STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365460	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Health Care Center	1735 Belmont Avenue Youngstown, OH 44504

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review the facility failed to ensure a low air loss mattress (a specialized therapeutic surface to help redistribute pressure across the body to prevent pressure ulcers) was initiated for Resident #32 as recommended per Wound Nurse Practitioner (NP) #479. This affected one (Resident #32) out of two residents reviewed for wounds. The facility identified 13 residents (#6, #7, #9, #11, #29, #30, #31, #32, #35, #36, #40, #48, #57) with wounds. The facility census was 57. Findings include: Review of medical record for Resident #32 revealed an admission date of 03/27/25 and diagnoses including diabetes, muscle wasting, chronic kidney disease, and peripheral vascular disease. Review of the Braden Scale dated 03/27/25, completed by Registered Nurse (RN) #440, revealed Resident #32 was at risk for developing pressure ulcers as she was very moist and had limited mobility. Review of Wound NP #479's progress note dated 03/27/25 revealed Resident #32 had barriers to wound healing that included immobility, malnutrition, and atrophy (muscle or tissue wasting). Wound NP #479 evaluated Resident #32, who was admitted with pressure ulcers to her left and right buttock. Wound NP #479 recommended Resident #32 to have a low air loss mattress and to be reposition every two hours. Review of the Medicare Five-Day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #32 had intact cognition. Resident #32 required total dependence of staff assistance with toileting and transfers and was unable to ambulate. Resident #32 required substantial to maximum staff assistance with rolling left and right in bed and putting or taking off footwear. Resident #32 was at risk for developing pressure ulcers and had pressures ulcers present on admission. Review of Wound NP #479's progress notes dated 04/28/25, and 05/05/25 revealed Wound NP #479 continued to recommend a low air loss mattress. Review of Wound Tracking dated 05/12/25, completed by RN/ Wound Nurse #403, revealed Resident #32 was found to have an intact non-blanchable (stays red/purple when skin pushed indicating little or no blood flow to area) purple discoloration to her left medial heel that measured two centimeters in length and two cm in width. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Wound NP #479's progress note dated 05/19/25 revealed Wound NP #479 continued to recommend a low air loss mattress. Resident #32 had a new deep tissue injury (DTI) to her left medial heel that was purple and non-blanchable. Wound NP #479 recommended to clean the wound bed, pat dry, apply skin prep (creates a protective layer on the skin to shield it from adhesive trauma, friction, and moisture damage) cover with ABD (large bulky gauze pad) and wrap with kling daily. Review of Wound NP #479's progress note dated 05/26/25 revealed Wound NP #479 continued to recommend a low air loss mattress. Review of the care plan dated 05/28/25 revealed Resident #32 was at risk for complications related to the pressure ulcer to her left heel. Interventions included administer treatments as ordered, monitor for signs of infection, instruct and assist to shift weight frequently as tolerated, and follow facility policies for the prevention and treatment of skin breakdown including use of pressure reducing mattress to bed. There was nothing in the care plan regarding a low air loss mattress. Review of June 2025 Physician Orders revealed Resident #32 had an order dated 03/27/25 for a pressure reducing mattress. She also had orders dated 04/21/25 to wear heel protectors while in bed and off load her bilateral heels with pillows while in bed. Review of Wound NP #479's progress note dated 06/02/25 revealed Resident #32's left medial pressure ulcer declined and was classified as an unstageable (full- thickness skin and tissue loss in which the extent of the tissue damage within the ulcer cannot be confirmed because it was obscured by slough (dead skin) and/or eschar). Wound NP #479 described the wound as having serosanguinous (combination of watery fluid and bloody) drainage) drainange with slough (dead tissue). Wound NP #479 changed the treatment to clean the wound bed, pat dry, apply mesalt (absorbs drainage from the wound) cut to size, apply ABD pad and wrap with Kerlix daily. Wound NP #479 continued to recommend a low air loss mattress. Review of Wound NP #479's notes dated 06/09/25 and 06/16/25 revealed Wound NP #479 continued to recommend a low air loss mattress. Observation on 06/16/25 at 4:00 P.M. and 06/17/25 at 7:26 A.M. revealed Resident #32 had a pressure reducing mattress, but it was not a low air loss mattress. Observation of wound care on 06/17/25 at 10:40 A.M. completed by RN/Wound Nurse #403 revealed the wound care was completed as ordered. RN/Wound Nurse #403 described the wound as an opened unstageable pressure ulcer with serous (clear or pale-yellow fluid) drainage that contained white slough. Resident #32 did not have a low air loss mattress in place. Interview on 06/17/25 at 10:51 A.M. with RN/Wound Nurse #403 verified Resident #32's left medial heel was opened with drainage and contained slough. RN/Wound Nurse #403 verified per Wound NP #479's weekly progress notes from 03/27/25 to 06/16/25 that Wound NP #479 recommended a low air loss mattress. RN/Wound Nurse #403 verified Resident #32 had not had a low air loss mattress since admission. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/18/25 at 10:05 A.M. with Wound NP #479 revealed she evaluated all wounds at the facility including Resident #32 weekly. Wound NP #479 verified she had recommended a low air loss mattress and that was still her recommendation as she felt it would help with wound healing and prevention especially since Resident #32 at times refused to wear her heel protectors. Wound NP #479 revealed the left medial heel was a DTI that was purple and non-blanchable but then declined to an unstageable pressure ulcer. Wound NP #479 said it was hard to say if the low air loss mattress could have prevented the DTI and/or decline as there were several other contributing factors including Resident #32 dangled her feet without elevating most of the day, and bumped into things with her feet while up but that it was possible especially with her noncompliance with the heel protectors. Review of the facility policy labeled, Pressure Ulcer Prevention and Care Protocol dated January 2025 revealed the facility would use the criteria as part of the resident's comprehensive assessment to determine risk of pressure ulcer development and development of resident's plan of care. The policy revealed all facility beds had a pressure redistribution mattress that reduced friction and shear during movement. The facility would select a surface that met the residents' needs based on risk assessment and current skin issues that could include a low air loss mattress. The policy revealed treatment of pressure ulcers would vary depending on orders from the consulting wound specialist and the nurse would carry out the treatment as ordered and implement measures to prevent pressure ulcers.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of medical record and review of facility policy the facility failed to ensure passive range of motion (PROM) and splinting restorative programs were completed per therapy recommendations. This affected two residents (#22 and #53) out of two residents reviewed for ROM. The facility identified 21 residents (#4, #6, #8, #10, #11, #12, #14, #15, #18, #19, #22, #23, #25, #26, #30, #32, #34, #35, #43, #51 and #53) with impaired ROM. The facility census was 57. Findings include: 1. Review of medical record for Resident #53 revealed an admission date of 02/14/25 and diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dementia, and heart failure. Review of physician orders and electronic task bar from 02/14/25 to 06/16/25 for Resident #53 revealed there were no orders or documentation for restorative range of motion and/or splints. Review of the Occupational Therapy (OT) Evaluation and Plan of Treatment dated 03/13/25 completed by Occupational Therapist (OT) #478 revealed Resident #53 had a cerebral infarction, muscle wasting and need for assistance with personal care. The evaluation revealed Resident #53 had impaired bilateral upper and lower range of motion and had functional limitation due to contractures to his bilateral upper hands and wrists which he had resting hand splints for. The evaluation recommended OT therapy three times a week for two weeks with a goal to safely wear his resting hand splints on his bilateral hands for up to four hours. The evaluation revealed he was wearing the splints currently less than 30 minutes. Review of the OT Discharge Summary dated 03/24/25 completed by OT #478 revealed Resident #53 was discharged from therapy and recommended a restorative PROM (passive range of motion) program with splint wearing schedule. The summary revealed upon discharge Resident #53 was safely wearing his bilateral hand splints for 30 minutes. Review of the Restorative Nursing Program Communication Form dated 03/24/25 completed by Former Occupational Therapy Assistant (OTA)/ Rehab Director #900 revealed Resident #53 was recommended a PROM to his upper and lower extremities and to be out of bed in a wheelchair three to five times a week. There was nothing on the communication form regarding bilateral hand splints. Review of the care plan dated 03/28/25 revealed Resident #53 had a self-care deficit. Interventions included therapy evaluation and treat as ordered, assisting with toileting as applicable, and encouraging to do as much as possible. There was nothing in the comprehensive care plan regarding contractures to his upper and lower extremities, PROM and/or bilateral hand splints. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #53 had impaired cognition. Resident #53 had impairment to both upper and lower extremities. Resident #53 was dependent of staff for his activities of daily living (ADLs) including toileting hygiene, bathing, rolling left and right in bed and transfers. There was no restorative ROM and splinting completed during this assessment period. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/16/25 at 10:25 A.M. revealed Resident #53 was lying in his bed, and his right hand was in a clenched position with his fingers touching the inside of his palm area in a contracted position. Resident #53's left hand also appeared to have the fingers bent towards his palm area in a contracted position. There were no splints to his bilateral hands. Observation on 06/16/25 at 3:58 P.M. revealed Resident #53 was up in a Broda chair (reclined chair on wheels), and his bilateral hands continued to be clenched with his fingers touching the inside of his palm area in a contracted position. There were no splints to his bilateral hands. Observation on 06/17/25 at 7:29 A.M. revealed Resident #53 was lying in bed and his bilateral hands continued to be clenched with his fingers touching the inside of his palm area in a contracted position. There were no splints to his bilateral hands. Observation on 06/17/25 at 8:55 A.M., 11:05 A.M. and 4:25 P.M. revealed Resident #53 continued to lay in bed with his bilateral hands clenched with his fingers touching the inside of his palm area in a contracted position. There were no splints to his bilateral hands. Interview on 06/17/25 at 11:14 A.M. with Rehab Director #477 and OT #478 verified Resident #53 had significant contractures to his bilateral hands and wrists. OT #478 verified Resident #53 was discharged on 03/24/25 from OT and it was recommended per the discharge summary that Resident #53 receive restorative nursing PROM of bilateral upper extremities and to follow with splint wearing schedule. OT #478 verified a restorative nursing program communication form was provided to nursing for a PROM program to his upper and lower extremities three to five days a week. OT #478 was unsure why the bilateral hand splints were not included in the communication form but felt it was because Resident #53 did not tolerate the splints well in therapy. OT #478 verified documentation on the discharge summary indicated Resident #53 did tolerate wearing the bilateral hand splints safely for 30 minutes and the discharge summary recommended a splint wearing schedule. Interview on 06/17/25 at 11:28 A.M. with Registered Nurse (RN)/ MDS #416 revealed she oversaw the restorative programs at the facility. RN/MDS #416 revealed therapy placed restorative communication forms in her mailbox for anyone that was to be on a program. RN/MDS #416 revealed she did not remember getting a form for Resident #53 to be on a program. RN/MDS #416 verified Resident #53 had not been receiving a PROM and/or splinting program since discharge from therapy on 03/24/25. Review of the nursing note dated 06/17/25 timed 12:35 P.M. completed by RN/ MDS #416 revealed an assessment was completed by Rehab Director #477 and noted bilateral upper and lower contractures which were present on admission. PROM was performed on all extremities and Resident #53 tolerated. The note revealed there was no change in contractures, and a PROM program was initiated. 2. Review of the medical record for Resident #22 revealed an admission date of 10/24/22 and diagnoses including cerebral infarction, muscle wasting, dementia, and diabetes. Review of the care plan dated 02/14/23 revealed Resident #22 required a PROM restorative program due to functional maintenance. Interventions included explaining procedure prior to performing exercises, providing rest periods, and stoping PROM if the resident had any signs of pain. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan dated 03/08/24 revealed Resident #22 had a restorative splinting program for contracture prevention. Interventions included explaining procedure, right hand and elbow splints for five hours per day, monitoring for redness, irritation, and/ or open areas, range of motion prior to applying and after removing the splints, and referring to therapy as ordered. Review of the Restorative Nursing Program Communication Form dated 02/20/25 completed by Former Occupational Therapy Assistant (OTA)/ Rehab Director #900 revealed Resident #22 was being discharged from OT on 02/25/25 and it was recommended to have a restorative PROM program to her bilateral upper extremities and left resting hand splint to be worn one to two hours. Review of the Occupational Therapy Discharge Summary dated 02/24/25 completed by OT #478 revealed Resident #22 had received OT therapy from 01/23/25 to 02/24/25 due to cerebral infarction, muscle wasting and need for assistance with personal care. During therapy it was documented Resident #22 had been tolerating wearing the left hand and elbow splint for one and a half hours. The summary revealed Resident #22 was referred to restorative for splint program for contractual management. Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #22 had impaired cognition and had impairments to her upper and lower extremities. Resident #22 was dependent on staff assistance with all her activities of daily living (ADLs) including toileting hygiene, bathing, rolling left and right in bed and transfers. There was no restorative range of motion and splinting completed during this assessment period. Review of the task bar per electronic record from 05/21/25 to 06/16/25 revealed Resident #22 had an order for restorative splint program that she was to wear her left hand and elbow splint for five hours per day as tolerated. There was no documentation the splint was applied on 05/23/25, 05/28/25, 05/30/25, 06/01/25, 06/05/25, and 06/10/25. There was also no documentation Resident #22 had refused. Interview on 06/17/25 at 11:14 A.M. with Rehab Director #477 and OT #478 revealed Resident #22 was discharged from OT on 02/24/25 and recommendations at that time were for a restorative splinting program to wear the left elbow and hand splint every day up to four hours. Interview on 06/17/25 at 11:28 A.M. with RN/MDS #416 revealed she oversaw the restorative programs at the facility. RN/MDS #416 revealed the facility used to have specific restorative certified nursing assistants (CNAs) that completed the restorative programs but beginning 05/01/25 there was no longer restorative CNAs; instead, the programs were to be completed per the CNAs on the floor. RN/MDS #416 revealed it had been an issue with the CNAs on the floor ensuring the programs were completed and documented appropriately as ordered. RN/MDS #416 verified Resident #22 had a restorative splinting program to wear her left hand and elbow splint for five hours per day as tolerated. RN/MDS #416 verified the communication form per Former Occupational Therapy Assistant (OTA)/ Rehab Director #900 revealed Resident #22 was to wear the splints one to two hours. RN/MDS #416 also verified per the task bar on the electronic medical record there was no documentation the program was completed six days including 05/23/25, 05/28/25, 05/30/25, 06/01/25, 06/05/25, and 06/10/25 out of the last 30 days. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy labeled, Range of Motion dated December 2022 revealed residents who had or could develop functional limitations in joint movement would be provided with active or passive range of motion to prevent further decline/ contractures and would maintain joint mobility. The policy revealed staff would document date, time, type of activity, resident participation, if any refusal of treatment and reason of refusal.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of facility policy the facility failed to ensure Resident #4's weights were obtained and the physician notified as ordered. This affected one resident (#4) out of four residents reviewed for nutrition. The facility census was 57. Findings include: Review of medical record for Resident #4 revealed an admission date of 11/20/24 and diagnoses including dysphagia, dementia, gastro-esophageal reflux disease, and hypertension. Review of weight records from 11/22/24 to 06/16/25 revealed on 11/22/24 Resident #4's weight was 119.6 pounds. The record revealed on 03/18/25 her weight was 129.6 pounds (10 pound gain from admission), on 03/23/25 her weight was 131.8 pounds (12.2 pound gain from admission), on 03/25/25 her weight was 132.8 pounds (13.2 pound gain from admission), on 04/03/25 her weight was 143.6 pounds (24 pound gain from admission), on 04/08/25 her weight was 143.4 pounds, 04/17/25 her weight was 121.2 pounds (22.2 pound weight loss in one week), 04/23/25 her weight was 121.2 pounds, 04/24/25 her weight was 121.2 pounds, on 05/01/25 her weight was 134.4 pounds (13.2 pound gain in one week), on 05/28/25 her weight was 138.2, on 06/06/25 her weight was 142.4 pounds, and 06/12/25 her weight was 139 pounds. There were entries documented per the weight record per Dietitian Tech #449 that a reweight was needed 04/02/25, 04/18/25, and 05/02/25. There was no record a weight was obtained from 05/01/25 to 05/28/25 even after a request on 05/02/25 for a reweight until 05/28/25. Review of the care plan dated 12/16/24 revealed Resident #4 had a nutritional problem related to dementia, and heart disease. Interventions included providing diet as ordered, monitoring intake, recording intake every meal, supplements as ordered, and monitoring monthly weights. There was nothing in the care plan regarding weekly weights per order and notifying physician if weight greater or less than three pounds from her admission weight. Review of Physician Significant Weight Notification dated 04/09/25 revealed Resident #4 had a six percent weight loss in one month. The notification revealed her oral intakes widely varied and she had a history of edema with diuretic therapy. The recommendation was to continue weekly weights. Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 had impaired cognition, and she ate independently. Her weight was recorded as 121 pounds, and she had weight loss that was not prescribed. Review of the Medical Nutrition Therapy Evaluation dated 05/21/25 completed by Dietitian Tech #449 revealed Resident #4's monthly weight was pending as her last weight on 04/24/25 was 121.2 pounds that triggered a significant weight loss for one month of eight percent and three month of 9.8 percent. The evaluation noted that the physician was notified, and a nutritious drink was added at breakfast for additional support. There was no mention of weekly weight not being completed as ordered. Review of the Physician Significant Weight Notification dated 05/28/25 completed by Dietitian Tech #449 revealed Primary Care Physician #475 was notified of Resident #4's significant weight gain of 15.6 percent in six months. The weight change was likely due to drinking 100 percent of nutritional supplements and good intakes. The notification recommended to follow and monitor. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of June 2025 physician orders revealed Resident #4 was on a regular diet, nutritious juice with meals, two Kcal supplement three times a day and an order dated 03/18/25 for a weekly weight and to notify the physician if greater and/or less than three pounds from admission weight. Interview on 06/17/25 at 1:27 P.M. with Dietitian #476 verified Resident #4 had an order for a weekly weight dated 03/18/25 and that the physician was to be notified if there was a three-pound gain and/or loss from her admission weight. Dietitian #476 verified there was no record a weight was obtained from 05/01/25 to 05/28/25. Dietitian #476 revealed per the record it appeared Dietitian Tech #449 had requested a reweight on 05/02/25 but that a reweight had not been completed until 05/28/25. Dietitian #476 verified Resident #4's weight on 04/24/25 was 121.2 and on 05/01/25 her weight was 133.4 (12.2 pound increase in one week). Dietitian #476 revealed notification to the physician would be by nursing since it was a physician order to notify if the resident gained or lost three pounds from admission. Dietitian #476 was unsure what weight nursing went by but verified her admission weight was 119.6 which was obtained on 11/22/24. Dietitian #476 verified Resident #4's weight increased on 05/01/25 from 133.4 to 138.2 on 5/28/25 which was a 4.8 pound gain, and then increased on 06/06/25 to 142.4 (4.2 pound increase). Dietitian #476 was unsure if the physician was notified of the weight increase as ordered as nursing would complete the notification. Interview on 06/17/25 at 2:00 P.M. with the Director of Nursing and Clinical Director #450 verified Resident #4 had an order dated 03/18/25 for a weekly weight and to notify the physician if greater and or less than three pounds from admission weight. They verified Resident #4 had no record a weight was completed from 05/01/25 to 05/28/25. They thought Dietician #476 or Dietician Tech #449 made notification regarding all weight changes including as ordered. They verified they had no further evidence the physician was notified each time the weekly weight was greater or less than three pounds from the admission weight including on 03/18/25, 04/03/25, 04/17/25, 05/01/25, 06/06/25, and 06/12/25 in which the weight was recorded greater or less than three pounds from her admission weight. Review of the facility policy labeled, Weight Protocol dated February 2025 revealed residents were to be weighed monthly or as ordered by the physician. Reweights would be completed if a five pound or greater variance was noted from the last recorded weight. Reweights would be completed within 24 to 72 hours. The nutrition clinician would send a physician significant weight notification with documentation of residents' weight changes for one, three and six months along with any recommendations. The notification was to be sent even if no recommendations were made.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on interviews, record review and facility policy review, the facility failed to provide trauma-informed care to Resident #28. This affected one resident (#28) out of three residents reviewed for trauma-informed care. The facility reported three residents (#28, #31 and #42) who had trauma related diagnoses. The facility census was 57. Findings include: Review of the medical record for Resident #28 revealed an admission date of 06/05/21 and diagnoses of dementia, major depressive disorder, anxiety disorder, intermittent explosive disorder, alcohol abuse, and post-traumatic stress disorder (PTSD). Review of a psychosocial note dated 06/11/21 revealed Resident #28 related memories of being in a fight where a jealous boyfriend hit him in the head with an object, and also being in the Vietnam War. Review of a psychosocial note dated 06/17/21 revealed Resident #28's family provided clarifying information of the resident getting beat up with a pipe at an apartment. The perpetrator was convicted and sentenced, and since the incident had some memory issues. Review of a psychosocial note dated 03/25/22 revealed Resident #28 voiced stories about being in the military and certain people triggered certain conversations. Review of a psychosocial note dated 07/19/22 revealed Resident #28 talked about what he went through in the military and the stories were very tragic. The resident voiced when seeing a person of authority then he knew it was alright to talk about what he had been through but otherwise kept so much bottled up inside. Review of a psychosocial note dated 10/04/22 revealed Resident #28 started counseling services. Review of the Minimum Data Set (MDS) screening completed on 01/02/24 revealed Resident #28 answered moderately to having repeated, disturbing memories, thoughts or images of a stressful experience from the past and feeling very upset when something reminded of a stressful experience from the past. Review of a psychosocial note dated 06/04/24 revealed Resident #28's counseling services were stopped due to the resident's declined cognition. Review of a psychosocial note dated 07/11/24 revealed Resident #28 had poor cognition and difficulty with forming sentences. The staff had to sometimes guess what the resident was trying to say. Resident #28 had a constant worried expression on the face but would follow another's lead. Review of a psychosocial note dated 10/09/24 revealed Resident #28 was getting combative during hands on care, and had progressing dementia, not always understanding staff's intentions or direction. It was believed the resident's resistance and combativeness might be from frustration. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS screening completed on 01/07/25 revealed Resident #28 answered a little bit to having repeated, disturbing memories, thoughts or images of a stressful experience from the past and feeling very upset when something reminded of a stressful experience from the past. Review of a psychosocial note dated 01/28/25 revealed Resident #28 displayed paranoia and hallucinations. Review of the care plan initiated on 06/05/21 and last reviewed on 04/28/25, revealed Resident #28 was dependent on staff for meeting emotional, intellectual, physical and social needs related to cognitive deficits. There was no reference in the care plan relevant to Resident #28's trauma including triggers and trauma-informed care. Review of the Quarterly MDS assessment completed 05/27/25 revealed Resident #28 had severe cognitive impairment and PTSD. Review of Resident #28's Kardex (patient information) for nursing assistants effective June 2025 revealed no information relevant to trauma including triggers and trauma-informed care. Review of nursing progress notes from June 2024 to June 2025 revealed no documentation relevant to Resident #28's trauma or trauma-informed care. Review of assessments for Resident #28 revealed no trauma focused assessments completed since admission. Interview on 06/17/25 at 11:09 A.M. with Licensed Practical Nurse (LPN) #406 revealed Resident #28 had behaviors including wandering, fear with personal care, and resistance during care. LPN #406 was able to identify Resident #28 as a Vietnam veteran but denied knowledge of specific trauma related care or trauma triggers. Interview on 06/17/25 at 11:15 A.M. with Certified Nursing Assistant (CNA) #466 revealed Resident #28 was resistive to care but denied knowledge of specific trauma related care or trauma triggers. Interview on 06/17/25 at 11:26 A.M. with Social Services (SS) #405 revealed there was no specific assessment related to trauma but there was a screening completed upon admission. SS #405 reported if a resident had a trauma diagnosis then psychiatric services were referred, but Resident #28 was now unable to participate in those services due to dementia. Interview on 06/17/25 at 11:40 A.M. with Registered Nurse (RN)/MDS #416 verified there was no trauma assessment used for Resident #28 but two questions for screening were completed last on 04/01/25. RN/MDS #416 reported knowing the resident was in the Vietnam War and had PTSD, but confirmed the care plan did not reflect any specific trauma related care or trauma triggers, including the Kardex because it was generated off the care plan. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy, Trauma Informed and Behavioral Health Care Policy, reviewed January 2025, revealed all residents were assessed on admission and quarterly for behavioral health and trauma related issues. The care plan was reviewed quarterly and with any significant change in condition. Interventions were updated as needed and as recommended or requested by residents, resident representatives, mental health professionals and the interdisciplinary team. The care plan included non-pharmacological interventions to address behaviors and reduce stress, triggers to avoid that would re-traumatize, behavioral health services provided, and cultural and religious preferences. The care plan included monitoring for effectiveness of the interventions with measurable goals.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, facility policy review, and review of the memorandum from the Department of Health and Human Services, the facility failed to initiate and use enhanced barrier precautions (EBP) when appropriate for Resident #32. This affected one resident (#32) out of two residents observed for use of enhanced barrier precautions. The facility identified 17 residents (#7, #14, #16, #18, #22, #29, #30, #32, #33, #35, #38, #40, #43, #52, #53, #56, and #57) on enhanced barriers. Facility census was 57. Findings include: Review of medical record for Resident #32 revealed an admission date of 03/27/25 and diagnoses including diabetes, muscle wasting, chronic kidney disease, and peripheral vascular disease. Review of the Medicare Five-Day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #32 had intact cognition, required total dependence of staff assistance with toileting and transfers, and was unable to ambulate. Resident #32 required substantial to maximum staff assistance with rolling left and right in bed and putting or taking off footwear and had pressures ulcers present on admission. Review of the Wound Tracking dated 05/12/25 completed by Registered Nurse (RN)/Wound Nurse #403 revealed Resident #32 was found to have an intact non-blanchable (stays red/purple when skin was pushed indicating little or no blood flow to area) purple discoloration to her left medial heel. Review of the care plan dated 05/28/25 revealed Resident #32 was at risk for complications related to the pressure ulcer to her left heel. Interventions included administering treatments as ordered and monitoring for signs of infection. There was nothing in the care plan regarding EBP. Review of June 2025 Physician Orders revealed Resident #32 did not have an order for EBP. Review of Wound Nurse Practitioner (NP) #479's progress note dated 06/02/25 revealed Resident #32's left medial pressure ulcer declined and was classified as unstageable (full- thickness skin and tissue loss in which the extent of the tissue damage within the ulcer could not be confirmed because it was obscured by slough (dead skin) and/or eschar). Wound NP #479 described the wound as having serosanguinous (a combination of watery fluid and blood) drainage with slough. Observation on 06/16/25 at 4:00 P.M. revealed Resident #32 had no signage and/or personal protective equipment (ppe) on or near her door indicating she was on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of wound care on 06/17/25 at 10:40 A.M. completed by RN/Wound Nurse #403 revealed she performed hand hygiene, applied gloves but no gown and proceeded to unwrap the ace wrap and dressing to Resident #32's left foot. RN/Wound Nurse #403 performed hand hygiene and applied new gloves but did not don a gown to cleanse the left medial heel with normal saline. RN/Wound Nurse #403 described the wound as an opened pressure ulcer with serous (clear or pale-yellow fluid) drainage that contained white slough. RN/Wound Nurse #403 then applied mesalt (absorbs drainage from the wound) that was cut to the size of the wound, covered with an ABD pad and wrapped with Kerlix. RN/Wound Nurse #403 then removed her gloves and performed hand hygiene. During the observation RN/Clinical Director #450, who was the infection control preventionist, was also in the room and observed the wound care but did not provide any hands-on care. Interview on 06/17/25 at 10:51 A.M. with RN/Wound Nurse #403 verified Resident #32's left medial heel was opened with drainage and contained slough. RN/Wound Nurse #403 verified Resident #32 did not have a physician order for EBP, and there was no signage in her room indicating to staff that she was on EBP. RN/Wound Nurse #403 verified that she did not follow EBP including wearing a gown during the wound care. RN/Wound Nurse #403 revealed she felt it was an oversight because at first Resident #32's wound was not opened but verified when the wound opened the facility should have obtained an order for EBP and implemented EBP during care including wound care. Interview on 06/17/25 at 2:13 P.M. with the Director of Nursing and RN/Clinical Director #450 they verified staff should have implemented EBP which would included use of a gown during Resident #32's care including wound care. Review of the memorandum, QSO-24-08-NH, entitled Enhanced Barrier Precautions in Nursing Homes, dated 03/20/24, by the Centers for Medicare & Medicaid Services, Department of Health & Human Services revealed enhanced barrier precautions were indicated for residents with wounds and/or indwelling medical devices even if the resident was not known to be infected or colonized with a multi-drug resistant organism (MDRO). The effective date for implementation of enhanced barrier precautions under the guidelines was 04/01/24. Review of facility policy labeled, Enhanced Barrier Precautions (EBP) dated November 2024 revealed EBP was an infection control intervention designed to reduce the transmission/ spread of multidrug resistant organisms. The policy revealed precautions were used in conjunction with standard precautions and expanded to the use of ppe with the donning of a gown and gloves during high contact resident care activities. Indications for EBP use included residents that had indwelling medical devices, or wounds. The policy revealed high contact care activities for which EBP was indicated included wound care and treatments. Communication to staff for the use of EBP was through EBP signage.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of the facility policy, the facility failed to utilize an effective antibiotic stewardship program that monitored antibiotic use including reducing the risk of adverse effects of the development of antibiotic resistant organisms from unnecessary or inappropriate antibiotic use. This affected 15 residents (#4, #7, #11, #19, #30, #31, #32, #33, #34, #37, #42, #49, #56, #57 and #61) out of 16 residents who were ordered antibiotics during the months of April 2025 and May 2025. The facility census was 57. Findings include: 1. Review of the Monthly Infection Log for April 2025 revealed the facility tracked residents who received antibiotics during the month. It included the resident name, admission date, onset of symptoms, the site of infection, if the infection was healthcare associated (nosocomial), the antibiotic received, and if the infection met McGeer criteria (infection surveillance definitions for long term facilities for antibiotic use). The following nine residents were identified on the log as receiving antibiotic treatment for infections but did not meet McGeer's criteria for infections: A. Resident #30 who was admitted on [DATE] received flagyl, cefepime and vancomycin for a left below the knee amputation; however, the log specified the indication for antibiotic use did not meet McGeer criteria for infections. B. Resident #11 who was admitted on [DATE] received doxycycline for pneumonia; however, the log specified the indication for antibiotic use did not meet McGeer criteria for infections. C. Resident #49 who was admitted on [DATE] received doxycycline for a urinary tract infection (UTI); however, the log specified the indication for antibiotic use did not meet McGeer criteria for infections. D. Resident #56 who was admitted on [DATE] received vancomycin and rocephin for an infection on the head; however, the log specified the indication for antibiotic use did not meet McGeer criteria for infections. E. Resident #4 who was admitted on [DATE] received doxycycline for a chronic infection of the right hip; however, the log specified the indication for antibiotic use did not meet McGeer criteria for infections. F. Resident #32 who was admitted on [DATE] received fluconazole for a UTI; however, the log specified the indication for antibiotic use did not meet McGeer criteria for infections. G. Resident #34 who was admitted on [DATE] received doxycycline and levofloxacin for a UTI; however, the log specified the indication for antibiotic use did not meet McGeer criteria for infections. H. Resident #7 who was admitted on [DATE] received cipro for a UTI; however, the log specified the indication for antibiotic use did not meet McGeer criteria for infections. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I. Resident #61 who was admitted on [DATE] received cefepime and vancomycin for a left foot infection; however, the log specified the indication for antibiotic use did not meet McGeer criteria for infections. Review of the medical records for Residents #4, #7, #11, #30, #32, #34, #49, #56 and #61 revealed there was no evidence the physician was made aware of the McGeer criteria results to evaluate for necessary and appropriate antibiotic use. 2. Review of the Monthly Infection Log for April 2025 revealed the following eight residents were identified on the log as receiving antibiotic treatment for infections but did not meet McGeer's criteria for infections: A. Resident #33 who was admitted on [DATE] received ceftin for pneumonia; however, the log specified the indication for antibiotic use did not meet McGeer criteria for infections. B. Resident #4 who was admitted on [DATE] received doxycycline for a chronic infection of the right hip; however, the log specified the indication for antibiotic use did not meet McGeer criteria for infections. C. Resident #57 who was admitted on [DATE] received ceftin for a respiratory infection; however, the log specified the indication for antibiotic use did not meet McGeer criteria for infections. D. Resident #37 who was admitted on [DATE] received acyclovir for a chronic blood infection; however, the log specified the indication for antibiotic use did not meet McGeer criteria for infections. E. Resident #19 who was admitted on [DATE] received cefdinir and flagyl for a gastrointestinal infection; however, the log specified the indication for antibiotic use did not meet McGeer criteria for infections. F. Resident #56 who was admitted on [DATE] received doxycycline for a left head infection; however, the log specified the indication for antibiotic use did not meet McGeer criteria for infections. G. Resident #42 who was admitted on [DATE] received cipro for a genitourinary infection; however, the log specified the indication for antibiotic use did not meet McGeer criteria for infections. H. Resident #31 who was admitted on [DATE] received keflex for a genitourinary infection; however, the log specified the indication for antibiotic use did not meet McGeer criteria for infections. Review of the medical records for Residents #4, #19, #31, #33, #37, #42, #56 and #57 revealed there was no evidence that the physician was made aware of McGeer criteria results to evaluate for necessary and appropriate antibiotic use. 3. Review of the medical record for Resident #11 revealed an admission date of 06/20/15 and diagnoses including quadriplegia, chronic pain syndrome, and epileptic spasms. Review of Resident #11's physician orders revealed an order dated 06/29/18 for the antibiotic cephalexin to be administered every six hours for a spinal abscess. The order had no stop date or duration for the antibiotic use. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medication administration records from June 2024 until June 2025 revealed Resident #11 received the antibiotic cephalexin as ordered. Review of the hospital record dated 11/27/13 revealed an assessment and plan for an antibiotic as Resident #11 would likely need lifelong prophylactic treatment. Review of the hospital record dated 10/14/15 revealed Resident #11 had an order for cephalexin four times daily and would receive it indefinitely due to a history of a spinal abscess. There was no McGeer criteria available for review related to this antibiotic use. Review of Resident #11's nursing and physician progress notes from 06/24/24 to 05/22/25 revealed no evidence the physician reviewed or evaluated the necessity and appropriateness for the ongoing antibiotic use. Interview on 06/17/25 at 2:14 P.M. with Clinical Director #450 and the Director of Nursing confirmed Resident #11's antibiotic order had no stop date or indication of duration and indicated the physician was aware of its ongoing use but was unable to verify or provide evidence the physician had reviewed its appropriateness or continued necessity. 4. Review of the facility policy, Antibiotic Stewardship Program, dated November 2017 revealed the infection preventionist monitored and supported antibiotic stewardship activities, and the Director of Nursing (DON) conveyed expectations to nursing staff and set practice standards for assessing, monitoring and communicating change in resident condition by front line nursing staff. The facility followed McGeer criteria for identification of infections and tracked how and why antibiotics were prescribed, how often and the number of antibiotics prescribed, and adverse outcomes if any from antibiotic use. Antibiotic use, tracking and trending was compiled monthly and results reported to infection control committee and quality assurance team. Clinicians, nursing, staff, residents and families were provided with antibiotic stewardship education. Every dose, duration, route and indication of every antibiotic was documented in the medical record and reviewed monthly to assess compliance. Providers utilized the assessment criteria when considering antibiotic use. There was no evidence on the facility policy of its annual review. Interview on 06/17/25 at 8:54 A.M. with Clinical Director (CD) #450, who was the infection preventionist, verified the above findings. CD #450 confirmed McGeer's criteria was not assessed for any residents who had chronic infections or came from the hospital but were noted on the infection log as not meeting criteria. If a resident was involved with an infection disease specialist, then McGeer's was not completed. Instead, orders were followed and any follow-up completed. The facility did not get involved with assessing or determining appropriateness or necessity of antibiotic use unless the infection started in the facility. CD #450 denied getting involved with any physicians outside of the facility because of being able to communicate with the facility physician, as other physicians were difficult to reach. CD #450 reported talking with the facility physician about antibiotic use but was unable to confirm or provide evidence for reviewing McGeer criteria for the residents unless it was reflected in a progress note. CD #450 stated the facility physician had a tendency to order antibiotics as did the hospitals. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/17/25 at 10:56 A.M. with the DON verified being a participant in staff training and confirmed there was no known staff training on antibiotic stewardship. The DON confirmed they lacked documentation for the assessment and evaluation of the necessity and appropriateness for ongoing antibiotic use. During interview on 06/17/25 at 2:14 P.M. with CD #450 and the DON, the DON indicated the antibiotic stewardship policy was reviewed annually despite the policy date being November 2017 but was unable to provide evidence of the last annual review.