STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365497	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER: Village at the Greene		STREET ADDRESS, CITY, STATE, ZIP CODE: 4381 Tonawanda Trail, Dayton, OH 45430	

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731 Based on medical record review, staff interview, and policy review, the facility failed to ensure significant change assessments were completed in a timely manner. This affected three (#43, #45, and #51) of three residents reviewed for hospice services. The facility census was 76. Findings include: 1. Review of the medical record of Resident #43 revealed an admitted [DATE]. Diagnoses included frontotemporal neurocognitive disorder, repeated falls, dementia with psychotic disturbance, depression, breast cancer, hypertension, anxiety, and history of multiple wedge compression fractures, clavicle fracture, multiple rib fractures. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognition. The resident required supervision for bed mobility, partial/moderate assistance for eating, substantial/maximal assistance for toileting, bathing, dressing, and was dependent on staff for transfers. Review of the medical record revealed the resident began receiving hospice services on 02/06/24. Review of the significant change MDS assessment dated [DATE] revealed the assessment was completed on 02/22/24. Interview on 02/27/25 at 1:42 P.M., Registered Nurse (RN) #139 verified Resident #43's significant change assessment dated [DATE], was not completed within 14 days of the identification of a significant change. RN #139 verified an MDS must be completed within 14 days of the identification of a significant change and Resident #37's significant change assessment should have been completed by 02/19/24. 2. Review of the medical record of Resident #45 revealed an admitted [DATE]. The resident transferred to the hospital on 12/18/24 and returned to the facility on [DATE]. Diagnoses included chronic kidney disease, dementia with agitation, chronic obstructive pulmonary disease, prostate cancer. Review of the comprehensive MDS assessment dated [DATE] revealed the resident had severely impaired cognition. Review of the medical record revealed the resident was picked up by hospice on 01/02/25. (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

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed a significant change MDS with a reference date of 01/09/25 was completed on 01/22/25. Interview on 02/27/25 at 1:52 P.M., RN #139 verified Resident #45's significant change MDS dated [DATE] was not locked within 14 days of being picked up by hospice and should have locked by 01/15/25. 3. Review of the medical record of Resident #51 revealed an admitted [DATE]. Diagnoses included hypertensive heart disease with heart failure, hallucinations, polyosteoarthritis, repeated falls, chronic kidney disease, chronic pain syndrome, psychosis, hypothyroidism, depression, anxiety, hypertension, colon cancer, unspecified hearing loss, amnesia, history of transient ischemic attack. Review of the quarterly MDS assessment dated [DATE] revealed the resident had moderately impaired cognition. The resident rejected care 1-3 days during the assessment period. The resident was independent with bed mobility, required setup assistance for eating, partial/moderate assistance for toileting, bathing, and transfers. The resident weighed 232 pounds and did not have any significant weight loss. Review of the medical record revealed the resident was picked up by hospice on 02/06/25. Review of the medical record revealed a significant change MDS with a reference date of 02/09/25 was completed on 01/22/25. Interview on 02/27/25 at 1:59 P.M., RN #139 verified Resident #51's significant change MDS dated [DATE] was completed on 02/22/25, and should have been completed by 02/19/25. Review of the facility policy titled, Resident Assessment, dated 11/19/15 revealed a comprehensive MDS assessment should be completed within 14 days of a significant change.

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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 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** 42731 Based on medical record review, staff interview, and policy review, the facility failed to ensure Minimum Data Set (MDS) assessments were completed accurately. This affected three (#22, #37, and #51) of 22 residents reviewed for assessment accuracy. The facility census was 76. Findings include: 1. Review of the medical record of Resident #37 revealed an admitted [DATE]. Diagnoses included alzheimer's disease, dementia with severe agitation, age-related osteoporosis, and muscle weakness. Review of the quarterly MDS assessment dated [DATE] revealed the resident had severely impaired cognition. The resident required set-up assistance with eating, supervision with bed mobility, and partial/moderate assistance with toileting, transfers, and dressing. The resident weighed 145 pounds. Review of weights revealed on 01/29/25, the resident weighed 132.4 pounds. On 02/07/24, the resident weighed 133.2 pounds. Interview on 02/26/25 at 3:06 P.M., Dietetic Technician (DT) #78 verified the weight entered on the MDS assessment dated [DATE] was not accurate. DT #78 verified the weight should have been entered as 132 pounds. Review of the plan of care dated 02/11/25 revealed the resident had an ADL self care performance deficit related to cognition and limited mobility. The resident required the use of a hoyer lift for transfers. Review of the documentation survey report for February 2025 revealed Resident #37 was dependent on staff for transfers on 02/01/25, 02/02/25, 02/04/25, 02/05/25, and 02/06/25. Interview on 02/27/25 at 1:57 P.M., Registered Nurse (RN) #139 verified Resident #37 was dependent on staff for transfers during the assessment period, which was not accurately reflected on the MDS dated [DATE]. 2. Review of the medical record of Resident #22 revealed an admitted [DATE]. Diagnoses included hemiplegia affecting right dominant side, chronic obstructive pulmonary disease, type 2 diabetes mellitus, and cervical cancer. Review of the quarterly MDS dated [DATE] revealed the resident had intact cognition. The resident required supervision for eating, toileting, and bed mobility, and partial/moderate assistance with bathing, dressing, and transfers. The resident weighed 238 pounds and had a significant, non-prescribed weight loss. Review of the medical record revealed on 01/13/25, the resident weighed 225.2 pounds. On 01/17/25, a weight of 238.4 pounds was noted, but was struck out on 01/22/25 at 1:55 P.M., indicating the resident was reweighed. On 01/22/25, the resident weighed 225 pounds. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village at the Greene	4381 Tonawanda Trail Dayton, OH 45430

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS assessment dated [DATE] revealed the resident had a weight of 238 pounds, which was signed by DT #78 on 01/27/25. Interview on 02/26/25 at 3:11 P.M., DT #78 verified Resident #22's weight was entered incorrectly and should have been 225 pounds. 3. Review of the medical record of Resident #51 revealed an admitted [DATE]. Diagnoses included hypertensive heart disease with heart failure, psychosis, hypothyroidism, and colon cancer. Review of the quarterly MDS assessment dated [DATE] revealed the resident had moderately impaired cognition. The resident rejected care 1-3 days during the assessment period. The resident was independent with bed mobility, required setup assistance for eating, partial/moderate assistance for toileting, bathing, and transfers. The resident weighed 232 pounds and did not have any significant weight loss. Review of Resident #51's weights revealed, on 01/27/25, the resident weighed 205.2 pounds. On 12/09/24, the resident weighed 220.2 pounds. On 08/12/24, the resident weighed 232.2 pounds. Interview on 02/26/25 at 4:47 P.M., DT #78 verified the information entered on Resident #51's MDS dated [DATE] was inaccurate. DT #78 stated she should have entered a weight of 205 and coded for a non-prescribed significant weight loss. Review of the facility policy titled, Resident Assessment, dated 11/19/15, revealed the MDS assessment would accurately reflect the resident's status.

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	365497	A. Building B. Wing	02/28/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42731 Based on observation, medical record review, staff interview, and policy review, the facility failed to provide care and services for residents who required staff assistance with Activities of Daily Living (ADLs). This affected five (#09, #22, #43, #53, and #73) of five residents reviewed for ADLs. The facility census was 76. Findings include: 1. Review of the medical record of Resident #22 revealed an admitted [DATE]. The resident transferred to the hospital on 12/18/24 and readmitted to the facility on [DATE]. Diagnoses included hemiplegia affecting right dominant side, type 2 diabetes mellitus, bipolar disorder with psychotic features, heart failure, atrial fibrillation, anxiety, depression, and cervical cancer. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The resident required supervision for eating, toileting, personal hygiene, and bed mobility, and partial/moderate assistance with bathing, dressing, and transfers. Review of the plan of care dated 11/08/24 revealed the resident had an ADL self-care deficit related to hemiplegia affecting the right dominant side. Interventions included to provide one-person assistance for grooming, hygiene, and bathing. Observation on 02/24/25 at 12:21 P.M. revealed Resident #22's fingernails on both hands were long, extending approximately one half inch beyond the finger tip. Resident #22's right hand was contracted. Interview at the same time revealed Resident #22 stated she wanted her fingernails cut and was unable to cut her fingernails and relied on staff to ensure her fingernails were not too long. Observation on 02/26/25 at 9:12 A.M., Resident #22's fingernails remained long, extending approximately one half inch beyond the finger tip. Interview at the same time revealed Resident #22 stated she had been given a shower on 02/25/25 and staff did not cut her fingernails. Resident #22 again stated she was unable to cut her own fingernails. Resident #22 stated she preferred to keep her fingernails cut short and stated her nails were way too long. Interview on 02/26/25 at 9:13 A.M. with Certified Nursing Assistant (CNA) #70 verified Resident #22's fingernails were long, extending approximately one half inch beyond the fingertip, and needed to be trimmed. CNA #70 stated she was not sure who was responsible for cutting Resident #22's finger nails. Observation on 02/27/25 at 9:28 A.M. revealed Resident #22's fingernails remained long, extending approximately one half inch beyond the finger tip. Interview at the same time revealed Resident #22 stated she was still waiting for someone to cut her fingernails. Interview on 02/27/25 at 9:28 A.M. CNA #102 verified Resident #22's fingernails were long and needed to be cut. CNA #102 stated she was unable to cut Resident #22's fingernails because she had diabetes. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/27/25 at 9:29 A.M., Licensed Practical Nurse (LPN) #76 verified Resident #22's fingernails were long and needed to be cut. LPN #76 stated she was unsure of who was supposed to provide nail care to Resident #22 since she was diabetic. Interview on 02/27/25 at 10:23 A.M., the Administrator stated nurses were responsible for cutting fingernails of residents with diabetes. 2. Review of the medical record of Resident #43 revealed an admitted [DATE]. Diagnoses included frontotemporal neurocognitive disorder, repeated falls, dementia with psychotic disturbance, depression, breast cancer, anxiety, and history of multiple wedge compression fractures, clavicle fracture, and multiple rib fractures. Review of the comprehensive MDS assessment dated [DATE] revealed the resident had severely impaired cognition. The resident required supervision for bed mobility, partial/moderate assistance for eating, substantial/maximal assistance for toileting, bathing, dressing, and was dependent on staff for transfers. Review of the care plan dated 01/09/25 revealed the resident was at risk for falls related to her diagnoses. Interventions included to get the resident up on third shift. Review of the care plan dated 02/06/25 revealed the resident had an ADL self care performance deficit related to Alzheimers and dementia. Interventions included to utilize a hoyer lift for transfers. Observation on 02/27/25 at 9:32 A.M. revealed Resident #43 was laying in bed with covers over her body. Observation on 02/27/25 at 12:45 P.M. revealed Resident #43 was laying in bed with covers over her body. 3. Review of the medical record of Resident #09 revealed an admitted [DATE]. Diagnoses included Parkinson's disease, hemiplegia and hemiparesis, right clavicle fracture, dysphagia, epilepsy, dysphagia, dementia with agitation, and cognitive communication deficit Review of the quarterly MDS assessment dated [DATE] revealed the resident had severely impaired cognition. The resident required setup assistance with eating, supervision for bed mobility, substantial/maximal assistance for transfers, and dependent for toileting, bathing, dressing, and personal hygiene. Review of the plan of care dated 02/12/25 revealed the resident had an ADL self care performance deficit related to impaired balance, left hand contracture, and non-displaced fracture of lateral right clavicle. Interventions included to provide 1-person extensive assistance with transfers. Observation on 02/27/25 at 9:33 A.M. revealed Resident #09 was laying in bed, with covers over her body and a breakfast tray in front of her, fully consumed. Observation on 02/27/25 at 12:45 P.M. revealed Resident #09 was laying in bed with covers over her body. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of the medical record of Resident #53 revealed an admitted [DATE]. Diagnoses included hyperosmolality and hypernatremia, alzheimer's disease, muscle weakness, syncope and collapse, heart failure, and osteoporosis. Review of the quarterly MDS assessment dated [DATE] revealed the resident had a severe cognitive impairment. The resident required supervision for eating, partial/moderate assistance for transfers, toileting, and bathing. Review of the plan of care dated 12/30/24 revealed the resident had an ADL self care performance deficit related to weakness and impaired mobility and alzheimers disease. The resident required 2-person assistance with a hoyer for transfers. Observation on 02/27/24 at 9:32 A.M. revealed Resident #53 was laying in bed with covers over her body. Observation on 02/27/25 at 12:45 P.M. revealed Resident #53 was laying in bed with covers over her body. Interview on 02/27/25 at 12:48 P.M., Certified Nursing Assistant (CNA) #113 verified Residents #09, #43 and #53 were still in bed. CNA #113 stated she was the only CNA on the unit from when she came in at 7:00 A. M. until noon, when another CNA came in to help. Review of the facility policy titled, Activities of Daily Living, dated 04/29/16, revealed the facility would provide the necessary care and services to residents who are unable to carry out ADLs. 34291 5. Medical record review for Resident #73 revealed an admitted [DATE]. His medical diagnoses included cirrhosis, neurogenic bladder, urinary tract infection, and asthma. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #73 was cognitively intact. Functional status was setup or clean-up for eating, dependent for toileting and transfers, and partial/moderate assistance for bed mobility. Review of the care plan for Resident #73 dated 01/11/25 revealed he had a activities of daily living deficit related to C-4/C-5 syndrome and arthritis. Review of the showers for Resident #73 from 01/15/25 through 02/25/25 revealed he received eight showers out of 11 opportunities. Further review of the documentation for showers revealed the resident had a shower on 02/09/25 and not again until 02/24/25. Interview with Resident #73 on 02/24/25 at 1:59 P.M. revealed he was not getting his showers in timely manner. He stated he is an easy going guy and was willing to switch days for his showers, but he felt the aides took advantage of his goodness and keeps telling him he would get a shower tomorrow and he doesn't get his shower. He stated he has received three showers in a little over three weeks. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator on 02/27/25 at 8:06 A.M. confirmed the showers for Resident #73 was not documented as completed and therefore wasn't given to the resident. Review of the policy titled, Activities of Daily Living, dated 04/29/16 revealed each resident will receive and the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being. in accordance with the comprehensive assessment and plan of care. This deficiency represents non-compliance investigated under Complaint Number OH00162997.

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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 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** 46613 Based on medical record review, staff interview, and policy review, the facility failed to ensure nephrostomy tube care was completed as ordered. This affected one (#234) resident out of the one resident reviewed for urinary catheters. The facility census was 76. Findings included: Review of the medical record for Resident #234 revealed an admitted [DATE] with medical diagnoses of end stage renal disease, atrial fibrillation, hypertension, anemia, and malignant neoplasm of cervix. Review of the medical record for Resident #234 revealed an admission Minimum Data Set (MDS) assessment, dated 02/17/25, which indicated Resident #234 was cognitively intact and was dependent upon staff for toilet hygiene, required substantial/maximum assistance with bathing, and partial/moderate assistance with bed mobility and transfers. The MDS indicated Resident #234 had an indwelling catheter. Review of the medical record for Resident #234 revealed a physician order dated 02/18/25 to change gauze dressing every other day to bilateral nephrostomy tubes. Review of the medical record for Resident #234 revealed hospital discharge orders dated 02/10/25 to change dressing to nephrostomy tube every other day and empty the bag as needed. Review of the medical record for Resident #234 revealed February 2024 Treatment Administration Record (TAR) which did not have documentation to support nephrostomy tube dressing changes were completed until 02/18/25. Interview on 02/27/25 at 10:50 A.M. with Administrator confirmed the facility did not have documentation to support the treatment for bilateral nephrostomy tube care was ordered until 02/18/25 and no documentation to support nephrostomy tube care was done as ordered until 02/18/25. Administrator stated the facility did not have a nephrostomy tube care policy.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731 Based on medical record review, staff interview, and policy review, the facility failed to ensure weights were obtained in a timely manner. This affected three (#49, #51, and #64) of four residents reviewed for nutrition. The facility census was 76. Findings include: 1. Review of the medical record of Resident #49 revealed an admitted [DATE]. The resident transferred to the hospital on 12/25/24 and returned to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, emphysema, acute and chronic respiratory failure with hypoxia, moderate protein-calorie malnutrition, vascular dementia, hemiplegia and hemiparesis following cerebral infarction, thyroid cancer, anxiety, and hypothyroidism. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognition. The resident required set-up assistance with eating and oral hygiene, however was dependent on staff for all other ADLs. Review of Resident #49's weights revealed the resident was weighed on 12/06/24 and 01/11/25. There were no weights documented between 12/06/24 and 01/11/25, including on 12/28/24 when the resident readmitted from the hospital. Further review revealed no documentation of any rationale for not obtaining Resident #49's weight upon readmission on 12/28/24. Interview on 02/26/25 at 2:59 P.M., Dietetic Technician (DT) #78 verified Resident #49 was not weighed upon readmission to the facility on [DATE]. DT #78 verified Resident #49 was weighed on 12/06/24 and on 01/11/25. DT #78 stated she expected admission and readmission weights to be obtained within 24 hours of admission. 2. Review of the medical record of Resident #51 revealed an admitted [DATE]. Diagnoses included hypertensive heart disease with heart failure, hallucinations, polyosteoarthritis, repeated falls, chronic kidney disease, chronic pain syndrome, psychosis, hypothyroidism, depression, anxiety, hypertension, colon cancer, unspecified hearing loss, amnesia, history of transient ischemic attack. Review of the quarterly MDS assessment dated [DATE] revealed the resident had moderately impaired cognition. The resident rejected care 1-3 days during the assessment period. The resident was independent with bed mobility, required setup assistance for eating, partial/moderate assistance for toileting, bathing, and transfers. Review of a Nutrition Services progress note dated 09/20/24 revealed Resident #51 triggered for significant weight loss on 09/17/24, with a weight of 215.4 pounds. The resident weighed 234.5 pounds on 08/24/24, indicating an 8.1% loss in the last 25 days. A reweigh was requested. Review of a Nutrition Services progress note dated 01/31/25 revealed the resident triggered significant weight loss on 01/27/25, when she weighed 205.2 pounds from 11/09/24, when she weighed 222.4 pounds. The progress note indicated the resident had a 17.2 pound loss (7.7%) in 80 days. A reweigh was requested. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #51's weights revealed, on 09/17/24, the resident weighed 215.4 pounds. On 11/09/24, the resident weighed 222.4 pounds. On 01/27/24, the resident weighed 205.2 pounds. There were no additional weights documented between 09/17/24 and 11/09/24 and there were no weights documented after 01/27/25. Interview on 02/26/25 at 3:14 P.M., DT #78 verified reweights were not obtained as requested on 09/20/24 and 01/31/25. DT #78 stated the expectation was for reweights to be obtained within 48 hours. 34291 3. Medical record review for Resident #64 revealed an admitted [DATE]. Medical diagnoses included neurogenic bladder, seizure disorder, and respiratory failure. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #64 was moderately cognitively impaired. Her functional status was eating was non-applicable, toileting was dependent, bed mobility was partial/moderate assistance and transfers was substantial/maximal assistance for transfers. She was always incontinent for bowels and bladder. Review of the care plan for Resident #64 dated 12/18/24 revealed she was at risk for alteration in nutrition and has had a significant weight loss. Intervention was to take weekly weights. Review of physician orders dated 08/26/24 for Resident #64 revealed weekly weights. Review of weights from 12/17/24 through 02/25/25 revealed out of eleven opportunities she had seven weights taken. Interview with the Registered Diet Tech (RDT) #78 on 02/26/25 at 2:58 P.M. confirmed the weights for Resident #64 was not taken weekly as ordered. Review of the facility policy titled, Weight Policy-Scales, dated 04/2024 revealed residents would be weighed within 24 hours of admission/readmission and residents would be re-weighed in a reasonable time frame if their weight shows a significant weight change of 5% from their previous weight.

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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** 46613 Based on medical record review, staff interview, and review of facility skills documentation form, the facility failed to ensure tracheostomy care/oral care was completed as ordered. This affected one (#13) of one resident reviewed for tracheostomy care. The facility census was 76. Findings included: Review of the medical record for Resident #13 revealed an admitted [DATE] with medical diagnoses of persistent vegetive state, respiratory failure, epilepsy, anoxic brain injury, quadriplegia, and tracheostomy. Review of the medical record for Resident #13 revealed a quarterly Minimum Data Set (MDS) assessment dated [DATE] which indicated Resident #13 was in a persistent vegetative state and was dependent upon staff for all activities of daily living. Review of the MDS revealed Resident #13 had a tracheostomy. Review of the medical record for Resident #13 revealed an order dated 01/25/25 for tracheostomy care/oral care three times per day and an order dated 01/15/25 to change inner cannula two times per day. Review of the medical record for Resident #13 revealed a February 2024 Respiratory Administration Record (RAR) which did not contain documentation to support the facility completed tracheostomy/oral care as ordered on 02/02/25 through 02/04/25, 02/08/25, 02/09/25, 02/14/25, 02/21/24 through 02/24/25. Interview on 02/27/25 at 9:30 A.M. with Administrator confirmed the medical record for Resident #13 did not contain documentation to support tracheostomy/oral care was completed as ordered on 02/02/25 through 02/04/25, 02/08/25, 02/09/25, 02/14/25, 02/21/24 through 02/24/25. Administrator stated the facility did not have a tracheostomy care policy. Review of a facility form titled, Skills Documentation/Evaluation Record Tracheostomy- disposable inner cannula stated staff are to chart procedure on treatment record.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, staff interview, and policy review, the facility failed to ensure dialysis communication forms were completed and sent to the dialysis center prior to dialysis. This affected one (#47) resident who attended hemodialysis. The facility census was 76. Findings included: Review of the medical record for Resident #47 revealed an admitted [DATE] with medical diagnoses of end stage renal disease, dependence on dialysis, diabetes mellitus, and hypertension. Review of the medical record for Resident #47 revealed a quarterly Minimum Data Set (MDS) assessment dated [DATE], which indicated Resident #47 was cognitively intact and required substantial/maximum assistance with toilet hygiene, bed mobility, and transfers and dependent upon staff for bathing. The MDS indicated Resident #47 received dialysis. Review of the medical record for Resident #47 revealed a physician order dated 11/05/24 to attend dialysis Monday, Wednesday, and Friday with pick up time at 6:00 A.M. and an order dated 11/20/24 to obtain residents weight and vital signs prior to dialysis and upon return to the facility. Review of the medical record for Resident #47 revealed documentation to support the facility obtained Resident #47's weight and vital signs prior to and upon return from dialysis. Review of Resident #47's dialysis communication book revealed no documentation to support the facility sent a communication form to Resident #47's dialysis on 02/03/25, 02/05/25, 02/10/25, 02/19/25, 02/21/25, 02/24/25. Interview on 02/27/25 at 10:59 A.M. with Administrator confirmed the facility did not have documentation to support dialysis communication forms were sent to the dialysis center on 02/03/25, 02/05/25, 02/10/25, 02/19/25, 02/21/25, and 02/24/25. Administrator stated Resident #47's vital signs were taken prior to and after each dialysis and stated the facility was in contact with the dialysis center via phone often. Administrator confirmed the medical record did not have documentation to support the facility contacted the dialysis center and updated on Resident #47 health condition via phone. Review of the facility policy titled, Dialysis Care Policy, dated February 2018, stated the Manor would ensure that residents who require dialysis receive such services, consistent with professional standards of practice and the comprehensive, person-centered plan of care. The policy stated the manor would provide ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility and ongoing assessment. The policy also stated the Manor would provide ongoing communication and collaboration with the dialysis facility regarding dialysis care and services.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record reviews, observations, staff interviews, and policy review, the facility failed to ensure resident's medications were administered as ordered resulting in three medication errors out of 29 opportunities or a 10.34 percent (%) medication error rate. This affected two (#33 and #62) residents out of the four residents reviewed for medication administration. The facility census was 76. Findings included: 1. Review of the medical record for Resident #33 revealed an admitted [DATE] with medical diagnoses of chronic kidney disease Stage III, morbid obesity, left hemiplegia, diabetes mellitus, heart failure, depression, and spina bifida. Review of the medical record for Resident #33 revealed a quarterly Minimum Data Set (MDS) assessment dated [DATE], which indicated Resident #33 was cognitively intact and was dependent for toilet hygiene, bathing, and transfers and required substantial/maximum assistance with bed mobility. Review of the medical record for Resident #33 revealed a physician order dated 08/29/24 for Stiolo Respimat inhalation aerosol 2.5-1.5 micrograms (mcg) per activation (act) two puffs orally daily and an order dated 09/26/24 for fluticasone propionate suspension (Flonase) 50 mcg/act two sprays in each nostril daily. Observation on 02/25/25 at 7:43 A.M. revealed Licensed Practical Nurse (LPN) #52 prepared Resident #33's medications. LPN #52 was observed to administer one puff of Stioto Respimat inhalation aerosol orally and one spray of Flonase to each of Resident #33's nostrils. Interview on 02/25/25 at 8:03 A.M. with LPN #52 she only administered one puff of Stiolo Respimat inhalation aerosol and one spray of Flonase to each nostril for Resident #33. 2.Review of the medical record for Resident #62 revealed an admitted [DATE] with medical diagnoses of left femur fracture, anemia, nondisplaced fracture of greater trochanter, diabetes mellitus, atrial fibrillation, Alzheimer's disease, and Depression. Review of the medical record for Resident #62 revealed an admission MDS assessment, dated 02/08/25, which indicated Resident #62 moderately cognitively impaired and required partial/moderate staff assistance with toilet hygiene, bathing, bed mobility, and transfers. Review of the MDS indicated Resident #62 received antidepressant medication. Review of the medical record for Resident #62 revealed a physician order dated 02/03/25 for sertraline 100 milligram (mg) one tablet by mouth daily. Observation on 02/25/25 at 8:30 A.M. revealed LPN #94 prepared Resident #62's medications for administration. The observation revealed LPN #94 administer one sertraline 25 mg tablet to Resident #62. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/25/25 at 8:28 A.M. with LPN #94 confirmed she administered Resident #62 one sertraline 25 mg tablet during medication administration and not 100 mg tablet as ordered. Review of the facility policy titled, Medication administration policy, reviewed 12/19/24 stated medications are to be administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. The policy stated prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician orders are checked for the correct dosage schedule. The policy stated medications are administered in accordance with written orders of the attending physician.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on observation, medical record review, and staff interview, the facility failed to prevent a significant medication errors when staff did not prime an insulin pen prior to administration. This affected one (Resident #33) of four residents observed for medication administration. The facility census was 76. Findings include: Review of the medical record for Resident #33 revealed an admitted [DATE] with medical diagnoses of chronic kidney disease Stage III, morbid obesity, left hemiplegia, diabetes mellitus, heart failure, depression, and spina bifida. Review of the medical record for Resident #33 revealed a quarterly Minimum Data Set (MDS) assessment dated [DATE], which indicated Resident #33 was cognitively intact and was dependent for toilet hygiene, bathing, and transfers and required substantial/maximum assistance with bed mobility. Review of the medical record for Resident #33 revealed a physician order dated 01/21/25 for Novolog solution 100 units per milliliter (ml) to inject 28 units subcutaneously (SQ) at breakfast daily. Observation on 02/25/25 at 7:43 A.M. revealed Licensed Practical Nurse (LPN) #52 prepared Resident #33's medications. The observation revealed LPN #52 set Humalog insulin kwikpen (substitute for Novolog solution) to 28 units and placed needle on the kwikpen. Interview on 02/25/25 at 8:03 A.M. with LPN #52 confirmed she did not prime Humalog insulin kwikpen with two units prior to administration of 28 units.

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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** 46613 Based on medical record reviews, observations, staff interviews, review of insulin pen checklist, and policy review, the facility failed to ensure over the counter medication bottle and insulin pen were dated after opened and failed to ensure medications were not left at the bedside. This affected two (#33 and 51) residents out of the four residents reviewed for medications. The facility census was 76. Findings included: 1. Review of the medical record for Resident #33 revealed an admitted [DATE] with medical diagnoses of chronic kidney disease Stage III, morbid obesity, left hemiplegia, diabetes mellitus, heart failure, depression, and spina bifida. Review of the medical record for Resident #33 revealed a quarterly Minimum Data Set (MDS) assessment, dated 12/06/24, which indicated Resident #33 was cognitively intact and was dependent for toilet hygiene, bathing, and transfers and required substantial/maximum assistance with bed mobility. Review of the medical record for Resident #33 revealed a physician order dated 09/29/24 for Vitamin B12 1000 micrograms (mcg) one tablet by mouth daily and an order dated 01/21/25 for Novolog solution 100 units per milliliter (ml) to inject 28 units subcutaneously (SQ) at breakfast daily. Observation was made on 02/24/25 at 10:22 A.M. revealed Resident #33 had Sevelamer Carbonate (to control high blood phosphate levels) was mixed with water in a cup sitting on her bedside table. The resident stated the nurses normally leave the medication at the bedside. Interview with the Licensed Practical Nurse (LPN) #76 on 02/24/25 at 10:27 A.M. confirmed she left the medication at the bedside for Resident #33. Observation on 02/25/25 at 7:43 A.M. revealed Licensed Practical Nurse (LPN) #52 prepare Resident #33 medications for administration. The observation revealed LPN #52 set Humalog insulin kwikpen (substitute for Novolog solution) to 28 units and placed needle on the kwikpen. The observation revealed the kwikpen did not indicate a date when the kwikpen was opened. The observation also revealed LPN #52 removed a Vitamin B12 tablet from an open bottle that was not dated and placed into the medication cup. LPN #52 was observed to administer 28 units of Humalog insulin kwikpen SQ and Vitamin B12 tablet to Resident #33. Interview on 02/25/25 at 8:03 A.M. with LPN #52 confirmed the Humalog insulin kwikpen and the Vitamin B12 bottle did not indicate the date the items were opened. 42731 2. Review of the medical record of Resident #51 revealed an admitted [DATE]. Diagnoses included hypertensive heart disease with heart failure. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS assessment dated [DATE] revealed the resident had moderately impaired cognition. The resident rejected care 1-3 days during the assessment period. The resident was independent with bed mobility, required setup assistance for eating, partial/moderate assistance for toileting, bathing, and transfers. Review of the plan of care dated 12/23/24 revealed the resident had a behavior problem related to holding medications under her tongue and spitting them out after the nurse leaves the room. Interventions included to monitor the resident and document observed behavior and attempted interventions. Review of physician orders revealed an order dated 12/06/24 for a Century Oral Tablet daily upon rising. Observation on 02/26/25 at 9:41 A.M. revealed an orange pill laying on the foot of Resident #51's bed. Interview at the same time, LPN #93 verified the pill was laying on Resident #51's bed. LPN #93 stated the pill was a multivitamin and stated she was not aware how long it had been there and stated she had watched the resident take her pills earlier that morning. Review of the facility policy titled, Medication Administration-General Guidelines, dated 12/19/24, revealed the resident is always observed after administration to ensure medications are completely ingested. Medications are administered at the time they are prepared Review of the facility policy titled, Medication Storage in the Facility, dated 12/19/24, revealed medications are stored safely, securely, and properly, following manufacturer's or supplier recommendations. Outdated medications are immediately removed from stock.

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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. 34291 Based on observation and staff interview, the facility failed to ensure gloves were changed between contaminated surfaces and food. This had the potential to affect 12 residents (#11, #18, #25, #28, #32, #34, #39, #40, #41, #54, #59, and #73) who were served from this kitchenette on the Pine Club unit. The census was 76. Findings included Observation on 02/24/25 at 12:00 P.M. revealed Dietary Aide (DA) #122 had on gloves and was using his gloved hands to touch the trays, silverware, and reaching into the cabinets. He trayed up a meal with the gloves on and reached into the package of rolls and used his gloved hands to place the roll on the plate. He removed his gloves and left the kitchenette and returned with two pots of coffee placed gloves on both hands and reached up into the cabinet with his right hand and gets down two coffee cups and fills one with his right hand placed the coffee on the tray. He continued with the gloves to plate up another meal and went to the bag of rolls and used his right hand to place a roll on the plate and covers the plate with the lid. He walks over to the microwave and hits the timer to heat up the tea. He continued to plate another tray of food and reach into the bag of rolls with his right gloved hand and placed it on the tray. He left the kitchenette and got a teabag right out of the kitchenette ledge and went back into the kitchen with his gloves on and continued to plate another tray and place his right gloved hand into the bag of rolls. Interview with the DA #122 on 02/24/25 at 12:10 P.M. confirmed he touched his contaminated gloves into the package of rolls and placed them on the plates of food for the residents. DA #122 verified he was serving Residents #11, #18, #25, #28, #32, #34, #39, #40, #41, #54, #59, and #73.

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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** 46613 Based on medical record review, observation, staff interview, and policy review, the facility failed to follow infection control procedures during tracheostomy care. This affected one (#13) resident of one resident observed for tracheostomy care. The facility census was 76 Findings include: Review of the medical record for Resident #13 revealed an admitted [DATE] with medical diagnoses of persistent vegetive state, respiratory failure, epilepsy, anoxic brain injury, quadriplegia, and tracheostomy. Review of the medical record for Resident #13 revealed a quarterly Minimum Data Set (MDS) assessment, dated 02/01/25 which indicated Resident #13 was in a persistent vegetative state and was dependent upon staff for all activities of daily living. Review of the MDS revealed Resident #13 had a tracheostomy. Review of the medical record for Resident #13 revealed a physician order dated 01/25/25 for tracheostomy care/oral care three times per day and an order dated 01/15/25 to change inner cannula two times per day. Review of the physician orders revealed no documentation to support an order for Enhanced Barrier Precautions (EBP). Observation on 02/24/25 at 10:14 A.M. revealed Respiratory Therapist (RT) #46 performing tracheal suctioning and oral care on Resident #13. RT #46 was observed wearing a mask and gloves. The observation revealed an EBP sign was posted on the wall behind Resident #13's bed. Continued observation of Resident #13's room revealed masks and gloves were available for staff but did not reveal gowns available for staff to use when providing care to Resident #13. Interview on 02/24/25 at 10:21 A.M. with RT #46 confirmed he did not wear a gown when providing tracheal suctioning or oral care for Resident #13. RT #46 verified Resident #13 coughed when he was providing the tracheal suctioning. RT #46 confirmed Resident #13's room did not have a sign posted to follow EBP or gowns available to wear during cares. Review of the facility policy titled, Enhanced Barrier Precautions, dated August 2022, stated it was the intent of the facility to use EBP in addition to Standard Precautions for residents to prevent transmission of multidrug resistant organisms (MDRO) in the care community. The policy stated an impervious gown should be worn when high-contact resident care activities are being performed. The policy also stated high-contact resident care activities included device care or use: central line, urinary catheter, feeding tube, and tracheostomy/ventilator.