STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365488	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare of Toledo	4420 South Avenue Toledo, OH 43615

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, resident and staff interview, and facility policy review, the facility failed to ensure the facility environment was maintained in a safe and sanitary manner. This affected five (#35, #36, #43, #46, and #47) of five residents reviewed for physical environment. The census was 61. Findings include: 1. Review of the medical record noted Resident #36 was admitted to the facility on [DATE] with the diagnoses including epilepsy, extended spectrum beta lactamase resistance, type II diabetes mellitus, hypertension, acute kidney failure, anxiety disorder, hypothyroidism, muscle wasting and atrophy, and dysphagia. Review of the current Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #36 with moderately impaired cognition, and the resident required partial to moderate assist with activities of daily living including toileting, and was frequently incontinent of bowel and bladder. Observation on 08/12/24 at 11:15 A.M. noted Resident #36 room with a strong urine odor. A four-foot section of drywall at the baseboard next to the shower was pealing paint, at the room entry a five-foot section of wall was identified with paint removed and exposed drywall, and at the head of the bed were large gouges were discovered in the wall with drywall exposed. On 08/12/24 at 11:20 A.M. observation with Licensed Practical Nurse (LPN) #446 verified Resident #36's room condition. Observation and interview on 08/15/24 at 8:42 A.M. with Maintenance Director (MD) #406 confirmed Resident #36's room condition. 2. Observation on 08/13/24 at 9:28 A.M. in Resident #43's room identified a foul odor and two soiled incontinence briefs were placed on the floor next to the bed with soiled clothing and linen. The room floor had scattered debris throughout. Located inside the bathroom discovered two soiled towels on the floor next to the toilet with brown stains, soiled toilet paper with a brown substance on floor next to the toilet, and the toilet seat also with a brown substance. (continued on next page)

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

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/13/24 at 10:32 A.M. interview with Housekeeper #495, during observation, verified the condition of Resident #43's room. Housekeeper #495 stated the room was frequently discovered in soiled condition when attempting to complete daily housekeeping. 3. Review of the medical record noted Resident #35 admitted to the facility on [DATE] with the diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left side, coronary artery disease, chronic obstructive pulmonary disease, type II diabetes mellitus, cardiomyopathy, hypertension, major depression, vascular dementia, muscle wasting and atrophy, and congestive heart failure. Review of the most current MDS assessment dated [DATE] assessed Resident #35 with moderate cognitive impairment, and was dependent on staff for the completion of activities of daily living including bed and wheelchair mobility. Observation on 08/13/24 at 11:47 A.M., 12:09 P.M., and 1:21 P.M., and on 08/14/24 at 12:20 P.M. and 3:09 P.M. discovered Resident #35 seated in a wheelchair. The chair was not equipped with an armrest pad to the left side and Resident #35's left arm was resting on a thin pipe without padding. On 08/14/24 at 12:20 P.M. interview with State tested Nurse Aide (STNA) #454 verified no arm rest was applied to the left side of Resident #35's wheelchair, and STNA #454 was unaware the armrest was missing. 4. Review of the medical record for Resident #46 revealed an admitted d of 06/10/22. Interview on 08/12/24 at 12:59 P.M. with Resident #46 stated her room air conditioning unit had dirt inside the cover. Observation of Resident #46's room on 08/12/24 at 12:59 P.M. revealed the air conditioning unit and the filters had dust on it that was rolling up when taken out of the filter holder on the air conditioning unit. Interview on 08/14/24 at 4:28 P.M. with STNA #443 verified the dust rolled in the filters and the dirty air conditioning unit in Resident #46's room. Interview on 08/14/24 at 4:48 P.M. with Activities Director (AD) #467 verified maintenance was responsible for cleaning the air conditioning unit filters. 5. Review of the medical record for Resident #47 revealed an admitted [DATE] with diagnoses of neoplasm of brain and anxiety. Review of the annual MDS assessment dated [DATE] revealed Resident #47 had intact cognition. Interview and observation on 08/12/24 at 2:25 P.M. with Resident #47 revealed his air conditioning unit vents in his room were coated with a brown substance along the front and top of the unit. The substance appeared stuck to the vents and was not removable with a swipe of the finger. Additionally, the window blinds had a heavy buildup of dust. Resident #47 stated the facility had not cleaned the air conditioning unit in three years although he stated he had cleaned it himself once. Resident #47 stated the dirty appearance of his air conditioner and blinds bothered him. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 08/12/24 at 2:55 P.M. with LPN #426 confirmed there was heavy dirty buildup and possible staining on all vent blades of the the air conditioning unit and there was heavy dust building on the window blinds in Resident #47's room. Observation on 08/15/24 at 10:35 A.M. revealed Resident #47 was cleaning out his room and a large chair was blocking the entrance, waiting for maintenance to remove it. Observation and interview with Resident #47 from his doorway revealed the air conditioning unit remained coated and discolored. Resident #47 stated the window blinds remained dusty. Resident #47 stated staff came in and cleaned the blades inside the unit. Observation and interview on 08/15/24 at 10:42 A.M. with Housekeeper #417, from the doorway of Resident #47's room, confirmed Resident #47's air conditioning unit was visibly dirty and Housekeeper #417 confirmed he planned to deep-clean Resident #47's room later in the day. Review of the policy titled, Safe and Homelike Environment, copyright 2024, revealed the facility, in accordance with residents' rights, will provide a safe, clean, comfortable, and homelike environment. 47057 44815

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on medical record review, resident interview, and staff interview, the facility failed to ensure Minimum Data Set (MDS) assessments were completed accurately. This affected two (#47 and #155) of 30 residents reviewed for MDS assessments. The facility census was 61. Findings include: 1. Review of the medical record for Resident #47 revealed an admitted [DATE] with diagnoses of neoplasm of the brain and anxiety. Review of the annual MDS assessment dated [DATE] revealed Resident #47 had intact cognition and no functional limitations in range of motion to his upper extremity (shoulder, elbow, wrist, hand). Review of the physical therapy progress report and updated therapy plan dated 07/08/24 through 08/06/24 revealed Resident #47 was assessed on 07/07/24 and 07/08/24 and was found to have left shoulder range of motion from zero to 90 degrees, with standard range of motion defined as zero to 120 degrees. Interview and observation on 08/12/24 at 2:25 P.M. with Resident #47 revealed he had pain in his left shoulder and demonstrated he could not lift his arm any higher than the level of his shoulder while holding it straight out in front of him. Interview on 08/15/24 at 3:10 P.M. with Rehabilitation Services Director #404, along with concurrent review of Resident #47's physical therapy progress note, confirmed a range of motion of 90 degrees was considered a limited range of motion to Resident #47's left shoulder. 2. Review of the medical record for Resident #155 revealed an admitted [DATE] with a diagnosis of a wound to the right forearm. Review of the MDS assessment dated [DATE] revealed Resident #155 had intact cognition and had a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. Review of the weekly wound evaluation dated 07/31/24 revealed Resident #155 was admitted with a trauma injury to her right forearm. Review of the skin observation tool, dated 08/02/24, revealed Resident #155 had a right forearm trauma/injury. Interview on 08/15/24 at 4:04 P.M. with the Director of Nursing (DON) confirmed Resident #47's range of motion was documented incorrectly in the MDS assessment dated [DATE] and Resident #155's trauma wound was documented incorrectly in the MDS assessment dated [DATE].

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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** 44815 Based on observation medical record review, resident interview, and staff interview, the facility failed to adequate ensure nail care was provided to residents dependent on staff for care. This affected two (#24 and #44) of three residents reviewed for assistance with activities of daily life (ADLs). The facility census was 61. Findings include: 1. Review of the medical record for Resident #24 revealed an admitted [DATE] with diagnoses of type II diabetes mellitus and anxiety. Review of the modified admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #24 had intact cognition and was dependent for personal hygiene. Review of the current care plan for Resident #24 revealed she had an ADL self-care performance deficit. Interventions included checking nail length and trimming and cleaning on bath day and as necessary. Observation and interview on 08/12/24 at 10:33 A.M. with Resident #24 revealed the nails on her left hand were long and had dark debris under them. Resident #24 stated she tried to clean them every day and she wanted her nails trimmed. Resident #24 heard someone came to the facility on ce a month to do nails. Observation on 08/13/24 at 3:57 P.M. revealed staff transferred Resident #24 from the chair to the bed. Continued observation when Resident #24 was settled in bed revealed the fingernails on her left hand continued to be long and have dark debris under them. Interview and observation on 08/14/24 at 3:20 P.M. revealed Resident #24 lying in bed. Her nails on the left hand remained long and had some dark debris under them. Additionally, the thumbnail on her right hand and dark debris under it. Resident #24 stated her sister visited earlier in the day and helped clean under her fingernails. Interview on 08/14/24 at approximately 3:21 P.M. with State tested Nurse Aide (STNA) #412 revealed Resident #24's showers were scheduled for Mondays and Thursdays on first shift. Interview and observation on 08/14/24 at 3:23 P.M. with Licensed Practical Nurse (LPN) #446 confirmed Resident #24's nails on her left and right hands were dirty. LPN #446 stated STNAs were responsible for nail care. Interview on 08/14/24 at 3:27 P.M. with STNA #469 revealed residents' nails were usually cleaned and trimmed on shower days; however, if she saw dirty nails she would clean them. 2. Resident #44 admitted to the facility on [DATE] with the diagnoses including, pervasive developmental disorder, schizoaffective disorder, moderate intellectual disorder, vascular dementia, depression, and obstructive and reflux uropathy. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most current MDS assessment dated [DATE] revealed Resident #44 was assessed with moderately impaired cognition and was dependent on staff for the completion of activities of daily living. Review of Resident #44's plan of care dated 06/20/24 revealed a focus area was initiated to address Resident #44's ADL self-care performance deficit related to disease process and impaired balance. Interventions included the resident was dependent on one to two staff for bathing, was dependent of one to two staff to assist with dressing, and was dependent on one staff with personal hygiene and oral care. Observation on 08/12/24 at 9:34 A.M. noted Resident #44 was seated in a wheelchair in his room. The resident was observed with long jagged finger nails with black/brown debris under the nails and heavy facial hair growth. On 08/13/24 at 9:14 A.M. interview with STNA #450 verified Resident #44 with heavy facial hair growth and jagged fingernails with debris under them. 15816

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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** 44815 Based on observation, resident and staff interviews, review of the medical record, review of a bowel protocol, and review of a facility policy, the facility failed to ensure wound dressings were completed per physician orders and failed to implement the facility bowel protocol as indicated. This affected one (#155) of two residents reviewed for wounds and two (#24 and #49) of two residents review for bowel movements. The facility census was 61. Findings include: 1. Review of the medical record for Resident #155 revealed an admitted [DATE] with a diagnosis of a wound to the right forearm. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #155 had intact cognition. Review of a physician order dated 07/26/24 revealed wound care orders to wash Resident #155's right forearm with normal saline, pat dry, cover the wound bed with collagen, then place adaptic over collagen, cover with foam, and change daily and as needed to be completed every day shift and as needed for wound care. Review of Resident #155's treatment records for August 2024 revealed no wound care documentation dated 08/11/24. Observation and interview on 08/12/24 at 2:47 P.M. with Resident #155 revealed she had a bandage on her right forearm. Resident #155 stated the bandage was not changed since 08/10/24. Observation of the bandage revealed it was dated 08/10/24. Interview on 08/12/24 at 2:53 P.M. with Licensed Practical Nurse (LPN) #426 with concurrent observation of Resident #155's bandage on her right forearm confirmed the bandage was dated 08/10/24. LPN #426 further confirmed the order for Resident #155's dressing change was once daily on day shift. Observation on 08/14/24 at 8:34 A.M. with Wound Specialist Physician (WSP) #503 revealed Resident #155 was not wearing a bandage on her right forearm upon WSP #503's arrival to assess the wound. Resident #155 stated the bandage had peeled off some and she pulled the whole thing off earlier in the morning. WSP #503 stated the wound was improving drastically and she had no concerns with the facility's treatment of Resident #155's wound. Interview on 08/14/24 at 1:18 P.M. with Regional Director of Clinical Reimbursement (RDCR) #501 confirmed Resident #155's August 2024 treatment records contained no evidence her wound dressing was completed to the right forearm on 08/11/24. Review of the policy titled, Clean Dressing Change, copyright 2023, revealed the physician's order for wound care will specify the type of dressing and frequency of changes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #24 revealed an admitted [DATE] with diagnoses of type II diabetes mellitus and anxiety. Review of the modified admission MDS assessment dated [DATE] revealed Resident #24 had intact cognition, was always continent of bowel and bladder, and was dependent for toileting and personal hygiene. Review of the current care plan for Resident #24 revealed she received pain medication and to monitor for adverse reactions, including constipation. Review of Resident #24's the physician orders revealed an order dated 05/29/24 for the narcotic pain medication Percocet oral tablet 5-325 milligrams (mg), with instructions to give one tablet by mouth in the morning for pain. Further review revealed an order dated 05/28/24 for the stool softeners docusate sodium oral tablet 100 mg, with instructions to give one tablet by mouth every 12 hours as needed for constipation, an order dated 05/28/24 for Bisacodyl rectal suppository 10 mg, with instructions to insert one suppository rectally every 24 hours as needed for constipation, and an order dated 05/28/24 for Senna S oral tablet 8.6-50 mg, with instructions to give two tablets by mouth every 24 hours as needed for constipation, take at bedtime as needed. Review of the Documentation Survey Report dated May 2024 revealed Resident #24 had no documented bowel movements (BMs) on 05/29/24, 05/30/24, and 05/31/24. Review of the Documentation Survey Report dated June 2024 revealed Resident #24 had no documented BMs from 06/01/24 through 06/06/24. Further review revealed Resident #24 had routine BMs through the remainder of the month. Review of the May 2024 and June 2024 medication administration record (MAR) revealed no as-needed stool softening medications were given to Resident #24 to address lack of bowel movements. Interview on 08/12/24 at 10:33 A.M. with Resident #24 revealed she was concerned her pain medications were causing her to be constipated. Interview on 8/14/24 at 9:00 A.M. with the Director of Nursing (DON) revealed the facility did not have a bowel policy but followed a protocol with standing orders to provide as-needed medications after 72 hours without a BM. The DON stated nurses could implement the protocol without having to notify the physician. Interview on 08/14/24 at 12:49 P.M. with RDCR #501 confirmed the bowel protocol should be implemented after 72 hours without a BM. Follow up interview with RDCR #501 on 08/14/24 at 1:18 P.M., with concurrent review of Resident #24's medical record, confirmed Resident #24 had no documented BM from 05/29/24 through 06/06/24. Further interview confirmed no as-needed medications to treat constipation were administered between 05/29/24 and 06/06/24 for Resident #24. 3. Review of the medical record for Resident #49 revealed an admitted [DATE] with diagnoses of irritable bowel syndrome and hypertension. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS assessment dated [DATE] revealed Resident #49 had intact cognition, required supervision or touching assistance for personal hygiene, required partial/moderate assistance for showering/bathing, and was frequently incontinent of bowel and bladder. Review of a physician order dated 05/25/24 revealed Resident #49 received the laxative Milk of Magnesia suspension 400 milligrams (mg) per 5 milliliters (ml), with instructions to give 30 ml by mouth every 24 hours as needed for constipation if the resident did not have a BM after three days with nursing to administer. Further review revealed an order dated 05/31/24 for the laxative Glycolax Powder, with instructions to give 17 grams (g) by mouth every 24 hours as needed for constipation if no BM in three days give daily until BM, and orders for a saline laxative Fleet enema, with instructions to insert one dose rectally every 24 hours as needed, to give rectally if no BM in three days. Review of a physician order initiated 05/31/24, and discontinued 06/03/24, revealed Resident #49 received Senna S oral tablet 8.6-50 mg, with instructions to give one tablet by mouth two times daily for constipation. Review of a nursing progress note dated 05/31/24 revealed a state tested nurse aide (STNA) was notified by the nurse that Resident #49 was on BM monitoring. Review of a progress note written by NP #502, dated 06/03/24, revealed Resident #49's constipation continued and NP #502 ordered to increase Senna S to two tablets twice daily, monitor BMs, and encourage increased fluids. Review of a physician order initiated 06/03/24 revealed Resident #49 received Senna S oral tablet 8.6-50 mg, with instructions to give two tablets by mouth two times a day for constipation. Review of a progress note written by Nurse Practitioner (NP) #502, dated 05/31/24, revealed Resident #49 had constipation and NP #502 ordered Senna S, one tablet twice daily and Fleets enema if no BM in three days. Review of the Documentation Survey Report dated June 2024 revealed Resident #49 had no documented BMs from 06/01/24 through 06/07/24. Review of the June 2024 MAR revealed Resident #49 received Senna S oral tablet as ordered. Further review revealed no additional as-needed medication for constipation was provided to Resident #49 between 06/01/24 and 06/07/24. Review of the current care plan revealed a care area was added 08/14/24 to indicate Resident #49 was at risk for episodes of pain. Interventions included monitoring for side effects of pain medication, such as constipation. Interview on 08/14/24 at 8:31 A.M. with STNA #403 revealed STNAs notify the nurse if a resident had no BM for three days. STNA #403 stated BMs were something she consistently monitored and documented for all residents. Interview on 08/14/24 at 8:46 A.M. with STNA #409 revealed STNAs should let nurses know when residents do not have a BM after three days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/15/24 at 8:39 A.M. with the DON, and concurrent review of the medical record, revealed Resident #49 had no documented BM between 06/01/24 and 06/07/24. Resident #49's dose of Senna S was increased from one tablet twice daily to two tablets twice daily on 06/03/24; however, no additional medications or interventions were implemented when Resident #49 continued to have no BM. Review of the bowel protocol order set revealed bowel protocol #1 was Milk of Magnesia, bowel protocol #2 was a suppository, bowel protocol #3 was a Fleet enema, and bowel protocol #4 was physician notification.

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, staff interview, and review of a facility policy, the facility failed to ensure interventions and treatments were implemented for a resident assessed at risk for pressure ulcers to prevent deterioration of an existing stage four pressure ulcer (full-thickness skin and tissue loss) and the development of additional pressure ulcers and failed to ensure pressure ulcer treatments were applied as ordered by the physician. Actual harm occurred to Resident #31 when the facility failed to initiate an alternative pressure relieving cushion or additional pressure reliving intervention to the resident's wheelchair after an existing cushion was damaged and removed and treatments were not administered as ordered. This resulted in Resident #31 developing two stage three in-house acquired pressure ulcers (full-thickness skin loss) with related worsening and drainage. This affected one (#31) of two sampled residents reviewed for pressure ulcer prevention and care in a facility census of 61. Findings include: Review of Resident #31's medical record revealed the resident admitted to the facility on [DATE] with diagnoses including, cervical cord syndrome, paraplegia, traumatic brain injury, type II diabetes mellitus, poly neuropathy, atrial fibrillation, venous thrombosis and embolism, respiratory failure, chronic obstructive pulmonary disease, ulcerative pancolitis, and spinal stenosis. Review of the most current Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #31 with intact cognition. The resident was dependent on staff for the completion of activities of daily living (ADLs) including bed mobility and repositioning. The resident utilized an indwelling catheter and colostomy, and was assessed at risk for pressure ulcer development with one or more unhealed pressure ulcers/injuries including a stage three pressure ulcer not present at the time of admission, one stage four present on admission, and one unstageable pressure injury (obscured full-thickness skin and tissue loss) present upon admission. Review of a nursing plan of care initiated on 10/11/21 revealed Resident #31 had actual impairment to skin integrity related to paraplegia including a stage four pressure ulcer to the right ischium. Interventions included to follow facility protocols for treatment of the injury; identify and document potential causative factors and eliminate and resolve where possible; monitor and document the location, size, and treatment of the skin injury, and report abnormalities, failure to heal, signs or symptoms of infection, or maceration to the physician; and weekly treatment documentation to include measurement of each area of skin breakdown with width, length, depth, type of tissue and exudate, and any other notable changes or observations. Review of the wound specialist physician evaluation documentation on 05/01/24 revealed a chronic stage four right ischium pressure ulcer present greater than 761 days. Further review revealed the wound evaluation description was noted with moderate serous exudate (drainage) and measured 3.3 centimeters (cm) long by (x) 1.8 cm wide x 1.1 cm deep. The recommended interventions included to off-load the wound, turn side to side and front to back in bed every one to two hours if able when in bed, lay flat in wheelchair for one hour every three hours, reposition per facility protocol, and continue application of specialized cushion (ROHO, pressure-reliving cushion) to the specialized wheelchair. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 05/02/24 the physician modified a treatment to the right ischium to cleanse Resident #31's wound with wound cleanser (Vashe), pat dry, apply a collagen sheet, then apply calcium alginate/AG to the wound bed, and cover with bordered gauze once daily and as needed every day shift for a pressure injury. Review of the pressure risk assessment dated [DATE] Resident #31 was assessed at moderate risk of pressure ulcer development. Review of wound specialist physician evaluation documentation on 07/19/24 noted a chronic stage four right ischium pressure ulcer. Further review of the wound evaluation description noted moderate serous exudate and measured 3.0 cm long x 1.9 cm wide x 0.5 cm deep. The recommended interventions included to off-load the wound, turn side to side and front to back in bed every one to two hours if able when in bed, lay flat in wheelchair for one hour every three hours, reposition per facility protocol, and continue application of ROHO cushion to specialized wheelchair. The primary dressing for the wound included the application of a collagen sheet apply once daily for 30 days, and alginate calcium with silver apply once daily for 30 days. On 07/31/24 a weekly wound evaluation noted Resident #31's stage four right ischium pressure ulcer was documented as worsening due to resident non-compliance with wound care and broken ROHO cushion. The wound description revealed there was moderate serous exudate, and the wound measured 4.2 cm long x 3.0 wide x 0.7 cm deep. No additional intervention was implemented to replace the broken ROHO cushion. In addition, two in-house pressure ulcers were discovered. Documentation indicated wound #1, which was a right buttock stage three pressure ulcer, was noted on 07/30/24 and was described with a small amount of serous exudate and measured 7.5 cm long x 4.0 cm wide x 0.1 cm deep. Treatment of the wound included to cleanse with soap and water apply Triad paste every shift and as needed. Wound #2, which was identified as left ischium moisture associated skin damage (MASD), measured 4.0 cm long x 7.5 cm wide x 0.1 cm deep with no drainage. The same treatment was applied as wound #1. Review of a wound specialist evaluation dated 07/31/24 noted the physician indicated Resident #31's custom ROHO cushion was taken to see if a repair could be made. The document continued that the resident continued to stay in his chair for 14-plus hours per day without getting up to off-load and had caused a quick breakdown of his skin. Resident #31 was encouraged to get back into bed or at least lay on his side when he got back into bed. The wound specialist documented the facility will also see if physical therapy might have a ROHO cushion available to use until they find out what was happening with the resident's personal ROHO cushion. Resident #31's wound progress was documented as exacerbated due to patient non-compliant with wound care and broken ROHO cushion. Wound measurement to the right ishium was 4.2 cm long x 3.0 cm wide x 0.7 cm deep with moderate serous drainage. Recommendations included to off-load the wound, reposition per facility protocol, and therapy consultation for ROHO cushion options. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 08/07/24 the wound specialist documented Resident #31's ROHO cushion was being repaired and his wounds and skin are breaking down further. The resident's right ischium was assessed with moderate serous drainage and measured 4.0 cm long x 2.7 cm wide x 1.0 cm deep with a new treatment to apply Methylene blue foam once daily for 30 days. The right buttock was assessed with moderate serous exudate and measured 3.5 cm long x 4.5 cm wide x 0.2 cm deep with wound treatment to apply Methylene blue foam apply once daily for 30 days. The left ischium MASD measured 0.5 cm long x 1.0 cm wide x 0.1 cm deep with continued application of Triad paste apply twice daily. In addition, a third in-house acquired wound was discovered to the posterior scrotum described as a stage three pressure wound measuring 2.0 cm long x 5.0 cm wide x 0.1 cm deep with no drainage. Treatment for this wound included application of Triad paste to be applied twice daily. Review of the medical record lacked documentation of additional interventions to address pressure relief while the resident was in the wheelchair, or a therapy evaluation related to temporary replacement of the ROHO cushion. Review of Resident #31's wound treatment orders dated 08/07/24 included, for the right buttock, right ischium, and left ischium, to cleanse with wound cleanser (Vashe), pat dry, apply Methylene Blue (Hydrofera Blue) to the wound bed, and cover with bordered gauze once daily and as needed every day shift for the pressure injuries. The treatment order for the posterior scrotal wound was to cleanse with soap and water and apply Triad paste every shift and as needed. Observation on 08/12/24 at 10:49 A.M. with State tested Nurse Aide (STNA) #409 noted Resident #31 in his room after being transferred with a mechanical lift. Resident #31 was placed in a specialized electric wheelchair, dressed, and groomed. Interview with Resident #31 at the time of the observation stated he was waiting on repair of his ROHO cushion for four weeks. STNA #409 stated Resident #31 developed an open area to his buttock with no treatment applied for two weeks. Observation at that time revealed Resident #31's wheelchair was noted without a pressure relief cushion to the seat. On 08/13/24 at 10:38 A.M. observation with STNA #409 and STNA #450, during morning activities of daily living with Resident #31, noted the resident was positioned to the left side and revealed exposed wounds to the bilateral ischium, right buttock, and posterior scrotum. There was no dressing or treatment applied to the wounds and blood-tinge drainage was identified contained in the incontinence brief under the resident. Interview with STNA #409 at the time of the observation verified no dressing was in place since assuming care of Resident #31 at 7:00 A.M. Interview on 08/13/24 at 10:43 A.M. with Licensed Practical Nurse (LPN) #422 revealed she was unaware Resident #31 required a dressing application to wounds on the ischium or buttock. LPN #422 indicated she thought a wound barrier cream was to be applied. Observation at that time revealed LPN #422 proceeded to obtain dressing treatment supplies following review of Resident #31's medical record and went to Resident #31's room. Interview with LPN #422 during observation of the resident confirmed no treatment was applied to the resident's wounds. Further observation revealed LPN #422 cleansed the resident's right ischium, right buttock, posterior scrotum, and left ischium with wound cleanser (Vashe) and patted them dry. LPN #422 applied Methylene Blue (Hydrofera Blue) to the wound bed of the bilateral ischium and right buttock, applied barrier cream to the posterior scrotum and peri-wounds, and covered all of the wounds with two absorbent dressings (ABD). Observations on 08/13/24 at 11:00 A.M., 12:20 P.M., 1:03 P.M., 08/14/24 at 12:10 P.M., and 2:00 P.M. noted Resident #31 seated in the wheelchair without a pressure relieving cushion to the seat. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 08/14/24 at 6:45 A.M. interview with the Director of Nursing (DON), during a review of the medical record, confirmed Resident #31 specialized pressure relief cushion (ROHO) to the wheelchair was removed approximately two weeks ago and no intervention was implemented in place of the cushion. The DON verified Resident #31 remained in the wheelchair for extended periods and was unable to reposition himself. Interview on 08/14/24 at 7:20 A.M. with Wound Specialist Physician (WSP) #503 confirmed Resident #31 had a ROHO cushion in place until a couple weeks ago when the cushion was broken, and no current intervention was placed in the chair to replace the missing cushion while being repaired. WSP #503 stated since the cushion had been removed the resident had developed new skin breakdown and deterioration of an existing wound. Observation on 08/14/24 at 9:08 A.M. with WSP #503 and LPN #500 noted Resident #31 in bed. LPN #500 positioned Resident #31 to the left and exposed the dressings. WSP #503 removed the dressings and noted a moderate amount of serous drainage. WSP #503 obtained wound descriptions with measurements to the right ischium wound as measuring 5.0 cm long x 2.0 cm wide x 1.4 cm deep, measurements to the right buttock wound were 5.0 cm long x 3.6 cm wide x 0.1 cm deep, the wound to the left buttock was noted as healed, and the wound to the posterior scrotum measured 5.0 cm long x 1.5 cm wide x 0.2 cm deep. Observation noted Resident #31 to exhibit verbal pain with evaluation of the right ischium wound and indicated the pain was a level of eight on a 10-point scale, with 10 being the worse pain. WSP #503 stated Resident #31 did not express pain when this wound was evaluated previously and indicated the wound appeared more tender and sensitive. Review of the undated pressure injury prevention and management policy revealed interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment. Evidence-based interventions for prevention will be implemented for all residents at risk or who have pressure injury present. Evidence-based treatments in accordance with current standards of practice will be provided for all residents who have pressure injury present. Review of the undated clean dressing change policy revealed the facility will provide wound care in a manner to decrease potential for infection and/or cross-contamination. Physician's orders will specify type of dressing and frequency of changes.

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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** 44815 Based on observation, medical record review, staff interview, and review of the facility policy, the facility failed to ensure residents were adequately supervised while smoking and failed to ensure smoking materials were maintained in a safe manner. This affected two (#21 and #156) of two residents reviewed for smoking. The facility census was 61. Findings include: 1. Review of the medical record for Resident #21 revealed an admitted [DATE] with diagnoses of bipolar disorder, dementia, and schizophrenia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/19/24, revealed Resident #21 had impaired cognition. Review of the smoking safety screen document, dated 04/10/24, revealed Resident #21 required supervision while smoking. Observation on 08/13/24 at 10:43 A.M. revealed five residents in the smoking area, including Resident #21, and no facility staff. Resident #21 was smoking two cigarettes at the same time, with one in each hand. Resident #21 was sitting in a wheelchair wearing shorts and a t-shirt. Continued observation revealed Resident #21 dropped a finished cigarette on the concrete and continued to smoke the other cigarette. Further observation revealed Resident #21 had cigarette ashes on his shorts. No burn holes were observed. Observation and interview on 08/13/24 at 10:51 A.M. with MDS Coordinator #456 confirmed Resident #21 had ashes on his shorts and confirmed cigarette butts were on the concrete, in the grass, and in the rocks around the ash trays. Further interview with MDS Coordinator #456 confirmed no facility staff was present in the smoking area while Resident #21 was outside. Interview on 08/13/24 at 11:08 A.M. with Licensed Practical Nurse (LPN) #480 confirmed Resident #21 should be supervised while he smoked. Interview on 08/15/24 at 9:45 A.M. with the Director of Nursing (DON) verified Resident #21 required supervision while smoking. 2. Review of the medical record for Resident #156 revealed an admitted [DATE] with diagnoses of chronic obstructive pulmonary disease and hypertension. Review of the comprehensive admission MDS assessment dated [DATE] revealed Resident #156 had intact cognition and used tobacco. Review of the smoking safety screen document, dated 07/26/24, revealed Resident #156 was safe to smoke without supervision. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/12/24 at 11:21 A.M. revealed Resident #156 was not in his room. Further observation revealed a half-smoked extinguished cigarette sitting on top of a cardboard pizza box on Resident #156's overbed table. An unopened pack of cigarettes was also on the table. Interview on 08/12/24 at 11:22 A.M. with LPN #426 revealed Resident #156 was out of the facility at a doctor's appointment. During the continued interview and concurrent observation of Resident #156's room, LPN #426 confirmed the half-smoked, extinguished cigarette was lying on top of a cardboard pizza box. Review of the policy titled, Resident Smoking, copyright 2024, revealed supervision will be provided as indicated on each resident's care plan. Further review revealed smoking materials of residents requiring supervision with smoking will be maintained by nursing staff.

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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 policy review, the facility failed to ensure timely incontinence care and interventions were provided following an episode of urinary incontinence. This affected one (#36) of three residents reviewed for urinary tract infections in a facility census of 61. Findings include: Review of the medical record noted Resident #36 admitted to the facility on [DATE] with diagnoses including, epilepsy, extended spectrum beta lactamase resistance, type II diabetes mellitus, hypertension, acute kidney failure, anxiety disorder, hypothyroidism, muscle wasting and atrophy, and dysphagia. Review of the most current Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 was assessed with moderately impaired cognition, required partial to moderate assist with activities of daily living (ADLs) including toileting, and was frequently incontinent of bowel and bladder. Review of Resident #36's care plan revealed on 09/10/21 a nursing plan of care was revised to address the resident's risk for alteration in elimination related to being occasionally incontinent of bowel and bladder, and acute kidney injury. Interventions included to administer medications as ordered, monitor for signs and symptoms of urinary tract infections (UTIs) including elevated temperature, dysuria, flank pain, hematuria, foul smelling urine, and report to a physician to seek diagnosis and treatment promptly, monitor for skin redness and irritation, and provide incontinent care as needed. Review of an additional nursing plan of care dated 05/05/23 was initiated to address Resident #36's risk for an ADL self-care performance deficit related to dementia, impaired balance, limited mobility, and pain. The care plan identified ADL support may fluctuate related to the resident's cognition. Interventions included the resident required limited assistance by one staff with bathing/showering as necessary, required limited to extensive assistance by one to two staff to turn and reposition in bed as necessary, required limited assistance by one staff to dress, required limited assistance by one staff with personal hygiene and oral care, required skin inspection with care to observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse, required limited to extensive assistance by one to two staff for toileting, and required limited assistance by one staff to move between surfaces as necessary. On 08/15/24 at 6:16 A.M. interview with State tested Nurse Aide (STNA) #405 stated she assumed care of Resident #36 during the night shift from 10:30 P.M. on 08/14/24 to 6:30 A.M. on 08/15/24. During the shift STNA #405 went into Resident #36's room to ask if the resident needed to use the restroom and she would not wake. STNA #405 was unaware Resident #36 had a history of urinary incontinence, and also stated she did not check under the resident's sheets to determine if the resident was soiled of urine. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/15/24 at 6:20 A.M. with STNA #405 noted Resident #36 in bed and covered with sheets. STNA #405 woke Resident #405 and observed the resident to be incontinent of a heavy amount of urine. The resident was assisted out of bed and it was noted the resident's pants and lift pad (cloth chux) bed linen were also saturated with urine with a strong urinary odor. STNA #405 assisted the resident to the restroom and placed the resident on the toilet. Resident #36 indicated she was done using the restroom and STNA #405 obtained a clean brief (pull-up) and pair of pants. STNA #405 reminded the resident to use a portion of toilet tissue to wipe herself and proceeded to assist the resident with placing the clean brief and pants on. No opportunity was provided to cleanse the resident of the residual urine on the resident's perineum or buttock. No perineal care was provided. On 08/15/24 at 6:34 A.M. interview with STNA #405 confirmed Resident #36 was heavily soiled of urine and was not observed for urinary incontinence during the night shift (10:30 P.M. to 6:30 P.M.). STNA #405 was unaware the resident was incontinent and indicated she thought the resident would take herself to the restroom when needed. STNA #405 also verified the resident was not cleansed of the soiled urine following the incontinence episode, and placed into a clean incontinence brief and pants. Interview with the Director of Nursing (DON) on 08/15/24 at 6:50 A.M. confirmed Resident #36 was identified as incontinent of bladder and required assistance with incontinence needs, and stated following an incontinence episode residents are to be thoroughly cleansed of urinary soiling. The DON stated a resident's bowel and bladder status are assessed on admission and quarterly. On 08/15/24 at 7:18 A.M. additional interview with the DON revealed the facility lacks a policy of procedure to assess resident bowel and bladder needs. Review of the facility perineal care policy, implemented 2022, revealed the facility practice was to provide perineal care to all incontinence residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and prevent and assess for skin breakdown.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44815 Based on observation, staff interview, and review of the facility policy, the facility failed to ensure hand hygiene was practiced during meal service. This affected six (#24, #155, #160, #161, #162, and #154) of six residents observed during meal service. The facility census was 61. Findings include: Observation on 08/12/24 at 12:17 P.M. revealed a cart with lunch trays was delivered to the 300 hall. Observation on 08/12/24 at approximately 12:18 P.M. revealed Licensed Practical Nurse (LPN) #426 pushing Resident #40 in a wheelchair to the scale in the lounge. LPN #426 assisted Resident #40 by touching his sleeve while he stood on the scale and she obtained his weight. LPN #426 then assisted Resident #40 back into his wheelchair and pushed him back to his room. LPN #426 did not practice hand hygiene before opening the meal cart and removing Resident #24's meal tray. LPN #426 entered Resident #24's room, moved items from her overbed table, and set down Resident #24's meal on the table. Interview on 08/12/24 at 12:24 P.M. with LPN #426 confirmed she did not clean her hands after assisting Resident #40 and providing Resident #24's meal. Continuous observation on 08/12/24 beginning at 12:24 P.M. revealed State tested Nurse Aide (STNA) #469 entered Resident #155's room and came out with her dirty breakfast tray. STNA #469 placed the dirty tray on top of the tray cart, then, without cleaning her hands, reached inside the cart and picked up Resident #155's lunch tray and delivered it. STNA #469 returned to the cart and picked up Resident #160's tray and delivered it to her. STNA #469 moved Resident #160's wheelchair and overbed table to make Resident #160 more comfortable to eat her meal. STNA #469 then closed Resident #155's door, then picked up and provided Resident #161's tray. STNA #469 returned to the tray cart and picked up Resident #162's tray and upon entering his room, picked up his fall mat from the floor, moved his tray table, set the tray down and removed the lid from his tray. STNA #469 did not clean her hands after touching Resident #162's personal items. Continued observation revealed Resident #160 asked for some salt and STNA #469 reached into the tray cart, found a salt packet and attempted to hand it to Resident #160. The salt packet fell on the floor and STNA #160 picked the salt packet up off the floor and handed it to Resident #160 who proceeded to open it and sprinkle salt on her meal. STNA #469 then returned to the tray cart to get Resident #154's lunch tray and provided it to him. At no time during this continuous observation was STNA #469 observed to perform hand hygiene. Interview on 08/12/24 at 12:31 P.M. with STNA #469 confirmed she touched several personal items and picked items up from the floor while delivering meal trays to multiple residents. STNA #469 confirmed she did not perform hand hygiene at any time while she was passing meal trays. STNA #469 believed she was expected to perform hand hygiene before she passed the first meal tray, and after she passed the final meal tray. Concurrent interview with LPN #426, who interjected into the interview, advised STNA #469 hand hygiene should be performed after contact with each resident. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy titled, Hand Hygiene, with the accompanying document titled, Hand Hygiene Table, copyright 2023, revealed staff should perform hand hygiene between resident contacts.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on staff interview, record review, and review of the Certification and Survey Provider Enhanced Reporting system (CASPER) Report, the facility failed to have an effective quality assurance program to address repeated quality concerns identified during three consecutive annual surveys. This affected all 61 residents in the facility. The census was 61. Findings include: Review of the CASPER Report dated 08/02/24 revealed the facility received deficiencies for failing to provide activities of daily life (ADL) care to dependent residents during the annual surveys conducted in August 2019 and August 2022. 1. Review of the medical record for Resident #24, during the current annual survey, revealed an admitted [DATE]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #24 had intact cognition and was dependent on staff for personal hygiene. Observations on 08/12/24 at 10:33 A.M., 08/13/24 at 3:57 P.M. and 08/14/24 at 3:20 P.M. revealed Resident #24's fingernails and thumbnails on her right and left hands had dark debris under them. Interview and observation on 08/14/24 at 3:23 P.M. with Licensed Practical Nurse (LPN) #446 confirmed Resident #24's nails on her left and right hands were dirty. 2. Review of Resident #44's medical record, during the current annual survey, revealed the resident admitted to the facility on [DATE] with a diagnosis of vascular dementia. Review of the MDS assessment dated [DATE] revealed Resident #44 had moderately impaired cognition, and was dependent on staff for the completion of activities of daily living. Observation on 08/12/24 at 9:34 A.M. noted Resident #44 seated in a wheelchair in his room. The resident was observed with long, jagged finger nails with black/brown debris under the nails, and heavy facial hair growth. On 08/13/24 at 9:14 A.M. interview with State tested Nurse Aide (STNA) #450 verified the resident with heavy facial hair growth and fingernails jagged with debris. Review of the policy titled, Quality Assurance and Performance Improvement (QAPI), copyright 2024, revealed the effectiveness of performance improvement activities will be monitored in QAA (Quality Assessment and Assurance) Committee meetings in accordance with the QAPI plan, but no less than annually to ensure improvements are sustained.

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	365488	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare of Toledo	4420 South Avenue Toledo, OH 43615

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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** 44815 Based on observation, staff interview, medical record review, and review of the facility policy, the facility failed to ensure enhanced barrier precautions (EBP) were followed during personal care and failed to ensure appropriate infection control procedures were practiced. This affected one (#24) of one residents reviewed for enhanced barrier precautions. The facility census was 61. Findings include: Review of the medical record for Resident #24 revealed an admitted [DATE] with diagnoses of type II diabetes mellitus and anxiety. Review of the modified admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #24 had intact cognition and was always continent of bowel and bladder and was dependent for toileting and personal hygiene. Review of the current care plan for Resident #24 revealed she had an activities of daily living (ADL) self-care performance deficit and was dependent on staff for toileting and personal hygiene. Review of Resident #24's care plan dated 05/30/24, and current at the time of the survey, indicated Resident #24 had a stage four pressure ulcer (full-thickness skin and tissue loss) to the coccyx. Review of the physician order initiated 07/02/24 revealed Resident #24 had EBP ordered and directed staff to wear gown and gloves during high contact activities. Observation on 08/12/24 at 10:33 A.M., on 08/13/24 at 3:57 P.M., and on 08/14/24 at 3:18 P.M. revealed Resident #24 had an orange sign on her door indicating to, See Nurse Before Entering, and had signage for EBP advising staff to wear a gown and gloves when changing briefs or assisting with toileting. Observation on 08/14/24 at 3:10 P.M. revealed State tested Nurse Aide (STNA) #412 entered Resident #24's room to answer her call light. Interview on 08/14/24 at 3:18 P.M. with STNA #412, as she exited Resident #24's room, revealed she changed Resident #24's brief. STNA #412 stated she did not wear a gown while providing care and was not sure if she needed to wear a gown when providing incontinence care to Resident #24. Observation revealed STNA #412 wearing gloves and carrying an unbagged brief in her hand. Continued observation revealed STNA #412 carried the brief past two resident rooms and past the nurses' station before entering the soiled utility room. Follow-up interview on 08/14/24 at 3:30 P.M. with STNA #412 confirmed she carried Resident #24's brief from her room to the soiled utility room without putting it in a bag because there was only one bag remaining in Resident 24's room and STNA #412 did not want to take the last bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/15/24 at 10:08 A.M. with the Director of Nursing (DON) revealed she updated Resident #24's physician order to include the reason for EBP was methicillin-resistant Staphylococcus aureus (MRSA) bacteremia and stated the MRSA was in her back. The DON further clarified it was in Resident #24's coccyx wound. Review of the policy, Enhanced Barrier Precautions,copyright 2022, revealed Enhanced barrier precautions referred to the use of gown and gloves for use during high-contact resident care activities for residents. Further review revealed high-contact resident care activities included changing briefs or assisting with toileting. Review of the Infection Prevention and Control Policy, copyright 2023, revealed soiled linens should be collected at the bedside and placed in a bag. The bag should be closed securely and placed in the soiled utility room.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 47057 Based on medical record review of vaccinations, staff interview, review of a facility policy, and review of the Centers for Disease Control and Prevention (CDC) website, the facility failed to offer COVID-19 booster vaccines for residents as indicated. This affected three (#12, #15, and #34) of five reviewed for COVID-19 vaccinations. The facility census was 61. Findings include: 1. Review of the medical record for Resident #12 revealed the last administration of COVID-19 vaccination was 08/19/22. Review of the immunization record for Resident #12 revealed no education or consent for acceptance or refusal of a COVID-19 booster vaccine following the administration in 2022. 2. Review of the medical record for Resident #15 revealed the last administration of COVID-19 vaccination was 08/19/22. Review of the immunization record for Resident #15 revealed no education or consent for acceptance or refusal of a COVID-19 booster vaccine following the administration in 2022. 3. Review of the medical record for Resident #34 revealed the last administration of COVID-19 vaccination was 08/19/22. Review of the immunization record for Resident #34 revealed no education or consent for acceptance or refusal of a COVID-19 booster vaccine following the administration in 2022. Interview on 08/13/24 at 4:46 P.M. with the Director of Nursing (DON) verified Resident #12, Resident #15, and Resident #34 were not offered COVID-19 vaccinations since 2022. Review of the facility policy titled, Infection Prevention and Control Program, dated 05/23, revealed residents and staff will be offered the COVID-19 vaccine when vaccine supplies are available to the facility. Residents and staff will be screened prior to offering the vaccination for prior immunization, medical precautions, and contraindications to determine candidacy for the vaccination. Education about the vaccine, risks, benefits, and potential side affects will be given to the resident or resident representative prior to offering the vaccine. Review of CDC website located at https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html, titled, Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States, updated 04/04/24, revealed COVID-19 vaccination is recommended for everyone ages six (6) months and older in the United States for the prevention of COVID-19. The CDC recommended special situations for people ages 65 and older include to receive one additional dose of any updated (2023-2024 formula) COVID-19 vaccine.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, and staff interview, the facility failed to ensure the facility had an effective pest control program to promote an environment that was free from pests. This affected one (#36) of five residents reviewed for the environment. The census was 61. Findings include: Review of the medical record noted Resident #36 was admitted to the facility on [DATE] with diagnoses including, epilepsy, extended spectrum beta lactamase resistance, type II diabetes mellitus, hypertension, acute kidney failure, anxiety disorder, hypothyroidism, muscle wasting and atrophy, and dysphagia. Review of the most current Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #36 with moderately impaired cognition, required partial to moderate assist with activities of daily living including toileting, and was frequently incontinent of bowel and bladder. Observation on 08/12/24 at 11:15 A.M. noted Resident #36's room with a lift pad (cloth chux) bed linen with 16 gnats on the surface with multiple house flies in the room. On 08/12/24 at 11:20 A.M. observation and interview with Licensed Practical Nurse (LPN) #446 verified Resident #36's room condition. Observation on 08/15/24 at 6:20 A.M. with State tested Nurse Aide (STNA) #405 noted Resident #36 in bed and covered with sheets. STNA #405 woke Resident #405 and observed the resident to be incontinent of a heavy amount of urine. Multiple gnats and house flies were observed in the room and restroom. STNA #405 was noted to swat at the insects while interacting with the resident. On 08/15/24 at 6:34 A.M. interview with STNA #405 confirmed the presence of gnats and house flies in Resident #36's room. Observation and interview on 08/15/24 at 8:42 A.M. with Maintenance Director (MD) #406 confirmed the gnats with house flies throughout Resident #36's room. MD #406 indicated he was unaware of the insects and was unable to provide documentation of house fly/gnat prevention treatments.

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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. 44815 Based on review of personnel files and staff interviews, the facility failed to ensure state tested nurse aides (STNAs) completed training on dementia care and completed 12 hours of continuing education annually. This had the potential to affect all 61 residents in the facility. The census was 61. Findings include: 1. Review of the personnel file for STNA #409 revealed a hire date of 09/20/18. Review of STNA #409's continuing education revealed all documents were on paper and the facility could not provide evidence of 12 hours of continuing education was conducted for STNA #409. Additionally, the file contained no evidence STNA #409 received training on caring for residents with dementia. 2. Review of the personnel file for STNA #479 revealed a hire date of 02/24/23. Review of STNA #479's new hire paperwork and continuing education revealed no evidence STNA #479 received training on caring for residents with dementia. 3. Review of the personnel file for STNA #419 revealed a hire date of 08/02/23. Review of STNA #419's new hire paperwork revealed no evidence STNA #419 received training on caring for residents with dementia. 4. Review of the personnel file for STNA #449 revealed a hire date of 08/23/23. Review of STNA #449's new hire paperwork revealed no evidence STNA #449 received training on caring for residents with dementia. Interview on 08/15/24 at 11:05 A.M. with Human Resources Director (HRD) #489 confirmed the facility could not provide evidence STNA #409 received 12 hours annually of continuing education. HRD #489 confirmed the facility did not provide dementia training to staff because the facility did not have a designated dementia unit. Interview on 08/15/24 at 11:10 A.M. with STNA #454 confirmed she had not received dementia education.