:09 A.M. upon entrance to Resident #108's room revealed her tube feeding of Diabetisource was running at 65 ml per hour. Licensed Practical Nurse (LPN) #75 placed her tube feeding on hold while she administered Resident #108 her medications through her feeding tube. LPN #75 then proceeded to re-start the tube feeding at 65 ml per hour after completion of administering her medication, proceeded out the room and documented the administration of the medications per the electronic medical record. Interview on 09/24/24 at 8:54 A.M. with LPN #75 verified Resident #108's tube feeding per the physician order was to be running at 50 ml per hour not 65 ml per hour. She revealed the previous nurse must have set the tube feeding at the wrong rate and that she had just continued the same setting without verifying the order when she restarted the tube feeding. Review of facility policy labeled, Enteral Tube Feeding- Bolus and Continuous (dated 11/30/23) revealed to assure safe and effective administration of enteral tube feeding. The policy revealed check physician order, explain procedure, position in bed with head of bed 30 degrees throughout feeding, and program pump per order.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442 Based on interview, observation, policy review and review of the medical record revealed the facility failed to ensure enteral feedings were labeled and dated appropriately. This affected one resident (#93) of two residents reviewed for enteral feedings. The facility census was 126. Findings include: Review of the medical record for Resident #93 revealed an admitted [DATE]. Diagnoses included but were not limited to encephalopathy, gastrostomy, dysphagia, and history of transient ischemia attack (TIAs). Review of the 09/02/24 annual Minimum Data Set (MDS) 3.0 for Resident #93 revealed a Brief Interview for Mental Status (BIMS) revealed severe cognitive impairment. Resident #93 and was dependent for all Activities of daily living (ADLs) and received a tube feeding. Review of physician orders dated 11/10/23 for Resident #93 revealed an order to change enteral feeding bag and syringe every night shift for routine care and label with date. Review of physician orders dated 09/01/24 for Resident #93 revealed an order for Isosource 1.5 calorie enteral feed at 50 milliliters (mL) per hour for 24 hours to provide 1200 mL volume, 1800 calories, 82 grams protein and 917 mL of free water. Review of physician orders dated 11/10/23 for Resident #93 revealed an order to change tube feeding bag and syringe daily every night shift. Label with date. Observation on 09/23/24 at 10:50 A.M. with Licensed Practical Nurse (LPN) #95 revealed an unlabeled, undated enteral tube feeding bag running at 50 mL connected to Resident #93. LPN #95 confirmed there was no resident name, no product name, date or time on the enteral feeding bag and stated there should have been. Interview on 09/24/24 at 7:18 A.M. with LPN #72 confirmed when checking a resident tube feeding, physician orders are to be followed when hanging a new bag including labeling the bag with the resident name, date and time as tube feeding products are only good for 24 hours. Interview on 09/25/24 at 2:54 P.M. with the Director of Nursing (DON) confirmed when a new tube feeding bag if hung, the date, time, product name and nurse's initials hanging the bag should be on the bag. Review of the 11/30/23 facility policy titled; Enteral Tube Feeding-Bolus and Continuous revealed the policy was to assure safe and effective administration of enteral feeding. The policy did not include any information regarding ensuring the tube feeding bag was labeled with the produce it contained and/or the date/time it was hung.

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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. 35768 Based on observations and interview the facility failed to maintain a sanitary kitchen. This had the potential to affect all residents residing in the facility except for three residents (#9, #93, and #123) who did not receive nutrition by mouth. The census was 126. Findings include: Observations on 09/23/24 at 8:35 A.M. of the kitchen revealed two garbage cans lids covered with dust and food debris, a paper inspection tag for the ancillary alarm located on the wall was located on the floor by doorway, the tag was covered with brownish debris and difficult to read inspection dates. The entire floor of kitchen was covered with food debris and miscellaneous grime, the bottom of a shelving unit holding clean sheet pans was covered with dust and miscellaneous food debris. Observations on the walk-in refrigerator revealed a bag of green/brownish lettuce on the self, the bag was not dated. There was a plastic container storing food scoops located under the serving table that had miscellaneous food debris surrounding the scoops. The outside including the handle of the microwave was covered with dust and miscellaneous food debris. A floor area by the microwave had a large fork, straws and miscellaneous food debris lying on top of a mouse trap. Food Service Director (FSD) #166 stated, I don't know why the fork is on the floor. Another plastic container holding plastic lids located on a bottom shelf was covered with thickening powder, which FSD #166 stated, well those need to be washed. Observations of the juice dispenser nozzles revealed the nozzles were covered with brown liquid, observations of the reach in cooler had a turkey sandwich in a baggie that was not dated, there were also containers of a thickening agent flavored cranberry and orange, and thickened milk that were opened and not dated. There was also a white liquid substance approximately six inches by six inches on the bottom shelf of the cooler. The outside of the door of the small refrigerator had white miscellaneous debris on the door and door handle. Observations of the dry storage area had revealed small packets of condiments on the floor with miscellaneous debris on the floor. Interview during the observations, FSD #166 verified all findings and directed kitchen staff to clean areas noted. Observations on 09/24/24 at 11:04 A.M. of the kitchen revealed an exhaust fan located in the ceiling just right of the tray line. The fan was covered with blackish, brownish dust. Interview during the observations, FSD #166 verified the finding. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observations on 09/24/24 at 11:10 A.M. of tray line preparation revealed Regional District Manager (RDM) #168 sanitized the cutting board located on the heating cart holding the cooked foods. The Manager then placed two thawed turkey patties on the cutting board along with a clean knife. FSD #166 verified the finding and directed staff to remove the patties and knife due to cross contamination. Review of the facility policy titled Food Preparation and Storage, (not dated) noted kitchen surfaces and equipment will be cleaned and sanitized as appropriate.

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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. 35768 Based on observations and interviews the facility failed to maintain a sanitary environment surrounding the dumpster area. This had to potential to affect all 126 residents residing in the facility. Findings include: Observations on 09/23/24 at 8:54 A.M. revealed plastic garbage bags filled with food and other miscellaneous items, soiled adult briefs, latex gloves, plastic forks/spoons, Styrofoam cups surrounding three dumpsters located in the parking lot. Interview during the observations, Food Service Director #166 verified the observations stating the garbage would be cleaned up immediately. No facility policy was provided related to maintaining a clean and sanitary area surrounding the dumpsters.

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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** 39973 Based on interview, observation, record review and review of facility policy revealed the facility failed to ensure enhanced barrier precautions were utilized for a resident during high contact resident care. This affected one resident (#108) of two residents observed for enhanced barrier precautions. Findings included: Review of the medical record for Resident #108 revealed an admitted [DATE] and diagnoses included heart failure, diabetes, cerebral infarction, and protein-calorie malnutrition. Review of care plan dated 12/08/23 revealed Resident #108 had a feeding tube to assist in maintaining or improving nutritional status related to cerebral infarction, and difficulty swallowing. Interventions included enhanced barrier precautions with high contact care including using a gown and gloves for dressing change and tube feeding care, check placement of feeding tube, keep head of bed elevated and monitor for complications. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #108 was rarely or never understood due to impaired cognition. She required substantial to maximum assistance of staff rolling left and right and was dependent on staff with most all her other activities of daily living. She had a feeding tube. Review of September 2024 physician orders revealed Resident #108 had an order dated 06/02/24 that she was to be on enhanced barrier precautions. The order included use gown and gloves for high contact resident care including dressing, bathing, showering, transfers, hygiene care, linen changes, changing of briefs, and care of any device including tube feeding. Observation on 09/24/24 at 8:09 A.M. upon entrance to Resident #108's room revealed Resident #108 had signage on the door to be on enhanced barrier precautions. Licensed Practical Nurse (LPN) #75 proceeded into her room only donning gloves and no gown and placed Resident #108's tube feeding on hold. LPN #75 provided high contact care for Resident #108 including repositioned her in bed, pulled her up in bed, obtained blood pressure, obtained oxygen saturation rate, auscultated placement of her tube feeding with her stethoscope, and proceeded to administer her medications and water flushes through her feeding tube. Interview on 09/24/24 at 8:54 A.M. with LPN #75 verified she did not wear a gown when she provided Resident #108's high contact care. She verified Resident #108 was on enhanced barriers but stated I believe that is for people with like C-Diff (Clostridium difficile) or highly contagious things like that and Resident #108 does not have anything like that. She revealed she was not trained and/ or educated to wear precautions including a gown for high contact resident care when a resident was on enhanced barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/24/24 at 9:13 A.M. with the Director of Nursing revealed she had talked to LPN #75 after the observation and revealed all staff including LPN #75 had been educated over and over regarding enhanced barriers. She verified LPN #75 was to wear a gown during the care she provided Resident #108 including when she repositioned her, pulled her up in bed, obtained her blood pressure, obtained her oxygen saturation rate, auscultated her placement of her tube feeding with her stethoscope, and administered her medications and water flushes through her feeding tube. Review of facility policy labeled; Enhanced Barrier Precautions (EBP) (dated 11/30/23) revealed enhanced barrier precautions (EBP) were an infection control intervention designed to reduce transmission of multidrug resistant organisms (MDROs). EBP were to be used for residents with wounds, indwelling medical devices including central line, urinary catheter, and feeding tube. The policy revealed gowns and gloves were to be used for high-contact resident care activities for those at increased risk of MDRO acquisition including residents with wounds or indwelling medical devices. The policy revealed examples of high contact care activities included device care or use including feeding tube. Review of the memorandum, QSO-24-08-NH, entitled Enhanced Barrier Precautions in Nursing Homes, (dated 03/20/24), by the Centers for Medicare & Medicaid Services, Department of Health & Human Services revealed enhanced barrier precautions were indicated for residents with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. The effective date for implementation of enhanced barrier precautions under the guidelines was 04/01/24.