STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365474	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Carroll	3680 Dolson Court NW Carroll, OH 43112

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on observation, interview, medical record review, and policy review, the facility failed to ensure residents who were dependent on staff for assistance received turning and repositioning and transferring to a char as ordered by the physician. This affected one (Resident #59) of two residents reviewed for positioning. The facility census was 96. Findings include: Review of the medical record for Resident #59 revealed an admitted [DATE]. Medical diagnoses included cerebral palsy, hydrocephalus, speech disturbances, contractures of muscle, dysphasia, cognitive communication deficit, and congenital deformities of skull, face and jaw. Review of the care plan dated 10/30/23 revealed Resident #59 had activities of daily living self-care performance deficit related to cerebral palsy, cognitive impairment, and an impaired ability to communicate. Listed interventions included placing the resident in a chair from 10 A.M. to 2 P.M. daily and encouraging participation in activities. The care plan also indicated Resident #59 was at risk for impaired skin integrity due to being confined to a chair most of the time, impaired cognition, bladder and bowel incontinence, need for assistance with daily living activities, and preventive tube feed site dressing. Interventions included turning and repositioning as needed, as well as encouraging the resident to reposition himself if able. Review of Resident #59's physician orders revealed an order dated 01/12/24 which stated Resident #59 was to remain in a chair from 10 A.M. to 2 P.M. daily and engage in activities. A follow-up order dated 10/31/24 instructed staff to turn and reposition Resident #59 every two hours. Review of the Minimum Data Set (MDS) 3.0 assessment completed 09/02/24 revealed Resident #59 was severely cognitively impaired, fully dependent on staff for all daily activities, and at high risk for developing pressure ulcers/injuries. Review of the Braden Scale for predicting pressure sore risk, dated 11/19/24, revealed Resident #59 had very limited sensory perception, was occasionally moist, chairfast, completely immobile, with adequate nutritional intake and potential for friction and shear. These factors indicated a moderate risk for skin impairments. Review of the task labeled turn and reposition every two hours and as needed (PRN) revealed on 12/11/24, Resident #59 was documented as being turned at 12:56 A.M., 1:59 P.M., and 8:33 P.M. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 12/11/24 at 11:43 A.M. of Resident #59 revealed the resident was awake and lying in bed. He was positioned with his knees pointed toward the wall, and his legs were bent, with the right leg on top of the left. He was wearing socks on both feet, but his heels were not elevated off the bed. The resident was not covered with a blanket. A specialized chair was present in the resident's room. The specialized chair had a lap tray positioned directly over the top of the seat. The lap tray contained a small amount of clutter on the top of the tray. Observation on 12/11/24 at 1:42 P.M. and 3:01 P.M. revealed Resident #59 remained in the same position in the bed as observed at 11:43 A.M. The specialized chair and lap tray remained in the same location in the resident's room. The clutter on the top of the tray remained unchanged. Observation on 12/11/24 at 4:12 P.M. of Resident #59 revealed both of his socks had been removed, he had been covered up with a blanket, and his legs were propped up on a pillow. His body position remained unchanged from the prior observations at 11:43 A.M, 1:42 P.M., and 3:01 P.M. Interview on 12/11/24 at 4:15 P.M. with Certified Nursing Assistant (CNA) #75 confirmed Resident #59 required assistance with turning and needed to be repositioned every two hours. She explained CNAs were not allowed to perform this task because the resident has a tube feed. CNA #75 clarified the nurse assigned to the resident was responsible for turning him. CNA #75 confirmed she had not transferred Resident #59 to his specialized chair nor had she turned him every two hours during her shift. Interview on 12/11/24 at 4:17 P.M. with Licensed Practical Nurse (LPN) #65 confirmed Resident #59 required assistance with turning, and both CNAs and nursing staff were responsible for repositioning Resident #59 every two hours. LPN #65 stated she had recently entered Resident #59's room to remove the resident's socks and apply lotion but was unable to recall when he was last turned before adjusting his legs. LPN #65 confirmed physician orders specified the resident should be placed in the chair from 10 A.M. to 2 P. M. daily and repositioned every two hours. She noted CNAs do not have direct access to physician orders but can read the care plan. Observation on 12/11/24 at 5:33 P.M. of Resident #59 showed he had been repositioned since the prior observation. Resident #59 was positioned on his left side, with his knees bent and left leg positioned above his right leg. Subsequent review of Resident #59's medical record revealed the task labeled turn and reposition every two hours and PRN on 12/11/24 at 5:35 P.M. revealed the resident's recent repositioning had not been documented in his medical record. Interview on 12/12/24 at 12:36 P.M. with the Administrator and Director of Nursing (DON) confirmed Resident #59's medical record lacked evidence to indicate the resident was regularly repositioned every two hours or placed in his chair between 10 A.M. and 2 P.M.as ordered. Review of the turning and repositioning policy, dated 01/01/22, revealed all residents at risk of pressure injuries should be turned and repositioned every two to four hours. This task is primarily the responsibility of nursing assistants, though all nursing staff are expected to assist. The routine turning schedule involves alternating between side-lying and back positions, rotating between the right side, back, and left side.

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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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on interview, record review, and review of facility policy the facility failed to ensure a referral to an ophthalmologist for cataract surgery was made for Resident #17. This affected one resident (#17) of two residents reviewed for communication and sensory. The facility census was 96. Findings include: Review of Resident #17's medical record revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, depression, anxiety, myasthenia gravis, dysphagia, personality disorder, and chronic respiratory failure. Review of Resident #17's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she had intact cognition. Review of Resident #17's plan of care dated 10/31/23 revealed the resident was at risk for visual impairment related to age, diabetes, and myasthenia gravis. Interventions included administering medications and treatments as ordered, arranging a consultation with the eye care provider as needed, encouraging the resident to wear glasses, and assist with applying glasses as needed. Review of Resident #17's note dated 07/23/24 from the eye care group revealed the eye doctor's plan for the resident included a recommendation for cataract survey through a ophthalmology consult. Review of Resident #17's medical record from 07/23/24 to 12/09/24 revealed no evidence a referral was made to ophthalmology. Interview on 12/09/24 at 12:38 P.M. with Resident #17 revealed she had seen the eye doctor that morning and he had told her the facility was supposed to have followed up to help her get cataract surgery. Interview on 12/11/24 at 3:00 P.M. with the Director of Nursing (DON) verified there had been a recommendation for a referral that was not completed. Review of the policy 'Hearing and Vision Services' dated 10/30/23 revealed once vision or hearing services have been identified the resident was to be assisted in making appointments and arranging for transportation if needed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review, staff interview, facility fall investigation reports, and facility policy review, the facility failed to develop and implement timely interventions after a resident fall. This affected one (Resident #1) of three residents reviewed for falls. The facility census was 96. Findings Include: Resident #1 was admitted to the facility on [DATE]. Her diagnoses were conversion disorder, intellectual disabilities, aneurysm of heart, hypertension, hyperparathyroidism, chronic obstructive pulmonary disease, lack of coordination, dysphagia, dementia, major depressive disorder, spondylosis, muscle weakness, cognitive communication deficit, difficulty walking, osteoarthritis, hypothyroidism, osteoporosis, and hypertensive heart disease. Review of Resident #1's Minimum Data Set (MDS) assessment, dated 11/18/24, revealed she had a mild cognitive impairment. Review of Resident #1 fall investigation, dated 09/30/24, revealed she attempted to go to the bathroom independently, and fell between the toilet and the wall. Review of the fall investigation report and summary revealed the interventions put in place were replacing the non-skid strips in the bathroom and continued reminders and education on unassisted transfers and toileting. Review of Resident #1 fall investigation, dated 11/08/24, revealed she attempted to go to the bathroom and fell in between the wall and the toilet. Review of the fall investigation report and summary revealed the intervention put in place was education to Resident #1 to use the call light both before and after using the toilet. Review of Resident #1 fall and incident investigation records and care plans, dated 09/30/24 to 11/15/24, revealed there were no other interventions put in place to reduce the likelihood of Resident #1 going to the bathroom independently or performing tasks in the bathroom without staff assistance. The only intervention to assist with preventing Resident #1 going to the bathroom independently, was educating her about asking for assistance prior to going. Interview with the Director of Nursing (DON) on 12/12/24 at 8:06 A.M. confirmed they have tried to educate Resident #1 about asking for help and educating staff to watch for signs Resident #1 exhibits when she is going to the bathroom. One sign that Resident #1 needs to go to the bathroom is when she wheels her chair into her room; staff should be aware of this. The DON stated Resident #1 spent most of her time in the hall and common areas. Interview with Certified Nursing Aide (CNA) #70 on 12/12/24 at 12:22 P.M. confirmed they are to check on Resident #1 every two hours to see if she needs to go to the bathroom. She confirmed she is aware that Resident #1 will go to the bathroom on her own; they try to catch her before she gets up or remind her to use her call light, but those are the interventions they have in place. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy Fall Prevention Program, dated 10/26/23, revealed each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. Interventions will be monitored for effectiveness and the plan of care will be revised as needed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 49039 Based on record review, interview, and facility policy review, the facility failed to ensure dietician recommendations were implemented timely and orders were followed. This affected 2 (Residents #12 and #74) of six residents reviewed for nutrition. The facility census was 96. Findings Include: 1. Review of the medical record for Resident #12 revealed an admitted [DATE]. Medical diagnoses included chronic kidney disease, dysphasia, muscle weakness, major depressive disorder, cognitive communication deficit, anemia, gastro-esophageal reflux disease (GERD) and unspecified psychosis. Review of Resident #12's care plan dated 10/31/23 revealed the resident was at risk for altered nutritional status related to therapeutic diet, and medical diagnosis that include hypertension, peripheral vascular disease, depression, cognitive communication deficit, anemia, and GERD. A listed goal included for Resident #12 to receive and tolerate his diet, and to maintain weight with no further significant changes. Care planned interventions included to periodically obtain the resident's weight, evaluate, and report to dietician, provider, and responsible party any significant weight changes. Review of Resident #12's Minimum Data Set (MDS) 3.0 quarterly assessment completed 09/19/24 revealed the resident was moderately cognitively impaired, was independent with activities of daily living including eating, was on a mechanically altered and therapeutic diet. Review of Resident #12's physician orders revealed an order dated 10/27/24 for weekly weight to be obtained in the morning every Sunday for weight monitoring. Resident #12 also had an order dated 09/11/24 for a diet of NAS (No Added Salt) diet, Level 3 texture, Regular fluid, thin consistency and fortified pudding with lunch and dinner. Review of Resident #12's weight summary revealed weekly weights were completed on 10/28/24, 11/03/24, 11/30/24, and 12/01/24. There was no recorded weekly weights for 11/10/24, 11/17/24, or 11/24/24, or 12/08/24. Interview on 12/11/24 at 4:03 P.M. with the Director of Nursing (DON) confirmed nursing staff did not obtain Resident #12's weights as ordered. 2. Review of the medical record for Resident #74 revealed an admitted [DATE]. Medical diagnoses included schizophrenia, major depressive disorder, anxiety, GERD, dysphasia and chronic kidney disease. Review of Resident #74's MDS 3.0 quarterly assessment completed 10/14/24 revealed the resident was cognitively intact, required setup/clean-up assistance with meal service and was on a therapeutic diet. (continued on next page)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Standards of Care Meeting dated 11/05/24 revealed the interdisciplinary team met to review Resident #74 weight loss and noted the resident had lost 6.9% of her body weight in one month. Resident #74 received 90 milliliters (ml) Med Pass (liquid nutritional supplement) three times per day, and the note indicated the Med Pass supplement was to be increased to 120 ml three times a day and Resident #74 would be placed on weekly weight monitoring. Review of Resident #74's progress notes dated 11/06/24 revealed the interdisciplinary team met regarding Resident #74's weight loss. The note indicated a new order was received to increase Med Pass supplement to 120 ml three times a day and to obtain weekly weights for four weeks. Review of Resident #74's physician orders revealed an order dated 07/04/24 for Med Pass 90 ml three times a day for nutritional supplement. Resident #74 had an order dated 11/10/24 for weekly weights for four weeks, to be completed on day shift every Sunday. An order dated 12/09/24 indicated Resident #74 required a regular diet with level 3 texture, and thin/regular liquid consistency. Review of Resident #74's weight summary revealed weights were taken on 11/03/24, 11/18/24, 11/24/24, 12/02/24 and 12/08/24 with weight gain. There was no recorded weekly weight for 11/10/24 which created a 15 day gap in weight tracking. Interview on 12/11/24 at 4:03 P.M. with the DON confirmed nursing staff did not obtain Resident #74's weights as ordered on 11/10/24. The DON additionally confirmed staff did not modify the residents order for Med Pass supplement to increase the amount to 120 ml three times a day. Review of the policy Weight Monitoring, dated 10/26/23, revealed a weight monitoring schedule will be created upon admission for all residents, with those experiencing weight loss being monitored on a weekly basis. Interventions will be identified, implemented, and regularly assessed and adjusted based on the resident's assessed needs, preferences, goals, and current professional standards to ensure the maintenance of an acceptable nutritional status.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50536 Based on interview, record review, and facility policy review, the facility failed to ensure residents received trauma-informed care that accounted for the resident's experiences and preferences in order to minimize or eliminate triggers that may cause re-traumatization of the residents. This affected two residents (#73 and #43) of two residents reviewed for trauma informed care. The facility census was 96. Findings include: 1. Review of Resident #73's medical record revealed an admitted [DATE]. Medical diagnoses included fracture of the left radius, chronic obstructive pulmonary disease, systemic lupus, major depressive disorder, muscle weakness, dysphasia, cognitive communication deficit, and post traumatic stress disorder (PTSD). Interview on 12/09/24 at 10:55 A.M. with Resident #73 confirmed that she had witnessed a family suicide, and was triggered by gun shots and loud noises. Resident #73 stated she had not been involved in care planning related to her PTSD diagnosis, but she used coloring and crafting as non-pharmacological coping methods to manage her mood. Interviews on 12/10/24 at 1:26 P.M. and 1:45 P.M. with Social Services Director (SSD) #48 confirmed upon admission, an initial social service assessment was completed for all residents. If a resident had identified triggers, the care plan was built around those triggers. SSD #48 was unaware of the nature and source of Resident #73's PTSD, and stated that no triggers had been reported or identified. Review of Resident #73's Initial Social Service History assessment dated [DATE] revealed the resident had a brief interview for mental status (BIMS) score of 15 (indicating intact cognition). Resident #73 was documented as having experienced a frightening, horrible, or traumatic event, such as, a loved dying through homicide or suicide. Resident #73 was documented as trying hard not to think about the event, was constantly on guard, and was easily startled. Review of Resident #73's Behavior Management Monthly Note dated 10/01/24, 10/30/24, and 11/27/24 revealed the resident had behavior-related diagnoses of bipolar disorder, major depressive disorder, anxiety, PTSD, and schizoaffective disorder. Resident #73 was documented as having no known triggers on all three documents. Review of Resident #73's PTSD care plan, revised 09/18/24, revealed the resident had impaired mood/psychiatric status related to depression, anxiety, bipolar disorder, PTSD, and schizoaffective disorder. The listed goal was for Resident #73 to remain free of signs and symptoms of depression, anxiety, or sad mood. Care planned interventions included to administer medications and treatments as ordered, assist Resident #73 to cope by discussing possible solutions to conflict, behavioral health consultations as needed, and encourage on-going involvement with family and friends. 49039 (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #43 revealed an admitted [DATE]. Medical diagnoses included schizophrenia, chronic pain syndrome, bipolar disorder, anxiety, PTSD, and impulsiveness. Review of Resident #43's Minimum Data Set (MDS) 3.0 quarterly assessment completed 11/05/24 revealed Resident #43 was moderately cognitively impaired, exhibited verbal behavioral symptoms towards others, and rejection of care four to six days of the week. Review of diagnoses coded on the assessment revealed psychiatric/mood disorders of anxiety, depression, bipolar disorder, schizophrenia, and PTSD. Review of Resident #43's care plan dated 09/06/23 revealed the resident had impaired mood/psychiatric status related to schizophrenia, depression, anxiety, bipolar disorder, PTSD, and insomnia. Interventions included administering medications and treatments, assisting the resident to cope by discussing possible solutions to conflict, behavioral health consults, observing for and reporting any signs and/or symptoms of changes in mood or acute psychosis from the resident's baseline, and observing mood to determine if problems appear to be related to external causes. Review of Resident #43's progress notes revealed a note dated 08/11/24 which stated the resident was noted to be agitated and yelling at beginning of shift and was medication-seeking. Review of Resident #43's two-week psychiatry follow-up note dated 08/15/24 revealed the provider re-evaluated the patient for a history of schizoaffective disorder, anxiety, PTSD, and dementia. Resident #43 reported situational irritability and was noted to have tolerated medication changes since the last session. Resident #43 remained at baseline for mood and behaviors. Anxiety remained at baseline, with no new or worsening symptoms reported. The note indicated there was no reports of depression, PTSD, aggression, irritability, or agitation. Review of Resident #43's progress notes revealed a note dated 08/28/24 which stated the resident was observed to be yelling at staff that morning. Review of Resident #43's Social Service Progress Review dated 05/08/24 revealed the resident was oriented, had no memory issues, and was independent with daily decision-making. She had a diagnosis of PTSD, with PTSD symptoms noted as being managed effectively, with no mention of any known triggers. Interview on 12/10/24 at 1:50 P.M. with Social Services Director (SSD) #48 confirmed Resident #43 has a current diagnosis of PTSD with no mention of triggers in the care plan or attempts to identify the triggers. SSD #48 confirmed the care plan does not include information pertinent to the treatment of PTSD, and therefore, she is unable to confirm symptoms are being managed effectively if the triggers are not identified. Review of a policy Trauma Informed Care dated 10/24/22 revealed the facility would ensure residents who are trauma survivors received culturally competent, trauma-informed care in accordance with professional standards of practice. The facility will account for residents' experiences, preferences, and cultural differences to eliminate or mitigate triggers that may cause re-traumatization of the resident. The facility care plans will be initiated and updated to address those residents identified. Individualized approaches will be identified, and interventions will be put into place.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on interview, record review, and policy review, the facility failed to ensure as-needed controlled medications were recorded on the Medication Administration Record (MAR) when administered. This affected one resident (Resident #81) of two residents reviewed for pain management. The facility census was 96. Findings include: Review of Resident #81's medical record revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, neuromuscular dysfunction of the bladder, anxiety disorder, osteomyelitis, cognitive communication deficit, depression, colostomy status, and resistance to vancomycin. Review of Resident #81's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. Review of Resident #81's plan of care dated 02/23/24 revealed Resident #81 was at risk for pain related to comorbidities. Interventions included but were not limited to administering medications as ordered, offering non-pharmacological interventions to relieve pain, and observing for effectiveness. Review of Resident #81's physician orders from 11/11/24 to 12/08/24 revealed an order for Oxycodone (a controlled, narcotic analgesic) 5 milligrams (mg), give two tablets by mouth every four hours as needed for pain. The order specified nonpharmacological interventions were to be attempted prior to medication administration. Reconciliation of Resident #81's MAR and Controlled Drug Receipt Record (CDRR) for November 2024 revealed the following discrepancies related to oxycodone: - 11/02/24 - four doses were signed out on the CDRR, and two doses recorded on the MAR - 11/05/24 - four doses were signed out on the CDRR, and two doses were recorded on the MAR - 11/06/24 - three doses were signed out on the CDRR, and two doses were recorded on the MAR - 11/09/24 - six doses were signed out on the CDRR, and three doses were recorded on the MAR - 11/13/24 - five doses were signed out on the CDRR, and three doses were recorded on the MAR - 11/23/24 - four doses were signed out on the CDRR, and two doses were recorded on the MAR - 11/24/24 - four doses were signed out on the CDRR, and three doses were recorded on the MAR - 11/25/24 - four doses were signed out on the CDRR, and two doses were recorded on the MAR (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 11/27/24 - four doses were signed out on the CDRR, and three doses were recorded on the MAR Reconciliation of Resident #81's MAR and CDRR from 12/01/24 to 12/08/24 revealed the following discrepancies related to oxycodone: - 12/04/24 - three doses were signed out on the CDRR, and two doses were recorded on the MAR - 12/07/24 - four doses were signed out on the CDRR, and two doses were recorded on the MAR - 12/08/24 - five doses were signed out of the CDRR, and four doses were recorded on the MAR. Interview on 12/11/24 at 3:42 P.M. with the Director of Nursing (DON) verified nursing staff had not documented in the MAR all administrations of Resident #81's Oxycodone.

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Arbors at Carroll	3680 Dolson Court NW Carroll, OH 43112

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on interview and medical record review the facility failed to ensure medication parameters were in place and followed for Resident #34, #69, and #79, who received blood pressure medication. This affected three residents (#34, #69, and #79) of six residents who were reviewed for medication administration. The facility census was 96. Findings include: 1. Review of the medical record for Resident #69 revealed an admitted [DATE] with diagnoses including cerebral infarction, type two diabetes mellitus, acute respiratory failure, osteomyelitis, cognitive communication deficit, anxiety disorder, osteoarthritis, and hypertension. Review of Resident #69's quarterly Minimum Data Set (MDS) 3.0 dated 11/22/24 revealed he had intact cognition. Review of Resident #69's plan of care dated 07/17/24 revealed the resident had impaired cardiovascular status related to hyperlipidemia and hypertension. Interventions included observing and reporting to the physician any signs of hypertension, administering medications as ordered, and observing vital signs as needed. Review of Resident #69's physician order dated 11/16/24 revealed an order for Metoprolol Tartrate (an antihypertensive) 25 milligrams (mg) one tablet by mouth every morning and at bedtime related to hypertension. There were no parameters for holding the medication Review of Resident #69's Medication Administration Record (MAR) from 12/01/24 to 12/08/24 revealed the resident's Metoprolol medication was held on 12/01/24 for a blood pressure of 94/54 mmHg, twice on 12/02/24 for a blood pressure of 102/59 mmHg and 98/61 mmHg, on 12/05/24 for a blood pressure of 110/57 mmHg and 106/61 mmHg, on 12/06/24 for a blood pressure of 96/54 mmHg, and on 12/08/24 for a blood pressure of 110/48 mmHg. His medication was not held on 12/03/24 for a blood pressure of 106/68 mmHg and on 12/09/24 for a blood pressure of 107/58 mmHg. His blood pressure was not recorded as assessed on 12/03/24, 12/04/24, 12/07/24, and 12/08/24. Review of Resident #69's progress notes dated 12/01/24 to 12/08/24 revealed no indication the physician was notified the medication was held. Interview on 12/12/24 at 9:09 A.M. and 9:12 A.M. with the Director of Nursing (DON) verified nursing was holding Resident #69's blood pressure medications without parameters and without notifying the physician. She reported blood pressure parameters should be in place. The DON indicated the medication should be held for a systolic blood pressure reading below 110 mmHg and/or a diastolic blood pressure reading below 60 mmHg. 2. Review of Resident #34's medical record revealed an admitted [DATE] with diagnoses including end stage renal disease with dependence on renal dialysis, type two diabetes mellitus, chronic obstructive pulmonary disease, psychosis, and cognitive communication deficit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #34's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she had intact cognition. Review of Resident #34's physician order dated 11/26/24 revealed an order for carvedilol (an antihypertensive) one tablet twice a day for high blood pressure. The medication was to be held prior to dialysis on Monday, Wednesday, and Friday. Review of Resident #34's MAR for 12/02/24 to 12/11/24 revealed carvedilol was not held prior to dialysis on 12/02/24, 12/04/24, 12/06/24, and 12/11/24. Interview on 12/12/24 at 9:09 A.M. with the Director of Nursing (DON) verified Resident #34's carvedilol was not held as ordered. 49039 3. Review of the medical record for Resident #79 revealed an re-admitted [DATE] with diagnoses of chronic kidney disease, type two diabetes mellitus, atrial fibrillation, essential hypertension, pain and venous insufficiency. Review of Resident #79's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he was cognitively intact and had hypertension. Review of Resident #79's care plan dated 10/31/24 revealed he had impaired cardiovascular status related to angina/chest pain, coronary artery disease, hyperlipidemia/hypercholesteremia, hypertension, obesity, and pacemaker placement. Listed interventions include labs/diagnostic testing as ordered, administering medications as ordered, observing for side effects and reporting to the physician, and observing vital signs as needed. Review of Resident #79's physician orders dated 09/06/24 revealed the resident received isosorbide mononitrate (a nitrate used to prevent chest pain and lower blood pressure) extended release 30 mg by mouth in the morning related to hypertension, nifedipine (an antihypertensive) extended release oral tablet 30 mg every morning related to hypertension, and carvedilol 3.125 mg every morning and bedtime related to hypertension. Review of Resident #79's MAR for 12/01/24 to 12/10/24 revealed no hold parameters were in place for the resident's ordered isosorbide mononitrate, nifedipine, and carvedilol. Resident #79 was listed as having received his ordered dose of carvedilol on the evening of 12/02/24 with a blood pressure result of 105/66 mmHg, on the morning of 12/03/24 with a blood pressure result of 108/62 mmHg, on the evening of 12/03/24 with a blood pressure result of 93/53 mmHg, on the morning of 12/04/24 with a blood pressure result of 108/92 mmHg, on the evening of 12/06/24 with a blood pressure result of 96/90 mmHg, on the evening of 12/09/24 with a blood pressure result of 102/72 mmHg, and on the evening of 12/10/24 with a blood pressure result of 107/64 mmHg. Review of Resident #79's progress notes dated 12/02/24 and 12/08/24 revealed carvedilol was held due to low blood pressure, but neither note indicated the physician had been notified. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #79's updated physician orders dated 12/12/24 revealed the resident's orders for carvedilol and nifedipine received parameters to hold if the systolic blood pressure reading below 110 mmHg and/or a diastolic blood pressure reading below 60 mmHg. Interview on 12/12/24 at 08:49 AM with Licensed Practical Nurse (LPN) #45 revealed nursing has parameters to hold the medication. The parameter is located in the medical record next to hypertension, stating (I10), which meant to hold the blood pressure medications if the blood pressure is under 110. LPN #45 was asked to clarify what the first digit next to hypertension was, and LPN #45 confirmed it was an I and not a 1 and stated the I must have been an error. LPN #45 confirmed some of the administrations on Resident #79's MAR were not held when the blood pressures were under 110. LPN #45 confirmed the residents' medication orders did not include specific parameters written in or in any additional areas. LPN #45 stated if Resident #79's systolic blood pressure is lower than 110, she is required to hold the medication and notify the physician, which should be documented in the resident's medical record. Interview on 12/12/24 at 09:08 AM with the DON confirmed all residents who receive blood pressure medications should have parameters to hold the medication if the systolic blood pressure is less than 110 mmHg and/or the diastolic blood pressure is less than 60 mmHg. The DON verified the nursing staff is also required to notify the physician of low blood pressure readings and medications which have been held.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on interview, medical record review and review of facility policy, the facility failed to complete laboratory testing as ordered by the physician for Resident #81. This affected one resident (#81) of two residents reviewed for hydration. The facility census was 96. Findings include: Review of Resident #81's medical record revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, neuromuscular dysfunction of the bladder, anxiety disorder, osteomyelitis, cognitive communication deficit, depression, colostomy status, and resistance to vancomycin. Review of Resident #81's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition. Review of Resident #81's laboratory results dated [DATE] revealed her potassium was high at 5.6 milliequivalents (mEq) per liter (L). Review of Resident #81's progress note dated 12/4/24 revealed her potassium was 5.6 mEq/L on her laboratory results. The Certified Nurse Practitioner (CNP) gave an order for Kayexalate (a medication used to lower the amount of potassium in the blood) and to repeat lab orders on 12/05/24. Review of Resident #81's medical record revealed her next labs were drawn on 12/10/24. Interview on 12/11/24 at 8:18 A.M. with the Director of Nursing (DON) verified Resident #81's labs were not redrawn on 12/05/24 as ordered by the CNP.