STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365453	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Healthcare of Oregon	3953 Navarre Ave Oregon, OH 43616

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528 Based on observation, medical record review, staff and resident interview, and facility policy review, the facility failed to ensure residents had access to their call lights and their bed mobility equipment. This affected three (#12, #48, and #67) of three residents reviewed for accommodation of needs. The facility census was 82. Findings include: 1. Review of the medical record revealed Resident #12 was admitted on [DATE]. Diagnoses included early-onset cerebellar ataxia, type two diabetes mellitus without complications, and peripheral vascular disease. Review of the Minimum Data Set (MDS) assessment, dated 03/09/24, revealed Resident #12 was cognitively intact. Resident #12 was dependent on staff for shower/bathing, lower body extremity, personal hygiene, and always incontinent of bowel and bladder. Observation on 04/29/24 at 2:05 P.M. revealed Resident #12 was sitting in a wheelchair next to the bedside. Resident #12 reported she wanted to go back to bed. Resident #12's call light was observed to be under the bed and inaccessible to the resident. Interview on 04/29/24 at 2:09 P.M. with State tested Nursing Assistant (STNA) #626 verified the call light was inaccessible to Resident #12. 2. Review of the medical record revealed Resident #67 was admitted on [DATE]. Diagnoses included type two diabetes mellitus, coronary artery disease, hypertension, and depression. Review of the Minimum Data Set (MDS) assessment, dated 01/27/24, revealed Resident #67 was severely cognitively impaired, required partial to moderate assistance from staff for mobility, and always incontinent of bowel and bladder. Observation on 04/29/24 at 2:07 P.M. revealed Resident #67 was sitting in a wheelchair near the end of the resident's bed. Resident #67's call light was observed to be clipped to the top of the bed near the pillow and was inaccessible to the resident. Interview on 04/29/24 at 2:09 P.M. with State tested Nursing Assistant (STNA) #626 verified the call light was inaccessible to Resident #67. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's undated policy titled Call Light Policy and Procedure revealed staff will ensure the resident is in a comfortable position and the call light is within reach of the resident before leaving the resident's room. 49742 3. Review of Resident #48's medical records revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), peripheral vascular disease (PVD), morbid obesity, muscle weakness, acute on chronic congestive heart failure (CHF), and muscle wasting and atrophy. Review of the Minimum Data Set (MDS) assessment, dated 04/08/24 revealed Resident #48 was cognitively intact. Review of the most recent care plan revealed Resident #48 was at risk for decline in activities of daily living (ADL) function and required extensive assistance with interventions including an overbed trapeze to assist with bed mobility. Interview and observation with Resident #48 on 04/30/24 at 11:14 A.M. revealed the resident did not have an overbed trapeze on her bed in approximately one month. Resident #48 indicated she utilized the over bed trapeze extensively to reposition herself in bed. There was no over bed trapeze for Resident #48 in her room Interview with Director of Rehabilitation #504 on 05/01/24 at 8:17 A.M. revealed Resident #48 has participated in 23 sessions of Occupational Therapy (OT) and was discharged from OT on 11/29/23. Director of Rehabilitation #504 indicated Resident #48 had an overbed trapeze for bed mobility. Interview with State tested Nursing Aide (STNA) #597 on 05/01/24 at 8:36 A.M. verified there was no overbed trapeze on Resident #48's bed.

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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** 49742 Based on medical record review and staff interview, the facility failed to consistently implement the bowel movement plan to administer medications as physician ordered for a resident not having a bowel movement for several days. This affected one (#7) of two residents reviewed for bowel incontinence. The facility census was 82. Findings include: Review of Resident #7's medical record revealed an admitted [DATE]. Diagnoses included methicillin resistant staphylococcus aureus (MRSA) infection, viral infection of urogenital system, and constipation. Review of the Minimum Data Set (MDS) assessment, dated 04/10/24, revealed Resident #7 had mild cognitive impairment and was always incontinent of bowel and bladder. Review of Resident #7's plan of care dated 10/05/23 revealed Resident #7 was at risk for alteration in elimination to rule out incontinent of bowel and bladder. Interventions included administer medications as ordered. Review of Resident #7's Bowel and Bladder Elimination Record for April 2024 revealed no documented bowel movements for eight days from 04/02/24 to 04/09/24. On 04/10/24, Resident #7 had a bowel movement. Resident #7 did not have bowel movements recorded for five days from 04/11/24 to 04/15/24. There were also no bowel movements recorded on 04/17/24, 04/20/24, 04/22/24, 04/23/24, 04/24/24, 04/25/24, 04/27/24, 04/28/24, and 04/30/24. Review of the Medication Administration Record (MAR) and physician orders for April 2024 for Resident #7 revealed an order for 17 grams of Miralax to be administered every six hours as needed for constipation. One dose was administered on 04/04/24. Interview on 05/01/2024 at 10:50 A.M. with the Director of Nursing (DON) verified the physician should have been notified after 72 hours of no bowel movements. The DON verified there were no documented bowel movements for Resident #7 on the above dates, no evidence of physician notification and once (on 04/04/24) the resident received Miralax.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, staff interview, and facility urinary continence and incontinence assessment and management policy, the facility failed to ensure a resident received timely incontinence care and services. This affected one (#67) of seven residents reviewed for bowel and bladder incontinence in a facility census of 82. Findings include: Review of Resident #67's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included type II diabetes mellitus, gastrointestinal hemorrhage, anemia, coronary artery disease, and depression. Review of the Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #67 had severe cognitive impairment, dependent on staff with activities of daily living, required partial to moderate assistance from staff with transferring and repositioning, utilized a wheelchair with partial to moderate assistance for mobility, and always incontinent of bowel and bladder. Review of the nursing plan of care dated 03/26/24 revealed Resident #67 was incontinent of bladder related to the need for assistance with all care. Goals were established indicating Resident #67 will remain free from skin breakdown due to incontinence and brief use through the review date. Interventions included: Clean peri-area with each incontinence episode. Monitor/document for signs and symptoms of urinary tract infection (UTI): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. The plan of care lacked documentation indicating a resident specific frequency of monitoring for incontinence, or the use of protective incontinence products. Review of the bowel and bladder assessment dated [DATE] noted Resident #67 to void appropriately without incontinence less than daily, incontinent of stool one to three times a week, able to get to the bathroom or transfer to the toilet/commode/bedpan with assistance of one person, sometimes aware of need to toilet. The assessment also indicated Resident #67 was identified with a skin condition to the genital, perineal, buttocks with some blanchable redness. No documentation contained in the medical record indicated a treatment or intervention was implemented to address the skin condition. No plan of care interventions addressed the residents ability to utilize the bathroom, resident knowledge regarding need for bathroom use or frequency to offer toileting. Observation on 04/30/24 at 10:48 A.M. noted Resident #67 seated in a wheelchair at the bedside. On 04/30/24 at 10:49 A.M., an interview with State tested Nurse Aide (STNA) #599 revealed Resident #67 required check and change for incontinence every two hours. STNA #599 stated at approximately 10:00 A.M. , the resident was provided morning activities of daily living including incontinence care following a bowel movement. STNA #599 also stated during incontinence care an area of skin breakdown, which appeared as a white spot, was discovered to the resident's buttock. STNA #599 indicated the resident reported the area to be painful to touch. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued observation on 04/30/24 at 12:34 P.M. noted Resident #67 seated in a wheelchair at the bedside eating lunch. On 04/30/24 at 1:15 P.M., an interview with STNA #599 revealed Resident #67 refused to be checked for incontinence and wanted to remain in the wheelchair. STNA #599 verified she had not informed the nurse of the skin breakdown to the resident's skin or the refusal of incontinence care. On 04/30/24 at 1:38 P.M., an interview with Licensed Practical Nurse (LPN) #580 stated she assumed care of Resident #67 at 6:00 A.M. LPN #580 confirmed she was not aware or informed Resident #67 was discovered with skin breakdown to the buttock or reports of associated pain. LPN #580 also verified she was not informed Resident #67 refused incontinence care. Observation on 04/30/24 at 1:50 P.M. noted STNA #599 and Unit Nurse Manager (UNM) #591 stand-pivot Resident #67 from the wheelchair and place the resident to her bed. Observation noted the seat cushion saturated with urine. STNA #599 proceeded to remove Resident #67's pants and adult incontinence brief also noted to be saturated through with urine and a small amount of bowel movement. STNA #599 provided incontinence care and cleansed Resident #67's buttock exposing an area of moisture associated skin breakdown (MASD). Resident #67 was observed to wince and vocalize pain to the MASD located on the sacrum. On 04/30/24 at 1:59 P.M., Wound Specialist Physician #500 assessed Resident #67 and discovered a non-pressure partial thickness sacrum wound identified as MASD measuring 1.5 centimeters (cm) long by (x) 3.8 cm wide x 0.1 cm deep. Review of the wound specialist examination documentation dated 04/30/24 indicated the wound duration was greater than (>) seven days, cluster wound noted as open ulceration area of 1.14 cm2 with light Serous exudate and open areas with exposed dermis. On 04/30/24 at 2:16 P.M., an interview with Licensed Practical Nurse (LPN) #580 and UNM #591 confirmed Resident #67 was heavily soiled of urine and discovered with an area of MASD to the sacrum. LPN #580 and UNM #591 verified no treatment or skin application was in place to prevent moisture damage to Resident #67's skin and were unaware Resident #67 was refusing toileting. Review of the facility's Urinary Continence and Incontinence Assessment and Management policy dated 10/01/22, revealed as part of the assessment, nursing staff will seek and document details related to continence including: voiding patterns, types of incontinence. The nursing staff and physician will identify risk factors for becoming incontinent or for worsening of current incontinence. The staff and physician will identify individuals with complications or existing incontinence, or who are at risk for such complications (skin maceration or breakdown, or perineal dermatitis. As indicated, if the individual remains incontinent despite treating transient causes of incontinence, the staff will initiate a toileting plan. The staff and physician will evaluate the effectiveness of interventions and implement additional pertinent interventions as indicated.

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F 0697 Level of Harm - Minimal harm or potential for 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** 47057 Based on record review, observation, staff and resident interview, and review of the facility policy, the facility failed to manage the resident's pain and administer pain medications as physician ordered. This affected one (Resident #287) of two residents reviewed for pain management. The facility census was 82. Findings include: Review of the medical record revealed Resident #287 had an admitted [DATE] with diagnosis of polyneuropathy (peripheral nerve pain). Review of the care plan initiated on 04/24/24 revealed Resident #287 was care planned for pain management with interventions of medications as ordered. Review of Resident #287's physician orders for 04/24/24 revealed an order for gabapentin (treats nerve pain) 300 milligrams (mg) three times daily. Review of the physician progress note dated 04/30/24 for Resident #287 revealed a medication adjustment for the gabapentin (used for nerve pain) to change the dose from original dose of 100 mg three times daily to 300 mg three times daily. Observation on 05/01/24 at 7:50 A.M. of Licensed Practical Nurse (LPN) #610 arrived to Resident #287's room to obtain vital signs and left to retrieve his morning medication. LPN #610 returned to Resident #287 and handed him a medication cup with his medications inside. Resident #287 inquired about gabapentin confirming with LPN #610 the dose was the 100 mg dose. LPN #610 verified with Resident #287 that the gabapentin was the 100 mg dose. Resident #287 stated to LPN #610, I saw the doctor yesterday and she said she would change the dose. LPN #610 stated to Resident #287 she would check on it and let the Resident #287 know. Observation and interview on 05/01/24 at 8:18 A.M. with LPN #610 verified the order on the Medication Administration Record (MAR) revealed gabapentin 300 mg three times a day. LPN #610 verified she did not read the whole order on the MAR and only administered gabapentin 100 mg. Review of the facility policy titled Medication Administration and General Guidelines, dated 2022, revealed medications are administered in accordance with written orders of the physician. Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions the physicians order are checked for the correct dosage. Review of the facility policy titled Pain Assessment and Management, revised 03/2022, revealed the pain management program is based on a facility wide commitment to appropriate assessment and treatment of pain.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on record review, staff interviews, and facility policy review, the facility failed to ensure ongoing communication and collaboration with the dialysis facility regarding dialysis care and services for a resident. This affected one (Resident #287) of one resident reviewed for dialysis. The facility census was 82. Findings include: Review of the medical record for Resident #287 revealed an admitted [DATE] with diagnoses of end-stage renal disease (ESRD) and dependence on dialysis. Review of the admission assessment dated [DATE] for Resident #287 revealed he was alert and oriented to person, place, time, and situation indicating he was cognitively intact. Review of the baseline care plan initiated on 04/24/24 for Resident #287 revealed he was care planned for dialysis. Review of the medical record for Resident #287 from 04/24/24 to 05/01/24 revealed there was no dialysis communication documentation. Interview on 05/01/24 at 4:43 P.M. with Registered Nurse (RN) #636 revealed the facility does not always send dialysis communication form. RN #636 stated if there was a problem at dialysis, the facility will send communication back to the facility, but if there were no issues no communication was exchanged. Interview on 05/02/24 at 8:23 A.M. with Licensed Practical Nurse (LPN) #611 stated she sends a facesheet, medication list, and will write the vitals signs (blood pressure, pulse, temperature, and respiratory rate) on the top of the paper work. LPN #611 stated she just learned about the red dialysis book this morning and has never seen the red book before. LPN #611 further stated any paperwork returned from dialysis will go in the hard chart. Further interview with LPN #611 verified there was no dialysis communication information in the hard chart. Interview on 05/02/24 at 8:34 A.M. with LPN #618 stated the red dialysis binder was newly created and in the unit manager's office. Interview on 05/02/24 at 8:47 A.M. with the Director of Nursing (DON) verified there was no dialysis communication forms for resident in the hard chart or in the electronic medical record. Review of the facility policy titled End-Stage Renal Disease, Care of a Resident with revised 09/10 revealed residents with ESRD will be cared for according currently recognized standards of care.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742 Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure the provider responded in a timely manner to pharmacy recommendations of an as needed psychotropic medications. This affected one (#7) of five residents reviewed for unnecessary medications. The facility census was 82. Findings include: Review of the medical record revealed Resident #7 was admitted on [DATE]. Diagnoses included major depressive disorder and generalized anxiety disorder. Review of the Minimum Data Set (MDS) assessment, dated 04/10/24, revealed Resident #7 was cognitively intact. Review of Medication Regimen Review, dated 02/19/24, revealed the pharmacy review identified a psychotropic as needed (PRN) medication and identified the need for anticipated duration and continued use rationale. Resident #7 was prescribed Clonazepam tablet 0.5 milligram (mg) with instructions to take one tablet by mouth every twelve hours as needed. There was no physician response. Review of Medication Regimen Review, dated 03/27/24, revealed the pharmacy review identified a psychotropic as needed (PRN) medication and identified the need for anticipated duration and continued use rationale. Resident #7 was prescribed Clonazepam tablet 0.5 milligram (mg) with instructions to take one tablet by mouth every twelve hours as needed. The physician response was dated the date of survey on 05/02/24. Interview on 05/02/24 at 2:04 P.M. with Registered Nurse Regional Support #635 and Director of Nursing (DON) verified Resident #7's pharmacy review for as need for psychotropic medications clearly were not addressed in a timely manner. Review of the facility policy titled Medication Monitoring, dated 2022, revealed the continued need for sedative medication is reassessed monthly by the responsible physician. The consultant pharmacist notifies the responsible physician if any sedative prescribed dose does not comply with the monitoring standards.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, resident and staff interview, and review of the facility policy, the facility failed to ensure medications were administered as ordered by the physician, within prescribed time frames, resulting in a medication error rate above five percent (%). A total of six medications errors were observed out of 40 opportunities for a medication administration error rate of 15.00%. This affected one (#4) of seven residents observed during medication administration. The facility census was 82. Findings include: Review of Resident #4's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included chronic respiratory failure, anxiety, chronic obstructive pulmonary disease (COPD), chronic kidney disease, gastric esophageal reflux disease (GERD), and peripheral vascular disease (PVD). Review of the Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #4 had intact cognition and received antianxiety, antidepressant, anticoagulant, diuretic, and opioid medications. Review of Resident #4's physician's orders revealed the medications had the prescribed timeframes: 05/21/23 Cilostazol 100 milligrams (mg) given twice daily for intermittent claudication between 7:00 A.M. - 10:00 A.M. (rising) and 7:00 P.M.-10:00 P.M. (HS range), 05/21/23 Budesonide 0.5 mg per(/)2.0 milliliters (ml) inhalation vial given twice daily for COPD between 7:00 A.M. - 10:00 A.M. (rising) and 7:00 P.M.-10:00 P.M. (HS range), 11/30/23 Elliquis 5.0 mg given twice daily for heart failure and PVD between 7:00 A.M. - 10:00 A.M. (rising) and 7:00 P.M.-10:00 P.M. (HS range), 11/01/23 Gabapentin 100 mg given every morning and evening for nerve pain at 8:00 A.M. and 8:00 P.M., 05/21/23 Pantoprazole 40 mg given twice daily for GERD between 7:00 A.M. - 10:00 A.M. (rising) and 7:00 P.M.-10:00 P.M. (HS range), 03/27/24 Buspirone 10 mg given three times a day for anxiety given between 7:00 A.M. - 10:00 A.M. (rising), 11:00 A.M. -2:00 P.M. (noon), and 7:00 P.M.-10:00 P.M. (HS range). Observation on 04/30/24 at 11:32 A.M. noted Licensed Practical Nurse (LPN) #610 obtaining medications from the medication cart for Resident #4. LPN # 610 stated getting ready to obtained Resident #4 pull morning medications due to the resident wanting to sleep in. LPN #610 confirmed assuming care for Resident #4 at 6:00 A.M. and no medication had been administered to the resident. LPN #610 proceeded to obtain the following medications: Cilostazol 100 mg, Budesonide 0.5 mg/2.0 ml inhalation vial, Elliquis 5.0 mg, Gabapentin 100 mg, Pantoprazole 40 mg, and Buspirone 10 mg. LPN #610 proceeded to administer the medications to Resident #4. Interview with Resident #4 at the time of administration confirmed she had not requested to hold morning medications. Interview on 04/30/24 at 11:49 A.M. with LPN #610 during of the medical record and associated medication administration records (MAR) revealed the medications were initialed as administered earlier in the morning. LPN #610 omitted the morning Buspirone 10 mg dose and proceeded to give the noon dose. Resident #4 did not receive morning dose and gave the noon dose. LPN #610 also verified no documentation was recorded in the medical record Resident #4 refused morning medications or notification of the physician regarding the missed dose of Buspirone. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/02/24 at 8:30 A.M. with the Director of Nursing (DON) during a medication review of the medical record verified rising medication times are between 7:00 A.M. and 10:00 A.M., and bedtime (HS) ranges were between 7:00 P.M.-10:00 P.M. for Resident #4. According to Medication Administration and General Guidelines Policy 2022 indicated medications are administered as prescribed in accordance with written orders of the attending physician. All current medications and dosage schedules are listed on the residents medication administration record (MAR). The person administering the medication records the administration on the MAR at the time the medication is given. Medications are administered within one hour of scheduled time, unless the physician specifies a specific time then the medication (med) must be given 30 minutes prior to or 30 minutes after the specified time. Routine medications are administered according to the established medication administration schedule for the facility. The resident's MAR is initialed by the person administering the medication. If a dose regularly scheduled medication is withheld, refused, or given at other than the scheduled time, the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for as needed (PRN) documentation.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on medical record review, observation, resident and staff interview, review of the facility policy, and review of the manufacturer guidelines of insulin administration, the facility failed to ensure medications were administered to the residents without a significant medication error. This affected one (Resident #287) of seven residents reviewed for medication administration. The facility census was 82. Findings include: Review of the medical record for Resident #287 revealed an admitted [DATE] with diagnoses of diabetes mellitus and long term insulin use. Review of the admission assessment dated [DATE] for Resident #287 revealed he was alert and oriented to person, place, time, and situation indicating he was cognitively intact. Review of the care plan initiated 04/25/24 revealed Resident #287 was care planned for diabetes with intervention to check blood sugar as ordered, resident has a dexcom continuous glucose monitoring (CGM) system. Review of the current physician orders from 04/2024 for Resident #287 revealed lispro insulin subcutaneously before meals and at bed time sliding scale for blood sugar 151-200=two units, 201-250=four units, 251-300=six units, 301-350=eight units, 351-400=ten units, and call for blood sugar less than 70 or greater than 400. Review of the Medication Administration Record (MAR) for Resident #287 revealed documentation by LPN #610 of administration of insulin sliding scale orders for the lispro insulin. Observation on 05/01/24 at 7:50 A.M. revealed Licensed Practical Nurse (LPN) #610 arrived to the room for Resident #287 and check blood sugar by way of dexcom CGM system. Resident #287 showed LPN #610 the CGM device and reported blood sugar as 185. LPN #610 left the room to gather morning medications prior to Resident #287 leaving for dialysis. Further observation revealed LPN #610 returned with a glass of water and a medication cup for morning medications (no insulin). Interview on 05/01/24 at 9:54 A.M. with Resident #287 stated he did not receive insulin that morning. Interview on 05/01/24 at 9:58 A.M. with LPN #610 verified she did not administer the prescribed lispro insulin as ordered before breakfast. LPN #610 verified she already documented the administration of the insulin on the MAR as administered. Further observation on 05/01/24 at 9:58 A.M. revealed LPN #610 obtained the lispro insulin pen from the medication cart, she attached the needle to the insulin pen for administration and she administered two units of lispro insulin to Resident #287 prior to Resident #287 leaving for dialysis. LPN #610 verified she did not prime the lispro insulin needle prior to administering the prescribed lispro insulin dose per sliding scale of two units to cover a blood sugar of 185. (continued on next page)

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Ayden Healthcare of Oregon	3953 Navarre Ave Oregon, OH 43616

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to Medication Administration and General Guidelines Policy 2022 indicated medications are administered as prescribed in accordance with written orders of the attending physician. All current medications and dosage schedules are listed on the residents medication administration record (MAR). The person administering the medication records the administration on the MAR at the time the medication is given. Medications are administered within one hour of scheduled time, unless the physician specifies a specific time then the medication (med) must be given 30 minutes prior to or 30 minutes after the specified time. Routine medications are administered according to the established medication administration schedule for the facility. The resident's MAR is initialed by the person administering the medication. If a dose regularly scheduled medication is withheld, refused, or given at other than the scheduled time, the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for as needed (PRN) documentation Review of the [NAME] Lilly and Company Lispro Manufacturer's recommendations revised 07/2023 for use for Lispro insulin kwik pen recommend priming the needle with two unit prior to administration of the intended prescribed insulin administration. The priming process removes any air bubbles and ensures insulin is in the needle prior to dialing and administering the insulin.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 44815 Based on observation, staff interview, and review of the menu portion spreadsheet, the facility failed to provide adequate protein portions for residents on a mechanical soft diet. This affected five (#15, #16, #22, #33, and #40) of six residents identified on a mechanical soft diet. The facility census was 82. Findings include: Review of the dietary menu spreadsheet for lunch on 04/30/24 revealed the portion for mechanical soft pork chop should have been six ounces. Observation during meal service on 04/30/24 beginning at 11:30 A.M. revealed Cook #553 used a size 20 scoop (equivalent to 1.52 ounces) to serve mechanical soft pork chops. Interview on 04/30/24 at 12:30 P.M. with Cook #553 confirmed some mechanical soft pork chop was leftover. Cook #553 stated it was because some residents on a mechanical soft diet chose the alternative menu option. Cook #553 confirmed he used the 20 scoop to serve mechanical soft pork to the residents on a mechanical soft diet. Interview and observation on 05/01/24 at 10:00 A.M. with Dietary Manager (DM) #569 confirmed the size 20 scoop held 1 5/8 ounces. DM #569, while reviewing the menu portion spreadsheet, confirmed the mechanical soft pork serving size should have been six ounces.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44815 Based on observations, staff interviews, and review of the facility policies, the facility failed to ensure safe food handling occurred during meal service, failed to ensure the thermometer used to check food temperatures was sanitized between food items, and failed to ensure the high-temperature dishwasher washed and/or rinsed at the proper temperatures. This affected two residents (#9 and #70) who received a cheeseburger and the potential to affect all 82 residents residing in the facility. The facility identified all 82 residents in the facility received food from the kitchen. Findings include: 1. Observation prior to meal service on 04/30/24 at approximately 11:20 A.M. revealed Cook #553 was preparing to take food temperatures. Cook #553 removed a cloth soaking in a red sanitizer bucket and wrung it out and placed it on the counter near the steam table. Cook #553 then used the cloth to wipe the thermometer, placed the cloth back on the counter, and tested the temperature of mashed potatoes. Cook #553 then picked up the cloth and wiped off the thermometer and placed the cloth back on the counter, and tested the temperature of the pork chops. Cook #553 continued to use the cloth to wipe the thermometer before testing the green beans, the pureed pork, the pureed green beans, the pureed mashed potatoes, and the mechanical soft pork. Observation on 04/30/24 at approximately 11:24 A.M. revealed Cook #553 testing the sanitation level of the water in the sanitation bucket revealed the color of the test strip remained nearly unchanged. Interview with Cook #553 at that time confirmed the test strip should have turned green to show adequate sanitizing levels of 200 parts per million (PPM). Cook #553 confirmed the test strip on 04/30/24 at approximately 11:24 A.M. revealed the liquid in the sanitizer bucket was approximately 100 PPM and further confirmed he used the cloth from that sanitizer bucket to wipe the thermometer he used to complete food temperatures. Cook #553 confirmed the test strip indicated the liquid in the sanitizer bucket was not concentrated to the required amount. Interview on 04/30/24 at 11:25 A.M. with Dietary Manager (DM) #569 confirmed the sanitizing solution should be 200 PPM and the test strip would turn green when it was at the proper concentration. Review of the policy Taking Accurate Temperatures, updated 03/07/21, revealed the thermometer should be cleaned, rinsed, sanitized and air-dried prior to use. Additionally, the thermometer should again be cleaned, rinsed, sanitized and air-dried between foods. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Observation during meal service on 04/30/24 beginning at approximately 11:30 A.M. revealed Cook #553 wearing plastic gloves and touching serving utensils, covers for the steam table, and utensil drawers while plating resident meals. Cook #553 continued to wear the same gloves and picked up a piece of cheese and placed it on a burger, and picked up the top of the bun and put it over the cheese and handed the plate to the dietary aide to put on the tray. Staff identified the cheeseburger was for Resident #9. Continued observation revealed Cook #553 continued to touch serving utensils and steam table lids before opening a package of hamburger buns, reaching into the buns with his gloved hand, placing the bun on a plate, using tongs to place a burger on the bun, then used his gloved hand to pick up a slice of cheese, place it on the burger and place the bun on top. Staff identified the cheeseburger was for Resident #70. Interview on 04/30/24 at 11:40 A.M. with Cook #553 confirmed he did not change his gloves or perform hand hygiene before touching the ready-to-eat cheese and buns for Residents #9 and #70. Interview on 05/02/24 at approximately 2:30 P.M. with Dietary Manager (DM) #569 confirmed ready-to-eat food should be touched with a clean pair of gloves. Review of the policy titled Employee Sanitary Food Practices, updated 03/07/21, revealed disposable gloves were a single-use item and should be discarded after each use and gloves must be worn if raw food was handled. 3. Observation and interview on 04/30/24 at 1:47 P.M. with Cook #553 revealed the high-temperature dishwasher had a label indicating the wash temperature should be at least 160 degrees Fahrenheit (F) and the rinse temperature should be at least 180 degrees F. Observation of the dishwasher, after running a wash cycle three times, revealed a wash temperature of 142 degrees F and a rinse temperature of 181 degrees F. Cook #553 confirmed the wash temperature did not reach the minimum temperature indicated by the label on the machine. Observation on 04/30/24 at approximately 4:40 P.M. revealed the facility served dinner using standard plates and silverware. Observation on 05/01/24 at approximately 8:00 A.M. revealed the facility served breakfast using styrofoam plates and plastic silverware. Interview and observation on 05/01/24 at 9:19 A.M. revealed an outside repair company was fixing the dish machine. The repair person stated they attempted and failed to repair the dish machine the previous evening. Interview and observation on 05/01/24 at 10:33 A.M. with Dietary Aide (DA) #548, who was actively running the dish machine, confirmed the wash temperature was 165 degrees F and the rinse temperature was 172 degrees F. Observation on 05/01/24 at approximately 1:00 P.M. revealed the facility served dishes on standard plates and silverware.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, staff interview, and review of the facility policy, the facility failed to ensure medication entries were accurately documented and contained in the medical record. This affected two of seven residents (#4 and #287) reviewed for medication administration. The facility census was 82. Findings include: 1. Review of Resident #4's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included chronic respiratory failure, anxiety, chronic obstructive pulmonary disease (COPD), chronic kidney disease, gastric esophageal reflux disease (GERD), and peripheral vascular disease (PVD). Review of Resident #4's physician's orders revealed the medications had the prescribed timeframes: 05/21/23 Cilostazol 100 milligrams (mg) given twice daily for intermittent claudication between 7:00 A.M. - 10:00 A.M. (rising) and 7:00 P.M.-10:00 P.M. (HS range), 05/21/23 Budesonide 0.5 mg per(/)2.0 milliliters (ml) inhalation vial given twice daily for COPD between 7:00 A.M. - 10:00 A.M. (rising) and 7:00 P.M.-10:00 P.M. (HS range), 11/30/23 Elliquis 5.0 mg given twice daily for heart failure and PVD between 7:00 A.M. - 10:00 A.M. (rising) and 7:00 P.M.-10:00 P.M. (HS range), 11/01/23 Gabapentin 100 mg given every morning and evening for nerve pain at 8:00 A.M. and 8:00 P.M., 05/21/23 Pantoprazole 40 mg given twice daily for GERD between 7:00 A.M. - 10:00 A.M. (rising) and 7:00 P.M.-10:00 P.M. (HS range), 03/27/24 Buspirone 10 mg given three times a day for anxiety given between 7:00 A.M. - 10:00 A.M. (rising), 11:00 A.M. -2:00 P.M. (noon), and 7:00 P.M.-10:00 P.M. (HS range). Observation on 04/30/24 at 11:32 A.M. noted Licensed Practical Nurse (LPN) #610 obtaining medications from the medication cart for Resident #4. LPN #610 proceeded to obtain the following medications: Cilostazol, Budesonide, Gabapentin, Pantoprazole, and Buspirone. LPN #610 proceeded to administer the medications to Resident #4. Interview on 04/30/24 at 11:49 A.M. with LPN #610 during review of the medical record and associated medication administration records (MAR) revealed the medications were initialed as administered earlier in the morning. LPN #610 omitted the morning Buspirone 10 mg dose and proceeded to give the noon dose. Resident #4 did not receive morning dose and gave the noon dose. LPN #610 also verified no documentation was recorded in the medical record Resident #4 refused morning medications or notification of the physician regarding the missed dose of Buspirone. 47057 2. Review of the medical record for Resident #287 revealed an admitted [DATE] with diagnoses of diabetes mellitus and long term insulin use. Review of the admission assessment dated [DATE] for Resident #287 revealed he was alert and oriented to person, place, time, and situation indicating he was cognitively intact. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the current physician orders from 04/2024 for Resident #287 revealed lispro insulin subcutaneously before meals and at bedtime sliding scale for blood sugar 151-200=two units, 201-250=four units, 251-300=six units, 301-350=eight units, 351-400=ten units, and call for blood sugar less than 70 or greater than 400. Review of the Medication Administration Record (MAR) for Resident #287 revealed documentation by LPN #610 of administration of insulin sliding scale orders for the lispro insulin. Observation on 05/01/24 at 7:50 A.M. of Licensed Practical Nurse (LPN) #610 arrived to the room for Resident #287 and check blood sugar by way of dexcom continuous glucose monitoring (CGM) system. Resident #287 showed LPN #610 CGM device and reported blood sugar as 185. LPN #610 left the room to gather morning medications prior to Resident #287 leaving for dialysis. Further observation revealed LPN #610 returned with a glass of water and a medication cup containing morning medications, pills only (no insulin). Interview on 05/01/24 at 9:54 A.M. with Resident #287 stated he did not receive insulin that morning. Interview on 05/01/24 at 9:58 A.M. with LPN #610 verified she did not give the prescribed lispro insulin as ordered verified she already documented the administration of the insulin on the MAR as administered. Review of the facility's policy titled Medical Records Procedures, revised 05/2022, revealed medical records will be accurate and complete. Review of the Medication Administration and General Guidelines Policy 2022 revealed the person administering the medication records the administration on the MAR at the time the medication is given. The resident's MAR is initialed by the person administering the medication. If a dose regularly scheduled medication is withheld, refused, or given at other than the scheduled time, the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for as needed (PRN) documentation.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 49742 Based on observations, staff interviews, and review of the facility policy, the facility failed to provide clean resident rooms. This affected four (#21, #27, #55, and #59) of four residents reviewed for environment. The facility census was 82. Findings include: 1. Observation on 04/30/24 at 8:51 A.M. revealed Resident #27 sitting in their room wearing a shirt with food on it and the floor of room was dirty and sticky and an area of dry yellowish fluid was noted under Resident #27's bed. Interview on 04/30/24 at 8:55 A.M. with Occupational Therapy Assistant (OTA) #564 verified Resident #27 was sitting in their room wearing a shirt with food on it and the floor of the room was dirty and sticky and a dried yellowish fluid was noted under Resident #27's bed. 2. Observation on 04/30/24 at 9:26 A.M. revealed the floor of the resident room, shared by Residents #55 and #59, was dirty and sticky. Subsequent observation on 04/30/24 at 2:44 P.M. revealed the floor of the resident room, shared by Residents #55 and #59, continued to be dirty and sticky. Interview on 04/30/24 at 4:05 P.M. with State tested Nursing Assistant (STNA) #507 verified the floor of the resident room, shared by Residents #55 and #59, was dirty and sticky. Review of the facility policy titled Cleaning and Disinfecting Residents' Rooms, dated August 2013, revealed housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visible soiled. 47057 3. Observation on 04/29/24 at 12:05 P.M. revealed a stool soiled and uncovered bed pan under Resident #21's bed. Resident #21 stated he used it and put it under his bed yesterday. Interview on 04/29/24 at 12:10 P.M. with State tested Nursing Aide (STNA) #551 verified the stool soiled and uncovered bed ban under Resident #21's bed. Review of the facility policy titled Quality of Life-Homelike Environment, revised 05/2017, revealed the facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting that includes a clean, sanitary, and orderly environment.

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F 0947 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 41528 Based on review of personnel files, staff interview, and review of the facility policy, the facility failed to ensure state tested nurse aides (STNAs) received twelve hours of annual training and had annual performance reviews. This had the potential to affect all 82 residents residing in the facility. Findings include: 1. Review of the personnel file for STNA #571 revealed a hire date of 04/07/22. Review of annual training the last employment year revealed from April 2023 to April 2024, STNA #571 had three trainings including over the phone survey education, fall intervention policy, and all staff training (no topics identified). No amount of time was documented on the trainings. STNA #571 did not have an annual performance evaluation. 2. Review of the personnel file for STNA #624 revealed a hire date of 02/18/19. Review of the annual training revealed in 2023, STNA #571 had three trainings including clinicomex (medical record) training, state education, and infection control. No amount of time was documented on the trainings. STNA #624 did not have an annual performance evaluation since 09/06/22. 3. Review of the personnel file for STNA #629 revealed a hire date of 02/21/22. Review of the annual training revealed in 2023, STNA #571 had four trainings including clinicomex (medical record) training, survey education, and two trainings titled nursing sign-in. No amount of time was documented on the trainings. STNA #629 did not have an annual performance evaluation since 09/30/22. Interview on 05/02/24 at 8:43 A.M. with the Administrator verified STNA #571, STNA #624, and STNA #629 did not have twelve hours of annual training in 2023 and did not have annual performance evaluations. Review of the policy titled Nurse Aide In-Service Training Program revealed all personnel are required to attend regularly scheduled in-service training classes and the facility will complete a performance review of nurse aides at least every twelve months. In-service training will be based on the outcome of the annual performance reviews. Annual in-service trainings must be no less than 12 hours per employment year.