

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365424	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/27/2025
NAME OF PROVIDER OR SUPPLIER Southbrook Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2299 S Yellow Springs Street Springfield, OH 45506	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>Based on medical record review, financial record review, staff interview, and review of the facility policy, the facility failed to obtain appropriate written authorization to manage residents' personal funds. This affected two (Residents #23 and #24) of five residents reviewed for personal funds. The facility census was 90 residents.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #23 revealed an admission date of 05/16/24 with diagnoses including cerebral infarction, hypotension and anxiety disorder.</p> <p>Review of the authorization form for the facility to manage resident funds for Resident #23 dated 05/30/24 revealed the resident's representative had signed to authorize the facility to manage the resident's funds, but the signature was not witnessed.</p> <p>2. Review of the medical record for Resident #84 revealed an admission date of 04/23/25 with diagnoses including cerebral vascular accident, transient ischemic attack, dementia and anxiety disorder.</p> <p>Review of the authorization form for the facility to manage resident funds for Resident #84 dated 05/04/25 revealed the resident's representative had signed to authorize the facility to manage the resident's funds, but the signature was not witnessed.</p> <p>Interview on 05/21/25 at 2:00 P.M. with the Administrator confirmed the facility had not obtained proper written authorization to manage Resident #23 and Resident #84's funds. The resident representatives for Resident #23 and #84 had signed consent forms for the facility to manage the funds but neither of the representative signatures had been witnessed. The form had a space for two witnesses, but the spaces were blank on Resident #23 and #84's fund authorization forms.</p> <p>Review of facility policy titled Resident Rights undated revealed when the facility accepted the responsibility for the resident's financial affairs, the resident or resident representative should designate in writing, the transfer of responsibility.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on medical record review, observation, resident interview, staff interview, and review the facility policy, the facility failed to ensure comfortable resident room temperatures. This affected one (Resident #48) of one resident reviewed for room temperatures. The facility census was 90 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #48 revealed an admission date of 03/02/21 with diagnoses including epilepsy, depression, and a cerebral infarction.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #48 dated 04/02/25 revealed the resident was moderately cognitively impaired and required staff assistance with activities of daily living (ADLs.)</p> <p>Observation on 05/18/25 at 11:06 A.M. of Resident #48 revealed the resident was in bed in her room and was covered with a thick blanket.</p> <p>Interview on 05/18/25 at 11:07 A.M. of Resident #48 confirmed the temperature in her room was too cold.</p> <p>Observation on 05/19/25 at 3:01 P.M. of the temperature in Resident #48's room with Maintenance Director (MD) #201 revealed the temperature of the resident's room was 68 degrees Fahrenheit (F.)</p> <p>Interview on 05/19/25 at 3:02 P.M. confirmed the temperature in Resident #48's room was 68 degrees</p> <p>Observation on 05/20/25 at 10:00 A.M. of Resident #48 revealed the resident was in bed in her room and was covered with a thick blanket.</p> <p>Interview on 05/20/25 at 10:01 A.M. of Resident #48 confirmed the temperature in her room was too cold.</p> <p>Observation on 05/20/25 at 10:15 A.M. with MD #201 revealed the temperature in Resident #48's room with Maintenance Director (MD) #201 revealed the temperature of the resident's room was 70.2 degrees F.</p> <p>Interview on 05/20/25 at 10:16 A.M. confirmed the temperature in Resident #48's room was 70.2 degrees.</p> <p>Review of the facility policy titled Extreme Cold Temperature Protocol undated revealed the facility would provide a safe, clean, comfortable and homelike environment including a comfortable and safe regulated temperature range of 71 to 81 degrees F. This ambient air temperature range minimized resident susceptibility to loss of body heat and risk of hypothermia or hyperthermia and provided a comfortable homelike setting.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on medical record review, staff interview, resident interview, review of the facility Self-Reported Incidents (SRIs) and review of the facility policy, the facility failed to ensure residents were free from verbal abuse. This affected three (Residents #15, # 59, and #69) of eight residents reviewed for abuse. The facility census was 90 residents.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #15 revealed an admission date of 04/12/23 with diagnoses of schizophrenia, congestive heart failure (CHF), and type two diabetes mellitus.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #15 dated 03/18/25 revealed the resident was cognitively intact and required set up assistance and supervision with activities of daily living (ADLs.)</p> <p>Review of the care plan for Resident #15 dated 03/25/25 revealed the resident had a focus on psychosocial well-being with a goal for the resident to feel safe, comfortable, and well cared for through next review date.</p> <p>Interview on 05/18/25 at 1:08 P.M. with Licensed Practical Nurse (LPN) #162 confirmed she witnessed Resident #63 call Resident #15 a bitch sometime in the last couple of weeks LPN #162 confirmed she did not report the abuse because the nurse believed the leadership team wouldn't do anything about Resident #63's behaviors and she was afraid to report it because she believed Resident #63 was always getting employees suspended or fired.</p> <p>Interview on 05/19/25 at 9:13 A.M. with Resident #15 confirmed Resident #63 always yelled at him and called him and his mom profane names. Resident #15 confirmed he was a religious man, and he was offended by the way Resident #63 spoke to him. Resident #15 confirmed the verbal abuse had occurred within the last few weeks.</p> <p>2. Review of the medical record for Resident #59 revealed an admission date of 11/16/22 with diagnoses of cerebral infarction, major depressive disorder, and hypertension.</p> <p>Review of the MDS assessment for Resident #59 dated 05/05/25 revealed the resident was cognitively intact and required staff assistance with ADLs.</p> <p>Review of the care plan for Resident #59 dated 11/28/22 revealed the resident had a focus of a behavior problem due to loss of independence with an intervention to approach and speak to the resident in calm manner.</p> <p>Interview on 05/19/25 at 8:56 A.M. with Certified Nursing Assistant (CNA) #112 confirmed Resident #63 was always yelling, cussing, and chasing residents and staff with his wheelchair. CNA #112 confirmed he witnessed Resident #63 cussing at Resident #59 and the nurse earlier in the day on 05/19/25.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/19/25 at 9:00 A.M. with LPN #166 confirmed she witnessed Resident #63 refer to Resident #59 ugly and also call the resident a profane name. LPN #166 confirmed she did not report this to the Administrator because of fear of retaliation and concern that Resident #63 got staff suspended or fired.</p> <p>3. Review of the medical record for Resident #69 revealed an admission date of 07/28/23 with diagnoses of chronic obstructive pulmonary disease (COPD), alcohol-induced psychotic disorder, and chronic hepatitis.</p> <p>Review of the MDS assessment for Resident #69 dated 04/11/25 revealed the resident had moderate cognitive impairment and was independent with ADLs.</p> <p>Review of the care plan for Resident #69 dated 05/01/25 revealed the resident had a focus of behavior problem with an intervention to approach and speak to the resident in a calm manner.</p> <p>Interview on 05/18/25 at 1:08 P.M. with LPN #161 confirmed she recently observed Resident #63 call Resident #69 an ugly bitch and a mortician, but she couldn't remember the exact date.</p> <p>Interview on 05/19/25 at 8:52 A.M. with Resident #69 confirmed Resident #63 had called her all kinds of names and she was embarrassed to repeat some of them because they were profane. Resident #63 confirmed she told LPN #161, but nothing was done about the verbal abuse.</p> <p>Review of the medical record for Resident #63 revealed an admission date of 08/08/23 with diagnoses of COPD, type two diabetes mellitus, and CHF.</p> <p>Review of the care plan for Resident #63 dated 01/06/25 revealed the resident had a behavior problem which included yelling and screaming, throwing objects, and using inappropriate language towards staff and residents with interventions for staff to intervene as necessary to protect the rights and safety of others, to monitor behavioral episodes, and to attempt to determine underlying causes.</p> <p>Review of the physician's orders for Resident #63 revealed an order dated 04/01/25 for staff to monitor the resident for false allegations, inappropriate language toward staff or residents, and yelling/screaming.</p> <p>Review of the MDS assessment for Resident #63 dated 05/08/25 revealed resident was cognitively intact and required set up and supervision with ADLs.</p> <p>Interview on 05/19/25 at 11:50 A.M. of Resident #63 confirmed he was not always mean to other residents and that he was only mean when people didn't do what he said they should do.</p> <p>Interview on 05/19/25 at 1:17 P.M. with Director of Plant Maintenance (DPM) #152 confirmed he had observed Resident #63 call other residents profane names on multiple occasions. DPM #152 confirmed he had not reported the abuse to management.</p> <p>Interview on 05/19/25 at 4:38 P.M. with the Administrator confirmed she was not aware of recent allegations of verbal abuse per Resident #63 towards Resident #15, #59, and #69 and the facility had not filed any SRIs related to the same, nor had the facility investigated any recent allegations of verbal abuse per Resident #63.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility SRIs dated 05/01/25 to 05/19/25 revealed there were no SRIs filed for verbal abuse per Resident #63 towards Residents #15, #59, #69.</p> <p>Review of the facility policy titled Ohio Abuse, Neglect, and Misappropriation undated revealed the facility would prevent abuse including resident to resident abuse and including verbal abuse which included any use of oral, written, or gestured language that willfully included disparaging or derogatory terms to residents and their families or within their hearing distance, to describe residents regardless of their age, disability, or ability to comprehend.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on medical record review, staff interview, resident interview, review of the facility Self-Reported Incidents (SRIs) and review of the facility policy, the facility failed to report allegations of resident to resident verbal abuse to the Ohio Department of Health (ODH). This affected three (Residents #15, # 59, and #69) of eight residents reviewed for abuse. The facility census was 90 residents.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #15 revealed an admission date of 04/12/23 with diagnoses of schizophrenia, congestive heart failure (CHF), and type two diabetes mellitus.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #15 dated 03/18/25 revealed the resident was cognitively intact and required set up assistance and supervision with activities of daily living (ADLs.)</p> <p>Review of the care plan for Resident #15 dated 03/25/25 revealed the resident had a focus on psychosocial well-being with a goal for the resident to feel safe, comfortable, and well cared for through next review date.</p> <p>Interview on 05/18/25 at 1:08 P.M. with Licensed Practical Nurse (LPN) #162 confirmed she witnessed Resident #63 call Resident #15 a bitch sometime in the last couple of weeks LPN #162 confirmed she did not report the abuse because the nurse believed the leadership team wouldn't do anything about Resident #63's behaviors and she was afraid to report it because she believed Resident #63 was always getting employees suspended or fired.</p> <p>Interview on 05/19/25 at 9:13 A.M. with Resident #15 confirmed Resident #63 always yelled at him and called him and his mom profane names. Resident #15 confirmed he was a religious man, and he was offended by the way Resident #63 spoke to him. Resident #15 confirmed the verbal abuse had occurred within the last few weeks.</p> <p>2. Review of the medical record for Resident #59 revealed an admission date of 11/16/22 with diagnoses of cerebral infarction, major depressive disorder, and hypertension.</p> <p>Review of the MDS assessment for Resident #59 dated 05/05/25 revealed the resident was cognitively intact and required staff assistance with ADLs.</p> <p>Review of the care plan for Resident #59 dated 11/28/22 revealed the resident had a focus of a behavior problem due to loss of independence with an intervention to approach and speak to the resident in calm manner.</p> <p>Interview on 05/19/25 at 8:56 A.M. with Certified Nursing Assistant (CNA) #112 confirmed Resident #63 was always yelling, cussing, and chasing residents and staff with his wheelchair. CNA #112 confirmed he witnessed Resident #63 cussing at Resident #59 and the nurse earlier in the day on 05/19/25.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/19/25 at 9:00 A.M. with LPN #166 confirmed she witnessed Resident #63 refer to Resident #59 ugly and also call the resident a profane name. LPN #166 confirmed she did not report this to the Administrator because of fear of retaliation and concern that Resident #63 got staff suspended or fired.</p> <p>3. Review of the medical record for Resident #69 revealed an admission date of 07/28/23 with diagnoses of chronic obstructive pulmonary disease (COPD), alcohol-induced psychotic disorder, and chronic hepatitis.</p> <p>Review of the MDS assessment for Resident #69 dated 04/11/25 revealed the resident had moderate cognitive impairment and was independent with ADLs.</p> <p>Review of the care plan for Resident #69 dated 05/01/25 revealed the resident had a focus of behavior problem with an intervention to approach and speak to the resident in a calm manner.</p> <p>Interview on 05/18/25 at 1:08 P.M. with LPN #161 confirmed she recently observed Resident #63 call Resident #69 an ugly bitch and a mortician, but she couldn't remember the exact date.</p> <p>Interview on 05/19/25 at 8:52 A.M. with Resident #69 confirmed Resident #63 had called her all kinds of names and she was embarrassed to repeat some of them because they were profane. Resident #63 confirmed she told LPN #161, but nothing was done about the verbal abuse.</p> <p>Review of the medical record for Resident #63 revealed an admission date of 08/08/23 with diagnoses of COPD, type two diabetes mellitus, and CHF.</p> <p>Review of the care plan for Resident #63 dated 01/06/25 revealed the resident had a behavior problem which included yelling and screaming, throwing objects, and using inappropriate language towards staff and residents with interventions for staff to intervene as necessary to protect the rights and safety of others, to monitor behavioral episodes, and to attempt to determine underlying causes.</p> <p>Review of the physician's orders for Resident #63 revealed an order dated 04/01/25 for staff to monitor the resident for false allegations, inappropriate language toward staff or residents, and yelling/screaming.</p> <p>Review of the MDS assessment for Resident #63 dated 05/08/25 revealed resident was cognitively intact and required set up and supervision with ADLs.</p> <p>Interview on 05/19/25 at 11:50 A.M. of Resident #63 confirmed he was not always mean to other residents and that he was only mean when people didn't do what he said they should do.</p> <p>Interview on 05/19/25 at 1:17 P.M. with Director of Plant Maintenance (DPM) #152 confirmed he had observed Resident #63 call other residents profane names on multiple occasions. DPM #152 confirmed he had not reported the abuse to management.</p> <p>Interview on 05/19/25 at 4:38 P.M. with the Administrator confirmed she was not aware of recent allegations of verbal abuse per Resident #63 towards Resident #15, #59, and #69 and the facility had not filed any SRIs related to the same, nor had the facility investigated any recent allegations of verbal abuse per Resident #63.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility SRIs dated 05/01/25 to 05/19/25 revealed there were no SRIs filed for verbal abuse per Resident #63 towards Residents #15, #59, #69.</p> <p>Review of the facility policy titled Ohio Abuse, Neglect, & Misappropriation undated revealed the facility should report allegations of resident abuse to the state agency in accordance with state law.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on medical record review, staff interview, resident interview, review of the facility Self-Reported Incidents (SRIs) and review of the facility policy, the facility failed to investigate allegations of abuse. This affected three (Residents #15, # 59, and #69) of eight residents reviewed for abuse. The facility census was 90 residents.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #15 revealed an admission date of 04/12/23 with diagnoses of schizophrenia, congestive heart failure (CHF), and type two diabetes mellitus.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #15 dated 03/18/25 revealed the resident was cognitively intact and required set up assistance and supervision with activities of daily living (ADLs.)</p> <p>Review of the care plan for Resident #15 dated 03/25/25 revealed the resident had a focus on psychosocial well-being with a goal for the resident to feel safe, comfortable, and well cared for through next review date.</p> <p>Interview on 05/18/25 at 1:08 P.M. with Licensed Practical Nurse (LPN) #162 confirmed she witnessed Resident #63 call Resident #15 a bitch sometime in the last couple of weeks LPN #162 confirmed she did not report the abuse because the nurse believed the leadership team wouldn't do anything about Resident #63's behaviors and she was afraid to report it because she believed Resident #63 was always getting employees suspended or fired.</p> <p>Interview on 05/19/25 at 9:13 A.M. with Resident #15 confirmed Resident #63 always yelled at him and called him and his mom profane names. Resident #15 confirmed he was a religious man, and he was offended by the way Resident #63 spoke to him. Resident #15 confirmed the verbal abuse had occurred within the last few weeks.</p> <p>2. Review of the medical record for Resident #59 revealed an admission date of 11/16/22 with diagnoses of cerebral infarction, major depressive disorder, and hypertension.</p> <p>Review of the MDS assessment for Resident #59 dated 05/05/25 revealed the resident was cognitively intact and required staff assistance with ADLs.</p> <p>Review of the care plan for Resident #59 dated 11/28/22 revealed the resident had a focus of a behavior problem due to loss of independence with an intervention to approach and speak to the resident in calm manner.</p> <p>Interview on 05/19/25 at 8:56 A.M. with Certified Nursing Assistant (CNA) #112 confirmed Resident #63 was always yelling, cussing, and chasing residents and staff with his wheelchair. CNA #112 confirmed he witnessed Resident #63 cussing at Resident #59 and the nurse earlier in the day on 05/19/25.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/19/25 at 9:00 A.M. with LPN #166 confirmed she witnessed Resident #63 refer to Resident #59 ugly and also call the resident a profane name. LPN #166 confirmed she did not report this to the Administrator because of fear of retaliation and concern that Resident #63 got staff suspended or fired.</p> <p>3. Review of the medical record for Resident #69 revealed an admission date of 07/28/23 with diagnoses of chronic obstructive pulmonary disease (COPD), alcohol-induced psychotic disorder, and chronic hepatitis.</p> <p>Review of the MDS assessment for Resident #69 dated 04/11/25 revealed the resident had moderate cognitive impairment and was independent with ADLs.</p> <p>Review of the care plan for Resident #69 dated 05/01/25 revealed the resident had a focus of behavior problem with an intervention to approach and speak to the resident in a calm manner.</p> <p>Interview on 05/18/25 at 1:08 P.M. with LPN #161 confirmed she recently observed Resident #63 call Resident #69 an ugly bitch and a mortician, but she couldn't remember the exact date.</p> <p>Interview on 05/19/25 at 8:52 A.M. with Resident #69 confirmed Resident #63 had called her all kinds of names and she was embarrassed to repeat some of them because they were profane. Resident #63 confirmed she told LPN #161, but nothing was done about the verbal abuse.</p> <p>Review of the medical record for Resident #63 revealed an admission date of 08/08/23 with diagnoses of COPD, type two diabetes mellitus, and CHF.</p> <p>Review of the care plan for Resident #63 dated 01/06/25 revealed the resident had a behavior problem which included yelling and screaming, throwing objects, and using inappropriate language towards staff and residents with interventions for staff to intervene as necessary to protect the rights and safety of others, to monitor behavioral episodes, and to attempt to determine underlying causes.</p> <p>Review of the physician's orders for Resident #63 revealed an order dated 04/01/25 for staff to monitor the resident for false allegations, inappropriate language toward staff or residents, and yelling/screaming.</p> <p>Review of the MDS assessment for Resident #63 dated 05/08/25 revealed resident was cognitively intact and required set up and supervision with ADLs.</p> <p>Interview on 05/19/25 at 11:50 A.M. of Resident #63 confirmed he was not always mean to other residents and that he was only mean when people didn't do what he said they should do.</p> <p>Interview on 05/19/25 at 1:17 P.M. with Director of Plant Maintenance (DPM) #152 confirmed he had observed Resident #63 call other residents profane names on multiple occasions. DPM #152 confirmed he had not reported the abuse to management.</p> <p>Interview on 05/19/25 at 4:38 P.M. with the Administrator confirmed she was not aware of recent allegations of verbal abuse per Resident #63 towards Resident #15, #59, and #69 and the facility had not filed any SRIs related to the same, nor had the facility investigated any recent allegations of verbal abuse per Resident #63.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility SRIs dated 05/01/25 to 05/19/25 revealed there were no SRIs filed for verbal abuse per Resident #63 towards Residents #15, #59, #69.</p> <p>Review of the facility policy titled Ohio Abuse, Neglect, and Misappropriation policy undated revealed the facility should investigate all allegations of resident abuse.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on medical record review, resident interview, staff interview, observation, and review of the facility policy, the facility failed to ensure staff provided timely resident incontinence care and failed to ensure staff provided resident nail care. This affected two (Residents #38 and #139) of four residents reviewed for activities of daily living (ADLs). The facility census was 90 residents</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #38 revealed an admission date of 08/24/18 with medical diagnoses including multiple sclerosis and glaucoma.</p> <p>Review of the care plan for Resident #38 dated 04/01/25 revealed the resident was at risk for impaired skin integrity related to incontinence. Interventions included to provide incontinence care as needed for the resident.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #38 dated 04/15/25 revealed the resident was cognitively intact, was always incontinent of bowel and bladder, and was dependent on staff assistance for incontinence care.</p> <p>Review of the task documentation for Resident #38 dated 05/16/25 revealed there was no toileting documented for the resident that day.</p> <p>Review of the staffing schedule for 05/16/25 revealed there were three aides on the unit where Resident #38 resided.</p> <p>Interview on 05/18/25 at 11:47 A.M. with Resident #38 confirmed she asked to be changed throughout the day on 05/16/25, but she didn't get changed and had to sit up for 16 hours in her wheelchair. Resident #38 confirmed Certified Nursing Aide (CNA) #131 told her they were short staffed and unable to provide incontinence care.</p> <p>Interview on 05/20/25 at 9:14 A.M with CNA #131 confirmed 05/16/25 was a hectic day because the facility was providing a cookout for the residents and they were short staffed. CNA #131 confirmed she was unable to provide incontinence care for Resident #38 on 05/16/25.</p> <p>Review of the facility policy titled Perineal Care Male/Female undated revealed the staff should provide incontinence care to dependent residents to promote a sense of well-being and meet hygiene standards of care.</p> <p>2. Review of the medical record for Resident #139 revealed an admission date of 05/01/25 with diagnoses including hypothyroidism, epilepsy, and post-traumatic stress disorder.</p> <p>Review of the care plan for Resident #139 dated 05/01/25 revealed the resident had an ADL self-care deficit and required moderate staff assistance with bathing.</p> <p>Review of MDS assessment for Resident #139 dated 05/08/25 revealed the resident was cognitively intact and she required staff assistance with hygiene and grooming.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 05/19/25 at 9:05 A.M., 11:21 A.M., and 2:18 P.M. of Resident #139 revealed the resident's fingernails were long, and had a dark substance under them, and her toenails were long and dirty.</p> <p>Interview on 05/19/25 at 2:18 P.M. with Resident #139 confirmed the aides didn't trim and clean her fingernails or toenails.</p> <p>Interview on 05/19/25 at 2:30 P.M with CNA #134 confirmed Resident #139's fingernails and toenails were long and dirty, and staff should provide nail care to include cleaning and trimming the resident's nails on bath day.</p> <p>Review of the facility policy titled Routine Resident Care undated revealed the aide should provide routine daily care which included assistance with bathing and grooming.</p>

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on medical record review, staff interview, review of the facility policy, and review of online guidelines per the National Pressure Ulcer Advisory Panel (NPUAP), the facility failed to thoroughly assess resident skin and failed to identify pressure ulcers until they had reached an advanced stage. This resulted in Actual Harm for Resident #54 who was admitted to the facility with a pressure ulcer to his sacrum, left scapula, and right scapula and developed an additional pressure ulcer to his right gluteal fold which was not identified until it had developed into an unstageable ulcer with slough (nonviable tissue which could impede wound healing) and necrotic (dead) tissue. This affected one (Resident # 54) of two residents reviewed for pressure ulcers. The facility census was 90 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #54 revealed an admission date of 04/22/25 with diagnoses including schizoaffective disorder, Alzheimer's Disease, and generalized anxiety disorder.</p> <p>Review of the pressure ulcer risk assessment for Resident #54 dated 04/22/25 revealed the resident was at high risk for the development of pressure ulcers.</p> <p>Review of the physician's orders for Resident #54 revealed an order dated 04/22/25 for daily skin sweeps at bedtime.</p> <p>Review of the care plan for Resident #54 initiated 04/22/25 and revised 05/05/25 revealed the resident had impaired skin integrity related to pressure ulcers on his sacrum, right scapula and right gluteal fold. Interventions included the following: air mattress with bolsters to bed frame, daily skin sweeps at bedtime, turn and reposition as tolerated every morning and at bedtime, float heels as tolerated, complete skin at risk assessment upon admission/readmission, quarterly, and as needed, encourage the resident to turn and reposition or assist as needed as resident allows, evaluate existing wound daily for changes (redness, edema, drainage, pain, foul odor), provide appropriate off-loading mattress and off-loading cushion.</p> <p>Review of the admission Minimum Data Set (MDS) assessment for Resident #54 dated 04/29/25 revealed the resident was severely cognitively impaired and required extensive staff assistance with bed mobility and other activities of daily living (ADLs).</p> <p>Review of the wound assessment for Resident #54 dated 04/24/25 revealed the resident was admitted to the facility with a stage I pressure ulcer on his left scapula, a stage III pressure ulcer on his right scapula, a stage I pressure ulcer on his left gluteal fold, and an unstageable pressure ulcer on his sacrum.</p> <p>Review of the weekly skin assessment for Resident #54 dated 04/29/25 per the Director of Nursing (DON) revealed the resident had no new skin issues.</p> <p>Review of the weekly skin assessment for Resident #54 dated 05/06/25 completed by Licensed Practical Nurse (LPN) #165 revealed the resident had new skin issues.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Treatment Administration Records (TAR) for April 2025 and May 2025 revealed daily skin sweeps at bedtime were signed off as completed from 04/22/25 through 05/04/25.</p> <p>Review of the progress note for Resident #54 dated 05/05/25 per Wound Nurse Practitioner (WNP) #250 revealed the resident had an unstageable pressure area to the right gluteal fold which measured 2.5 centimeters (cm) in length by 2.0 cm in width by 0.2 cm in depth. The wound bed was 40 percent (%) epithelial tissue, 30% slough tissue, and 30% eschar (dead) tissue.</p> <p>Interview on 05/20/25 at 11:12 A.M. with the DON confirmed WNP #250 found the unstageable pressure ulcer on Resident #54's right gluteal fold on 05/05/25. The DON further confirmed Resident #54 had a physician's order for a daily skin sweep which the staff had signed off as completed daily from 04/022/25 to 05/04/25. The DON confirmed Resident #54's right gluteal fold pressure ulcer was not identified until 05/05/25 when it had reached an advanced stage, and staff should have identified the pressure ulcer sooner.</p> <p>Review of the facility policy titled Skin Care and Wound Management undated revealed the facility staff would identify residents at risk for the development of pressure ulcers, provide daily monitoring of existing wounds, and implement prevention strategies to decrease the potential for developing pressure ulcers.</p> <p>Review of the NPUAP guidelines dated 2014 pages 70-71 at https://npiap.com/general/custom.asp?page=2014Guidelines revealed facilities should educate health professionals on how to undertake a comprehensive skin assessment that included the techniques for identifying blanching response, localized heat, edema, and induration. Further review of the guidelines revealed ongoing assessment of the skin was necessary in order to detect early signs of pressure damage. Visual assessment for erythema (redness of the skin) was the first component of every skin inspection. Skin redness and tissue edema resulting from capillary occlusion was a response to pressure, especially over bony prominences. Staff should conduct a head-to-toe assessment with particular focus on skin overlying bony prominences including the sacrum, ischial tuberosities, greater trochanters and heels and each time the patient was repositioned was an opportunity to conduct a brief skin assessment.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>Based on medical record review, observation, resident interview, and staff interview, the facility failed to ensure range of motion devices were in place. This affected one (Resident #48) of two residents reviewed for positioning and mobility. The facility census was 90 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #48 revealed an admission date of 03/02/21 with diagnoses including epilepsy, depression, and cerebral infarction.</p> <p>Review of the care plan for Resident #48 dated 03/22/25 for revealed the resident had an activities of daily living (ADL) self-care deficit related to hemiplegia and hemiparesis following a cerebral infarction affecting the resident's right side with an intervention to place a rolled cloth in the resident's right hand as tolerated.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #48 dated 04/02/25 revealed the resident was moderately cognitively impaired and was dependent on staff assistance with ADLs.</p> <p>Observations on 05/18/25 at 11:07 A.M. and on 05/20/25 at 8:24 A.M. and 11:30 A.M. of Resident #48 revealed the resident's right hand had limited range of motion (ROM) and the resident did not have a cloth placed in her right hand.</p> <p>Interview on 05/20/25 at 11:31 A.M. with Resident #48 confirmed she had sustained a stroke, and the staff used to place a carrot in her right hand, but someone threw it away and she hadn't received another one.</p> <p>Interview on 05/20/25 at 11:30 A.M. with Registered Nurse (RN) #180 confirmed the Resident #48 didn't have a rolled cloth in her right hand and she should have had one.</p> <p>Interview on 05/20/25 at 2:51 P.M with Therapy Manager (TM) #200 confirmed therapy had recommended staff place a cloth carrot in Resident #48's right hand as tolerated. TM #200 reported she wasn't aware the cloth carrot had been lost.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure residents received the appropriate level of supervision during transfer to prevent falls with injury. This affected one (Resident #61) of six residents reviewed for accidents. The facility census was 90 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #61 revealed an admission date of 12/23/22 with diagnoses including cerebral infarction, vascular dementia, and anxiety disorder.</p> <p>Review of the care plan for Resident #61 dated of 07/15/24 revealed the resident had an ADL self-care performance deficit and required assistance with ADLs with an intervention of two or more staff to assist the resident with bed mobility.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #61 dated 02/19/25 revealed the resident had severe cognitive impairment and was dependent on staff assistance for all activities of daily living (ADLs) including bed mobility.</p> <p>Review of the fall risk assessment for Resident #61 dated 04/09/25 revealed the resident was at risk for falls.</p> <p>Review of the progress note for Resident #61 dated 04/29/25 timed at 12:38 A.M. revealed an incident occurred during peri-care where staff rolled the resident onto the floor.</p> <p>Review of the fall investigation for Resident #61 dated 04/29/25 revealed Certified Nursing Assistant (CNA) #136 was providing peri-care to Resident #61 and the aide rolled the resident onto his right side causing the resident to roll out of bed and onto the floor. Resident #61 sustained a skin tear to his right elbow and bruising to his forehead and was sent to the hospital for an evaluation and returned to the facility with no new orders.</p> <p>Interview on 05/21/25 at 2:01 P.M. with the Administrator confirmed Resident #61 required the assistance of two staff with peri-care. The Administrator further confirmed CNA #136 was performing peri-care on Resident #61 without additional helpers, and the aide rolled the resident out of bed and onto the floor.</p> <p>Review of the facility policy titled Fall Prevention and Management undated revealed it was the policy of the facility to provide physical care to meet the needs of the resident. The care plan was to include interventions that addressed resident ADL needs.</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>Based on personnel record review and staff interview, the facility failed to ensure annual evaluations were completed for staff. This had the potential to affect all of the residents who resided in the facility. The facility census was 90 residents.</p> <p>Findings include:</p> <p>Review of the personnel file for Certified Nursing Assistant (CNA) #120 revealed a hire date of 10/27/22 with no annual evaluation.</p> <p>Review of the personnel file for CNA #128 revealed a hire date of 08/15/23 with no annual evaluation.</p> <p>Review of the personnel file for CNA #117 revealed a hire date of 07/19/22 with no annual evaluation.</p> <p>Interview on 05/21/25 at 10:09 A.M. with Human Resource Manager (HRM) #153 confirmed annual evaluations were not completed for CNAs #120, #128, and #117.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, staff interview, and review of the facility policy, the facility failed to ensure food was stored in a safe and sanitary manner. This had the potential to affect all of the residents residing in the facility excluding Resident #52 and #62 who did not eat food from the kitchen. The facility census was 90 residents.</p> <p>Findings include:</p> <p>Observation on 05/18/25 from 08:22 A.M. to 8:52 A.M. with Dietary Manager (DM) #201 revealed the following findings in the kitchen:</p> <ul style="list-style-type: none"> -The dry storage area contained eleven undated cereal bowls, one container of breadcrumbs open to air, four clear plastic containers of cereal with cloudy sides and residue buildup, one clear plastic container of sugar with cloudy sides, one clear plastic container of flour with cloudy sides, one clear plastic container of brown sugar with cloudy sides, one unrefrigerated sheet cake, an uncovered trash can filled with waste. -The walk-in refrigerator contained two undated packages of salami, 20 undated individually wrapped dinner rolls, seven undated premade salads, 15 undated bowls of coleslaw, one undated and uncovered package of butter. -The walk-in freezer contained two pitchers of ice open to air, one box of beef patties open to air, and one box of sausage patties open to air. <p>Interview on 05/18/25 at 8:53 A.M. with Dietary Manager (DM) #201 confirmed the concerns in the dry storage area, the walk-in refrigerator, and the walk-in freezer.</p> <p>Review of the facility policy titled Food Storage: Dry Goods dated February 2023 revealed all packaged and canned food items should be kept clean, dry, and properly sealed. Storage areas would be neat, arranged for easy identification, and date marked as appropriate.</p> <p>Review of the facility policy titled Food Storage: Cold Foods dated February 2023 revealed all foods should be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, staff interview, and review of the facility policy, the facility failed to ensure staff followed safe hand hygiene practices during medication administration and handling of resident food. This affected two (Residents #32 and #55) of 26 sampled residents. The facility census was 90 residents.</p> <p>Findings include:</p> <p>1. Observation on 05/18/25 at 8:56 A.M. of Licensed Practical Nurse (LPN) #154 revealed the nurse was preparing medications to administer to Resident #32. LPN #154 removed medication from Resident #32's medication dose pack and placed the medication in her ungloved hand before placing the medication into a medication cup.</p> <p>Interview on 05/18/25 at 8:57 A.M. with LPN #154 confirmed she touched Resident #32's medications with her ungloved hands.</p> <p>Review of facility policy titled Medication Administration dated 2013 revealed nurses should not touch medications with ungloved hands.</p> <p>2. Observation on 05/19/25 at 12:06 P.M. of main dining room revealed Certified Nurse Aide (CNA) #110 served Resident #55 a turkey club sandwich with a packet of mayonnaise, a slice of lettuce, two slices of tomato, and at least three slices of onion on the side. CNA #110 asked Resident #55 if she wanted mayonnaise, lettuce, tomato, or onion on her sandwich. CNA #110 removed the top piece bread from Resident #55's sandwich with her ungloved hands, opened the packet of mayonnaise and applied mayonnaise, lettuce, tomato, and onion to Resident #55's sandwich without gloves on.</p> <p>Interview on 05/19/25 at 12:09 P.M. with CNA #110 confirmed she touched Resident #55's turkey club sandwich, lettuce, tomato, and onion with ungloved hands and she should not have done so.</p>		