STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365515	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Respiratory and Nursing Center of Dayton	3421 Pinnacle Road Moraine, OH 45439

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, observation, resident representative interview, and staff interviews, the facility failed to ensure resident representative preferences were honored. This affected one (Residents #54) of six residents reviewed for activities of daily living (ADL) assistance. The facility also failed to honor resident needs and preferences regarding bathroom accomodations. This affected one (Resident #49) of six residents reviewed for ADL assistance. The facility census was 75 residents. Findings include: Review of the medical record for Resident #54 revealed an admitted [DATE] diagnoses including chronic respiratory failure, end stage renal disease, dependence on renal dialysis, atrial fibrillation, diabetes mellitus, and atherosclerotic heart disease. Review of the Minimum Data Set (MDS) assessment for Resident #54 dated 06/27/24 revealed the resident had severe cognitive impairment, was dependent upon staff for toileting hygiene, bathing, and bed mobility, and did not transfer out of bed during the review window. Review of the social service note for Resident #54 dated 08/13/24 revealed the facility held a care conference was held with Resident #54's representative, the unit nurse, the dietician, and social service staff. Resident #54's representative requested staff transfer Resident #54 out of bed to a chair on Tuesday and Thursdays. Review of the ADL records for Resident #54 dated 07/30/24 to 08/28/24 revealed staff transferred the resident out of bed on 08/02/24 (Friday), 08/14/24 (Wednesday), and 08/30/24 (Friday). The record did not include documentation of staff transferring Resident #54 out of bed twice weekly on Tuesdays and Thursday per the resident representative's request. Interview on 08/25/24 at 12:25 P.M. with Resident #54's representative confirmed the staff had agreed to get Resident #54 out of bed and up into a chair on Tuesdays and Thursdays, but the staff had not accommodated the request. Resident #54's representative further confirmed the resident attended dialysis on Monday, Wednesday, and Fridays. Observation on 08/27/24 at 1:08 P.M. revealed Resident #54 was lying in bed. (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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/28/24 at 10:40 A.M. with State tested Nursing Assistant (STNA) #43 stated she provided care for Resident #54 and had never seen the resident sitting in a chair. STNA #43 stated she was never informed of Resident #54's representative's request for the resident to be up in chair on Tuesdays and Thursday. Interview on 08/28/24 at 2:04 P.M. with Licensed Practical Nurse (LPN) #50 confirmed staff did not get Resident #54 out of bed and into a chair on Tuesdays or Thursdays, and she was not aware of the request to get the resident up made by Resident #54's representative. Interview on 09/03/24 at 10:53 A.M. with Director of Nursing (DON) confirmed Resident #54 was dependent on staff to transfer him out of bed. The DON confirmed Resident #54's record did not include documentation of staff transferring the resident out of bed to a chair on Tuesdays and Thursday per the resident representative's request. 36648 2. Review of the medical record for Resident #49 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, asthma, heart failure and depression. Review of the physician's orders for Resident #49 dated August 2024 revealed there were no orders for the resident to have a toilet riser to the commode. Interview on 08/25/24 at 10:35 A. M. with Resident #49 confirmed he was unhappy with his room. He recently returned to the facility from the hospital, and they changed his room upon his return. Resident #49 confirmed he had to use the restroom in the shower room to go to the bathroom because the commode in his room had a toilet riser. Resident #49 confirmed he was unable to sit on the commode with the toilet riser in place. Observation on 08/26 /24 at 11:00 A. M. of Resident #49's bathroom revealed there was a toilet riser on the commode in the resident's room. Interview on 08/26/24 at 11:00 A.M. with State tested Nurse Aide (STNA) #101 confirmed there was a toilet riser on the commode of Resident #49's bathroom. Interview on 08/27/24 at 02:44 P. M. with STNA #95 confirmed Resident #49 was able to go to the restroom independently but he did not use the commode in his room because there was a toilet riser on it.

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on record review, staff interview, and review of the Resident Assessment Instrument (RAI) Manual 3. 0, the facility failed to ensure comprehensive admission Minimum Data Set (MDS) assessments were completed timely. This affected one (Resident #56) of eight residents reviewed for timely assessments. The facility census was 75 residents. Findings include: Review of the medical record for Resident #56 revealed an admitted [DATE] with diagnoses including chronic respiratory failure with hypoxia, sepsis, end stage renal disease, anoxic brain injury, and tracheostomy. Review of the admission MDS assessment for Resident #56 with an assessment reference date (ARD) of 06/20/24 revealed the resident had severe cognitive impairment and was dependent upon staff for all activities of daily living. Review of the MDS revealed a completion date of 07/15/24. Interview with Regional MDS Nurse #110 confirmed Resident #56's comprehensive admission assessment was not completed as per RAI manual guidelines. Regional MDS Nurse #110 confirmed the facility utilized the RAI manual for guidelines and instructions on how and when to complete the MDS assessments. Review of RAI User's Manual dated October 2023, on pages two through 22 revealed an admission assessment was the comprehensive assessment for a new resident and that it must be completed by the end of day 14, counting the date of admission to the nursing home as day one.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record reviews, staff interview, and review of the Resident Assessment Instrument (RAI) User's Manual 3.0, the facility failed to ensure quarterly Minimum Data Set (MDS) assessments were completed timely. This affected four (Residents #06, #08, #22, and #50) of 23 residents reviewed for timely MDS assessments. The facility census was 75 residents. Findings include: 1. Review of the medical record for Resident #06 revealed an admitted [DATE] with diagnoses including chronic respiratory failure, dependence on ventilator, multiple sclerosis (MS), spastic paraplegia, schizoaffective disorder, dementia, and diabetes mellitus (DM). Review of the quarterly MDS assessment for Resident #06 with an assessment reference date (ARD) of 07/03/24 revealed the resident had severely impaired cognition and was dependent upon staff for all activities of daily living (ADLs). Review of the MDS revealed a completion date of 08/05/24. 2. Review of the medical record for Resident #08 revealed an admitted [DATE] with diagnoses including chronic respiratory failure, DM, seizures, chronic obstructive pulmonary disease (COPD), and hypertension. Review of the quarterly MDS assessment for Resident #08 with ARD of 05/31/24 revealed the resident had severely impaired cognition and was dependent upon staff for all ADLs. Review of the MDS revealed a completion date of 06/24/24. 3. Review the medical record for Resident #22 revealed an admitted [DATE] with diagnoses including MS, chronic respiratory failure, hypothyroidism, and hypertension. Review of the medical record for Resident #22 revealed a quarterly MDS assessment with ARD of 06/21/24 which indicated Resident #22 had moderate cognitive impairment and was dependent upon staff for all ADLs. The MDS revealed a completion date of 07/15/24. 4. Review of the medical record for Resident #50 revealed an admitted [DATE] with medical diagnoses of chronic respiratory failure, dependence upon a ventilator, tracheostomy, anoxic brain injury and hypertension. Review of the quarterly MDS assessment for Resident #50 with an ARD of 07/03/24 revealed the resident had severely impaired cognition and was dependent upon staff for all ADLs. Review of the MDS revealed a completion date of 08/05/24. Interview on 08/27/24 at 1:00 P.M. with Regional MDS Nurse #110 confirmed the quarterly MDS assessments for Residents #06, #08, #22, and #50 were not completed timely per RAI Manual guidelines. Regional MDS Nurse #110 further confirmed the facility utilized the RAI Manual for guidelines and instructions on how and when to complete the MDS assessments. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of MDS RAI 3.0 User's Manual dated October 2023, pages two through35 revealed the quarterly MDS completion date must be no later than 14 days after the ARD.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36648 Based on medical record review and staff interview, the facility failed to update resident care plans regarding changes in condition. This affected one (Resident #68) of two residents for hospitalization s. The facility census was 75 residents. Findings include: Review of the medical record for the Resident #68 revealed an admitted [DATE] with diagnoses including chronic respiratory failure with hypoxia, dependence on respirator, non-traumatic intracerebral hemorrhage, embolism and thrombosis of thoracic aorta. Review of the care plan for Resident #68 last updated 04/19/24 revealed it was not updated to include the resident's behavior of pulling out her tracheostomy tube. Review of the nurse progress note for Resident #68 dated 07/11/24 revealed the respiratory therapist (RT) entered the resident's room in response to a pulse oximetry alarm and found the resident's tracheostomy tube had been pulled out and the resident was unresponsive. The RT replaced the tracheostomy tube, and the nurse and RT started cardiopulmonary resuscitation and called 911. The resident was transported to the hospital for an evaluation. Interview on 09/03/24 at 9:30 A.M. with Minimum Data Set (MDS) Coordinator #84 confirmed the care plan for Resident #68 had not been updated to include the resident's behavior of pulling out her tracheostomy tube and interventions and steps for staff to take in response to the behavior. Interview on 09/03/24 at 9:45 A. M. with the Director of Nursing (DON) confirmed Resident #68 had a history of pulling out her tracheostomy tube, and the behavior should be care planned. The DON confirmed the facility did not have a policy regarding care planning.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record reviews, observations, and staff interviews, the facility failed to ensure activity of daily living (ADL) care and services were provided for dependent residents. This affected two (Residents #50 and #46) of six residents reviewed for ADL assistance. The facility census was 75. Findings include: 1. Review of the medical record for Resident #50 revealed an admitted [DATE] with diagnoses including chronic respiratory failure, dependence upon a ventilator, tracheostomy, anoxic brain injury and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #50 dated 07/03/24 revealed the resident had severely impaired cognition and was dependent upon staff for all ADLs and had limited range of motion (ROM) to bilateral upper and lower extremities. Review of the body assessment forms for Resident #50 dated 07/27/24, 07/31/24, 08/03/24, 08/07/24, 08/10/24, 08/14/24, 08/17/24, 08/21/24, and 08/24/24 were completed by State tested Nursing Assistants (STNAs) and signed by the nurse. Further review of the forms revealed Resident #50 received a bath on those days, but staff did not perform nail care. Observation on 08/26/24 at 8:10 A.M. of Resident #50 revealed the resident was in bed with contractures to bilateral hands and her fingernails were long and jagged. Observation on 08/27/24 at 1:19 P.M. with Licensed Practical Nurse (LPN) #42 revealed Resident #50's hands were contracted with long and jagged fingernails. Further observation revealed when LPN #42 opened the Resident #50's right hand there was dark brown debris and dirt on the resident's right hand. Interview on 08/27/24 at 1:19 P.M. with Licensed Practical Nurse (LPN) #42 confirmed Resident #50's hands were contracted, and her fingernails were long and jagged. LPN #42 further confirmed when she opened the resident's contracted hands there was dark brown debris and dirt on the resident's right hand. 44070 2.Review of the medical record for Resident #46 revealed an admitted [DATE] with diagnoses including acute respiratory failure, liver cirrhosis, chronic hepatitis C, heart failure, and anxiety. Review of the Minimum Data Set (MDS) assessment for Resident #46 dated 07/24/24 revealed the resident was cognitively intactand required extensive assistance of two staff for toileting. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care for Resident #46 dated dated 08/08/24 revealed the resident required assistance with ADLs and was at risk of developing complications associated with decreased ADL self performance. Interventions included two staff should use a Hoyer lift for all transfers and the resident required total care for toileting. Interview on 08/25/24 at 2:20 P.M. with Resident #46 confirmed the facility staffing was low and at times call lights took awhile to be answered. Resident #46 confirmed she needed assistance after using the bathroom and she would activate her call light on. Observation on 08/25/24 at 2:51 P.M. revealed Resident #46's call light remained activated since the resident had turned on the light at 2:20 P.M. Interview on 08/25/24 at 2:51 P.M. with Resident #46 confirmed the resident had been incontinent and staff had not provided incontinence care. Resident #46 confirmed the nurse came in and said an aide would be back to provide care. Observation on 08/25/24 at 2:54 P.M. revealed State tested Nursing Aide (STNA) #60 went into Resident #46's room, deactivated the call light and asked resident for the reason of her call light being on. Resident #46 told STNA #60 she needed help in getting cleaned up. STNA #60 informed Resident #46 she would let the assigned STNA know. Observation on 08/25/24 at 2:58 P.M. revealed STNA #60 returned to inform resident the assigned STNA would come back in five minutes. Interview on 08/25/24 at 3:01 P.M. with STNA #60 confirmed she turned Resident #46's call light off without preforming care and revealed she informed the assigned aide, STNA #43 that the resident needed assistance. Interview on 08/25/24 at 3:09 P.M. with STNA #43 confirmed she did not know Resident #46 had been waiting for approximately 49 minutes to receive incontinence care. STNA #43 further confirmed Resident #46 was incontinent and needed care. STNA #43 confirmed staff should be assisting each other and should not make a resident wait until their assigned aide was available. Interview on 08/27/24 from 3:00 P.M. with Administrator and the Director of Nursing (DON) confirmed the facility had no written policy regarding time frames for answering call lights.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on record review, observation, resident interview, staff interview, and review of the facility activity calendar, the facility had failed to ensure activities were provided daily and throughout the day to include late afternoon and evening activities. This affected one (Resident #44) of two residents reviewed for activities and had potential to affect nine additional facility-identified residents (#12, #14, #29, #44, #45, #46, #53, #55, and #63) who attended activities during the day and evening. The facility census was 75 residents. Findings include: Review of the medical record for Resident #44 revealed an admitted [DATE] with diagnoses including unspecified fracture of left femur, diabetes, anxiety, atrial fibrillation, and vascular disease. Review of the plan of care for Resident #44 dated 07/17/24 revealed the resident enjoyed socialization including parties, games, crafts, puzzles and chatting with visitors. Interventions included the following: invite resident to attend preferred activities, give verbal reminders of activity before commencement, offer assist and escort resident to activity functions. Interview on 08/26/24 at 9:52 A.M. with Resident #44 confirmed the facility needed more weekend activities. Resident #44 confirmed the facility only had activities every other Saturday and they ended around 1:30 P.M. or 2:00 P.M. six days a week. Interview on 08/27/24 at 4:30 P.M. with Activity Aide (AA) #116 confirmed the facility did not offer later afternoon and evening activities six days a week and no activities every other weekend. AA #16 confirmed they had a staff member that worked on Sundays, and another worked every other Saturday. Activity Aide confirmed they did not have the staffing to provide additional activities on evenings and weekends per resident request. Interview on 08/28/24 at 10:00 A.M. with Activity Director (AA) #26 and AA #116 confirmed there were no activities after 1:30-2:00 P.M. except for once weekly for bible study at 6:00 P.M. They also confirmed there no weekend activities every other weekend. Review of the activity calendars dated July and August 2024 revealed except for a Monday bible class at 6:00 P.M., the facility activities ended at 2:00 P.M. The facility also had no activities scheduled every other Saturday on 07/13/24, 07/27/24, 08/10/24, and 08/24/24. Interview on 08/28/24 at 3:00 P.M. with Administrator confirmed the facility had no policies regarding scheduling of activities.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, observation, and staff interview, the facility failed to ensure staff properly positioned dependent residents in bed. This affected one (Resident #50) resident of four residents reviewed for positioning. The facility census was 75 residents. Findings include: Review of the medical record for Resident #50 revealed an admitted [DATE] with diagnoses including chronic respiratory failure, dependence upon a ventilator, tracheostomy, anoxic brain injury and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #50 dated 07/03/24 revealed the resident had severely impaired cognition and was dependent upon staff for all activities of daily living (ADLs) and had limited range of motion (ROM) to the bilateral upper and lower extremities. Review of the physician's orders for Resident #50 revealed an order dated 10/17/22 to place a pillow between resident's hands and face to offload pressure. Observation on 08/26/24 at 8:10 A.M. of Resident #50 revealed the resident was lying in bed on her side without a pillow placed between her hands and face. Resident #50's chin was pressed against her oxygen tubing to ventilator. Observation on 08/27/24 at 1:19 P.M. of Resident #50 revealed the resident was in bed and did not have a pillow placed between her face and hands as ordered. Interview on 08/27/24 at 1:19 P.M. with Licensed Practical Nurse (LPN) #42 confirmed Resident #50's body was contracted, and the resident had a physician's order to have a pillow placed between her hands and face. LPN #42 confirmed the pillow was not in place as ordered.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, observation, staff interview, and policy review, the facility failed to provide care and services to prevent worsening of contractures and to prevent limited range of motion (ROM). This affected one (Resident #50) of four residents reviewed for ROM. The facility census was 75 residents. Findings include: Review of the medical record for Resident #50 revealed an admitted [DATE] with diagnoses including chronic respiratory failure, dependence upon a ventilator, tracheostomy, anoxic brain injury and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #50 dated 07/03/24 revealed the resident had severely impaired cognition, was dependent upon staff assistance with all activities of daily living (ADLs) and had limited ROM to the bilateral upper and lower extremities. Review of the care plan for Resident #50 revealed the resident was at risk for alteration in skin integrity care plan related to incontinence, impaired mobility, and joint contractures. Review of the occupational therapy (OT) discharge summary for Resident #50 dated 10/02/23 revealed the resident received treatment from 09/05/23 to 10/02/23 to maximize functional ROM to bilateral upper extremities for splint wear and to reduce risk of skin breakdown and contractures. Further review of the summary revealed the resident had good tolerance to ROM exercises and splint wearing and staff had a good understanding of splint wearing schedule. Review of the restorative flow records for Resident #50 dated October 2023 to December 2023 revealed the resident had a restorative splint program but the records did not indicate where the splints were to be applied, for how long the splints were to be applied, how the resident tolerated the program, or if any instructions were provided to staff upon discharge from the restorative program related to the splint/brace placement or maintenance. Review of the medical record for Resident #50 revealed it did not include documentation regarding the application of splints to the resident's bilateral upper extremities. Observation on 08/26/24 at 8:10 A.M. of Resident #50 revealed the resident was lying in bed with contractures to bilateral hands and had no splints in place. Further observation revealed Resident #50's bilateral hands were almost closed into a fist due to contractures to the bilateral hands. Observation on 08/27/24 at 1:19 P.M. revealed Resident #50 was lying in bed with no splints in place to the resident's bilateral hands. Interview on 08/27/24 at 1:19 P.M. with Licensed Practical Nurse (LPN) #42 confirmed Resident #50 had contractures to both hands and was not wearing splints. LPN #42 further confirmed Resident #50's record did not include documentation of splint application. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/28/24 at 2:49 A.M. with Rehab Manager (RM)#126 confirmed upon Resident #50's discharge from OT services on 10/02/23, therapy had recommended staff to apply bilateral hand splints daily for up to four hours as tolerated. Interview on 09/03/24 at 9:51 A.M. with State tested Nursing Assistant (STNA) #61 confirmed Resident #50 was on a passive ROM restorative program to bilateral hands from October 2023 to December 2023. STNA #61 stated upon discharge from the restorative program the floor staff was told to place a carrot or splint into each of Resident #50 hands for three to four hours per day and to complete passive ROM daily with care. STNA #61 confirmed the facility had no record of placement of a carrot or splint to Resident #50's hands for 2024. Interview on 09/03/24 at 10:32 A.M. with Registered Nurse (RN) #38 confirmed he has taken care of Resident #50 for a long time and had never seen a splint/brace in place to bilateral hands. RN #38 confirmed Resident #50 did not have an order for a splint/brace to bilateral hands. RN #38 confirmed Resident #50 had carrots placed in bilateral hands today. Review of the facility polity titled Restorative Nursing Program revised August 2016 revealed residents would be provided with maintenance and restorative services designed to maintain or improve their highest practicable level.

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	365515	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Respiratory and Nursing Center of Dayton	3421 Pinnacle Road Moraine, OH 45439

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36648 Based on medical record review and staff interview, the facility failed to properly inform the staff of interventions and approaches for care of residents with Post Traumatic Stress Disorder (PTSD.) This had the potential to effect one (Resident #27) of one resident reviewed for trauma-informed care. The census was 75 residents. Findings include: Review of the medical record for Resident #27 revealed an admitted [DATE] with diagnoses including stroke, anemia, hypertension and post-traumatic stress disorder (PTSD). Review of the trauma assessment for Resident #27 dated 8/25/24 completed per Social Services Designee (SSD) #104 revealed the resident had served in the military during a war, had a history of a heart attack, and prior to the age of 18 had been physically punished and or beaten by someone he knew and had received bruises, cuts welts, lumps and other injuries as a result of the assault. Additionally Resident #27 he had been pressured into having unwanted sexual contact. No additional information was documented on the assessment other than loud noises and music could be triggering for the resident's PTSD. Review of the care plan for Resident #27 last updated 06/12/24 revealed the resident's diagnosis of PTSD was included, but the care plan did not include interventions to eliminate or mitigate triggers of the PTSD. Interview on 08/28/24 at 3:17 P. M. with SSD #104 confirmed she completed trauma assessment for Resident #27, but she had not asked the resident for details regarding his PTSD in order to identify what staff should do or not do related to triggering the resident's PTSD symptoms. Interview on 08/28/24 at 3:20 P.M. with Minimum Data Set Nurse (MDSM) # 84 and Regional MDS Coordinator #110 confirmed Resident #27's care plan did not include approaches to care for Resident #27 related to his PTSD diagnosis and did not include triggers to PTSD symptoms. Further interview confirmed the facility did not have a policy regarding trauma-informed care. Interview on 08/28/24 at 04:05 P.M. with Licensed Practical Nurse (LPN) #76 confirmed she worked on Resident #27's unit full time. LPN #76 confirmed she had no knowledge of interventions or ways to work with the resident if he should experience triggers of his PTSD. LPN #76 confirmed Resident #27 routinely got upset and angry with staff during incontinence care. Interview on 08/28/24 at 4:06 P.M. with State tested Nurse Aide (STNA) #95 confirmed she worked on Resident #27 full time, but she was not familiar with what the symptoms would be if the resident was experiencing episodes related to his PTSD diagnosis. STNA #95 confirmed the resident routinely refused incontinence care.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 44070 Based on observation and staff interview, the facility failed to ensure staffing was posted daily including date, census and total numbers of actual hours worked per staff. This had the potential to affect all facility residents. The facility census was 75 residents. Findings include Observation on 08/25/24 at 10:20 A.M. revealed the daily staffing posting was dated 08/20/24. Interviews on 08/05/24 at 10:20 A.M. with the Administrator confirmed the staff posting at the front desk was dated 08/20/24. The Administrator confirmed the daily staffing posting should be updated daily, and the facility had no written policy regarding the staffing posting.

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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 review, observation, staff interview, and policy review, the facility failed to ensure open vials of insulin were properly dated after opened and used. This had the potential to affect two (Residents #44 and #60) residents of four residents observed for medication administration. The facility also failed to ensure tuberculin (TB) testing solution was properly dated after opening. This had the potential to affect all of the residents residing in the facility. The facility census was 75 residents. Findings include: 1. Review of the medical record for Resident #44 revealed an admitted [DATE] with diagnoses including left femur fracture, diabetes mellitus (DM), atrial fibrillation, and congestive heart failure. Review of the Minimum Data Set (MDS) assessment for Resident #44 dated 06/08/24 revealed the resident was cognitively intact, required staff assistance with activities of daily living (ADLs), and received insulin for seven days of the review period. Review of the physician's orders for Resident #44 revealed an order dated 04/24/24 for Admelog insulin inject 10 units subcutaneously before meals. Review of the Medication Administration Record (MAR) for Resident #44 dated August 2024 revealed Resident #44 received Admelog insulin as ordered. Observation on 08/27/24 at 8:35 A.M. with Licensed Practical Nurse (LPN) #69 revealed the vial of Admelog insulin for Resident #44 was opened and neither the vial nor the box holding the vial was marked with date of opening. Manufacturer's instructions on the Admelog vial indicated the vial should be discarded 31 days after vial was opened. Interview on 08/27/24 at 8:36 A.M. with LPN #69 confirmed the Admelog insulin vial for Resident #44 was opened, and neither the vial nor the box containing the vial were marked with date opened. LPN #44 further confirmed the written instructions printed on the Admelog insulin vial indicated the vial should be discarded 31 days after opening. LPN #44 was unable to determine the date the vial had been opened. 2. Review of the medical record for Resident #60 revealed an admitted [DATE] with diagnoses including of encephalopathy, DM, chronic obstructive pulmonary disease, and respiratory failure with hypoxia. Review of the MDS assessment for Resident #60 dated 05/29/24 revealed the resident was cognitively intact required supervision with ADLS and received insulin for seven days during the review period. Review of the physician's orders for Resident #60 revealed an order dated 02/28/24 for Insulin Lispro 100 units inject per sliding scale subcutaneously before meals. (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 MAR for Resident #60 revealed the resident received Insulin Lispro subcutaneously as ordered. Observation on 08/27/24 at 8:40 A.M. with LPN #69 revealed the Insulin Lispro vial for Resident #60 was opened and neither the vial nor the box containing the vial was marked with the date opened. Review of the Lispro vial revealed there were instructions to discard the vial 31 days after vial was opened. LPN #69 confirmed the Lispro vial for Resident #60 did not contain the date when the vial was opened and could not determine the date the vial had been opened. Interview on 08/27/24 at 8:42 A.M. with LPN #69 of the medication storage room on the South Unit revealed Mantoux TB skin test solution vial in the refrigerator which was opened and not dated. LPN #69 confirmed the Mantoux TB skin solution vial was opened and not dated and was unable to determine when the vial was opened. 3. Observation on 08/27/24 at 8:53 A.M. with LPN #69 of the medication storage room on the Central Unit revealed the TB skin test solution vial was in the refrigerator and had been opened but was not dated. Interview on 08/27/24 with LPN #69 confirmed the TB skin test solution vial was opened but was not dated. LPN #69 was unable to determine when the vial was opened. Review of the facility polity titled Medication Storage dated 07/03/19 revealed medications and biologicals were to be stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. Review of the policy revealed outdated should be immediately removed from stock and disposed of according to procedures for medication destruction, and reordered from the pharmacy, if replacements were needed.

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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. 36648 Based on observation and staff interview, the facility failed to practice food service safety and maintain a sanitary environment to prevent food and beverage contamination. This had the potential to effect 63 residents who received food from the facility kitchen. The facility census was 75 residents. Findings include: 1.Observation on 08/27/24 at 10:05 A.M. with [NAME] #44 revealed Dietary Supervisor (DS) #52 placed a small bin of cooked carrots on prep table and did not cover the carrots. A ledge directly above the uncovered bin of carrots was covered with crumbs and debris. Above the ledge to the right was a window that housed a working air conditioner which blew cold air into the kitchen. On the right side of air conditioner there was a plastic accordion-style casing which sealed the unit to the window. The casing was covered with dust and black specks. The left side of the running air conditioner was smaller than the window and allowed for an approximately four-inch opening from the window directly to the outside. Interview on 08/27/24 at 10:05 A.M. with DS #52 confirmed the cooked carrots were uncovered and sitting directly below the ledge which was covered with crumbs and debris. The carrots were also adjacent to air conditioner casing which was covered with dust and to the window which was open to the outside. 2. Observation on 8/27/24 at 10:10 A.M. of food preparation revealed [NAME] #44 removed her gloves, discarded them, and donned new gloves without performing hand hygiene. Interview on 08/27/24 at 10:11 A.M. with [NAME] #44 confirmed staff are to wash their hands after removing gloves and prior to donning new gloves. 3. Observation on 08/27/24 at 10:20 A. M. of food preparation revealed DS #52 removed his gloves, lifted the lid to the garbage can, discarded the gloves, and walked to the stove and stirred the gravy. DS #52 did not perform hand hygiene after lifting the garbage can lid and discarding his gloves. Interview on 08/27/24 at 10:22 A.M. with Regional Dietitian (RD) #120 confirmed DS #52 should have washed his hands immediately after discarding his gloves and prior to continuing with food preparation. 4. Observation on 08/27/24 at 10:25 A.M. with RD #120 revealed the ice machine in the dining room had a scoop being stored directly in the ice. RD #120 removed the scoop. Interview on 08/27/24 at 10:26 A.M. with RD #120 confirmed the ice scoop should not be stored directly in the bin of ice.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interviews, and review of the facility policy, the facility failed to ensure the staff utilized proper hand hygiene and infection control practices during tracheostomy care. This affected one (Resident #56) of 18 residents with tracheostomies. The facility also failed to ensure staff donned appropriate personal protective equipment (PPE) to prevent the spread of Coronavirus (COVID-19). This affected one (Resident #10) of two facility-identified COVID-19 positive residents. The facility census was 75 residents. Findings include: 1. Review of the medical record for Resident #56 revealed an admitted [DATE] with diagnoses including chronic respiratory failure with hypoxia, sepsis, end stage renal disease, anoxic brain injury, and tracheostomy. Review of the admission Minimum Data Set (MDS) assessment for Resident #56 dated 06/20/24 revealed the resident had severe cognitive impairment and was dependent upon staff for all activities of daily living (ADLs). Review of the physician's orders for Resident #56 revealed an order dated 06/11/24 to complete tracheostomy care every shift and as needed. Observation on 08/28/24 at 10:41 A.M. of tracheostomy care for Resident #56 per Respiratory Therapist (RT) #96 revealed the RT suctioned the resident which caused the resident to have a productive cough. After suctioning was completed, RT #96 then removed the old dressing covered with dried mucus from around Resident #56's tracheostomy site. RT #96 used the old dressing to wipe around Resident #56's tracheostomy site and discarded the dressing in the trash. RT #96 unlocked and removed Resident #56's disposable inner cannula and discarded it in the trash. RT #96 then inserted a new disposable inner cannula touching the outer locking portion of the cannula and locking it into place. RT #96 applied a new dressing around the tracheostomy site, connected the resident back to oxygen, removed gown and gloves, and performed hand hygiene. Interview on 08/28/24 at 10:49 A.M. with RT #96 confirmed she removed the soiled dressing from Resident #56's tracheostomy site and used it to wipe around Resident #56's tracheostomy. RT #96 confirmed she did not change gloves or perform hand hygiene after removing the soiled dressing and prior to insertion of new disposable inner cannula or new dressing applied. Review of the facility policy titled Infection control revised 11/28/17 revealed all staff should perform hand hygiene when coming on duty, between resident contacts, after handling contaminated objects, after personal protective equipment (PPE) removal, before/after toileting, and before going off duty. Review of the policy revealed gloves were changed and hand hygiene was performed before moving from a contaminated body site to a clean body site during resident care. 44070 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses including sepsis, bipolar disorder, other psychotic disorder, autism, heart failure encephalopathy and paranoid schizophrenia. Review of the MDS assessment for Resident #10 dated 07/01/24 revealed the resident was cognitively impaired. Review of the care plan for Resident #10 dated 08/26/24 revealed the resident was COVID-19 positive with interventions including contact and droplet precautions and update the physician with any abnormal or new findings for possible evaluation or further treatment as needed. Review of physician's orders for Resident #10 revealed an order dated 08/26/24 to maintain droplet isolation precautions till 09/04/24. Interview on 08/25/24 from 9:45 A.M. with the Administrator confirmed the facility had two residents in the facility who tested positive for COVID-19 on 08/24/24, Residents #10 and #25. see nurse before entering sign on the door and a contact and droplet isolation above the isolation cart outside of Resident #10's room. Resident #10's door was open, and the resident was walking around her room when she fell to the ground. Licensed Practical Nurse (LPN) #106 observed the resident on the ground and informed LPN #113 and State tested Nurse Aide (STNA) #61 of the fall. LPN #113 and STNA #61 were wearing surgical masks and then donned gowns and gloves prior to entering Resident #10's room. Neither LPN #113 nor STNA #61 donned N-95 (respirator masks) and eye protection when they entered Resident #10's room. Interviews on 08/25/24 at 11:00 A.M. with LPN #113 and STNA #61 confirmed they did not don N-95 masks or eye protection prior to entering a COVID positive environment. They confirmed an N-95 mask and face shield along with a gown and gloves should have been donned prior to entering Resident #10's room. Interview on 08/25/24 at 11:19 A.M. with Infection Preventionist (IP) #105 confirmed staff should wear N-95, eye protection, gown and gloves when entering a COVID-19 positive resident room. Review of facility policy titled Infection Prevention and Control Program dated 11/28/17 revealed the facility shall maintain and establish infection prevention and control to ensure safe, sanitary and comfortable environment and prevent the transmission of communicable diseases. Review of facility policy titled COVID-19 Prevention, Response, and Reporting dated 05/11/23 revealed the facility should ensure appropriate interventions were implemented to prevent the spread of COVID-19. Source control measures included use of an N-95 filter mask or higher. When caring for residents with COVID-19 facility should initiate transmission-based precautions.