STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365423	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Washington Care Center	6900 Beechmont Avenue Cincinnati, OH 45230

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44083 Based on observation, staff interviews and record review, the facility failed to serve meals to all residents in the dining room in a timely manner. This affected two Residents (#65 and #71) of the three residents dependent on staff in the 200-unit dining room. The facility census was 80. Findings Include: 1) Review of medical record for Resident #65, revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #65 include dementia, cerebral infarction, hemiplegia, dysphagia, anxiety disorder, restlessness and agitation. Review of the Minimum Data Set, (MDS) comprehensive assessment dated [DATE], revealed the resident had severely impaired cognition and was dependent on staff for meal assistance. The resident received a regular puree diet. 2) Review of the medical record for Resident #71 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident # 71 include hemiplegia, dysphagia, restlessness and agitation. Review of the MDS comprehensive assessment dated [DATE], revealed the resident had severely impaired cognition and the resident required set up meal assistance. The resident received a regular mechanically altered diet. Observation on 02/26/25 at 12:33 P.M., revealed in the 200-unit Main Dining Room, Resident #65 in a tilting wheelchair in a corner area of the dining room within 10 feet of approximately 15 residents seated at dining room tables. The 15 residents had been served and were consuming their lunch meals. Resident #65's lunch meal was at her table at 12:33 P.M. and the resident appeared anxious with body movements in the tilting wheelchair. Resident #65 was not assisted by Certified Nursing Assistant, (CNA) #195 until 12:54 P.M. Observation on 02/26/25 at 12:33 P.M., revealed Resident#71 was seated at the dining room table with approximately 15 residents who were served and were consuming their lunch meal at 12:33 P.M. Resident #71 did not receive his lunch meal tray until 12:51 P.M. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/26/25 at 12:51 P.M. with CNA #178 revealed Resident #71's meal tray was sent to the 100 unit instead of the 200 unit and meal tray had been misrouted daily for nearly two weeks. STNA #178 verified Resident #71 waited for nearly 20 minutes while other residents consumed their meal in front of him. CNA #178 verified that all residents should be served meals at the same time. Interview on 02/26/25 at 12:51 P.M. with Registered Dietitian, (RD) #300 verified Resident #65 and #71 should have received their meal tray and provided assistance with the lunch meal tray when the other 15 residents received their meal tray. Interview on 02/26/25 at 12:54 P.M. with CNA #195, verified Resident #65's meal was delivered and was on the table in front of her for over twenty minutes. CNA # 195 stated there were two CNAs available to feed the three residents who required meal assistance. CNA #195 stated Resident #65 becomes anxious when waiting for assistance.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on interview and record review, the facility failed to notify the Ombudsman when residents were transferred or discharged from the facility. This affected two Residents (#42 and #58) of the two residents reviewed for Ombudsman notification. The facility total census was 80. Findings Include: 1) Review of the medical record for Resident #42 revealed an admitted [DATE]. Diagnoses included pneumonia, type two diabetes mellitus (DM II), acute respiratory failure with hypoxia, and major depressive disorder. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #42 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of nine. This resident was assessed to require setup with eating, partial assistance with toileting and transfers, and supervision with bathing and dressing. Review of the medical record revealed Resident #42 was sent to the hospital and admitted on the following dates: 08/10/24, 08/24/24, and 09/16/24 with no documentation of notification to the Ombudsman. Review of records provided by the facility, revealed no evidence the Ombudsman was notified of Resident #42's discharges to the hospital on the dates of 08/10/24, 08/18/21, and 09/16/24. Interview on 02/26/25 at 3:26 P.M. with Social Services Director (SSD) #106, verified the Ombudsman had not been notified of hospitalization s and/or discharges since April 2024. 44083 2) Review of the medical record revealed Resident #58 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction with hemiplegia, dysphagia, chronic obstructive pulmonary disease (COPD), diabetes mellitus and malnutrition. The resident was discharged to the hospital on the date of 08/19/24. Review of records provided by the facility, revealed no documented evidence the Ombudsman was notified of Resident #58's discharge to the hospital on the date of 08/19/24. Interview on 02/26/25 03:26 P.M. with SSD #106, verified the Ombudsmen had not been notified of resident discharges and admissions to the hospitals since April 2024. SSD #106 verified there should have been notification to the Ombudsmen when Residents #42 and #58 were discharged to the hospital from the facility. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Transfer or Discharge Notice, revised March 2021 revealed residents and/or representatives were notified in writing, and in a language and format they understand, at least 30 days prior to a transfer or discharge. A copy of the notice was sent to the Office of the State Long-Term Care Ombudsman at the same time as the notice of transfer or discharge was provided to the resident and representative.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771 Based on medical record review, resident and staff interviews, and policy review, the facility failed to ensure care conferences were held as required for residents and their representatives. This affected seven Residents (#02, #10, #17, #35, #36, #42 and #56) of the seven residents reviewed for care conferences. The facility census was 80. Findings include: 1) Review of the medical record revealed Resident #02 was admitted to the facility on [DATE]. Diagnoses included osteoarthritis of right knee, diabetes mellitus, Stage IV pressure ulcer (sacrum). Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE], revealed Resident #02 had no cognitive impairment. Review of a Care Conference Meeting Summary documents with the Administrator, revealed Resident #02 did not have documented care conferences in the first quarter (January, February and March) and third quarter (July, August and September) of 2024. The only care conference meetings that were documented for 2024 were held on 05/09/24 and 12/12/24. 2) Review of the medical record revealed Resident #10 was admitted to the facility on [DATE]. Diagnoses included multiple sclerosis (MS), urinary tract infection, chronic osteomyelitis, severe sepsis with septic shock, bacterial infection and nicotine dependence. Review of the MDS annual assessment dated [DATE], revealed Resident #10 had no cognitive deficits and had a suprapubic catheter and colostomy. Review of Care Conference Meeting Summary documents with the Administrator, revealed Resident #10 did not have documented care conferences in the first quarter (January, February and March) and third quarter (July, August and September) of 2024. The only care conference meetings that were documented for 2024 were held on 06/25/24 and 11/06/24. 3) Review of the medical record for Resident #17 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, type two diabetes mellitus, paranoid schizophrenia, and major depressive disorder. Review of the Annual MDS assessment dated [DATE], revealed Resident #17 was unable to complete a Brief Interview for Mental Status (BIMS) because he was rarely/never understood. Review of the medical record for care conferences for the last 12 months revealed Resident #17 received a care conference on 05/28/24, 08/13/24, and 01/09/25. Interview on 02/26/25 at 3:20 P.M. with Social Services Director (SSD) #106 revealed care conferences should be held quarterly. SSD #106 verified Resident #17 had not received care conferences quarterly as required. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) Review of the medical record revealed Resident #35 was admitted to the facility on [DATE]. Diagnoses include cerebral infarction with right (dominant) side hemiplegia and hemiparesis, unspecified dementia and methicillin-resistant staphylococcus aureus (MRSA). Review of the MDS quarterly assessment dated [DATE], revealed Resident #35 had moderate cognitive impairment. Review of Care Conference Meeting Summary documents with Administrator, revealed Resident #35 did not have documented care conferences in the first quarter (January, February and March), second quarter (April, May and June) and third quarter (July, August and September) of 2024. The only care conference meeting that was documented for 2024 was held on 11/18/24. Interview on 02/26/25 at 3:31 P.M. with the SSD #106, verified Resident #35 had one care conference in 2024 (11/18/24); verified Resident #02 had two care conferences in 2024 (05/09/24 and 12/12/24); and verified Resident #10 had two care conferences in 2024 (06/25/24 and 11/06/24). 44412 5).Review of the medical record for Resident #36 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, depression, and chronic respiratory failure with hypoxia. Review of the MDS assessment dated [DATE], revealed Resident #36 had intact cognition as evidenced by a BIMS score of 14. Review of the medical record for care conferences for the last 12 months revealed Resident #36 had a care conference on 04/15/24 and 10/09/24. 6) Review of the medical record for Resident #42 revealed an admitted [DATE]. Diagnoses included pneumonia, type two diabetes mellitus, acute respiratory failure with hypoxia, and major depressive disorder. Review of the MDS assessment dated [DATE], revealed Resident #42 had moderate cognitive impairment as evidenced by a BIMS score of nine. Review of the medical record for care conferences for the last 12 months revealed Resident #42 had a care conference on 08/23/24 and 10/01/24. 7) Review of the medical record for Resident #56 revealed an admitted [DATE]. Diagnoses included major depressive disorder, fracture of left femur, generalized anxiety disorder (GAD), and atrial fibrillation. Review of the MDS assessment dated [DATE], revealed Resident #56 had severe cognitive impairment as evidenced by a BIMS score of five. Review of the medical record for care conferences for the last 12 months revealed Resident #56 had a care conference on 07/11/24 and 01/31/25. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/26/25 at 3:20 P.M. with SSD #106, revealed care conferences should be quarterly. SSD #106 verified Residents #36, #42 and #56 had not received care conferences quarterly as required. Review of the policy titled, Care Planning-Resident Participation, dated 08/24, revealed the facility supports the resident's right to be informed of, and participate in, his or her planning and treatment (implementation of care). The facility will discuss the plan of care with the resident and/or resident representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, and at routine intervals, and after significant changes.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44083 Based on observations, medical record review and staff interviews, the facility failed to ensure residents who were at risk for skin breakdown, had interventions implemented to prevent skin breakdown. This affected one Resident (#23) of the three residents reviewed for pressure ulcers. The facility census was 80. Findings include: Record review of Resident #23 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #23 include hemiplegia, aphasia, dementia, dysphagia, and malnutrition. Review of a physician order for Resident #23 dated 12/04/24, revealed the resident was ordered to wear heel lift boots to bilateral extremities when in bed for prevention of skin breakdown. Review of the Minimum Data Set, (MDS) comprehensive assessment for Resident #23 dated 12/31/24, revealed the resident had severely impaired cognition and was dependent on staff for activities of daily living (ADS). Review of a therapy note for Resident #23 dated 12/31/24, revealed the resident should have a pillow under the right flexed knee and should have heel lift boots on the feet for prevention of skin breakdown. Resident #23 tolerated the positioning pillow and the heel lift boots. Review of the February 2025 Medication Administration Record (MAR) for Resident #23, revealed no documented refusals of heel lift boots or positioning pillows. Observations on 02/24/25 at 9:22 A.M., revealed Resident #23 had no positioning pillows or heel protection boots in place. Interview with Licensed Practical Nurse (LPN) #177 on 02/24/25 at 9:22 A.M. verified Resident #23's right knee was contracted and lying on top of the left leg. LPN #177 verified there were no positioning pillows between right knee and no heel lift boots in place. Observations on 02/25/25 at 3:47 P.M., revealed Resident #23 had no positioning pillows or heel protection boots in place. Observations on 02/27/25 at 9:01 A.M.,, revealed Resident #23 had no positioning pillows or heel protection boots in place. Interview with LPN #126 on 02/27/25 at 9:32 A.M., verified Resident #23 did not have any positioning pillows or heel lift boots in place. LPN #126 verified the resident should have the pillow between the right knee to the left leg and heel lift boots to prevent skin breakdown. Interview with the Director of Nursing (DON) on 02/27/25 at P.M., revealed Resident #23 should have had the heel lift boots as orders and position pillows to prevent skin breakdown.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44083 Based on observation, staff interview and record review, the facility failed to utilize the correct transfer lifting sling for the mechanical lift, as listed in the manufacture directions. This affected one Resident (#22) but had the potential to affect 13 additional Residents (#17, #10, #15, #1, #66, #76, #233, #25, #40, #58, #23, #231 and #63) who the facility identified as being dependent on staff for transfer via mechanical lift. The facility also failed to properly assess/evaluate residents for safe smoking practices. This affected two Residents (#10 and #33) of the two residents identified as being smokers. The facility census was 80. Findings Include: 1) Review of the medical record for Resident #22 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #22 include multiple sclerosis, left above knee amputation, muscle weakness, peripheral vascular disease, gout, and neuromuscular dysfunction of bladder. Review of a physician order dated 12/19/23 for Resident #22, revealed the resident was ordered to be transferred via a mechanical lift for all transfers. Review of the Minimum Data Set (MDS) comprehensive assessment dated [DATE], revealed the resident had intact cognition and was dependent on staff for transfers via mechanical lift. Observation of a mechanical lift/Hoyer transfer for Resident #22 on 02/25/25 at 3:40 P.M., revealed Certified Nursing Assistants (CNAs) #103 and #127 placed all four loops of a Proactive mechanical lift transfer sling into two attachment points on the bar of a Handicare mechanical lift. CNAs #103 and #127 transferred Resident #22 from a wheelchair to the bed using the Handicare mechanical lift. Interview with CNAs #103 and #127 immediately afterwards, revealed they were unsure which transfer sling was supposed to be used with a Handicare mechanical lift. CNAs #103 and #127 verified they used a transfer sling labeled for a Proactive mechanical lift and there were no Handicare mechanical lift transfer slings in the facility. Observation of the storage area for the mechanical lift transfer slings on 02/25/25 at 3:50 P.M. with CNA #143, revealed only Proactive mechanical lift transfer slings were on hand to be used. Observation revealed no there were no Handicare mechanical lift transfer slings on hand and there were four transfer slings with no manufacture labels or instruction for use. Interview at the same time with CNA #143, verified there were no Handicare mechanical lift transfer slings on hand in the facility. CNA #143 stated Proactive mechanical lift transfer slings were used for showers and they were also used with the Handicare mechanical lifts. CNA #143 indicated he was unable to identify the four unlabeled transfer slings brand and stated the staff used all the slings from the storage area. Interview with CNA #142 on 02/27/25 from 9:25 A.M. through 9:35 A.M., verified there were no Handicare mechanical lift transfer slings on hand in the facility. CNA #142 indicated she had no knowledge of a specific transfer sling having to be used with the mechanical lifts and she just grabbed any sling that was available. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/27/25 at 3:13 P.M. with the Director of Nursing (DON), revealed the Proactive mechanical lift transfer slings were universal and could be used on the Handicare mechanical lifts. The DON verified there was no documentation provided in Handicare mechanical lift manufacture instructions of allowance of any universal transfer slings. Interview with Proactive Representative #600 on 03/03/25 9:35 A.M., revealed the Proactive mechanical lift transfer slings were not universal and they were only to be used with their mechanical lifts. Proactive Representative #600 stated he would not advise using their slings on the Handicare mechanical lifts because their mechanical lifts utilized a different attachment set-up for the patient. Review of the Handicare mechanical lift/Hoyer manufacture instructions (related to Model EVA400EE being utilized in the facility), revealed their transfer slings were to be used with their brand. Handicare mechanical lifts had one bar with two attachment points and contained no chains or S type hooks for attaching the transfer slings to the mechanical lifts. The instructions indicated there was no allowance for the use of any universal transfer slings. Review of the Proactive mechanical lift transfer sling instructions provided by the facility, revealed the Proactive mechanical lift transfer sling instructions were to be used for their lifts which included two attachment points bar and utilized chains and S type hooks to allow positioning adjustments to be made by selecting different links. Instructions for use included a chain-link with the red markings connected to the cradle, and attachment at the shoulder level of the patient and there was an attachment of chains at the patient's legs. There was an S type hook to be inserted through the metal sleeve from the patient side of the sling out, to avoid injuring the patient. Review of facility policy titled, Using a Mechanical Lifting Machine, dated 2017, revealed the general principles of the policy is not a substitute for manufacturer's instructions. Lift and design and operation vary across manufacturers. Staff must be trained and demonstrate competencies using specific machines utilized in the facility. 49771 2) Review of the medical record for Resident #10, revealed the resident was admitted to the facility on [DATE]. Diagnoses included multiple sclerosis (MS), urinary tract infection, chronic osteomyelitis, severe sepsis with septic shock, bacterial infection and nicotine dependence. Review of the MDS annual assessment dated [DATE], revealed Resident #10 had no cognitive deficits. Review of the medical record revealed Resident #10 did not have any documented evidence a Safe Smoking Evaluation was ever completed. Interview with Resident #10 on 02/25/25 at 8:40 A.M., revealed he smokes on a regular basis, usually in the late afternoon, and he was observed to have his smoking materials in his possession. 3) Review of the medical record revealed Resident #33 was admitted to the facility on [DATE]. Diagnoses included lumbar disc degeneration, morbid obesity, psychotic disorder with delusions, unspecified dementia and diabetes mellitus. Review of the MDS quarterly assessment 12/30/24, revealed Resident #33 no cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record for Resident #33, revealed the most recent Safe Smoking Evaluation was completed on 04/02/24. Interview with Licensed Practical Nurse (LPN) #117 on 02/26/25 at 7:49 A.M., verified Residents #10 and #33 are smokers. Interview with the Director of Nursing (DON) on 02/27/25 at 10:59 A.M., verified Resident #10 had never been evaluated for safe smoking, and the last time Resident #33 was assessed for safe smoking was 04/02/24. The DON verified residents identified to smoke were to be assessed/evaluated on a quarterly basis. Review of documentation provided by the facility, identified Residents #10 and #33 as being the only residents in the facility who smoked. Review of the policy titled, Smoking Policy-Residents, dated 2001, revealed the resident will be evaluated on admission to determine if she is she is a smoker or non-smoker and the evaluation will include the current level of tobacco consumption, method of tobacco consumption (traditional cigarettes, electronic cigarettes, pipe, etc.), desire to quit smoking, and the ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation). A resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by staff.

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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** 44412 Based on record review, observations, staff interviews, review of hospital records, and policy review, the facility failed to provide adequate hydration for a dependent resident. This affected one Resident (#17) of the residents reviewed for hydration. The facility also failed to adequately monitor residents weight loss/gain, notify the physician and implement interventions. This affected two Residents (#10 and #73) of the four residents reviewed for nutrition. The facility census was 80. Findings include: 1) Review of the medical record for Resident #17 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, type two diabetes mellitus, paranoid schizophrenia, and major depressive disorder. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #17 was unable to complete a Brief Interview for Mental Status (BIMS) because he was rarely/never understood. Resident #17 was dependent on staff with eating, toileting, bathing, dressing, and transfers. Review of the hospital records dated 02/23/25, revealed Resident #17 was admitted related to urinary tract infection (UTI), acute encephalopathy, and acute kidney injury on chronic kidney disease stage three, likely due to poor oral intake. Observation on 02/24/25 at 2:05 P.M., revealed Resident #17's water pitcher was sitting on end table of the adjacent wall and not within his reach. Interview on 02/24/25 at 2:06 P.M. with Resident #17's wife, revealed she filled his water pitcher up every day before she left the facility and reported it was in the same spot and completely full when she returned the next day. Observation on 02/25/25 at 3:36 P.M., revealed Resident #17's water pitcher was sitting on end table of the adjacent wall and not within his reach. Observation on 02/26/25 at 1:59 P.M., revealed Resident #17's water pitcher was sitting on end table of the adjacent wall and not within his reach. Interview on 02/26/25 at 3:54 P.M. with Certified Nursing Assistant (CNA) #166, verified Resident #17's water pitcher was out of reach, and fluids had not been offered during the interaction. Observation on 02/27/25 at 10:03 A.M., revealed Resident #17's water pitcher was sitting on end table of the adjacent wall and not within his reach. Review of the facility titled, Hydration - Clinical Protocol, revised in September 2017 revealed the physician and staff would help define the individual's current hydration status. The staff, with the physician's input, would identify and report to the physician individuals with signs and symptoms or lab test results that might reflect existing fluid and electrolyte imbalance. (continued on next page)

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	365423	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Washington Care Center	6900 Beechmont Avenue Cincinnati, OH 45230

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	49771 2) Review of the medical record revealed Resident #10 was admitted to the facility on [DATE]. Diagnoses included multiple sclerosis (MS), urinary tract infection, chronic osteomyelitis, severe sepsis with septic shock, bacterial infection and nicotine dependence. Review of comparative graph of Resident #10's weights over a period from 03/14/24 to 02/23/25, revealed an unplanned weight gain of 36.81 percent from 184.2 pounds (lbs.) on 03/14/24 (admission) to 252 lbs on 02/23/25. Review of the plan of care dated 03/16/24, revealed Resident #10 had a focus area for being at a moderate to severe nutritional risk, with a goal to have no significant weight changes. The interventions included Boost (nutritional supplement) 237 milliliters (ml) three times a day (resident is refusing) initiated on 03/16/24 and revised on 09/02/24; Juven (nutritional supplement) one packet initiated on 12/05/24 and discontinued on 01/07/25; large portions of protein for all meals initiated on 11/18/24 and discontinued on 01/07/25; and Prostat (protein supplement) advanced wound care (AWC) 30 ml two times a day initiated 03/16/24. Review of a nutrition progress note for Resident #10 dated 03/16/24 and authored by Registered Dietitian (RD) #695, revealed Resident #10 was admitted for rehabilitation after hospitalization due to osteomyelitis (bone infection) in the left fibula. The resident stated his usual body weight was 180 lbs. The resident's weight was 184.2 lbs and a body mass index (BMI) of 25.0, which indicated a normal status for his height per the BMI parameters. The resident was on a regular diet with thin liquids, Boost plus supplement 237 milliliters (ml) three times a day and Prostat AWC supplement 30 ml two times a day. The resident's skin was impaired with multiple wounds and laboratory findings were altered. The resident appeared hydrated per a visual assessment. The resident was at moderate nutritional risk and will be monitored for change in status and reentry into nutrition care. The ideal body weight for the resident was 166 lbs. plus or minus 10 percent. The resident feeds himself with set up assistance. The current diet offerings per day (with supplements): 2200 -2400 kilocalorie (kcal)/95 -105 grams (gms) of protein. His estimated needs per day are: 2479 kcal/100 gms protein. Review of a nutrition progress note dated 04/10/24 and authored by RD #695, revealed Resident #10 had been requesting seconds for breakfast & lunch and would serve him large portions for breakfast and lunch. Review of a nutrition progress note dated 11/11/24 and authored by RD #695, revealed Resident #10 recently returned from the hospital following treatment for a urinary tract infection. The resident's weight on 11/09/24 was 248.1 lbs. This was a significant weight gain of 69 lbs. The accuracy of the weight was questioned and alerted nursing to his weight gain. Review of a nutrition progress note dated 11/25/24 and authored RD #695, revealed Resident #10 weighed 235.6 lbs. on 11/18/24. This would represent a significant weight loss in 30 days. The resident ate 75 to 100 percent of most meals. The resident stated he was getting plenty to eat and wanted no additional food/supplements at this time. Nursing was alerted to his weight fluctuations. Review of the progress notes for Resident #10 from 12/16/24 to 02/12/25, revealed no documentation the physician was notified of the resident's 20.63 percent weight loss between 12/16/24 and 02/12/25. (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 the MDS annual assessment dated [DATE], revealed Resident #10 had no cognitive deficits and had a suprapubic catheter and colostomy. The resident required set-up assistance for eating. Section K (Swallowing/Nutritional Status), dated 03/20/24 revealed Resident #10 was six feet tall and weighed 184 lbs. On 06/18/24, assessments revealed Resident #10 weighed 181 lbs. On 09/18/24, assessments revealed Resident #10 weighed 178 lbs. On 10/25/24, assessments revealed Resident #10 weighed 179 lbs. On 11/08/24, assessments revealed Resident #10 weighed 248 lbs. and on 02/17/25, Resident #10 weighed 252 lbs. Review of a nutrition progress note dated 01/07/25 and authored by RD #695, revealed Resident #10 weighed 239.1 lbs. on 01/05/25, which represented a significant weight gain for 180 days. The resident's BMI was now 32.4 which indicated an obese status for his height per BMI parameters. The resident is on a regular diet with regular texture and thin liquids, and receives Prostat AWC 30 ml two times a day, Juven one packet every day and double portions of protein for all meals. The resident's skin impairments were healed. The resident appeared hydrated at visual assessment. Juven was discontinued and double portions of protein for all meals. The mini nutritional assessment (MNA) was at 13, which indicated normal nutritional status. The resident is at a moderate nutritional risk and will continue with the current plan of care/clinical course. Review of Resident #10's weights, revealed on 01/01/25 the resident weighed 186.6 lbs. and on 02/27/25 the resident weighed 175 lbs. This represented a 6.22 percent weight loss. Review of a nutrition progress note dated 02/23/25 and authored by RD #695, revealed Resident #10 weighed 252 lbs. on 02/20/25 which represented a significant weight gain for 180 days. The resident was currently being treated for a urinary tract infection. The resident remains on a regular diet with thin liquids and Prostat AWC 30 ml two times a day. The resident appeared hydrated per a visual assessment. The MNA was at 12, which indicated normal nutritional status. Nursing was alerted to the resident's weight gain and will continue with the current plan of care/clinical course. Interview with RD #695 via Phone on 02/27/25 at 1:48 P.M., revealed she was only a consultant, and she had asked for a reweight and alerted nursing to the resident's weight gain. RD #695 thought the weight gain was due to the weight of the resident's wheelchair being added to the resident's body weight. When surveyor mentioned the resident's weight on 02/20/25 was also 252 pounds and was obtained using the Hoyer lift scale, she responded by saying this was a nursing problem. Review of Resident #10's weights, revealed on 02/27/25 the resident weighed 175 lbs. The weights recorded on 02/12/25 and 02/15/25 were documented on 02/27/25 as being incorrect by RD #695 and Registered Nurse (RN) #181. Interview with the Director of Nursing (DON) on 02/27/25 at 2:34 P.M., verified Resident #10's significant weight gain between 10/04/24 and 11/04/24 but could offer any insight as to how and why the resident had a 40.63 percent weight gain in a 30-day period or of specifics as to how the facility responded to the resident's weight gain. The DON also verified the physician had not been made aware of the resident's significant weight gain. 3) Review of the medical record revealed Resident #73 was admitted to the facility on [DATE]. Diagnoses included peripheral vascular disease, abdominal aortic aneurysm, malignant neoplasm of right renal pelvis, chronic kidney disease stage III and diabetes mellitus type II. (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 the plan of care dated 12/16/24, revealed Resident #73 was at a moderate nutritional risk secondary to diagnoses of diabetes mellitus, peripheral vascular disease, hypertension, hyperlipidemia and chronic kidney disease stage III. Interventions included Boost 237 ml two times a day, monitor laboratory finds (labs), intakes, weights, skin assessments, ordered a no added salt, no concentrated sugars, regular texture, thin liquid diet, observe for signs and symptoms of dehydration and difficulties with chewing/swallowing and Prostat 30 ml daily. Review of the documented weights for Resident #73, revealed the resident weighed 189 lbs. on 12/16/24 and 150 lbs. on 02/12/25. This represented a 20.63 percent weight loss in 60 days. The weight on 02/15/25 was documented as obtained using a standing scale. A re-weight on 02/15/25 confirmed the weight of 150 lbs. and was documented as obtained using a mechanical lift scale. Review of a nutrition progress note dated 12/19/24 and authored by RD #695, revealed Resident #73 was admitted for rehabilitation after hospitalization due to left lower extremity graft thrombectomy. The resident's BMI was 26.4 which indicated the resident was overweight. It was recommended the resident receive Prostat 30 ml and Boost 237 ml daily. The MNA indicated the resident was at risk for malnutrition. Review of the MDS five-day assessment dated [DATE], revealed Resident #73 had moderate cognitive impairment and was occasionally incontinent of bowel and bladder. The resident required set-up assistance for eating. Review of a nutrition progress note dated 12/23/24 and authored by RD #695, revealed Resident #73 weighed 180 lbs. on 12/22/24. RD #696 questioned the accuracy of the admission weight. The resident's Boost will be increased to 237 ml two times a day. This dietary progress note was the most recent dietary note for Resident #73. Interview via phone with RD #696 on 02/27/25 at 1:48 P.M., verified Resident #73 was not assessed and there were no dietary progress notes for the resident between 12/23/24 and 02/27/25. Interview with DON on 02/27/25 at 2:04 P.M., revealed there is a weekly meeting with RD #695 where residents with weight loss/gain are discussed. There was a risk meeting on 02/19/25 and Resident #73 was not discussed. Review of the policy titled, Nutrition (Impaired)/Unplanned Weight Loss, revised 09/17, revealed the nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparison over time. The staff will report to the physician significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake. The physician will review medical causes of weight gain, anorexia and weight loss before ordering interventions.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on record review, review of a fall investigation, review of hospital records, staff interviews, and facility policy review, the facility failed to effectively manage one Resident's (#56) pain following an unwitnessed fall on 08/15/24, which subsequently resulted in a left subcapital femoral neck fracture. Actual harm occurred on 08/15/24 around 11:15 P.M. when Resident #56 had an unwitnessed fall in her room and reported left leg and knee pain to Licensed Practical Nurse (LPN) #212 and LPN #213. Resident #56 received one as needed (PRN) Tylenol but no documentation was completed on the medication administration record (MAR). The resident verbally yelled out and had facial grimacing and refused to get out of bed related to continued pain and discomfort in her left leg. The On-call Nurse Practitioner (NP) #214 ordered Resident 56 to receive a left knee x-ray and an ice pack for pain. Resident #56 did not receive any additional pain medications or non-pharmacological pain interventions until the resident arrived at the hospital on 08/16/24 at 6:34 P.M. (approximately 19 hours after the fall occurred) with left leg pain. A computed tomography (CT) scan of Resident #56's left leg pain revealed Resident #56 sustained an acute traumatic mildly impacted subcapital left femoral neck fracture and required a surgical intervention to repair the fracture. This affected one Resident (#56) of the 25 residents assessed for pain. The facility census was 80. Findings include: Review of the medical record for Resident #56 revealed an admitted [DATE]. Diagnoses included major depressive disorder, fracture of left femur, generalized anxiety disorder (GAD), and atrial fibrillation. Review of a physician order for Resident #56 dated 07/08/24, revealed the resident was ordered Tylenol 325 milligrams (mg), give two tablets by mouth every four hours as needed (PRN) for general discomfort. Review of a fall risk assessment for Resident #56 dated 07/08/24, revealed the resident was at risk for falls. Review of the most recent pain assessment for Resident #56 dated 07/22/24, revealed the resident had not been in any pain in the last five days. Review of a Neurological (neuro) checklist dated 08/15/24, revealed Resident #56 expressed pain at a six out of 10 scale (a pain scale where zero is no pain and 10 is severe pain) and the resident also showed nonverbal signs of pain including grimacing and withdraws to the left knee/leg. Review of the fall investigation dated 08/15/24 at 11:15 P.M., revealed Resident #56 was observed sitting on the floor with legs stretched out. Resident #56 attempted to transfer and ambulate self. Resident #56 fell due to weakness, poor safety awareness, and did not use call light. Intervention was to ask Resident #56 before going to bed if she wanted her television on or off and offer the television remote. No statements were collected from the resident or staff. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the August 2024 Medication Administration Record (MAR) for Resident #56, revealed no documented evidence that the resident received any pain medications after the fall on 08/15/24. A non-pharmacological intervention (ice pack) was attempted for Resident #56 but refused. Review of the pain levels listed on the MAR on 08/15/24 and 08/16/24 for Resident #56 revealed no pain levels were documented. Review of a progress note for Resident #56 dated 08/16/24 at 6:48 A.M., revealed around 11:15 P.M. (on 08/15/24), the resident was observed on the floor directly on her bottom with legs stretched out in front. Resident #56 reported she was trying to turn off the television. An assessment, vital signs, and neuro checks were initiated. Resident #56 was lifted from the floor by three staff members and placed into bed. NP #214 was notified and gave orders for the resident to have an x-ray of her left knee, and an ice pack applied to the resident's left knee. The guardian and on-call supervisor were notified. PRN Tylenol was given for pain. Review of a progress note for Resident #56 dated 08/16/24 at 12:30 P.M., revealed the Interdisciplinary Team (IDT) met regarding Resident #56's fall. Upon investigation, the resident attempted to self-transfer and ambulate to turn off the television and fell . Resident #56 did not use the remote on the bedside table and did not call for assistance. Resident #56 was confused, had weaknesses, and poor safety awareness. An assessment was completed immediately after the fall and the resident complained of left knee pain. Range of motion was within normal limits for right leg and bilateral arms. Review of a progress note for Resident #56 dated 08/16/24 at 3:19 P.M., revealed the x-ray results for the resident's left knee were negative. Resident #56 continued to complain of pain and discomfort. A new order received for a stat x-ray of the resident's left hip, femur, and tibia/fibula. Review of a progress note for Resident #56 dated 08/16/24 at 3:30 P.M., revealed the x-ray service was unable to get a good x-ray of left hip/femur due to the resident moving and hollering out in pain upon movement. Review of a progress note for Resident #56 dated 08/16/24 at 5:40 P.M., revealed the resident continued to yell out and had facial grimacing. Resident #56 ate very little breakfast and laid in her bed all day, not wanting to get up due to the pain and discomfort she was experiencing in her left leg. Resident #56 refused lunch and dinner. The X-ray Technologist came to get an x-ray of the resident's left hip but was unable to get a good picture even with staff assistance because Resident #56 was not able to hold still due to her pain. Resident #56 was sent out to the emergency room (ER) for evaluation to rule out injury of left leg per Resident #56's daughter's request. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the hospital records for Resident #56 dated 08/16/24, revealed Resident #56 arrived at the hospital at 6:34 P.M. complaining of pain after a fall on 08/15/24. Per the Nursing Home report, Resident #56 fell last night when attempting to ambulate to the bathroom. Resident #56 was complaining of left leg pain and the x-rays at the Nursing Home were apparently negative. The Nursing Home reports Resident #56 continued to complain of pain, therefore they sent her to the hospital. The Nursing Home staff was unaware if Resident #56 hit her head, but the resident is on an anticoagulant. Resident #56 was unable to perform left straight leg raise and had tenderness with palpation of the left hip. A Computerized Tomography (CT) scan revealed the resident had an acute traumatic mildly impacted subcapital left femoral neck fracture. The orthopedics were notified, and preoperative laboratory tests (labs) were completed, and Resident #56 had a left hip hemiarthroplasty (a surgical procedure that replaces the ball portion of the hip joint with a metal prosthesis) to repair the femur fracture. Resident #56 was discharged from the hospital on 08/20/24. Review of the care plan for Resident #56 revised on 08/16/24, revealed Resident #56 had a left hip closed bone fracture related to a fall. Interventions included administering pain, anti-inflammatory medications as ordered, handle gently when moving or positioning, monitor, document, and report as needed edema, bruising, loss of sensation distal to fracture, and use ice to affected area as needed. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #56 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of five. This resident required set-up assistance with activities of daily living (ADL). Attempted interviews with LPN #212 on 02/26/25 at 10:08 A.M. and 11:17 A.M. during the survey were unsuccessful. The staff member involved in the incident was not employed at the facility at the time of the survey and calls to LPN #212 were never returned. Interview with Certified Nursing Assistant (CNA) #148 on 02/26/25 at 10:09 A.M., who was tasked with caring for Resident #56 on 08/15/24, revealed she was sitting in the hallway across from Resident #56 when she heard a loud commotion. CNA #148 reported Resident #56 was on the floor on her bottom between her bed and the dresser. CNA #148 stated Resident #56 was complaining of pain to her left leg/knee. CNA #148 reported this information to Licensed Practical Nurse (LPN) #212. CNA #148 stated she did not help lift Resident #56 back into bed because she did not feel comfortable moving her with the amount of pain she was in. CNA #148 explained Resident #56 was in pain throughout the rest of the shift and did not want to get out of bed related to pain. CNA #148 reported these findings to LPN #212. Attempted interviews with LPN #213 on 02/26/25 at 10:12 A.M. and 11:15 A.M. during the survey were unsuccessful. The staff member involved in the incident was not employed at the facility at the time of the survey and calls to LPN #213 were never returned. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Interview with Director of Nursing (DON) on 02/27/25 at 10:50 A.M., verified Resident #56 had an unwitnessed fall on 08/15/24. The DON stated the nurse charted a PRN Tylenol on 08/16/24 at 6:48 A.M. via the progress note; however, the Tylenol was not documented on the MAR as being administered. The DON verified Resident #56 had expressed multiple signs of pain after the fall and there was no documentation of pain medications given to Resident #56 before the resident was sent out to the hospital on 08/16/24 after 6:00 P.M. The DON verified a stat x-ray was unsuccessful because Resident #56 was unable to sit still related to pain. The DON also stated she could not provide an explanation on why the nurses did not treat Resident #56's pain, but that's part of the reasons why these nurses were no longer employed at the facility. Review of the facility policy titled, Pain Assessment and Management, revised in March 2020, revealed the purposes of this procedure were to help the staff identify pain in the resident, and to develop interventions that were consistent with the resident's goals and needs and that address the underlying causes of pain. Pain Management was defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals. Acute pain should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief was obtained. Ask the resident if he/she was experiencing pain. Be aware the resident may avoid the term pain and use other descriptors such as throbbing, aching, hurting, cramping, numbness or tingling. Review the medication administration record to determine how often the individual requests and receive as needed pain medication, and to what extent the administered medications relieve the resident's pain.

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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** 49771 Based on observatoin, medical record review, staff interviews, and review of the facility policy, the facility failed to ensure insulin vials were properly labeled and stored. This affected four Residents (#09, #30, #41 and #49) of the 17 residents with medications stored in the two-center medication cart. The facility census was 80. Findings include: 1) Review of the medical record revealed Resident #09 was admitted to the facility on [DATE]. Diagnoses of diabetes mellitus type 1 with diabetic polyneuropathy, hypertension, chronic kidney disease state III and moderate protein-calorie malnutrition. Review of the Minimum Data Set (MDS) annual assessment dated [DATE] revealed Resident #09 had severe cognitive impairment and was dependent on staff for medications. Review of a physician order for Resident #09 dated 04/05/25 revealed the resident was ordered to receive Novolog (Aspart fast acting insulin) 100 Unit/milliliter (mL) dated 04/05/24 per sliding scale according to the resident's blood sugar readings. Review of the February 2025 Medication Administration Record (MAR) revealed Resident #09 received Novolog insulin one to three times daily from 02/01/25 through 02/25/25. 2) Review of the medical record revealed Resident #30 was admitted to the facility on [DATE]. Diagnoses of diabetes mellitus type 2 with ketoacidosis, encephalopathy, adult failure to thrive and sepsis. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #30 had moderate cognitive impairment and was dependent on staff for medications. Review of physician orders for Resident #30 dated 09/14/24 revealed the resident was ordered to receive Humalog (Lispro fast acting insulin) 100 Unit/mL per sliding scale according to the resident's blood sugar readings. A physician order dated 09/24/24 revealed the resident was ordered eight units of Lantus glargine at bedtime for diabetes mellitus. Review of the February MAR revealed Resident #30 received Humalog insulin one to two times daily from 02/01/25 through 02/25/25 and Lantus daily from 02/01/25 through 02/25/25. 3) Review of the medical record revealed Resident #41 was admitted to the facility on [DATE] Diagnoses included diabetes mellitus type 2 with circulatory complications, necrotizing fasciitis, morbid obesity and chronic kidney disease. Review of the MDS quarterly assessment dated [DATE], revealed Resident #41 had no cognitive impairment and was dependent on staff for medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a physician order dated 08/30/24 for Resident #41 revealed the resident was ordered Lantus glargine 15 units at bedtime for diabetes mellitus. A physician order dated 08/30/24 revealed the resident was ordered Novolog 100 Unit/mL per sliding scale according to the resident's blood sugar readings. Review of the February 2025 MAR revealed Resident #41 received Lantus insulin daily from 02/01/25 through 02/25/25; and sporadic doses of Novolog in December 2024, sporadic doses in January 2025 and no documented doses in February. 4) Review of the medical record revealed Resident #49 was admitted to the facility on [DATE]. Diagnoses included diabetes mellitus type 2 with polyneuropathy, cerebral infarction, sepsis and moderate protein-calorie malnutrition. Review of the MDS quarterly assessment dated [DATE] revealed Resident #49 had severe cognitive impairment and was dependent on staff for medications. Review of a physician order dated 12/02/24 revealed the resident was ordered d 12/02/24 for Humalog 100 Unit/mL per sliding scale according to the resident's blood sugar readings. Review of the February 2025 MAR for Resident #49 revealed the resident Humalog insulin one to three doses daily from 02/01/25 through 02/15/24. Observation of the two-center medication cart on 02/26/25 at 9:10 A.M. with LPN #55 revealed Resident #09's Novolog insulin vial was opened on 01/22/25. Resident #30's Lantus glargine insulin vial was opened 01/03/25 and Resident #30's Humalog insulin was opened 11/13/24. Resident #41's Lantus insulin was opened without an open date and Resident #41's Novolog insulin was opened on 11/13/24. Resident #49's Humalog insulin was opened 01/14/25. Interview with LPN #155 on 02/26/25 at 9:20 A.M. verified insulin vials should be dated when opened and that Resident #30 had Lantus insulin with an opened date of 01/03/25 and a Lispro insulin opened date of 11/13/24; Resident #41 had Lantus insulin that was in the medication cart and was not dated and a Novolog insulin opened date of 11/13/24; Resident #09 had Novolog insulin opened date of 01/22/25; and Resident #49 had Humalog insulin dated 01/14/25. Interview with Consulting Pharmacist #199 on 02/26/15 at 12:46 P.M. revealed Lispro insulin, Humalog insulin, Novolog insulin and Lantus insulin had 28-day expirations after being opened or removed from refrigeration. Review of document titled, Expiration Guidelines for Insulin Products, written by the facility's pharmacy provider, revealed insulin products are to be labeled with the date opened when taken from the refrigerator or put in the medication cart; and to discard and reorder insulin at least three (3) days before expiration or patient runs out. The expiration for Lispro (Humalog) insulin was 28 days; Aspart (Novolog) insulin 28 days; and Glargine (Lantus) 28 days after opened. Review of the policy titled, Storage of Medications, revised 11/20, revealed that drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.

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	365423	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Washington Care Center	6900 Beechmont Avenue Cincinnati, OH 45230

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44083 Based on observation, staff interview and record review, the facility failed to provide timely dental care services. This affected one Resident (#58) of one resident reviewed for dental services. The facility total census was 80. Findings Include: Record review of Resident #58 revealed the resident was admitted to the facility on [DATE] and discharged to the hospital on 08/19/24. Diagnoses included hemiplegia, cerebral infarction, dysphagia, chronic obstruction pulmonary disease, diabetes, and malnutrition. Review of a physician order dated 09/01/23, revealed the resident may see dental services as needed. Review of a care conference dated 12/04/24, revealed Resident #58 requested a dental appointment to have dentures repaired. There was no documented evidence that the resident had a dental appointment since admission of 09/01/23. Review of Dental Service Contract dated 12/16/24, revealed Resident #58's Power of Attorney, (POA) signed an authorization for the resident to have dental services. Review of the Minimum Data Set (MDS) comprehensive assessment dated [DATE], revealed Resident #58 had intact cognition and was dependent on staff for Activities of Daily Living (ADLS). Observation on 02/24/25 at 9:30 A.M., revealed Resident #58 had no natural teeth and no dentures in place. Interview with Resident #58 on 02/24/25 at 9:30 A.M., revealed the resident had all of his teeth extracted several years ago. The resident stated he had dentures, but they needed repaired. The resident stated he would like to eat the pleasure foods, as ordered, but does not like the puree consistency required for not having dentures. The resident stated if he had dentures he would enjoy the food. He also stated the thought he would look better if he had his dentures. The resident stated he had not seen a dentist since his admission on 09/01/23. Interview with Licensed Practical Nurse, (LPN) #104 on 02/27/25 at 10:52 A.M., verified there was no documentation Resident #58 had been seen by a dentist since admission on 09/01/23. LPN #104 was unaware of any dental appointment currently set up or knowledge of previous dental appointments being made for Resident #58. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Social Services Designee #106 on 02/27/25 at 2:04 P.M., revealed the facility had delayed dental services due to appointment complications since the resident's admission on 09/01/23. SSD #106 stated during the care conference on 12/04/24, Resident #58 repeated his request for dental services. SSD #106 verified paperwork for the contract dental services had been signed by the POA, and the resident had a physician order for dental services. SSD #106 verified there was no documentation Resident #58 had dental services provided since admission and there had been no contracted dental services set up since.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44083 Based on observation, staff interviews and record review, the facility failed to maintain a sanitary kitchen to prevent cross contamination of food. This affected 78 Residents who received food from the kitchen. The faciity identified two residents who did not receive any food from the kitchen. The facility total census was 80. Findings Include: Observation on 02/24/25 at 8:50 A.M., revealed there was a gray material blowing off of the grill of the wall fan blowing towards a table where foods were being prepared by [NAME] #180. In the dry food storage area, there were three bags of open, undated and unlabeled foods. There was an outputting air vent, three feet from foods being cooked on the stove, with a heavy buildup of grayish debris. Above the stove, the exhaust vents were noted with gray debris hanging over foods cooking on the stove. There were approximately 30 large unopened food cans in a storage rack with no date of delivery. In the walk-in refrigerator, there was an opened cottage cheese container with an expiration date of 02/17/25. Interview on 02/24/25 at 8:55 A.M., the Registered Dietitian, (RD) #695 verified the kitchen storage area did not have labeling to ensure foods were sealed, dated and rotated to ensure safe food practices. The RD #695 verified the fans, and inputting and exhaust vents needed to be cleaned. Observation on 02/25/25 at 8:15 A.M., revealed [NAME] #180 picked up a food plate, then a utensil, then touched the counter, with gloved hands. With the same gloved hands, the [NAME] #180 picked up bacon and toast put on residents' breakfast plate. [NAME] #180 then touched the counter, the oven door, and dish rack, and then returned to pick up bacon and serve onto residents' meal plate. [NAME] #180 did not change gloves, use food utensils for the toast or bacon or perform hand hygiene during the meal service. Interview on 02/26/25 8:18 AM [NAME] #180 verified she did not change her gloves or perform hand hygiene between touching non-food items and food items. [NAME] #180 verified she should have used utensils to serve the bacon and toast. Observation on 02/25/25 at 11:43 A.M., revealed [NAME] # 150 and Diet Aid #135 did not have beard coverings to cover facial hair. [NAME] #150 had 10 to 20 one half inch wide by six-inch-long hair strands surrounding the head and extending beyond the hairnet on the top of [NAME] #150's head. [NAME] #150 was preparing food for the lunch meal and Diet Aid #135 was storing clean dishes. Interview on 02/25/25 at 11:43 A.M. [NAME] #150 and Diet Aid #135 verified they should have beard coverings, and the hair net should cover the entire head of hair. Observation on 02/26/25 at 11:14 A.M., revealed [NAME] #180 was preparing puree foods using a rotary blender. [NAME] #180 disassembled the blender blade from the blender bowl into the dishwasher with gloved hands. [NAME] #180 touched the dishwasher area while awaiting the dishwashing completion. [NAME] #180 reassembled the clean food blade into the clean blender bowl with the same gloved hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/26/25 at 11:53 A.M., [NAME] #180 verified she did not change gloves or perform hand sanitation between disassembling the puree blender blade from the blender bowl and then reassembling the clean blade into the clean blender bowl. Interview on 02/26/25 at 11:53 A.M., RD #300 verified the staff must have hair and beards covered and gloves must be changed from the dirty side of dishwashing to the clean side of dishwashing. Review of facility policies entitled, Food Safety, Food Storage, Personal Hygiene, and Dish Machine, dated 2021, revealed food passed expiration date should be discarded. Foods in unmarked containers should be marked with the current date the food was stored. Foods will be stored to keep foods safe and to prevent contamination. Employees will wear hair restraints and beards must be retrained using beard covers. The person loading dirty dishes will not handle clean dishes unless the hands are washed thoroughly before moving from dirty to clean.

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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** 44412 Based on review of the medical record, observations, staff interviews, review of online resources from the Centers for Disease Control (CDC), and policy review, the facility failed to provide appropriate infection control measures while performing incontinence care and failed to ensure enhanced barrier precautions (EBPs) were implemented and followed according to guidelines. This affected one Resident (#17) of the 17 residents reviewed for incontinence care and being on EBPs. The facility census was 80. Findings include: Review of the medical record for Resident #17 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, type two diabetes mellitus, paranoid schizophrenia, and major depressive disorder. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #17 was unable to complete a Brief Interview for Mental Status (BIMS) because he was rarely/never understood. This resident was dependent on staff for activities of daily living (ADLs). Review of the hospital records dated 02/22/25, revealed Resident #17 was admitted to the hospital for a urinary tract infection (UTI). Resident #17 had a history of frequent UTI's with extended spectrum beta-lactamase (ESBL). Observation on 02/27/25 at 10:01 A.M., revealed incontinence care was provided to Resident #17 by Certified Nursing Assistant (CNA) #103. Hand hygiene was not performed prior applying gloves. After gathering supplies, CNA #103 placed clean linens on bedside table without cleaning the bedside table. CNA #103 performed incontinence care on Resident #17 with those linens. Observation revealed CNA #103 only wore gloves during the incontinence care. Observation revealed no signage on the door or within the resident's room, indicating Resident #17 was to be in EBPs. Interview on 02/27/25 at 10:07 A.M. with CNA #103, verified she did not perform hand hygiene prior to applying gloves. CNA #103 also verified she put clean linens on the bedside table without cleaning it and then used those linens while providing incontinence care. CNA #103 verified she only used gloves to provide incontinence care to Resident #17 and wasn't aware she needed to wear any additional personal protective equipment (PPE). Interview on 02/27/25 at 10:43 A.M. with the Director of Nursing (DON), verified Resident #17 was not in EBPs and there were no active orders for the resident to be in EBPs Interview on 02/27/25 at 11:27 A.M. with Registered Nurse (RN) #181, verified Resident #17 had ESBL which was considered a Multi Drug Resistant Organism (MDRO), and Resident #17 should be in EBPs. Review of the February 2025 active physician orders for Resident #17, revealed he was not ordered to be in EBPs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Hand Hygiene, dated 2023, revealed all staff were to perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately removing gloves. Review of CDC website at (https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html) dated 06/28/24, revealed infection control management of MDROs in healthcare settings revealed MDRO's were defined as microorganisms, predominantly bacteria, that were resistant to one or more classes of antimicrobial agents. ESBL was considered a MDRO and was resistant to multiple classes of antimicrobial agents. EBPs are an infection control intervention designed to reduce transmission of MDROs in nursing homes. EBPs precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Review of the facility policy titled, Enhanced Barrier Precautions, undated, revealed it was the policy of the facility to implement enhanced barrier precautions for the prevention of transmission of multi-drug-resistant organisms. Enhanced barrier precautions referred to an infection control intervention designed to reduce transmission of multi-drug-resistant organisms that employed targeted gown and glove use during high contact resident care activities.