STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365520	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Phoenix of Maple Heights	19900 Clare Ave Maple Heights, OH 44137

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32650 Based on observation, interview, record review, and facility policy review facility failed to prevent public indecency to ensure residents were treated with dignity at all times. This affected one resident (#72) of three residents reviewed for dignity and had the potential to affect all residents that may have witnessed Resident #72's public indecency. The facility census was 88. Findings include: Review of the medical record revealed Resident #72 was admitted to the facility on [DATE] with diagnoses including psychosis, schizoaffective disorder, bipolar disorder, factitious disorder (a condition in which a patient intentionally falsifies medical or psychiatric symptoms and can be self-induced or fabricated), and mood disorder. Review of the quarterly comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #72 was cognitively intact. Observation on 06/03/24 at 11:58 A.M. through 12:15 P.M. revealed Resident #72 was sitting in a wheelchair in the hallway wearing only a T-shirt. The bottom of the shirt rested on the resident's upper thighs. No briefs or underwear were worn. Resident #72's genitals were exposed and visible to anyone in the hallway. Residents and staff were observed in the hallway during the time span of the observation. Interview with Resident #72 revealed no information related to the observation. Staff did not intervene or redirect the resident at any time during the observation. Interview with the Director of Nursing (DON) on 06/11/24 at 2:45 P.M. revealed Resident #72 always refused to wear pants or underwear whenever staff requested that he put them on. Review of the facility's dignity policy revealed the facility provided a copy of the document from the Ohio Revised Code Section 3721.13 titled Residents' Rights. Right (2) stated the resident has the right to be treated at all times with courtesy, respect, and full recognition of dignity and individuality. This deficiency represents noncompliance investigated under Master Complaint Number OH00154790 and Complaint Number OH00153937.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER: Phoenix of Maple Heights		STREET ADDRESS, CITY, STATE, ZIP CODE: 19900 Clare Ave Maple Heights, OH 44137	

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 39969 Based on observation, interviews, and review of the facility policy and procedure, the facility failed to ensure the residents' environment was clean, sanitary, and was in good repair. This had the potential to affect all residents residing in the facility. The census was 88. Findings include: Observations during a tour of the facility on 06/12/24 from 1:43 P.M. to 4:49 P.M. with two surveyors revealed: Residents #56 and #81's room revealed the non- skid strips on floor were coming up off the floor and the privacy curtain rod off was the track. Residents #57 and #139's room revealed the baseboard heater cover was missing, exposing the heating element. The wall outside of the locked unit revealed the baseboard heater cover was hanging off and exposing the heating element. The locked unit had a strong, malodorous smell. At 1:48 P.M. the Director of Nursing (DON) entered the unit. The DON stated there were drops of feces in the hallway, and that was the cause of the odor. The DON then went to get staff to clean up the feces on the floor. Residents #7 and #22's room revealed the floor was dirty, sticky, and there were black markings on the floor near the bed by the window. There were no curtains or blinds on the window. There was brown staining and chipped paint on the windowsill near the air conditioning (AC) unit. There was one closet door with the other door missing. The bathroom had feces on toilet, a missing toilet paper holder, a hole in the door, stains on floor, and a strong urine odor. There was a white, plastic three drawer bin that had various, dried, brown stains on it in the hallway. Residents #33 and #83's room had dirty bed linens, and the dry wall was crumbling behind the door. The bathroom had feces on back of toilet, brown stains around the toilet, and a missing toilet paper holder. This bathroom was shared with Residents #7 and #22. The dining room on the secured unit had a fan lying on the table with the feet/stand missing. The back wall was dirty with various stains, and there was moderate amount of various, dried food crumbs on the baseboard heater and floor. There was also debris on the windowsill. Residents #29 and #69's room had various dry stains on the floor, the privacy curtain was stained, and there were no curtains or blinds on the window. The bathroom had a smear of feces on toilet. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Residents #40 and #72's room revealed no closet doors, and the baseboard heater cover was pulled away. Residents #36 and #54's room had missing closet doorknobs. The bathroom had missing tile, a missing toilet paper holder, a hole in wall behind the door that was five inches by five inches, and the lid to the toilet tank was chipped. This bathroom was shared with Residents #40 and #72. Residents #11 and #45's room had television hanging off wall, one closet door missing, and molding coming off the wall. The bathroom had a big chip in the counter of the sink. There was a strong odor of urine, the floor was sticky, there was a missing toilet paper holder, and a dried substance on the bathroom door. The bathroom was shared with Resident #140. The hallway had bowing ceiling tiles, and at the very end of the hallway, where the window was, there was no drywall. There was a loose piece of a board knee high, that was placed a few inches in front of this area. Behind the board was the baseboard heater with the cover off, exposing the heating element. There was also various debris and trash. Observation of the second-floor shower room revealed peeling paint above the shower, 50 or more black drain flies in the shower area and toilet, the shower curtain was heavily soiled on the bottom, and the safety strips were peeling off the floor. Residents #35 and #42's room had a missing knob on the closet door, a stained privacy curtain, and debris on the threshold in the entryway to the bathroom. The bathroom had feces in the toilet, two of the three lights were burned out, the fixture was heavily coated with dust, there was crack in the toilet base, and a dried yellowish stain down front of the base of the toilet. Residents #12 and #13's room had debris and dead bugs on the windowsill, and the baseboard was heavily stained. Residents #47 and #48's room had a missing closet door, and the windowsill was covered with dust and/or spiderwebs. The bathroom door and wall were soiled. The baseboard between the bathroom door and closet was warped. Residents #30 and #32's room had a missing closet door, debris around the bottom of the AC unit, and the baseboard cover was dirty with stains, dust, and debris. The wallpaper was peeling, and the floor mattress pushed up against the closet door was dirty. Residents #28 and #85's room had the AC unit in the window was missing the cover, hanging, and was in disrepair. Resident #66's room had a missing baseboard, one closet door was missing, paint bubbling/rusted around the top of the AC unit, peeling paint on windowsill, cracked ceiling paint above the bed by the door. The bathroom had a missing ceiling tile, the toilet paper holder was broken, stained tile on the floor near toilet, and two of three lights were burned out. The wall in doorway to the resident's room had chipped paint, and the baseboard was coming off wall. This bathroom was shared with Residents #41 and #49. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Residents #41 and #49's room had an electrical outlet hanging off the wall near the bed by the door, black dirt and debris on the floor under the bathroom door, the windowsill paint was chipping, a missing closet door, a cable cord cover broken between the beds, the floors dirty with various crumbs throughout, and a dirty floor mat. Residents #2 and #21's room revealed the closet doors had worn paint and were not on the track, the windowsill paint was peeling, there was a small hole in wall behind the door, and the baseboard heating cover was pulled away from the unit. Residents #71 and #190's room had an odor of urine, the floor was sticky with various crumbs and debris, one closet door was missing a knob, missing paneling at the bottom of the closet door, and the knob on the second closet door was chipped leaving a sharp edge. Residents #10 and #46's room had a closet door missing a knob, the baseboard between the closet and the bathroom door was heavily soiled. The bathroom doors had worn paint. This bathroom was shared with Residents #16 and #189. Residents #16 and #189's room had no closet doors, there was duct tape around the AC unit, a missing piece of the baseboard near the bed by the window, the baseboard near the door was coming off the wall, the nightstand top drawer was missing a knob/handle, the privacy curtain in front of the bed by the window was hanging off the track, and silver tape on the threshold of the floor under the bathroom door. Residents #51 and #79's room had water spots on the ceiling tile outside of the room, a missing frame and rusting around the AC unit, and two of the three light bulbs were burned out in the bathroom. Resident #18's room revealed the wall near the closet was in disrepair, the baseboard was coming off the wall, a hole in the wall by the bathroom door, a missing closet door, brown staining on ceiling above the AC unit, peeled paint on the walls near the bathroom. The curtain was off track. The bathroom toilet paper holder was off the wall, there was large brown stain on the ceiling tile in the left corner near the toilet, a tile broken off the wall under the sink near the trash can. Residents #60 and #72's room revealed no closet doors, broken window blinds, the privacy curtain was hanging off the track, and there was a missing ceiling tile in the bathroom. Residents #9 and #63's room had no closet doors and broken window blinds. The bathroom had missing ceiling tiles, the light fixture was hanging not affixed to the wall giving dim lighting in the bathroom. This bathroom was shared with Residents #62 and #82. Residents #19 and #47's room had no closet doors, a hole in the wall, missing baseboards, a hole in the bathroom door, and the lower part of the wall was cracked and rusted where the AC unit was located. The bathroom had a toilet paper holder, cracked/chipped sink counter leaving a jagged/rough edge, a hole in wall underneath the sink, and two of three light bulbs were burned out. The hallway near Residents #62 and 82's room had a loose handrail. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Residents #50 and #53's room had missing closet doors, a missing baseboard near the closet, and the drywall was pulled away from the wall near the bathroom door. The bathroom had missing ceiling tiles exposing the sprinkler head, and there were black markings across the lower part of the bathroom door. Residents #5 and #55's room revealed the bed rail was loose and hanging off of Resident #55 bed, a missing closet door, and a missing knob on the other closet door. Interview on 06/03/24 at 3:59 P.M. with State tested Nurse Aide (STNA) #502 verified the bed rail was very loose. Residents #17 and #59's room had no closet doors and a soiled privacy curtain that was also partially off the track. The bathroom had plaster patches needing to be painted, two of three light bulbs were burned out, two water stained ceiling tiles, and there was a missing wood piece in the door jamb that was approximately six inches long. Residents #4 and #69's room revealed the cable covers between the beds were missing and broken, there was a missing threshold strip under bathroom door, a tannish substance was observed along this area, rusting on the baseboard heater unit, and missing closet doors. Observation of the first-floor shower room revealed it was cluttered, the shower curtain was torn, there was missing tile in the shower, three of six lights were not working above the sink, the floor was dirty, and there was a spider web in corner behind the door. Residents #31 and #70's room had crumbs on floor. The bathroom floor was dirty with brown stains and debris, and there were three cracked ceiling tiles. Residents #44 and #75's room had a missing doorknob on the closet door, and half of the second closet door was missing. Residents #15 and #74's room revealed the over the bed light cover was missing, there was a small hole in bathroom door, the closet doors were missing, the bathroom floor was dirty with brownish stains, odor, and one of three light bulbs was burned out. Residents #1 and #27's room had a missing closet door, a dirty wall with brown stains near the bathroom door, and one of three light bulbs was burned out in the bathroom. Resident #92's room revealed the baseboard heating cover was hanging off and was rusted near the AC unit. Residents #61 and #86's room had no knobs on the closet doors, and the window blinds were broken. The bathroom toilet paper holder was broken, there was a brown spot on the ceiling tile above the toilet, and one of three light bulbs was burned out. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #26's room revealed peeling paint around the AC unit, the baseboard was rusty, there were no closet doors, there was no cover on the light over the bed by window, the backing on the wall/wall protector was peeling off the wall behind the bed by the door, there was a hole in the bathroom door, the door jamb was in disrepair, there was a missing piece of wood and black markings on the doors. The bathroom ceiling tile was brown and bowing above the toilet, there was peeling paint near the light fixture, one of three light bulbs was burned out, the counter of the sink was chipped/broken, and there was a missing threshold strip between the room and the bathroom. Residents #24 and #84's room had missing closet doors. Residents #34 and #76's room had no closet doors, soiled privacy curtains, missing tile above toilet, the toilet tank was dirty with a brown, dried substance on the floor around the toilet, and the toilet paper holder was missing. This bathroom was shared with Residents #6 and #64. Residents #65 and #77's room revealed closet doors were off the tracks, and the window blinds were broken with a crocheted blanket covering the window. The bathroom had missing tile near the toilet, and two of three light bulbs were burned out. This bathroom was shared with Residents #14 and #20. Interview at this time with Resident #65 stated the blind had been broken for about a week, and she put her crocheted blanket over the window so no one could look in. Resident #65 stated she wanted the blinds fixed so she could take her blanket down. Residents #14 and #20's room had missing closet doors, and the door handle to the room was very loose, slightly hanging, and not affixed to the door. Resident #67's room had a missing closet door. The bathroom had two water-stained ceiling tiles, stool in the toilet, and the toilet tank lid was off with no water in the tank. Interview on 06/03/24 at 11:31 A.M. with Resident #62 stated her bathroom flooded about one month ago, and the wall was torn down around sink area. Resident #62 stated it's been that way now for one month. Interview on 06/04/24 at 9:56 A.M. with Resident #77 stated her only concern was that her closet doors would not stay on track. Interview on 06/04/24 at 10:06 A.M. with Resident #4 stated he did not have closet doors when he moved into his room. Interview on 06/05/24 at 8:58 A.M. with Housekeeper (HSK) #458 stated Resident #62's bathroom had a leak and looked that way for about two weeks. HSK #458 stated that bathroom was scary looking to her. Interview on 06/05/24 at 9:03 A.M. with Registered Nurse (RN) #466 stated she felt they could invest more in the building. Interview on 06/05/24 at 10:03 A.M. with Interim Maintenance Director (IDM) #497 revealed he was only interim for this week, and the facility had not been without maintenance staff. IMD #497 stated the last maintenance director was terminated on 06/03/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Tour of the facility on 06/05/24 from 10:13 A.M. to 12:06 P.M. with IMD #497 the strip along the entryway onto the elevator was heavily worn down, uneven, and missing pieces. During the tour, IMD #497 verified the above identified findings. IMD #407 stated things needed to be done, some things sooner than later. IMD #497 stated he would help the new maintenance man get it all done. Interview on 06/05/24 at 1:21 P.M with Resident #73 stated she had difficulty getting out of the elevator due to the flooring having a missing part. Resident #73 stated she almost fell three times in the elevator because of the ripped out piece of flooring. Interview on 06/06/24 at 11:05 A.M. with Housekeeping/Laundry Director (HLD) #512 stated the turnover for both housekeeping and maintenance had been horrible. HLD #512 stated housekeeping staff were fully staffed at this time. HLD #512 stated resident rooms and common areas were cleaned daily. HLD #512 stated when staff reported concerns, she would fix what she could, but they did not have a steady maintenance director. HLD #512 stated the last maintenance director was lazy and stayed for only three weeks. HLD #512 stated the one before him stayed for about one year and left because he was overwhelmed. HLD #512 stated the maintenance director from 2020 took down all the closet doors in the residents' rooms because he thought it looked better. HLD #512 stated the Administrator had been trying to get in a maintenance director. Observation on 06/06/24 at 3:10 P.M. of Resident #140's room revealed no curtain or window blinds. There was also no curtain rod. Interview at this time with STNA #420 verified the observation and stated the rod had been hanging, and the resident removed it from off the wall. STNA #420 stated Resident #140 was walking around with it, and he had taken it from the resident. STNA #420 stated Resident #140 didn't try to hit anyone with it but was just walking around with it. Review of the facility policy titled Environmental Cleaning and Disinfecting, dated 11/19/20, revealed housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when surfaces are visibly soiled. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled. This deficiency represents noncompliance investigated under Master Complaint Number OH00154790.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442 Based on record review and staff interview the facility failed to notify the appropriate state agency (The Ohio Department of Mental Health) of a significant change in Resident #26's mental health condition as required. This affected one resident (#26) of one resident reviewed for preadmission screening and resident review (PASARR). The facility census was 88. Findings include: Review of the medical record for Resident #26 revealed an admitted [DATE]. Diagnoses included but were not limited to delusional disorder, depression, vascular dementia, and mood disorder. Review of the 12/29/2017 facility PASARR Identification Screen for Resident #26 revealed it was the most recent PASARR completed. Under section D indications of serious mental illness revealed a diagnosis of delusional (paranoid) disorder and psychiatric services had been utilized within the past two years due to mental disorder. Review of Resident #26's medical diagnoses revealed a diagnosis of schizoaffective disorder on 03/30/21 was added. Review of both the electronic and paper chart revealed no evidence the appropriate state agency (The Ohio Department of Mental Health) was notified of the new diagnosis for PASARR. Interview on 06/05/24 at 1:16 P.M. with the Administrator confirmed the last PASARR for Resident #26 was completed on 12/19/17 and a new one should have been completed following the new diagnosis of schizoaffective disorder on 03/30/21.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442 Based on medical record review, observation, interview, and facility policy review the facility failed to ensure comprehensive care plans were created for Resident #26, #63, and #72. This affected three residents (#26, #63, and #72) of three residents reviewed for care plans. The facility census was 88. Findings include: 1. Review of the medical record for Resident #26 revealed an admitted [DATE]. Diagnoses included but were not limited to delusional disorders, depression, vascular dementia, osteoarthritis, morbid obesity, gastro esophageal reflux disorder, and schizoaffective disorder. Resident #26 was noted to be cognitively intact and require supervision for eating and oral hygiene. No evidence was found related to a dental care plan to address dental issues. Review of the facility resident dental list for the past twelve months revealed Resident #26's last dental visit was 06/27/23. Review of the 6/27/23 dental summary report for Resident #26 revealed partial dentition, and multiple root tips needed to be extracted. Oral Surgery referral was noted to be written to a local dental institute for evaluation and treatment. Follow-up was to occur after oral surgery has been completed. Review of Resident #26's nursing progress notes from 06/27/23 to 06/10/24 revealed no indication of the follow-up for a dental consult for Resident #26 following his 06/27/23 appointment. Interview on 06/03/24 at 3:55 P.M. with Resident #26 revealed he desired a dental appointment, was unsure of his last appointment, had some broken teeth, and was experiencing pain. Interview on 06/10/24 at 10:30 A.M. with Minimum Data Set (MDS) Coordinator #523 confirmed there was no dental care plan to address dental concerns and/or the ordered dental follow-up for Resident #26. 2. Review of the medical record for Resident #63 revealed an admitted [DATE]. Diagnoses included but were not limited to end stage renal disease, dependence on renal dialysis, congestive heart failure, and moderate protein-calorie malnutrition. Review of Resident #63's care plan initiated on 08/19/23 revealed monitor fistula for bruit and thrill and to weigh resident the same time every day. No updates were noted since admission. No evidence was found as to what to do if bleeding was observed at the site or whether meals were to be given prior to dialysis or were to be sent with the resident. Review of Resident #63's physician orders dated 10/04/23 for monthly weights and an order dated 11/21/23 revealed to check dialysis catheter on left chest every shift. (continued on next page)

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Interview on 06/06/24 at 12:20 P.M. with Licensed Practical Nurse (LPN) #425 confirmed there was no evidence of a dialysis care plan in the paper chart for the facility or the dialysis center.

Interview on 06/06/24 at 12:27 P.M. with the Director of Nursing (DON) confirmed Resident #63's care plan had not been updated to reflect having a port rather than a checking for bruit and thrill, did not address how meals were being provided, did not identify transportation needs, the correct frequency to monitor weights, or to complete pre and post dialysis assessments.

Interview on 06/10/24 at 10:30 A.M. with MDS Coordinator #523 confirmed the care plan had not been updated since admission, did not give clear instructions as to what to do if there was bleeding at the dialysis port site, did not reflect discontinuation of checking for bruit and thrill since Resident #63 had a dialysis port, did not reflect the frequency of weight monitoring change, and did not give instructions as to ensure Resident #63 was provided meals consistently with dialysis.

Review of the facility policy titled; Care Planning, dated 11/13/20, revealed the facility care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident. A comprehensive care plan for each resident is developed within seven days of completion of the resident assessment.

32650

3. Review of the medical record revealed Resident #72 was admitted to the facility on [DATE] with diagnoses including psychosis, schizoaffective disorder, bipolar disorder, factitious disorder (a condition in which a patient intentionally falsifies medical or psychiatric symptoms and can be self-induced or fabricated), and mood disorder.

Review of the quarterly comprehensive MDS 3.0 assessment dated [DATE] revealed Resident #72 was cognitively intact.

Review of the progress notes for Resident #72 revealed he refused all medications daily, refused to see the psychiatric nurse practitioner at each visit, and had numerous disruptive behaviors.

Review of Resident #72's care plans (undated) revealed a behavior care plan for the diagnosis of factitious disorder, medication noncompliance, refusing care, and lying in bed with no clothes on and with a towel across him at times. The goals were to have a decrease in noncompliance and not have any negative outcomes related to noncompliance. The interventions to achieve the goal were to document education attempts made with the resident regarding compliance, educate regarding the negative outcomes which could occur due to noncompliance, and explain all procedures to the resident. No interventions were initiated on ways to deal with the resident's behaviors and were not resident centered.

Observation on 06/03/24 at 11:58 A.M. through 12:15 P.M. revealed Resident #72 was sitting in a wheelchair in the hallway wearing only a T-shirt. The bottom of the shirt rested on the resident's upper thighs. No briefs or underwear were worn. Resident #72's genitals were exposed and visible to anyone in the hallway. Residents and staff were observed in the hallway during the time span of the observation. Staff did not intervene or redirect the resident at any time during the observation.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Phoenix of Maple Heights	19900 Clare Ave Maple Heights, OH 44137

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with MDS Coordinator #522 on 06/10/24 at 12:35 P.M. revealed she was unaware of Resident #72's behavior of exposing his genitals in the hallway and did not realize there were no interventions for his preference of wearing no clothes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
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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** 32650 Based on observation, interview, and record review the facility failed to revise care plans with ways to intervene when Resident #72 exhibits inappropriate behaviors. This affected one resident (#72) of 16 residents residing on the secured unit. The facility census was 88. Findings include: Review of the medical record revealed Resident #72 was admitted to the facility on [DATE] with diagnoses including psychosis, schizoaffective disorder, bipolar disorder, factitious disorder (a condition in which a patient intentionally falsifies medical or psychiatric symptoms and can be self-induced or fabricated), and mood disorder. Review of the quarterly comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #72 was cognitively intact. Review of the progress notes for Resident #72 revealed he refused all medications daily, refused to see the psychiatric nurse practitioner at each visit, and had numerous disruptive behaviors. Review of Resident #72's care plans (undated) revealed a behavior care plan for the diagnosis of factitious disorder, medication noncompliance, refusing care, and lying in bed with no clothes on and with a towel across him at times. The goals were to have a decrease in noncompliance and not have any negative outcomes related to noncompliance. The interventions to achieve the goal were to educate the resident upon refusing care and the potential consequences of the refusal and to document the education provided. No interventions were provided on ways to deal with the resident's behavior of exposing his genitals and were not resident centered. Observation on 06/03/24 at 11:58 A.M. through 12:15 P.M. revealed Resident #72 was sitting in a wheelchair in the hallway wearing only a T-shirt. The bottom of the shirt rested on the resident's upper thighs. No briefs or underwear were worn. Resident #72's genitals were exposed and visible to anyone in the hallway. Residents and staff were observed in the hallway during the time span of the observation. Staff did not intervene or redirect the resident at any time during the observation. Interview with MDS Coordinator #522 on 06/10/24 at 12:35 P.M. revealed she was unaware of Resident #72's behavior of exposing his genitals in the hallway and did not realize there were no interventions for his preference of wearing no clothes.

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096 Based on record review, interview, and facility policy review the facility failed to ensure Resident #67 had orders to care for a urostomy and failed to ensure supplies were available. This affected one resident (#67) of one resident who received ileostomy and colostomy care. The facility census was 88. Findings include: Review of the medical record for Resident #67 revealed an admitted [DATE] with diagnoses including history of other infectious and parasitic disease, pressure ulcer of sacral region, pressure ulcer right heel, colostomy status, artificial opening of the of the urinary tract, chronic kidney disease, and malignant neoplasm of the endometrium, the lining of the uterus. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #67 had intact cognition and had an ostomy. The resident was required substantial to maximum assistance with toileting. Review of the care plan dated 04/05/24 revealed Resident #67 had alterations in elimination related to a colostomy status, bilateral nephrostomy tubes, and urostomy related to diagnoses of obstructive and reflux uropathy. Interventions included assessing abdominal distention and changing appliances as ordered. Review of the nurses note dated 05/19/24 at 6:34 A.M. written by Licensed Practical Nurse (LPN) # 415 revealed the nurse changed Resident #67's left side colostomy bag. The residents urostomy bag on the right side was leaking. This nurse attempted to change the urostomy bag but was unable to locate any supplies and temporarily covered the bag with a towel. The supervisor was notified, and they searched the supply room, cabinet, and resident's room. The urostomy bag will need to be replaced and will pass on the information to the oncoming A.M. staff. Resident #67 was very verbally aggressive and argumentative towards staff. Review of the physicians' order for June 2024 revealed and order to change the colostomy bag every seven days, empty urostomy bag when half full, and to flush bilateral nephrostomy tubes weekly. There was no order to change the urostomy bag. Interview on 06/05/24 at 4:36 P.M. with LPN #415 revealed on 05/19/24 at approximately 10:00 P.M., she went into the room to check the Resident #67's urostomy bag, and it was leaking. LPN #415 notified the nursing supervisor, LPN #446, she needed to replace the urostomy bag and could not find one. Both searched for supplies; however, none were located. In the meantime, LPN #415 used a towel to absorb the liquid. The resident got the bag changed when the day supervisor came in the next day. LPN #415 stated Resident #67 was very upset that supplies were not available, and she had to calm her down. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/06/24 at 10:22 A.M. with Resident #67 stated she feels the staff does not use the same technique or the same supplies that the hospital used. Many times, the nurses have put on the wrong size bag that causes it to overflow and leak. Resident #67 stated she ordered her urostomy supplies to ensure her urostomy and colostomy bags were maintained. Interview on 06/06/24 at 10:50 A.M. with State tested Nursing Assistant (STNA) #492, central supply person, regarding the incident on 05/19/24 revealed Resident #67 had two urostomy bags located in the closet in her room. The nurse did not look in the closet, there were two bags left. The day shift nurse located and replaced the urostomy bag. STNA #492 stated the resident was picky with her supplies. The urostomy and colostomy bags were standard and could be cut to ensure proper fit. She now ensures supplies were ordered, and there were supplies available for staff prior to leaving her shift. Interview on 06/06/24 at 4:28 P.M. with the Director of Nursing (DON) verified that there were no orders for urostomy bags to be changed. Review of the facility policy titled Colostomy and Ileostomy site care, dated 11/13/22, revealed the purpose of the policy is to prevent infection and skin irritation.

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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** 37096 Based on observation, interview, record review, and facility policy review the facility failed to ensure Resident #12 had current oxygen orders and an oxygen care plan and failed to ensure portable oxygen tanks were secured. This affected one resident (#12) of ten residents receiving oxygen. The facility census was 88. Findings include: Review of the medical record for Resident #12 revealed an admitted [DATE] with diagnoses including acute kidney failure, dementia, and abnormalities of gait and mobility. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #12 had impaired cognition and required substantial to maximal assistance for transfers, hygiene, and dressing. The assessment stated the resident was not receiving oxygen therapy. Review of the care plan dated 03/12/24 revealed Resident #12 did not have an oxygen care plan. Review of the profile computer tab revealed a picture of Resident #12 wearing a nasal canula for oxygen. Review of the physician orders for June 2024 revealed there were no oxygen orders and/or orders to change oxygen tubing. Observation on 06/03/24 at 11:23 A.M. revealed Resident #12 was sitting in her wheelchair next to her bed and receiving oxygen by nasal canula through a concentrator unit. There were three portable oxygen tanks located next to the window. One was secured in a stand and two were unsecured. Interview on 06/03/24 at 11:30 A.M. with Licensed Practical Nurse (LPN) #517 verified the resident had three portable tanks and two were unsecured. LPN #517 stated every morning staff ensures all empty tanks are taken out of the room. Interview on 06/06/24 at 1:53 P.M. with the MDS Nurse #522 stated at the time of the MDS assessment on 3/12/24, Resident #12 was not on oxygen. MDS Nurse #522 stated she checks the medication administration and treatment records for verifications. MDS #522 stated she had no idea why nursing put the resident on oxygen. Interview on 06/06/24 2:35 P.M. with LPN #49 verified there was no current oxygen order; however, there was a discontinued oxygen order in December 2023. Interview on 06/06/24 at 2:57 P.M. with the Director of Nursing (DON) verified there were no current oxygen orders and/or orders to change oxygen tubing. In addition, there was no oxygen care plan. The DON stated Resident #12 was sent out the hospital and all orders were discontinued. Upon arrival back at the facility, the nurse had to re-enter all the orders and forgot to input the oxygen order. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Oxygen Safety, dated 11/19/21, revealed cylinders are secured either by a chain or strap or supported by cylinder base or cart designed not to tip over. Review of the facility policy titled Care Planning, dated 11/13/20, revealed the interdisciplinary team is responsible for the development of a comprehensive care plan for each resident.

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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** 45442 Based on record review, interview, and facility policy review the facility failed to ensure monitoring prior to and following dialysis treatments for Resident #63. This affected one resident (#63) of one resident residing at the facility receiving dialysis. The facility census was 88. Findings include: Review of the medical record for Resident #63 revealed an admitted [DATE]. Diagnoses included but were not limited to end stage renal disease, dependence on renal dialysis, congestive heart failure, and moderate protein-calorie malnutrition. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #63 was receiving dialysis treatments. Review of the facility pre and post dialysis assessments for Resident #63 for the month of April, May, and June of 2024 revealed no documented evidence of pre and post assessments for 04/01/24, 04/03/24, 04/05/24, 04/08/24, 04/10/24, 04/12/24, 04/15/24, 04/17/24, 04/19/24, 05/01/24, 05/08/24, 05/10/24, 05/13/24; no documented evidence of pre-dialysis assessments for 04/22/24, 04/26/24, 04/29/24, and 05/20/24; and no documented evidence of post dialysis assessments for 04/24/24, 05/06/24, 05/15/24, 05/22/24, 05/27/24, 05/29/24, 05/31/24, and 06/03/24. Interview on 06/06/24 at 12:20 P.M. with Licensed Practical Nurse (LPN) #425 confirmed when Resident #63 goes to dialysis, there was no communication form sent with him or any information that comes back with him, and LPN #425 was not aware of any email communication with the dialysis center. LPN #425 also confirmed there was no additional dialysis communication information in the paper chart. Interview on 06/06/24 at 12:47 P.M. with the Director of Nursing (DON) confirmed staff were to complete a pre and post dialysis assessment and send the pre-dialysis assessment with Resident #63 when he goes. The DON confirmed there was no documented evidence of pre and post dialysis assessment dates listed above. The DON also confirmed since the pre and post dialysis assessments were not being consistently completed, weights as ordered by the physician were also not being monitored consistently. Interview on 06/10/24 at 8:37 A.M. with the DON confirmed the facility did not have a copy of the short-term care plan and/or the long-term care plan as stated in the facility dialysis contract under collaboration of care. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Long Term Care Facility Outpatient Dialysis Services Coordination Agreement revealed the facility will provide for the interchange of information useful or necessary for the care of the end stage renal dialysis (ESRD) residents including a contact person at the Long-Term Care Facility (LTCF) whose responsibilities include assisting with the coordination of Renal Dialysis Services for ESRD residents. Under Mutual Obligations under Collaboration of Care revealed both parties shall ensure that there is documented evidence of collaboration of care and communication between the Long-Term Care Facility and ESRD Dialysis unit. Documentation shall include, but not be limited to, participation, as members of the interdisciplinary team, in care conferences, continual quality improvements program, annual review of infection control of policies and procedures, and the signatures of team members from both parties on a short-term care plan (STCP) and Long-term care plan (LTCP). Team members shall include the physician, nurse, social worker, and dietitian from the ESRD Dialysis Unit and a representative from LTCF. The LTCF shall maintain a copy of the STCP and LTCP. Review of the facility policy titled; Hemodialysis Policy and Procedure, dated 03/23/19, revealed all residents receiving dialysis must have a pre and post dialysis assessment completed in the electronic medical record by a licensed nurse.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 45442 Based on record review and staff interview the facility failed to maintain the services of a registered nurse for at least eight consecutive hours a day, seven days a week as required. This had the potential to affect all 88 residents currently residing in the facility. Findings include: Review of the Payroll Based Journal (PBJ) staffing data report for quarter 1 (10/01/23 - 12/31/23) revealed six identified dates (10/07/23, 10/21/23, 11/18/23, 11/19/23, 12/17/23, and 12/31/23) that had no registered nurse coverage. Review of the following staffing dates on 06/05/24 at 7:46 A.M. with State tested Nurse Aide (STNA) #492 using the staffing tool worksheet revealed: 10/07/23 (listed as 12/26/23), 10/21/23 (Listed as 12/27/23), 11/18/23 (listed as 12/28/23), 11/19/23 (listed as 12/29/23), 12/17/23 (listed as 12/30/23), 12/31/23 (listed as 12/31/23) and 01/01/24 (listed as 01/01/24) did not have a registered nurse working during the 24 hours for each of the identified dates. Interview on 06/05/24 at 8:33 A.M. with STNA #492 confirmed the above listed dates there were no registered nurses working as direct care staff during the 24-hour periods. Review of the staffing schedules and Benefits Improvement and Protection Act (BIPA) for 05/01/24 - 05/31/24, and 06/03/24 - 06/05/24, revealed 05/23/24 was also identified as not having a RN scheduled. Interview on 06/06/24 at 12:35 P.M. with the Director of Nursing (DON) confirmed she worked on 05/23/24 but did not work on the floor providing resident care. The DON asked if her scheduled management working hours counted towards the required eight hours for a registered nurse. The DON also confirmed there were no scheduled registered nurses working the floor to provide direct care on 10/07/23, 10/21/23, 11/18/23, 11/19/23, 12/17/23, and 12/31/23. Interview on 06/10/24 at 11:42 A.M. with STNA #492 confirmed she was not aware that a registered nurse was required for at least eight hours every day doing resident direct care.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32650 Based on observation, interview, and record review, the facility failed to monitor resident behaviors, develop resident centered care plans with interventions specific for the resident's behaviors, or implement interventions when behaviors occurred for Resident #72. This affected one resident (#72) of two residents reviewed for behavioral health. The facility census was 88. Findings Include: Review of the medical record revealed Resident #72 was admitted to the facility on [DATE] with diagnoses including psychosis, schizoaffective disorder, bipolar disorder, factitious disorder (a condition in which a patient intentionally falsifies medical or psychiatric symptoms and can be self-induced or fabricated), and mood disorder. Review of the physician's orders for Resident #72 dated 06/23/23 was an order to document resident's behaviors every shift. Review of the Medication Administration Record (MAR) for April, May, and June 2024 for Resident #72 revealed the resident refused all medications every day. Behavior monitoring was also located on the MAR and was to be assessed each shift. A Y indicated the resident had demonstrated behaviors and a nurse's note was to be documented as to what the behavior was. Review of the progress notes for Resident #72 revealed he refused all medications daily, refused to see the psychiatric nurse practitioner at each visit, and had numerous disruptive behaviors. On 04/25/24 the Administrator, who is also the facility's social worker, summarized the resident's behaviors as being aggressive, targeting certain employees, leaving threatening emails for staff in the facility as well as the community, and noncompliance with care. On 04/30/24 the resident shoved another resident and claimed the other resident punched him in the chest. The MAR behavior tracking for Resident #72 during the quarterly MDS look back period revealed the resident exhibited behaviors on 04/24/24 during the 7:00 A.M. to 7:00 P.M. shift and on the 04/28/24 7:00 P.M. to 7:00 A.M. shift but no associated nursing documentation was found in the nurses' progress notes. Review of the quarterly comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #72 was cognitively intact and had delusions but exhibited no behaviors during the seven-day look back period of the assessment time frame. Review of Resident #72's care plans (undated) revealed a behavior care plan for the diagnosis of factitious disorder, medication noncompliance, refusing care, and lying in bed with no clothes on and with a towel across him at times. The goals were to have a decrease in noncompliance and not have any negative outcomes related to noncompliance. The interventions to achieve the goal were to educate the resident upon refusing care and the potential consequences of the refusal and to document the education provided. No interventions were provided on ways to deal with the resident's behavior of exposing his genitals and were not resident centered. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Observation on 06/03/24 at 11:58 A.M. through 12:15 P.M. revealed Resident #72 was sitting in a wheelchair in the hallway wearing only a T-shirt. The bottom of the shirt rested on the resident's upper thighs. No briefs or underwear were worn. Resident #72's genitals were exposed and visible to anyone in the hallway. Residents and staff were observed in the hallway during the time span of the observation. Staff did not intervene or redirect the resident at any time during the observation. Review of the June 2024 MAR indicated behaviors had occurred, but no associated documentation of the incident was located. Interview with MDS Coordinator #522 on 06/10/24 at 10:32 A.M. revealed she bases her decision on how frequently a resident exhibited behaviors and what type of behavior was exhibited by reviewing the nursing documentation, the aide's documentation, and through staff interviews. A second interview on 06/10/24 at 12:35 P.M. revealed she was unaware of Resident #72's behavior of exposing his genitals in the hallway and did not realize there were no interventions for his preference of wearing no clothes.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442 Based on record reviews, interviews, and facility policy review the facility failed to ensure all medications had an appropriate diagnosis for Residents #1, #15, #16, and #62. This affected four residents (#1, #15, #16, and #62) of five residents reviewed for unnecessary medications. The facility census was 88. Findings include: 1. Review of the medical record for Resident #1 revealed an admitted [DATE]. Diagnoses included but were not limited to human immunodeficiency virus (HIV), acute and chronic respiratory failure, schizophrenia, dementia with agitation, bipolar disorder, and anxiety disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had intact cognition, antidepressants were being administered, and no behaviors were noted. Review of the physician orders for Resident #1 revealed the following medications listed the class of medication instead of the diagnosis: An order dated 01/04/24 for Omeprazole 20 milligram (mg) capsule delayed release (proton pump inhibitor to treat gastroesophageal reflux disease). Give one capsule by mouth one time a day. No diagnosis was listed. Interview on 06/10/24 at 1:28 P.M. with the Director of Nursing (DON) confirmed the above-listed concerns related to the appropriate diagnoses not being listed on the physician orders. 2. Review of the medical record for Resident #15 revealed an admitted [DATE]. Diagnoses included but were not limited to unspecified convulsion, type II diabetes mellitus, major depressive disorder, sleep apnea, multiple sclerosis, conversion disorder with seizures or convulsion, and anxiety disorder. Review of the quarterly MDS assessment dated [DATE] revealed Resident #15 had intact cognition, an antipsychotic and antidepressant were administered, and no behaviors were noted. Review of the physician's orders for Resident #15 revealed the following medications listed the class of medication instead of the diagnosis: An order dated 02/24/24 for Losartan Potassium Oral Table 50 mg (antihypertensive). Give one tablet once a day for antihypertensive. No diagnosis of hypertension was listed. An order dated 02/24/24 for Prednisone Oral Tablet 20 mg (steroid). Give one tablet by mouth two times a day for corticosteroid. No diagnosis was listed. An order dated 04/05/24 for Olanzapine oral table five mg (antipsychotic) by mouth one time a day for antipsychotic. No diagnosis was listed. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An order dated 02/24/24 for Montelukast Sodium Oral Tablet 10 mg (anti-inflammatory). Give one tablet by mouth at bedtime for anti-asthmatic. No diagnosis was listed. Interview on 06/10/24 at 1:28 P.M. with the DON confirmed the above-listed concerns related to the appropriate diagnoses not being listed on the physician orders. 39969 3. Review of the medical record for Resident #62 revealed an initial admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), hypothyroidism, atherosclerotic heart disease of native coronary artery without angina pectoris, type II diabetes mellitus, acute bronchitis, hypertension, atrial fibrillation, convulsions, and vitamin d deficiency. Review of the physician orders for June 2024 revealed the following medications listed the class of medication instead of the diagnosis: Insulin Glargine Subcutaneous Solution 100 UNIT/ milliliters (ml) (Insulin Glargine). Inject 30 units subcutaneously two times a day for itching. Ergocalciferol (vitamin D) Oral Tablet 50 MCG (2000 UT). Give 2000 micrograms (mcg) by mouth one time a day. Claritin (antihistamine) Oral Tablet 10 MG (Loratadine). Give 10 milligrams (mg) by mouth one time a day. Thera-M Oral Tablet (Multiple Vitamins w/ Minerals). Give 400 mcg by mouth one time a day. Mirabegron ER Oral Tablet Extended Release 24 Hour 25 mg (medication to treat overactive bladder). Give one tablet by mouth one time a day. Metformin (antidiabetic) HCl Oral Tablet 1000 mg (Metformin HCl). Give one tablet by mouth two times a day. Cozaar (antihypertensive) Oral Tablet 50 mg (Losartan Potassium). Give 50 mg enterally one time a day. Levothyroxine Sodium (thyroid product) Oral Tablet (Levothyroxine Sodium). Give 150 mcg by mouth one time a day. HumaLOG Injection Solution 100 UNIT/ML (Insulin Lispro). Inject 8 units subcutaneously with meals. Furosemide (diuretic) Oral Tablet 20 mg (Furosemide). Give one tablet by mouth one time a day. Apixaban (anticoagulant) Oral Tablet 5 MG (Apixaban). Give 5 mg by mouth two times a day. Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate). Two puffs inhale orally every 4 hours as needed for pain. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rOPINIRole HCl (anti-Parkinson) Oral Tablet 1 MG (Ropinirole Hydrochloride). Give one tablet by mouth at bedtime. rOPINIRole HCl Oral Tablet 0.5 MG (Ropinirole Hydrochloride). Give 1 tablet by mouth two times a day. Interview on 06/10/24 at 1:29 P.M. with the DON verified the orders for the medication did not include the diagnoses. The DON also verified the diagnoses listed for the Insulin Glargine Subcutaneous Solution 100 UNIT/ml and the Albuterol Sulfate HFA Inhalation Aerosol Solution were inaccurate for those medications. 37096 4. Review of the medical record for Resident #16 revealed an admitted [DATE] with diagnoses including psychotic disorder with delusions, type II diabetes Alzheimer's disease, Parkinson's disease, anxiety, insomnia, chronic kidney disease, depression, polydipsia, and paranoid schizophrenia. There were no diagnosis seizures or genitourinary. Review of the quarterly MDS assessment dated [DATE] revealed Resident #16 had intact cognition and behaviors that included inattention and disorganized thinking that fluctuated. The resident was receiving an antipsychotic, an antibiotic, antiplatelet, and hypoglycemic medications. Review of the physician orders for June 2024 revealed the following medications listed the class of medication instead of the diagnosis: Cholecalciferol 5000 units on daily for vitamin. Divalproex sodium 500 mg for anticonvulsants. Flomax 0.4 mg daily for genitourinary. Oxcarbazepine 150 mg for anticonvulsant. Sodium chloride 1gram (gm) for electrolyte. Interview on 06/10/24 at 1:46 P.M. with the DON verified the medications had incorrect diagnosis, and the facility was in the process of reviewing medications for correct diagnosis. Review of the facility policy titled Medication Management, dated August 2020, revealed when the resident receives a new medication, the medication should include a written diagnosis, an indication, or documented objective findings supporting each medication.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on record review, staff interview, and facility policy review the facility failed to ensure physician orders for psychotropic medications included the diagnosis for each medication for Residents #11, #15, #16, and #62. The facility also failed to ensure monitoring of behaviors and adverse side effects from the use of psychotropic medications affecting for Residents #16 and #62. This affected four residents (#11, #15, #16, and #62) of five residents reviewed for unnecessary medications. The facility census was 88. Findings include: Review of the medical record for Resident #62 revealed an initial admitted [DATE]. Diagnoses included schizoaffective disorder, bipolar type, major depressive disorder, persistent mood [affective] disorder, psychotic disorder with delusions, personality disorder, manic episode, severe with psychotic symptoms, bipolar disorder, and post-traumatic stress disorder. Review of the care plan revised on 06/12/23 revealed Resident #62 was at risk for adverse effects of antipsychotic medication and antidepressant medication. Resident #62 received Klonopin for a diagnosis of schizoaffective disorder, bipolar type. Interventions included monitoring for side effects of psychotropic such as nausea, vomiting, and diarrhea, dry mouth, blurred vision, and change in appetite, weight etc. Notify the physician. Monitor adverse reactions to medications: headaches, abdominal pain, constipation, flatulence, esophageal ulcer, vomiting, dysphagia, abdominal discomfort, gastritis, taste perversion, and musculoskeletal pain. Monitor for side effects sedation, hypotension, extrapyramidal symptoms (EPS), anticholinergic signs, headache, insomnia, anorexia, and constipation. Report changes in mood or behavior. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 had intact cognition, had moods that included little interest, feeling, trouble falling asleep, feeling tired, poor appetite, feeling bad, trouble concentrating 12 to 14 days of the look back period. The assessment indicated the resident had behaviors that included hallucinations, delusions, other behaviors that occurred daily, and rejection of care daily. The resident also received antipsychotic, antianxiety, and antidepressant medications. Review of the June 2024 physician orders revealed active orders for: KlonoPIN (antianxiety) oral tablet one milligram (mg) (Clonazepam). Give one mg by mouth two times a day with a start date of 11/22/23. Aristada (antipsychotic) Intramuscular Prefilled Syringe 882 mg/3.2 milliliters (ml) (Aripiprazole Lauroxil). Inject 3.2 ml intramuscularly one time a day every four weeks on Monday with a start date of 11/27/23. Further review of the physician orders revealed no orders to monitor for behaviors or for side effects from the use of antipsychotic medications and no diagnoses listed for the medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/10/24 at 1:29 P.M. with the Director of Nursing (DON) verified the above findings. 45442 2. Review of the medical record for Resident #15 revealed an admitted [DATE]. Diagnoses included but were not limited to unspecified convulsion, type II diabetes mellitus, major depressive disorder, sleep apnea, multiple sclerosis, conversion disorder with seizures or convulsion, and anxiety disorder. Review of the 05/24/24 quarterly MDS assessment for Resident #15 revealed intact cognition, an antipsychotic and antidepressant medication were noted to being received and no behaviors were noted. Review of the physician's orders for Resident #15 revealed: An order dated 04/05/24 for Olanzapine oral table five mg. Give five mg by mouth one time a day for antipsychotic. No diagnosis was listed. An order dated 02/24/24 for Sertraline HCL Oral tablet 50 mg. Give one tablet by mouth one time a day for antidepressant. No diagnosis was listed. Interview on 06/10/24 at 1:28 P.M. with the DON confirmed the above listed concerns related to the appropriate diagnoses not being listed on the physician orders. Review of the 08/2020 facility policy titled; Medication Management revealed under procedures section f: number one and two stated; The dose, route of administration, duration and monitoring are in agreement with current clinical practice, clinical guidelines, and/or manufacturer's specifications for use. A written diagnosis, an indication and/or documented objective findings support each medication. 37096 3. Review of the medical record for Resident #16 revealed an admitted [DATE] with diagnoses including history of other infectious psychotic disorder with delusions, type II diabetes, Alzheimer's disease, Parkinson's disease, anxiety, insomnia, chronic kidney disease, depression, polydipsia, and paranoid schizophrenia. There were no diagnoses related to seizures or genitourinary. Review of the quarterly MDS assessment dated [DATE] revealed Resident #16 had intact cognition and behaviors that included inattention and disorganized thinking that fluctuated. The resident was receiving an antipsychotic, an antibiotic, antiplatelet, and hypoglycemic medications. Review of the progress notes revealed Resident #16 had no documented behaviors. Review of the care plan dated 04/15/24 revealed a behavior plan with assisting Resident #16 with activities of daily living and Resident #16 had delusions, wore multiple layers of clothing, and exhibited manic behavior at times related to diagnoses of schizophrenia and psychotic disorder. Review of the physician orders for June 2024 revealed the following medications had classes of medication listed instead of diagnoses: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Desvenlafaxine 50 milligram (mg) for antidepressant Olanzapine 10 mg for antimanic There were no orders to monitor behaviors. Interview on 06/10/24 at 1:46 P.M. with the DON verified the medications had incorrect diagnoses and stated the facility was in the process of reviewing medications for correct diagnoses. The DON stated some residents have behaviors documented in the medication administration record (MAR) or the treatment administration record (TAR) and the progress notes. However, behaviors should be documented in MARS and TARS. Review of the facility policy titled Medication Management. dated August 2020, revealed in order to optimize the therapeutic benefit of medication therapy and minimize prevent potential adverse consequences, the facility, the attending physician, and the consultant pharmacist will perform ongoing monitoring for appropriate, effective and safe medication use. In addition, when the resident receives a new medication, the medication should include a written diagnosis, an indication, or documented objective findings supporting each medication. 32650 4. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including bipolar disorder, disorganized schizophrenia, psychosis, paranoid schizophrenia, anxiety, cannabis dependence, insomnia, nicotine dependence, chronic viral hepatitis C, and chronic obstructive pulmonary disease. Review of the physician's orders for Resident #11 revealed the following medications were ordered for the associated diagnosis: Lithium 600 milligrams (mg) orally every morning and 300 mg orally every evening for behaviors Depakote (a medication used to treat seizures) 500 mg orally two times a day for anticonvulsant. The resident does not have a diagnosis of seizures or convulsions. Provera (a medication used to prevent pregnancy) 30 mg orally three times a day for hormone Haloperidol Decanoate (an antipsychotic used to treat mental illness) 50 mg/milliliter (ml) give 1 ml intramuscularly every 14 days for psych Benadryl (an antihistamine) 25 mg orally every eight hours for agitation as needed Interview with the DON on 06/06/24 at 4:30 P.M. confirmed the diagnoses and their associated medications were accurate. The DON said she would speak with the psychiatric nurse practitioner and obtain appropriate diagnoses for Resident #11's medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 32650 Based on observation and interview the facility failed to ensure a medication cart remained locked when the nurse was not in attendance. This affected one of two medication carts located on the second floor and had the potential to affect all residents except for 14 residents (#7, #11, #22, #25, #29, #33, #36, #40, #45, #54, #72, #78, #83, and #140) located on the secure unit. The facility census was 88. Findings include: Observation of medication cart located in front of the wall between rooms [ROOM NUMBERS] on 06/03/24 at 12:06 P.M. revealed the cart was unlocked, no nurse was in sight, and residents were in the hallway heading to lunch. A housekeeper was in the hallway and said she would locate the nurse. A staff member walked up to the cart and stood there. When asked who she was, the employee identified herself as Licensed Practical Nurse (LPN) #517. Interview with LPN #517 at 06/03/24 at 12:08 P.M. revealed LPN #517 did not realize what was wrong with the cart and was unable to identify the cart was unlocked. LPN #517 replied oh when informed the medication cart was unlocked but did not move to lock it. When questioned if she was going to lock it, LPN #517 replied she needed to get into the cart. Interview with the Administrator on 06/03/24 at 12:15 P.M. confirmed the medication cart should be locked when the nurse is away from it. The facility store is located on the second floor, and residents from both floors, except for the secured unit, would have potentially had access to the cart. The facility was a psychiatric facility for residents with behavior problems.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442 Based on medical record review, ancillary services appointment lists, interviews, and facility policy review the facility failed to ensure dental services were provided to Resident #26 as needed. This affected one resident (#26) of one resident reviewed for dental services. The facility census was 88. Findings include: Review of the medical record for Resident #26 revealed an admitted [DATE]. Diagnoses included but were not limited to delusional disorders, depression, vascular dementia, osteoarthritis, morbid obesity, gastro esophageal reflux disorder, and schizoaffective disorder. Resident #26 was noted to be cognitively intact and require supervision for eating and oral hygiene. No evidence was found related to a dental care plan to address dental issues. Review of the facility resident dental list for the past twelve months revealed Resident #26's last dental visit was on 06/27/23. Review of the 06/27/23 dental summary report for Resident #26 revealed partial dentition, and multiple root tips needed to be extracted. An oral surgery referral was noted to be written to a local dental institute for evaluation and treatment. Follow-up was to occur after oral surgery has been completed. Review of Resident #26's nursing progress notes from 06/27/23 to 06/10/24 revealed no indication of follow-up for a dental consult for Resident #26 following his 06/27/23 appointment. Interview on 06/03/24 at 3:55 P.M. with Resident #26 revealed he desired a dental appointment, was unsure of his last appointment, had some broken teeth, and was experiencing pain. Interview on 06/05/24 at 1:16 P.M. with the Administrator, who is the facility social worker, confirmed Resident #26 had a chip in the root tips per the 06/27/23 consult. The Administrator confirmed she was unable to provide any additional documentation as to why no follow-up had occurred for dental concerns for Resident #26 since 06/27/23. Review of the facility policy titled Dental Services, dated 04/12/16, revealed routine and emergency dental services are provided to our residents. Nursing services is to notify social services of a resident's need for dental services. Social services personnel will be responsible for assisting the resident/family in making dental appointments and transportation arrangements as necessary.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442 Based on facility assessment review and staff interview, the facility failed to ensure its facility assessment contained the necessary required information related to contracted nurses and state tested nurse aides. This had the potential to affect all 88 residents residing at the facility. Findings include: Interview on 06/06/24 at 12:35 P.M. with the Director of Nursing (DON) confirmed the facility does use agency when needed for staffing shortages. Interview on 06/10/24 at 10:17 A.M. with the Administrator confirmed the facility utilizes agency for staffing when needed and confirmed the facility assessment stated under the contracts section, the facility utilizes contractors for emergencies when they need staff. Interview on 06/10/24 at 11:42 A.M. with State tested Nurse Aide (STNA) #492, who is the facility scheduler, confirmed the facility uses agency usually at least a couple times a week. STNA #492 also confirmed on 10/07/23, two agency Licensed Practical Nurses (LPNs) were used, on 10/21/23 one agency LPN was used, on 11/18/23 one agency STNA was used, on 12/31/23 one agency LPN was used, and on 05/23/24 one agency STNA was used to fill call offs in the staffing schedule. Review of the Facility assessment dated [DATE] revealed the facility staffing is based on resident population and acuity. Under section E called; Contracts/Memorandum/Agreements with Third Parties for Services section revealed the Medical Director, physicians, pharmacy, hospice providers, nurse practitioners, dietitian, ambulance company, hospital transfer agreement, language translation services, information technology (IT), snow removal, repair, laundry, transportation, lab services, service provider under contract for emergencies (e.g. HVAC,) etc. No evidence was found for contracted direct care providers such as registered nurses (RNs), LPNs, or STNAs. Review of the facility contract agency Client Staffing Service Agreement, dated 01/06/22, revealed under terms of contract; the agency will assign employees to the client on an as needed basis to supplement the client's own work force.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 39969 Based on record review and staff interview, the facility failed to ensure the medical director was an active participant of the Quality Assessment and Assurance (QAA) committee. This had the potential to affect all residents. The facility census was 88. Findings include: Review of the facility sign-in sheets for the QAA meeting minutes for the meetings dated 07/06/23 through 05/01/24 revealed no evidence the medical director attended the meetings. Interview on 06/11/24 at 12:54 P.M. with the Administrator verified the medical director's signature was not on any of the sign-in sheets for the QAA meetings. The Administrator stated the medical director would at times attend the meetings via phone but was unable to indicate which meetings the medical director attended via phone.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32650 Based on observation, interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidelines, and facility policy review the facility failed to maintain an effective infection control program, failed to ensure appropriate personal protective equipment (PPE) was utilized during resident care, and failed to ensure annual Tuberculosis (TB) assessments were completed annually since the last annual survey dated 04/28/22. This had the potential to affect all 88 residents residing in the facility. Findings Include: 1. The entrance conference was held on 06/03/24 at 9:19 A.M. with the Administrator and Chief Clinical Officer (CCO) #490. The facility identified Licensed Practical Nurse (LPN) #517 as the facility's Infection Preventionist (IP). Interview with the Director of Nursing (DON) on 06/10/24 at 3:33 P.M. revealed the IP, LPN #517, had completed her testing and was certified as the IP today. CCO #490 was one acting as the IP for the facility for the last few months. Interview with CCO #490 on 06/10/24 at 3:40 P.M. revealed she has been the IP for the facility for the past eight months. She completed her certification program on 10/28/21. LPN #517 has been completing the infection control tracking each month with CCO #490 reviewing it to ensure the correct information was captured and if any trends of infection were identified. Review of the Infection Control logs for March, April, and May 2024 revealed the facility was completing tracking of infections but not providing laboratory results or x-ray results regarding the determination of what antibiotic a resident was placed on. All infections were marked as not meeting the McGreer's criteria for antibiotic treatment and had incorrect diagnoses for antibiotic use. Review of the facility's undated Infection Prevention and Control Program revealed the facility has developed and maintained an infection prevention and control program that provides a safe, sanitary, and comfortable environment to help prevent the development and transmission of infection. The infection control program will be monitored quarterly or as indicated by the Infection Prevention and Control Committee or other designated committee. A second interview with CCO #490 on 06/11/24 at 12:36 P.M. confirmed she should have been paying more attention to the infection control program than she had. CCO #490 also confirmed they do not have an infection control committee. They do a conference call between various staff to discuss what's going on in the facility related to infection control. 2. Interview with Unit Manager, LPN #453, on 06/10/24 at 5:22 P.M. revealed annual TB screening should be found under immunizations in the EMR. Review of immunizations for Residents #9, #11, #63, #72, and #81 revealed no annual screening for signs and symptoms of TB. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Interview with CCO #490 on 06/11/24 at 8:55 A.M. revealed the DON keeps a binder in her office with the annual TB signs and symptoms review for the residents. The facility does not use the assessments tab in the EMR, and they do not scan it into the EMR. TB screens were provided for Resident #11 dated 03/28/23 and 03/27/24. TB screens were not provided for Residents #9, #63, #72, or #81. A second interview with CCO #490 on 06/11/24 at 12:02 P.M. revealed CCO #490 requested the DON bring the TB annual screening binder to her since the last annual survey on 04/28/22. The DON did not understand what was needed, and CCO #490 explained it was the annual screening completed each year regarding if a resident had any sign or symptoms of TB. At 12:35 P.M. CCO #490 again asked the DON to bring the TB annual screening binder to her. The binder was provided at 12:45 P.M. The TB annual screening binder only contained the screens for 2024 and not back to the last annual, 04/28/22. The DON revealed she does not know where the screens are from the previous DON. She will look through the boxes the former DON left and see if she can locate them. As far as she knows they may have not been completed. Review of the TB annual screening binder revealed the screening for Resident #92's was completed on 06/03/24, but the signs and symptoms portion was incomplete. Interview with CCO #490 at the time of the review confirmed the binder only contained screenings for 2024 and did not know why Resident #92's screening form had not been completed. Review of the medical record for Resident #92 revealed the resident was admitted to the facility on [DATE] with diagnoses of lung cancer with metastases to the brain, atrial fibrillation, high blood pressure, and opioid abuse. Review of the MAR revealed a TB test was administered on 06/03/24 and also had the result read on 06/03/24. No further information was documented regarding if anyone else had read the test result 48 to 72 hours after the test was administered. Interview with the DON on 06/11/24 at 2:05 P.M. confirmed the facility had no annual TB screening for signs and symptoms from the last annual in April 2022 through when she started in the position a year ago. The DON did not know how a copy of Resident #11's TB signs and symptoms screening was found dated 03/28/23 as she was unable to locate them. Regarding Resident #92, she was not familiar with the nurse who administered the admission TB test. The facility has hired new graduate nurses who were not yet familiar with the procedures. The DON said the test would have to be repeated as no one else appears to have read the results. 37096 3. Review of the medical record for Resident #67 revealed an admitted [DATE] with diagnoses including history of other infectious and parasitic disease, pressure ulcer of sacral region, pressure ulcer right heel, colostomy status, artificial opening of the of the urinary tract, chronic kidney disease. and malignant neoplasm of the endometrium, the uterus. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #67 had intact cognition and had an ostomy. The resident was required substantial to maximum assistance with toileting and was dependent for showering, partial to maximum assistance with rolling side to side and positioning from a sitting to a lying positioning. The resident had a stage II [NAME] ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red, pink wound bed, without slough, may also present as an intact or open/ruptured serum filled blister) on admission and received pressure ulcer care. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of the care plan dated 04/05/24 revealed Resident #67 had alterations in elimination related to a colostomy status, bilateral nephrostomy tubes and urostomy related to diagnoses of obstructive and reflux uropathy. Interventions included assessing abdominal distention and changing appliances as ordered. The resident was care planned for enhanced barrier precautions (EBP) to prevent the spread of infection. Interventions included assisting with hand hygiene as needed and the use EBP. Review of the physician order for June 2024 revealed the resident had an order for EBP. Observation on 06/05/24 at 8:21 A.M. of medication administration with Registered Nurse (RN) #466 to Resident #67 revealed she walked into the room with the medications and donned gloves. Resident #67 asked RN #466 to check her ostomy and colostomy bags for leakage. RN #466 did not don a gown. She lifted Resident #67's gown and began touching and lifting the colostomy and urostomy bags for leakage. RN #67 sanitized her hands, donned gloves and administered Resident #67's medications. Interview on 06/05/24 at 8:27 A.M. with RN #466 stated the facility's policy is to wear a gown and gloves when providing direct care for residents. RN #466 stated she was not required to wear gown and gloves while administering medications. RN #466 verified she did not don a gown when assessing the Resident's #67's colostomy and urostomy bags. Follow up observation on 6/05/24 at 12:07 P.M. of Resident #67 revealed State tested Nursing Assistant (STNA) #499 entered the room to drop off Resident #67's lunch tray. STNA was not wearing gloves or a gown. Resident #67 asked STNA #499 to be repositioned properly to eat her lunch. STNA #499 did not don gloves or a gown and began to reposition Resident #67. STNA sanitized her hands and left the room. Interview at this time with STNA #499 verified she did not don gloves or a gown prior to repositioning Resident #67. Review of the facility policy titled Enhanced Barrier Precautions, revised 07/25/22, revealed EBP involve gown and gloves use during high-contact resident care activities for residents known to be colonized ore infected with a multidrug-resistant organisms (MDRO) as well as those at increased risk of MDRO. Review of the CDC guidelines titled Implementation of Personal Protective Equipment (PPE) use in nursing homes to prevent spread of MDRO, dated 04/02/24, stated EBP is used with resident's wounds and or indwelling medical devices regardless of MDRO colonization status during high-contact resident care including: activities dressing, bathing, showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use. wound care: any skin opening requiring a dressing.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 32650 Based on interview, record review, and policy review, the facility failed to implement an effective antibiotic stewardship program. This had the ability affect all 88 residents residing in the facility. Findings Include: Interview with the Chief Clinical Officer (CCO) #490 on 06/11/24 from 11:44 A.M. through 1:15 P.M. she has been overseeing the antibiotic stewardship program for approximately the last eight months. The facility's identified Infection Preventionist (IP) at the start of the survey process was Licensed Practical Nurse (LPN) #517. CCO #490 confirmed LPN #517 just received her IP certification on 06/10/24. LPN #517 has been tracking infections and the antibiotics used to treat the infections. LPN #517 is a full-time 7:00 P.M. to 7:00 A. M. supervisor. Every night, a report was run identifying who was on an antibiotic and why. CCO #490 said the facility received monthly reports from both the laboratory and the pharmacy regarding culture results and antibiotic use. She oversaw the program and reviewed the data tracking that LPN #517 completes. Review of the Infection Control logs from March 2024 through May 2024 revealed the tracking was not completed accurately or thoroughly. Review of the March 2024 log revealed each resident's name who had an infection. No site of infection was listed. Signs and symptoms of the infections were documented for 11 of 12 residents identified as having an infection. Resident #62 did have a site described as other. No signs or symptoms, and the infection related diagnosis was listed as an ear infection. No cultures were obtained for any of the infections except for those that were completed in the hospital. One resident had an x-ray done for pneumonia. No other residents had a diagnosis that would require an x-ray for diagnosis. The antibiotic start date was listed for all 12 residents. The antibiotic order was listed but the duration of the antibiotic was not provided. Ten of 12 residents had a date listed as the stop date when the antibiotic treatment was completed. McGreer's Criteria for antibiotic use was marked as N for all residents. One resident of the 12 required isolation precautions. Only one infection was listed as an in-house acquired infection, and that was Resident #62's ear infection. (continued on next page)

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	365520	A. Building B. Wing	06/13/2024

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the April 2024 infection control log revealed five residents were diagnosed with infection. Three residents had urinary tract infections (UTI), one was diagnosed with a yeast infection, and one diagnosis for Resident #16 the infection treated was hyponatremia (low sodium levels in the blood). The site of the infection was identified for all five residents. Signs and symptoms were identified for only two of the five residents. An infection related diagnosis was identified. Two of the five residents had cultures completed while hospitalized . Two other residents had cultures completed in the facility. No cultures were obtained for hyponatremia. No x-rays were obtained as the diagnosis was made without one. Three of the five residents had the culture organism identified as not applicable. The two in facility culture results were recorded. All five residents had an antibiotic start date listed. The antibiotic each resident was on was identified but the duration of treatment was not listed. An antibiotic stop date was listed for four of the five residents. The one resident without a stop date for the antibiotic was Resident #16. McGreer's criteria was again marked negative for four of the five residents. The fifth resident was left blank. Isolation precautions were not used for any resident, and all five residents acquired their infections in-house. Review of the May 2024 infection control log revealed eight residents were diagnosed with an infection. All eight residents had a site listed. Signs and symptoms were identified for five of eight residents. An infection related diagnosis was listed for seven of the eight residents. Six of eight residents had cultures obtained in the hospital. No x-rays were obtained for any resident. Antibiotic start dates were listed for all eight residents. The date antibiotic treatment was to end was listed for seven of the eight residents. McGreer's criteria was marked as not met for five of the eight residents, and three residents were left blank. Isolation was not required for any residents, and five of the eight residents acquired their infection in the facility and three were listed as not being acquired in the facility. Review of the facility's Antibiotic Stewardship Program program, last revised 02/21/22, revealed the facility will maintain a multi-disciplinary stewardship program that defines and provides guidance for optimal antimicrobial use. The purpose of the antibiotic stewardship program was to monitor the use of antibiotics in the facility's residents. Incidents identified under the Infection Prevention and Control Program will be recorded and corrective action will be taken and reported to the Quality Assurance and Performance Improvement (QAPI) committee. The facility uses McGreer's Definitions of Infection to determine appropriate infectious diagnoses and treatment. Staff will receive education regarding antibiotic stewardship. The training will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects residents and the overall community. The provider must include the name of the antibiotic; the dose; how often to administer the antibiotic; when it is to be started and stopped, or the number of days of therapy is to be administered; how it is to be administered; and the indication for use. Nursing staff will notify the Infection Preventionist when an infection is suspected. This will allow for early detection and management of a potential infection, as well as implementation of appropriate transmission-based precautions, if appropriate. When a culture is obtained, the results and current clinical situation will be communicated to the physician to determine if antibiotic therapy should be started, continued, modified, or discontinued. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with CCO #490 on 6/11/24 at 12:50 P.M. revealed she was unable to provide a reason why McGreer's criteria were marked as not being met for all three months and confirmed McGreer's criteria should be met when a resident was placed on an antibiotic and if the physician wanted the antibiotic administered despite not meeting the criteria, then the infection control committee meeting should be discussing the reason why. CCO #490 said the infection control committee does not meet on a specified date but instead they talk with the others involved over the phone. Review of the tracking logs with CCO #490 revealed Resident #19 was started on an antibiotic in March 2024 due to an elevated white blood cell count despite having no signs or symptoms of an infection. All laboratory tests were negative. The antibiotic was ordered to prevent a transfer to the emergency room for an evaluation. In April 2024 log Resident #16 was listed as being on an antibiotic for hyponatremia. CCO #490 confirmed hyponatremia is not an infection. She reviewed the resident's notes and said Resident #19 was placed on an antibiotic as it raises the resident's sodium levels and this should have been noted on the infection log. CCO #490 confirmed she should have paid more attention to the infection control tracking log.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 32650 Based on interview, record review, and policy review, the facility failed to have an Infection Preventionist providing qualified oversight of the facility's infection control. This had the ability to affect all 88 residents residing in the facility. The facility census was 88. Findings Include: The entrance conference was held on 06/03/24 at 9:19 A.M. with the Administrator and Chief Clinical Officer (CCO) #490. The facility identified Licensed Practical Nurse (LPN) #517 as the facility's Infection Preventionist (IP). Interview with the Director of Nursing (DON) on 06/10/24 at 3:33 P.M. revealed the IP, LPN #517, had completed her testing and was certified as the IP today. CCO #490 was the person acting as the IP for the facility for the last few months. Interview with CCO #490 on 06/10/24 at 3:40 P.M. revealed she has been the IP for the facility for the past eight months. She completed her certification program on 10/28/21. LPN #517 has been completing the infection control tracking each month with CCO #490 reviewing it to ensure the correct information was captured and if any trends of infection were identified. Review of immunizations for Residents #9, #63, #72, and #81 revealed no annual screening for signs and symptoms of TB. Review of the Infection Control logs for March, April, and May 2024 revealed the facility was completing tracking of infections but not providing laboratory results or x-ray results regarding the determination of what antibiotic a resident was placed on. All infections were marked as not meeting the McGreer's criteria for antibiotic treatment, and had incorrect diagnoses for antibiotic use. Review of the facility's undated Infection Prevention and Control Program revealed the facility has developed and maintained an infection prevention and control program that provides a safe, sanitary, and comfortable environment to help prevent the development and transmission of infection. The infection control program will be monitored quarterly or as indicated by the IP and Control Committee or other designated committee. Interview with CCO #490 on 06/11/24 at 8:55 A.M. revealed the DON keeps a binder in her office with the annual TB signs and symptoms review for the residents. The facility does not use the assessments tab in the electronic medical record (EMR), and they do not scan the information to the EMR. TB screens were provided for Resident #11 dated 03/28/23 and 03/27/24. TB screens were not provided for Residents #9, #63. #72, or #81. Review of the TB annual screening binder revealed residents were screened for signs and symptoms of TB for the past year; however, no information was found from the last annual survey dated 04/28/22. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the DON on 06/11/24 at 12:45 P.M. revealed she did not know if the annual TB screens were completed by the former DON. She would look through the boxes of things left by the former DON and see if she was able to find them. Interview with the DON on 06/11/24 at 2:05 P.M. confirmed the facility had no annual TB screening for signs and symptoms from the last annual in April 2022 through when she started in the position a year ago. Review of the Infection Control logs from March 2024 through May 2024 revealed the tracking was not completed accurately or thoroughly. Signs and symptoms were not documented for all residents with infections, lab work and/or radiology testing were not completed on all residents when they were symptomatic, McGreer's criteria was marked as not met for any of the infections reviewed. Review of the facility's undated Infection Prevention and Control Program revealed the facility has developed and maintained an infection prevention and control program that provides a safe, sanitary, and comfortable environment to help prevent the development and transmission of infection. The infection control program will be monitored quarterly or as indicated by the Infection Prevention and Control Committee or other designated committee. Review of the facility's Antibiotic Stewardship Program program, last revised 02/21/22, revealed the facility will maintain a multi-disciplinary stewardship program that defines and provides guidance for optimal antimicrobial use. The purpose of the antibiotic stewardship program is to monitor the use of antibiotics in the facility's residents. Incidents identified under the Infection Prevention and Control Program will be recorded and corrective action will be taken and reported to the Quality Assurance and Performance Improvement (QAPI) committee. The facility uses McGreer's Definitions of Infection to determine appropriate infectious diagnoses and treatment. Staff will receive education regarding antibiotic stewardship. The training will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects residents and the overall community. The provider must include the name of the antibiotic; the dose; how often to administer the antibiotic; when it is to be started and stopped, or the number of days of therapy is to be administered; how it is to be administered; and the indication for use. Nursing staff will notify the Infection Preventionist when an infection is suspected. This will allow for early detection and management of a potential infection, as well as implementation of appropriate transmission-based precautions, if appropriate. When a culture is obtained, the results and current clinical situation will be communicated to the physician to determine if antibiotic therapy should be started, continued, modified, or discontinued. Interview with CCO #490 on 6/11/24 at 12:50 P.M. revealed she was unable to provide a reason why McGreer's criteria were marked as not being met for all three months and confirmed McGreer's criteria should be met when a resident was placed on an antibiotic, and if the physician wanted the antibiotic administered despite not meeting the criteria, then the infection control committee meeting should be discussing the reason why. CCO #490 confirmed she should have paid more attention to the infection control tracking log and increased her supervision of the infection control process.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096 Based on record review, observation, interview, and facility policy review the facility failed to ensure call lights were functional and in reach for Residents #5, #12, and #13. This affected three residents (#5, #12 and Resident #13) of 88 residents reviewed for call lights. The facility census was 88. Findings include: 1. Review of the medical record for Resident #12 revealed an admitted [DATE] with diagnoses including acute kidney failure, dementia, and abnormalities of gait and mobility. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #12 had impaired cognition and required substantial to maximal assistance for transfers, hygiene, and dressing. The resident was dependent for transferring. Review of the care plan dated 03/12/24 revealed Resident #12 had a self-care deficit related to weakness and behaviors. Interventions included one staff for assistance with dressing, eating, and toileting. 2. Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including dementia, malnutrition, and vertigo. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #13 had memory problems, disorganized thinking, and inattention. The resident required partial to moderate assistance with eating, toileting, showering, and dressing. The resident was incontinent of bowel and bladder. Review of the care plan dated 05/16/24 revealed Resident #13 had a self-care deficit related to cognitive impairment and confusion. Interventions included encouraging the resident to participate while performing activities of daily living, and to monitor and report a decline to the physician. Observation on 06/03/24 at 11:23 A.M. of Resident #12's room revealed she was sitting in her wheelchair next to her bed. There was no call light in reach. Resident #12's roommate, Resident #13, was lying in her bed resting. There was no call light in reach. The call light system located on the wall had the face plate that was pulled away from the wall and hanging. There were no call light cords attached to the call light system. Interview at this time with Resident #12 revealed the call light system in the room was not functioning and has not been functioning for a long time. Resident #12 stated there was no other way to contact staff. Interview with Resident #13 at this time, stated she was able to use her call light if she had one. Interview with on 06/03/24 at 11:30 A.M. with Licensed Practical Nurse (LPN) #517 verified Resident #12 and Resident #13's call lights were not functioning. LPN #517 revealed the call light system in this room had issues for several weeks. The room was located close to the nurses' station. Resident #12 would yell if she needed help, and Resident #13 would come to the nurses' station if she needed help. LPN #517 stated she would have maintenance fix the call lights. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further observation on 06/03/24 at 2:20 P.M. of Resident 12's room revealed Resident #12 was yelling for help. Resident #12 was sitting in her wheelchair next to her bed. There was no call light in reach. Resident #12's roommate, Resident #13, was lying in her bed resting. There was no call light in reach. The call light cords were plugged into the call light system on the wall. Interview at this time with Resident #12 stated her call light was not within her reach, and she needed the state tested nursing assistant (STNA). Interview on 06/03/24 at 2:25 P.M. with Registered Nurse (RN) #439 verified Resident #12 and Resident #13's call lights were not within reach. RN # 439 stated the maintenance man was in prior fixing the call light system. The maintenance probably forgot to put the call lights in reach of the residents. 39969 3. Review medical record for Resident #5 revealed an initial admitted [DATE]. Diagnoses included schizoaffective disorder, bipolar type, muscle weakness, low back pain, and unsteadiness on feet. Review of the quarterly MDS assessment dated [DATE] revealed Resident #5 had impaired cognition, used a wheelchair, and required partial/moderate assistance from staff for transfers from the bed or chair to the chair and for toileting. Observation on 06/03/24 at 3:54 P.M. of Resident #5 in bed sleeping, and the call light was on the floor not within reach. Interview on 06/03/24 at 3:59 P.M. with STNA #502 verified the call light was not within the resident's reach. Observation at this time of STNA #502 pick the call light up off the floor and place it within reach of Resident #5. Interview on 06/04/24 at 11:02 A.M., Resident #5 stated she was able to use her call light, and that she used her call light when she needed assistance from staff. Review of the facility policy titled Call Light, Use Of, revised 10/20/19, revealed assure call system is in working order, report to maintenance defective call lights with exact location, and be sure all call lights are placed within reach of the resident at all times.

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F 0947 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 45442 Based on facility employee file review and interview, the facility failed to ensure two State tested Nurse Aides (STNAs) #494 and #498 of four STNAs reviewed received the required 12 hours annually of continuing education credits. This had the potential to affect all 88 residents residing at the facility. Findings include: Review of the staff education for STNA #494 revealed evidence of four one-hour education in-services (06/08/23, 12/27/23, 01/31/24, and 04/26/24) in the past 12 months. Review of the staff education for STNA #498 revealed evidence of nine one-hour education in-services (07/26/23, 08/30/23, 10/25/23, 11/29/23, 01/31/24, 02/28/24, 03/21/24, 04/26/24, and 05/29/24) in the past 12 months. Review of the facility education in-service sign in sheets from the past 12 months revealed STNAs #494 and #498 were not listed on all 12 months to meet the required 12 hours of education annually for staff. Interview on 06/11/24 at 9:07 A.M. with Chief Clinical Officer #490 and the Administrator confirmed they were unable to produce proof of 12 education credits for STNAs #494 and #498 for the past twelve months as required.