STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365489	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Manor Rehabilitation & Healthcare Center	1330 S Fulton St Port Clinton, OH 43452

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on medical record review, review of the facility Self-Reported Incident (SRI), review of the facility investigation, review of the facility census, resident interview, and staff interview, the facility failed to ensure a resident was free from staff to resident verbal abuse. This affected one (#16) of five residents reviewed for abuse. The facility census was 65. Findings include: Review of the SRI dated 05/14/24 revealed Resident #16 was stating that a State tested Nurse Aide (STNA) was verbally abusive to her. Review of the medical record revealed Resident #16 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, muscle weakness, sleep deprivation, urge incontinence, anxiety, depression, hyperlipidemia, and hypertension. Review of the quarterly Minimum Data Set assessment dated [DATE] identified the resident as cognitively intact. The resident was always incontinent of urine and bowel and required staff assistance for a majority of the activities of daily living. Review of Resident #16's plan of care, revised 02/07/24, identified the resident had episodes of bladder and bowel incontinence. Interventions included assisting the resident with toileting needs and providing perineal care after each incontinent episode. Review of Resident #16's nursing progress notes dated 05/14/24 and timed 5:29 P.M. revealed the nurse was notified of alleged verbal abuse by an STNA. The STNA was removed from the building pending investigation. The resident was tearful at the time. Review of Resident #16's social service progress notes dated 05/14/24 and timed 7:13 P.M. revealed social services was notified of alleged verbal abuse by an STNA and the STNA was suspended pending investigation. Social services would interview the alleged STNA in the morning. An initial interview was conducted by the Director of Nursing (DON). Social services or the DON would also interview the resident and all residents and staff residing or working on the unit. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #16's social service progress notes dated 05/15/24 and timed 6:35 P.M., revealed the resident was interviewed, was at their baseline mentally, had not had issues with the staff member in the past, and was not concerned about the situation. Review of a written statement provided by STNA #334 revealed STNA #402 walked into the room where STNA #334 and another STNA were. STNA #402 was complaining about a resident and stating she keeps peeing and she needs to stop drinking so much pop. STNA #402 requested help changing the resident. STNA #334, STNA #402, and an STNA responsible for training STNA #334 went into the resident's room. STNA #402 was complaining about the resident peeing (urinating) so much and the resident stated you're going to be in my shoes one day. STNA #402 then cursed and continued to repeat phrases including stop drinking so much pop! STNA #402 said all of these things in a mean manner, picked a dirty towel up off the floor, and whipped the resident with it because the resident started urinating in their new brief. STNA #402 then said she is peeing again. Review of a written statement dated 05/14/24 provided by STNA #323, revealed while assisting with a bed change for Resident #16, Resident #16 and STNA #402 were going back and forth arguing about how much the resident urinated and the mess the resident made when they urinated. STNA #323 attempted to diffuse the situation and STNA #402 was cussing at Resident #16 and being really mean and nasty to her. Review of the interview dated 05/15/24 with Resident #16's daughter revealed the resident's daughter stated according to Resident #16 that STNA #402 was cussing and telling Resident #16 they drank too much and ate too much ice. Review of the facility investigation dated 05/14/24 revealed the facility did not substantiate that verbal abuse occurred. Resident #16 was interviewed and stated they were shocked STNA #402 would make a comment to them. At the time of the incident, STNA #402 was removed from the facility and placed on suspension pending investigation. STNA #402 was written up and was suspended for one day without pay. STNA #402 then returned to work, no longer providing care for Resident #16. Review of the disciplinary action form dated 05/15/24, revealed it was reported that STNA #402 was cursing at a resident in regard to how much the resident needed to be changed and how much they wetted their bed. The applicable work rule on the form was verbal abuse toward a resident, and STNA #402 received suspension beginning on 05/14/24 and ending on 05/16/24 as a result. In the future, STNA #402 was expected to perform work duties and complete them in a professional manner, respecting residents' rights and dignity. Interview on 07/01/24 with Resident #16 revealed the resident had a previous incident with a staff member. Resident #16 reported they had urinated and needed to be changed. A STNA had come into the room and jumped all over me. Resident #16 reported the STNA was cursing and saying the resident drank too much, ate too much ice, and urinated too much. Resident #16 reported they were shocked because the STNA had never acted that way before. Resident #16 reported the STNA was no longer allowed in the resident's room following the incident. Interview on 07/02/24 at 2:19 P.M. with STNA #334 revealed the staff member relayed the incident as written in the previous witness statement. STNA #334 reported STNA #402 had been cursing at Resident #16 and telling the resident they urinated too much. STNA #334 reported they felt uncomfortable and reported the incident to the nurse on duty at the time of the incident. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/02/24 at 4:21 P.M. with STNA #323 verified the details within the staff member's written statement. STNA #324 reported witnessing STNA #402 cursing at and telling Resident #16 they should not drink so much pop and eat so much ice. STNA #323 felt STNA #402 was belittling Resident #16. Resident #16 stated they did not know why STNA #402 was talking to them that way and that they could not help having to urinate that much. STNA #323 reported you could tell she (the resident) was hurt. Interview on 07/03/24 at 7:42 A.M. with the Administrator verified the facility did not substantiate verbal abuse had occurred although STNA #402 received disciplinary action for verbal abuse to a resident. The Administrator also verified the nurse aide registry was not contacted and STNA #402 returned to work following the incident. The Administrator reported STNA #402 admitted to saying they thought Resident #16 drank too much pop and ice. This deficiency represents non-compliance investigated under Complaint Number OH00154857.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528 Based on medical record review, interviews with staff, review of Self-Reported Incidents (SRI), and review of facility policy, the facility failed to ensure instances of resident elopement were reported for Resident #54. Additionally, the facility failed to ensure staff allegations of a unlicensed staff member administering unprescribed melatonin were reported for four (#3, #29, #55, and #60) residents. This affected five (Residents #3, #29, #54, #55, and #60) of five residents reviewed for abuse. The facility census was 65. Findings include: 1. Review of the medical record revealed Resident #54 was admitted on [DATE]. Diagnoses included noninfective gastroenteritis and colitis, cognitive communication deficit, muscle weakness, enterocolitis due to clostridium difficile, hyo-osmolality and hyponatremia, chronic obstructive pulmonary disease, acute embolism and thrombosis of unspecified deep veins of distal lower extremity, schizophrenia, and anxiety order. Review of the Minimum Data Set (MDS) assessment, dated 06/25/24, revealed the resident was rarely understood. The resident required the use of a wheelchair and was dependent for toileting and showers. Review of the MDS assessment, dated 10/18/23, revealed the resident was moderately cognitively impaired with no impairment to range of motion. Resident #54 was independent for toileting, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. Review of the Dementia Unit Determination Evaluation, dated 04/13/23, revealed Resident #54 is appropriate for the memory care unit. The assessment revealed the resident was at home with family and as his memory declined he could not care for self. The resident was a flight risk as he wanted to go outside unsupervised and was not safe to do so. The family feels he would only be safe in a secured unit Review of the Dementia Unit Determination Evaluation, dated 07/11/23, revealed Resident #54 is appropriate for the memory care unit. The assessment revealed the resident is a flight risk to leave the building and he had some cognitive delays and prefers the environment. Review of the Dementia Unit Determination Evaluation, dated 12/28/23, revealed Resident #54 is appropriate for the memory care unit. The assessment revealed the resident is an elopement risk and meets the criteria for the unit. Review of the elopement evaluation, dated 12/28/24, revealed the resident was at high risk of elopement. Review of the most recent care plan revealed Resident #54 was at risk for elopement and exit seeking behaviors with appropriate interventions. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of nursing progress notes dated 12/28/23 at 4:19 A.M., revealed the resident was found sitting at the front door outside the facility around 3:45 A.M. by a staff member. Staff were unaware the resident was off the unit. Staff let the resident back into the locked unit. Resident was stumbling and slurring his words. Resident #54 had reported he walked to a local bar to listen to karaoke and he drank ice water and next he walked to another local bar to play pool and a [NAME] there bought him three beers then walked back to the facility. Resident #54 initially stated he could not remember who let him out of the facility. Staff went into the resident's room and found his bedroom window was able to open all the way and the screen was pushed out. Upon further questioning the resident admitted to going out the window but does not know the time he left. Vitals were taken, water and a peanut butter and jelly sandwich were provided. Initially the physician had instructed to monitor the resident and encourage fluids but later instructed for the resident to be sent to the emergency room to be evaluated. Review of nursing progress note dated 12/28/23 revealed Resident #54 was last seen at 7:45 P.M. (on 12/27/23) standing next to the nurse's station and the resident received his medication. Review of nursing progress notes dated 12/28/23 at 7:39 A.M. revealed report was received from the emergency department and reported no abnormalities were noted. Resident #54 ate and drank fluids and was transported back to the facility by his sister. Resident informed his resident room door must remain open and fifteen-minute checks were initiated. Review of hospital notes dated 12/28/23 revealed Resident #54 was treated for alcohol intoxication and medical evaluation. Review of nursing progress notes dated 12/28/23 at 9:59 A.M. revealed the writer performed a head to toe assessment on the resident and found no concerns. At the time of the incident the resident was wearing tan khaki pants, a long sleeve shirt with a flannel, a brown hat, and loafers. Review of social services progress notes dated 12/28/23 at 12:19 P.M. revealed Resident #54 exited the building through his window and went to two bars before walking back to the building and sitting outside by the front door in a chair when a staff found him sitting there. Resident #54 reported he wanted to go out so he unscrewed his window screen, climbed out, went to the first bar and drank water, then walked to the next bar and had three beers. The resident reported he stayed until close (2:00 A.M.) and walked back to the facility. Resident #54 reported he then sat down and waited for someone to come to the door. Resident #54 acknowledged it was wrong and would not do it again. Resident #54 was informed he was able to leave with family and could also have alcohol in the facility if it was kept at the nurse's station. The resident was not confrontational or confused and had a flat affect when discussing the incident. Review of social service progress note dated 12/28/23 at 4:12 P.M. with Resident #54's Power of Attorney (POA) regarding the severity of the incident last night of the resident's elopement. The discussion included who Resident #54 could leave with, shopping, and bringing back items not safe (scissors, screwdriver, wrench). The conclusion was Resident #54 may only leave with his sister, two brothers, and a church representative on Sundays. The person taking him out must monitor his shopping. Resident #54 stated he bought the tools that allowed him to open his window. Review of SRIs dated from 12/27/23 to current revealed no SRI's had been submitted regarding Resident #54's elopement. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 07/01/24 at 6:55 P.M. with Licensed Practical Nurse (LPN) #302 verified approximately six to seven months ago Resident #54 had popped out of his window and went to a bar then walked back to the facility. LPN #302 verified he had not been observed from the time he received medication pass approximately between 8:00 P.M. and 9:00 P.M. and when he returned approximately 1:00 A.M. to 2:00 A.M. After he returned the staff opened his door to find that he had used a screwdriver to take out the screws to get the window open and then popped out the screen. LPN #302 reported prior to being admitted he was living with family and drinking every day and the family felt they could not keep him safe anymore. LPN #302 verified no checks were completed on the resident to know he was missing. Interview on 07/02/24 at 9:38 A.M. with the Administrator revealed Resident #54 was initially placed on the secure memory care unit and later determined to move him to the unsecure unit with guidelines for him to sign out. The Administrator revealed on 12/27/23 the Administrator was out of town and but had been notified. The Administrator verified no SRI was completed. 47057 2. Review of the medical record for Resident #3 revealed she was admitted on [DATE] with diagnosis of dementia. Review of the current physician orders from 07/24 for Resident #3 revealed she was prescribed melatonin one milligram (mg) at bedtime. Review of the quarterly Minimum Data Set (MDS) dated [DATE] for Resident #3 revealed she was cognitively impaired. 3. Review of the medical record for Resident # 29 revealed an initial admitted [DATE] and a re-admitted [DATE] with diagnosis of Alzheimer's disease Review of the significant change MDS dated [DATE] for Resident #29 revealed he was cognitively impaired. Review of the current physician orders for 07/24 for Resident #29 revealed he was not prescribed melatonin. 4. Review of the medical record for Resident # 55 revealed she was admitted on [DATE] with diagnosis of dementia and senile degeneration of brain. Review of the most recent MDS dated [DATE] for Resident #55 revealed she was cognitively impaired and rarely understood. Review of the current physician orders from 07/24 for Resident #55 revealed no order for melatonin. 5. Review of the medical record for Resident # 60 revealed an admitted [DATE] with diagnosis of metabolic encephalopathy, dementia, and Alzheimer's disease. Review of the most recent MDS dated [DATE] for Resident #60 revealed she was cognitively impaired. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the current physician orders from 07/24 for Resident #60 revealed no order for melatonin. Interview on 07/02/24 at 8:37 A.M. with Resident #29 stated he does not recall or know of a time anyone other than a nurse gave him medication, he was not aware of a pill to help him sleep, and stated he really does not know. Interview on 07/02/24 at 2:02 P.M. with the Administrator stated she did not file a self-reported incident for an allegation of abuse of administration of unprescribed medication of melatonin by unlicensed staff. Interview on 07/02/24 at 2:28 P.M. with the Director of Nursing (DON) revealed she was notified of an allegation of melatonin being administered by an State tested Nursing Assistant (STNA) and spoke with the nurse and reported it to the Administrator. The DON further stated she spoke with the nurse and did not conduct any further reporting. Review of the facility policy titled, Abuse Investigation and Reporting, dated 09/21 revealed all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management. This deficiency represents non-compliance investigated under Complaint Number OH00154857.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on medical record review, interviews with residents, interviews with staff, and review of facility policy, the facility failed to investigate an allegation of unlicensed staff administered unprescribed melatonin to residents. This affected four (Residents #3, #29, #55, and #60) of five residents reviewed for abuse. The facility census was 65. Findings include: 1. Review of the medical record for Resident #3 she was admitted on [DATE] with diagnosis of dementia. Review of the current physician orders from 07/24 for Resident #3 revealed she was prescribed melatonin 1 milligram (mg) at bedtime. Review of the quarterly Minimum Data Set (MDS) dated [DATE] for Resident #3 revealed she was cognitively impaired. 2. Review of the medical record for Resident #29 revealed an initial admitted [DATE] and a re-admitted [DATE] with diagnosis of Alzheimer's disease Review of the significant change MDS dated [DATE] revealed he was cognitively impaired. Review of the current physician orders for 07/24 for Resident #29 revealed he was not prescribed melatonin. 3. Review of the medical record for Resident #55 revealed she was admitted on [DATE] with diagnosis of dementia and senile degeneration of brain. Review of the current physician orders from 07/24 for Resident #55 revealed no order for melatonin. Review of the most recent MDS dated [DATE] for Resident #55 revealed she was cognitively impaired and rarely understood. 4. Review of the medical record for Resident #60 revealed an admitted [DATE] with diagnosis of metabolic encephalopathy, dementia, and Alzheimer's disease. Review of the current physician orders from 07/24 for Resident #60 revealed no order for melatonin. Review of the most recent MDS dated [DATE] for Resident #60 revealed she was cognitively impaired. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 07/02/24 at 2:28 P.M. with the Director of Nursing (DON) verified she was notified of an allegation of melatonin being administered by a State tested Nursing Assistant (STNA) and spoke with the nurse and reported it to the Administrator. The DON further stated she spoke with the nurse and did not conduct any further reporting or investigating. Interview on 07/02/24 at 2:02 P.M. with the Administrator stated she did not file a self-reported incident for an allegation of abuse of administration of unprescribed medication of melatonin by unlicensed staff and did not investigate the allegation. Review of the facility policy titled Abuse Investigation and Reporting, dated September 2021, revealed all reports of abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown origin would be reported and thoroughly investigated by facility management. The individual conducting the investigation would interview the resident, as well as the staff members who have had contact with the resident during the alleged incident. This deficiency represents non-compliance investigated under Complaint Number OH00154857.

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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** 41528 Based on medical record review, observation, staff interview, and facility policy, the facility failed to provide adequate supervision to prevent resident elopement. This affected one (#54) of three residents reviewed for elopement. Additionally, the facility failed to ensure fall interventions were in place for one (#58) of three residents reviewed for falls. The facility census was 65. Findings include: 1. Review of the medical record revealed Resident #54 was admitted on [DATE]. Diagnoses included noninfective gastroenteritis and colitis, cognitive communication deficit, muscle weakness, enterocolitis due to clostridium difficile, hypo-osmolality and hyponatremia, chronic obstructive pulmonary disease, acute embolism and thrombosis of unspecified deep veins of distal lower extremity, schizophrenia, and anxiety order. Review of the Minimum Data Set (MDS) assessment, dated 06/25/24, revealed the resident was rarely understood. The resident required the use of a wheelchair and was dependent for toileting and showers. Review of the MDS assessment, dated 10/18/23, revealed the resident was moderately cognitively impaired with no impairment to range of motion. Resident #54 was independent for toileting, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. Review of the Dementia Unit Determination Evaluation, dated 04/13/23, revealed Resident #54 is appropriate for the memory care unit. The assessment revealed the resident was at home with family and as his memory declined he could not care for self. The resident was a flight risk as he wanted to go outside unsupervised and was not safe to do so. The family feels he would only be safe in a secured unit Review of the Dementia Unit Determination Evaluation, dated 07/11/23, revealed Resident #54 is appropriate for the memory care unit. The assessment revealed the resident is a flight risk to leave the building and he had some cognitive delays and prefers the environment. Review of the Dementia Unit Determination Evaluation, dated 12/28/23, revealed Resident #54 is appropriate for the memory care unit. The assessment revealed the resident is an elopement risk and meets the criteria for the unit. Review of the elopement evaluation dated 12/28/24 revealed the resident was at high risk of elopement. Review of the most recent care plan revealed Resident #54 was at risk for elopement and exit seeking behaviors with appropriate interventions. (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 nursing progress notes dated 12/28/23 at 4:19 A.M., revealed the resident was found sitting at the front door outside the facility around 3:45 A.M. by a staff member. Staff were unaware the resident was off the unit. Staff let the resident back into the locked unit. Resident was stumbling and slurring his words. Resident #54 had reported he walked to a local bar to listen to karaoke and he drank ice water and next he walked to another local bar to play pool and a [NAME] there bought him three beers then walked back to the facility. Resident #54 initially stated he could not remember who let him out of the facility. Staff went into the resident's room and found his bedroom window was able to open all the way and the screen was pushed out. Upon further questioning the resident admitted to going out the window but does not know the time he left. Vitals were taken, water and a peanut butter and jelly sandwich were provided. Initially the physician had instructed to monitor the resident and encourage fluids but later instructed for the resident to be sent to the emergency room to be evaluated. Review of nursing progress note dated 12/28/23 revealed Resident #54 was last seen at 7:45 P.M. (on 12/27/23) standing next to the nurse's station and the resident received his medication. Review of nursing progress notes dated 12/28/23 at 7:39 A.M. revealed report was received from the emergency department and reported no abnormalities were noted. Resident #54 ate and drank fluids and was transported back to the facility by his sister. Resident informed his resident room door must remain open and fifteen-minute checks were initiated. Review of hospital notes dated 12/28/23 revealed Resident #54 was treated for alcohol intoxication and medical evaluation. Review of nursing progress notes dated 12/28/23 at 9:59 A.M. revealed the writer performed a head to toe assessment on the resident and found no concerns. At the time of the incident the resident was wearing tan khaki pants, a long sleeve shirt with a flannel, a brown hat, and loafers. Review of social services progress notes dated 12/28/23 at 12:19 P.M. revealed Resident #54 exited the building through his window and went to two bars before walking back to the building and sitting outside by the front door in a chair when a staff found him sitting there. Resident #54 reported he wanted to go out so he unscrewed his window screen, climbed out, went to the first bar and drank water, then walked to the next bar and had three beers. The resident reported he stayed until close (2:00 A.M.) and walked back to the facility. Resident #54 reported he then sat down and waited for someone to come to the door. Resident #54 acknowledged it was wrong and would not do it again. Resident #54 was informed he was able to leave with family and could also have alcohol in the facility if it was kept at the nurse's station. The resident was not confrontational or confused and had a flat affect when discussing the incident. Review of social service progress note dated 12/28/23 at 4:12 P.M. with Resident #54's Power of Attorney (POA) regarding the severity of the incident last night of the resident's elopement. The discussion included who Resident #54 could leave with, shopping and bring back items not safe (scissors, screwdriver, wrench). The conclusion was Resident #54 may only leave with his sister, two brothers, and a church representative on Sundays. The person taking him out must monitor his shopping. Resident #54 stated he bought the tools that allowed him to open his window. (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 social service progress notes dated 02/15/24, revealed Resident #54's cognition had improved since admission and was unhappy being on the memory care unit. Resident #54 wants to come and go as he wishes off the unit and socialize with others on the North unit in addition to attending all of the facility activities. Resident #54 also enjoys leaving the facility with his friends to go out to eat and play pool. Resident #54 has become very sneaky at getting off the unit because he does not enjoy being with those people. New cognitive assessments were completed with a Brief Interview for Mental Status (BIMS) of 12 (increased from 9) indicating moderate cognitive impairment and scored a 23 (minimal cognitive deficit) on St. Louis university Mental Status (SLUMS). The resident and the POA asked for him to be moved to the unsecured unit. An order was obtained from the physician and the resident will now be able to sign himself out when he chooses to go out with his friends. His POA requested a call when he exits the building and returns. The resident agreed to the guidelines to sign out and tell a nurse. Interview on 07/01/24 at 6:55 P.M. with Licensed Practical Nurse (LPN) #302 verified approximately six to seven months ago Resident #54 had popped out of his window and went to a bar then walked back to the facility. LPN #302 verified he had not been observed from the time he received medication pass approximately between 8:00 P.M. and 9:00 P.M. and when he returned approximately 1:00 A.M. to 2:00 A.M. After he returned the staff opened his door to find that he had used a screwdriver to take out the screws to get the window open and then popped out the screen. LPN #302 reported prior to being admitted he was living with family and drinking every day and the family felt they could not keep him safe anymore. LPN #302 verified no checks were completed on the resident to know he was missing. Interview on 07/02/24 at 9:38 A.M. with the Administrator revealed Resident #54 was initially placed on the secure memory care unit and later determined to move him to the unsecured unit with guidelines for him to sign out. Review of policy, Elopements, dated September 2021, verified staff shall investigate and report all cases of missing residents. Staff was promptly report any resident who tries to leave the premises or is suspected of being missing to the charge nurse of DON. 44454 2. Review of the medical record revealed Resident #58 was admitted to the facility on [DATE]. Diagnoses included muscle weakness, difficulty in walking, anxiety, depression, and disorientation. Review of the admission MDS assessment dated [DATE] identified Resident #58 was cognitively impaired and required supervision or touching assistance for transfers and ambulation. Review of the plan of care, revised 04/15/24, revealed Resident #58 was at risk for falls related to incontinence, cerebrovascular accident, weakness, impaired cognition with decreased safety awareness, and needs assistance with activities of daily living. Interventions included bed against wall, call light within reach, and mat to floor next to bed when occupied. Observations on 07/01/24 at 9:43 A.M., 07/01/24 at 12:48 P.M., and 07/02/24 at 6:56 A.M., revealed Resident #58 was in their bed and there was no mat in place on the floor next to the bed. A blue, padded mat was leaning up against a wall of the room on each occasion. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/02/24 at 7:02 A.M. with Resident #58's roommate revealed there was never a mat next to Resident #58's bed. Interview on 07/02/24 at 7:04 A.M., with STNA #323 verified Resident #58 was in bed and did not have a mat in place next to the bed. STNA #323 reported noticing the mat in the room on 06/29/24 or on 06/30/24 and meant to ask whether the resident still needed the mat but had not yet. Interview on 07/02/24 at 7:07 A.M. with LPN #337 verified Resident #58's plan of care stated the mat was still supposed to be in place when the resident was occupying the bed. This deficiency represents non-compliance investigated under Complaint Number OH00154857.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on medical record review, observation, and staff interview, the facility failed to ensure Resident #16 received oxygen at the correct rate as prescribed by the physician. This affected one (Resident #16) of two residents reviewed for respiratory care. The facility census was 65. Findings include: Review of the medical record revealed Resident #16 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, muscle weakness, sleep deprivation, urge incontinence, anxiety, depression, hyperlipidemia, and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified the resident was cognitively intact. The resident was always incontinent of urine and bowel and required staff assistance for a majority of the activities of daily living. The resident received oxygen. Review of Resident #16's physician orders for July 2024 identified a current order dated 08/03/23 for two liters of oxygen via nasal cannula. Review of Resident #16's plan of care, revised 01/25/24, identified the resident had impaired respiratory status. Interventions included oxygen as ordered by the physician. During an observation on 07/01/24 at 9:19 A.M., Resident #16's oxygen concentrator was running at three liters per minute while Resident #16 was receiving the oxygen via nasal cannula. During an interview at the time of observation, Resident #16 reported they were supposed to receive two liters of oxygen per minute. During an interview on 07/01/24 at 9:25 A.M., Registered Nurse #351 confirmed Resident #16 should have been receiving two liters of oxygen per minute via nasal cannula. Registered Nurse #351 reported the control for Resident #16's oxygen concentrator must have gotten bumped.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 41528 Based on review of the staffing schedule, interviews with staff, and facility policy, the facility failed to ensure required Registered Nurse (RN) coverage. This had the potential to affect all 65 residents. Findings include: Review of staff timesheets for 01/21/24, 03/02/24, 03/16/24, 03/17/24, 03/30/24, 03/31/24, 06/29/24, and 06/30/24 revealed the facility did not have a Registered Nurse (RN) working a minimum of eight hours a day. Interview on 07/03/24 at 3:25 P.M. with the Administrator verified the facility did not have a RN working a minimum of eight hours a day on the above dates. Review of policy, Staffing, dated September 2021, verified the facility will maintain adequate staffing on each shift to ensure the resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on observation, staff interview, and review of the facility policy, the facility failed to discard expired insulin. This affected three residents (#18, #32, and #38) reviewed for insulin storage. The facility census was 65. Findings include: 1. Review of the medical record for Resident #18 revealed an admitted [DATE] with a diagnosis of diabetes mellitus type II. Review of the current physician orders for ,d+[DATE] for Resident #18 revealed an order for novolog flex insulin pen. 2. Review of the medical record for Resident #32 revealed an admitted [DATE] with a diagnosis of diabetes mellitus type II. Review of the current physician orders for ,d+[DATE] for Resident #32 revealed an order for fiasp insulin pen. 3. Review of the medical record for Resident #38 revealed an admitted [DATE] with diagnosis of diabetes mellitus type II. Review of the current physician orders for ,d+[DATE] for Resident #38 revealed an order for novolog insulin. Observations on [DATE] at 8:52 A.M. of the medication cart labeled south-one revealed one multi-dose vial of aspat insulin opened and dated [DATE] for Resident #38, one fiasp insulin pen opened and dated [DATE] for Resident #32, and one novolog insulin pen opened and dated for [DATE] for Resident #18. Interview at the time of the observation with Licensed Practical Nurse (LPN) #344 verified the opened and expired insulin pens and multi-use vial. Review of the facility policy titled, Storage of Medications, dated ,d+[DATE] revealed the facility shall store all drugs and biological in a safe, secure, and orderly manner. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. Review of the facility policy titled, Administering Medications, undated, revealed the expiration/beyond use date on the medication label must be checked prior to administering.

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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** 44454 Based on review of the pharmacy recommendation, review of the medical record, staff interview, and review of the facility policy, the facility failed to ensure laboratory tests were completed per pharmacist recommendation and physician order. This affected one (#53) of one resident reviewed for laboratory testing. The facility census was 65. Findings include: Review of the medical record revealed Resident #53 was admitted to the facility on [DATE]. Diagnoses included type II diabetes mellitus with diabetic polyneuropathy, obesity, muscle weakness, anxiety, and depression. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #53 as cognitively intact. Review of the plan of care, revised 08/23/23, revealed Resident #53 had an impaired metabolic status related to diabetes and obesity. Interventions included monitoring labs/diagnostic testing per physician order. Review of Resident #53's medical record including laboratory results revealed the last Hemoglobin A1C (HbA1c) test was completed on 12/28/24. Review of the pharmaceutical recommendation made to the attending physician for Resident #53 on 05/24/24 stated to please consider monitoring HbA1c every three months for diabetes therapy. The recommendation was reviewed on 06/11/24 with an order for monitoring of HbA1c every three months. Review of physician orders for 2024 identified an order dated 06/11/24 with a start date of 06/12/24 for HbA1c one time per day every three months, starting on the 12th. Review of the laboratory results dated [DATE] revealed the resident had laboratory work completed on 06/12/24, but did not include the HbA1c. An interview on 07/08/24 at 9:12 A.M. with the Director of Nursing (DON) verified Resident #53 did not have the HbA1c completed per order on 06/12/24. The DON further verified the most recent HbA1c that was completed for the resident was on 12/28/23. Review of the facility policy titled, Request for Diagnostic Services, not dated, revealed orders for diagnostic services would be carried out as instructed by the physician's order.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44454 Based on observation, staff interview, and review of the pest control service logs, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner. This had the potential to affect 65 of 65 residents who received meals from the kitchen. Findings include: Observations during an initial tour of the kitchen on 07/01/24 beginning at approximately 7:40 A.M. revealed excessive buildup and grime in between and behind the fryer and stove, buildup and debris on the lower part of a metal food cart being used for resident meal trays, buildup and debris located on the floor and along the edges of the walls surrounding the interior side of an exit door located in the dry storage room, and excessive buildup which was black in color located under tables and appliances throughout the kitchen. During observations and interviews on 07/02/24 beginning at approximately 12:40 P.M., Regional Dietary Manager #391 verified the debris and buildup on the floors and meal cart. Review of facility pest control service logs dated 05/17/24 and 06/21/24 revealed the kitchen was inspected and spot treated. Corrective action recommendations included kitchen needs cleaned. An interview on 07/03/24 at 12:14 P.M. with the Maintenance Director verified the pest control logs stated the kitchen needed cleaned.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 41528 Based on observation, staff interview, resident representative interview, and facility policy the facility failed to ensure the facility was maintained in a clean and sanitary manner. This affected 28 (#3, #5, #14, #15, #18, #20, #22, #23, #26, #27, #29, #32, #33, #34, #36, #38, #39, #42, #43, #44, #45, #46, #51 #52, #55, #56, #60, and #61) residents residing in the memory care unit. The facility census was 65. Findings include: Observation on 07/01/24 at 10:16 A.M. of the memory care unit revealed the flooring of the edges of the hallways had a thick layer of dust and grime. Observation on 07/01/24 at 2:08 P.M. of Resident #60's room revealed the flooring, specifically around the corners and edges were unclean with built-up substance. Observation on 07/02/24 at 3:50 P.M. of the memory care unit revealed the flooring of the edges of the hallways had a thick layer of dust and grime. Resident #60's room flooring, specifically around the corners and edges remained unclean. In addition, Resident #45's room flooring around the corners and edges were unclean with a layer of dust. Observation on 07/03/24 at 10:50 A.M. of the memory care halls revealed the flooring remained visually dirty. In addition, Resident #45's and Resident #60's resident room flooring continued to appear to have a obvious build up and dust around the corners and edges. Interview on 07/03/24 at 10:52 A.M. with Housekeeping #322 verified the areas along the halls, Resident #45's room, and Resident #60's room flooring had a layer of dirt and debris. Housekeeping #322 reported they just started deep cleaning today and plans on completing two rooms per day. Review of policy, Housekeeping/Environmental Services, no date, revealed housekeeping and laundry departments shall implement and follow established work schedules in accordance with the needs of the facility. Cleaning schedules are developed and implemented to assure that each area of the facility is maintained in a safe, clean, and comfortable environment.