STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365539	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Nursing & Rehab	2473 North Rd NE Warren, OH 44483

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** 39973 Based on interview, observation, record review, and review of the facility policy the facility did not ensure Resident #80 was treated in a dignified, respectful manner after he requested a blanket from staff because he was cold, and the blanket was not provided. This affected one resident (#80) out of two residents reviewed for dignity. The facility census was 86. Findings included: Review of the medical record for Resident #80 revealed an admitted [DATE] with diagnoses including chronic respiratory failure with hypoxia, epilepsy, atrial fibrillation, presence of tracheostomy, chronic obstructive pulmonary disease (COPD), and pneumonia. He was assessed as cognitively intact. Review of the care plan dated 02/20/24 revealed Resident #80 had a self-care deficit related to diagnoses of COPD, chronic lung disease, cerebral infarction that affected activities of daily living (ADL) due to shortness of breath, decreased activity tolerance, and weakness. Interventions included assist with ADL as needed and monitor for increased shortness of breath and fatigue. Observation on 03/27/24 at 6:09 A.M. revealed Resident #80 rang his call light and Agency Licensed Practical Nurse (LPN) #700 answered the call light. Resident #80 requested his tube feeding to be turned off, and he requested a blanket as he was cold. Agency LPN #700 proceeded to check the linen closet and went back to tell Resident #80 that there were no blankets in the closet and that there was only a sheet. Resident #80 began yelling and using profanity stating, this is [expletive] every night I just can't get a blanket. Agency LPN #700 apologized and stated the best she could do was offer a sheet. Resident #80 again yelled, so I will just continue to freeze, this place is ridiculous . cannot even get a blanket. She proceeded to walk out of his room and State tested Nursing Assistant (STNA) #954 was at the nursing station and stated to Agency LPN #700, as she had heard the above incident, that it was almost an every night occurrence that there was never enough linen, including blankets. They then proceeded to hear Resident #80 continue to remain in bed and yell out verbalizing his frustration of not having a blanket. Both Agency LPN #700 and STNA #954 stated there was nothing they could do as there was not enough linen. Interview and observation on 03/27/24 at 6:14 A.M. with Agency LPN #700 showed this surveyor the linen closet on the unit Resident #80 resided on and there were no blankets in the closet. Agency LPN #700 revealed she was from the agency and only knew where the linen room was on the unit and was not aware how to access the laundry room to check if there were blankets. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 03/27/24 at 6:16 A.M. with STNA #954, when asked about if there were any blankets in the laundry room, stated even if she would go down to the laundry room there would not be any blankets. Observation on 03/27/24 from 6:16 A.M. to 6:45 A.M. revealed Agency LPN #700 sat behind the nursing station and STNA #954 sat in a chair by the nursing station and both staff did not attempt to go check other units and/or the laundry room to see if there was a blanket. Interview and observation on 03/27/24 at 6:37 A.M. revealed Resident #80 remained only with sheets and without a blanket. Resident #80 revealed he was still cold. Observation on 03/27/24 at 6:47 A.M. of the unlocked laundry room revealed approximately a dozen blankets folded on the table. Interview on 03/27/24 at 6:50 A.M. with the Director of Housekeeping #834 revealed if there was not any linen on the unit in the linen closets including blankets that any staff had access to the laundry room as they left laundry on the table for back up for staff to use if needed. She verified there were approximately a dozen blankets sitting on the table available to staff. Interview on 03/27/24 at 7:45 A.M. with the Administrator verified staff had access to linen including blankets in the laundry room and should have checked in the laundry room to accommodate Resident #80's request. Review of the facility policy labeled, Resident Rights, dated December 2016, revealed federal and state laws guarantee certain basic rights to all residents of the facility. The rights included a dignified existence, treated with respect, kindness and dignity, and self-determination.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49774 Based on record review, resident representative interviews, and staff interviews, the facility failed to ensure residents and/or their responsible parties were included in and offered the opportunity to participate in quarterly care plan meetings. This affected five residents (#13, #18, #25, #42, and #56) of five residents reviewed for care planning. The facility census was 86. Findings include: 1. Review of Resident #13's medical record revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), muscle weakness, difficulty walking, paranoid schizophrenia, bipolar disorder, delusional disorder, generalized anxiety disorder, unspecified atrial fibrillation, and morbid obesity. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 11 of 15, moderate cognitive impairment, and suffered from inattention, disorganized thinking which fluctuated in severity, and impaired thought processes due to paranoid schizophrenia. Resident #13 required partial to moderate assistance with toileting and moderate to maximal assistance with dressing. Resident #13 was compliant with all medications, including psychotropic medications, during the review period. Review of the resident care plan meeting documentation revealed the last care plan meeting for Resident #13 was completed on 09/29/23. Interview on 03/27/24 at 3:24 P.M., with the Social Service Designee (SSD) #916, confirmed the care plan meetings were not performed timely or on a quarterly schedule for Resident #13 and confirmed the last care conference occurred on 09/29/23. Resident #13 has not been involved in the care planning since September 2023. 2. Review of Resident #18's medical record revealed an admitted [DATE]. Diagnoses included acute kidney failure, chronic pain syndrome, unspecified dementia, adult failure to thrive, and delirium due to known physiological condition. Review of the annual MDS assessment dated [DATE] revealed the resident had a BIMS score of three, severely cognitively impaired, and suffered from both short and long-term memory problems. Resident #18 required hands on assistance with bathing or showering. Interview on 3/26/24 at 9:46 AM with Resident #18's guardian revealed the guardian had not been contacted for any care plan meetings although one was requested. Review of medical record revealed Resident #18 had not had a care plan meeting since being admitted on [DATE]. The medical record included a progress note for a phone call from SSD #916 to Resident #18's guardian dated 03/27/24 at 9:55 A.M. requesting a returned call to schedule a care conference. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/27/24 at 10:03 A.M., with SSD #916, confirmed the care plan meetings were not performed timely or on a quarterly schedule for Resident #18. 3. Review of Resident #25's medical record revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, end stage renal disease, type two diabetes, anemia, and dependence on renal dialysis. Review of the quarterly MDS assessment dated [DATE] revealed the resident had a BIMS score of 15 and was cognitively intact. Resident #25 was independent with all ADL and refused assistance with bathing or showering. Review of the care plan revealed Resident #25 was non-compliant with treatments including dialysis treatments and medications. Review of the resident care plan meeting documentation revealed the last care plan meeting for Resident #25 was completed on 11/27/23. Interview on 03/28/24 at 1:49 P.M. with SSD #916, confirmed the care plan meetings were not performed timely or on a quarterly schedule; confirmed the last care plan meeting with Resident #25 occurred on 11/27/23. SSD #916 scheduled an upcoming care plan meeting on 04/04/24 at 11:30 A.M. 4. Review of Resident #56's medical record revealed an admitted [DATE]. Diagnoses included hepatic encephalopathy, end stage renal disease, type two diabetes with diabetic chronic kidney disease, other cirrhosis of liver, and chronic diastolic heart failure. Review of the MDS assessment dated [DATE] revealed Resident #56 had a BIMS score of 13 indicating the resident was cognitively intact, had no behaviors, required assistance with transfers and showers, and used a wheelchair for mobility. Review of medical record revealed Resident #56 had not had a care plan meeting since being admitted [DATE]. The medical record included a progress note for a phone call from SSD #916 on 03/27/24 at 1:24 P. M. to Resident #56's family member for a care plan meeting. The record indicated an upcoming care plan meeting was scheduled for 04/08/24 at 11:00 A.M. Interview with SSD #916 on 3/28/24 at 1:52 P.M. confirmed the care plan meetings were not performed timely or on a quarterly schedule. Interview on 04/02/24 at 2:22 P.M. with Resident #56 who reported that she had never had a care plan meeting but does have one scheduled for next week. 5. Review of Resident #42's medical record revealed an admitted [DATE]. Diagnoses included unspecified combined systolic and diastolic heart failure, essential hypertension, chronic kidney disease, unspecified dementia morbid obesity, and atherosclerotic heart disease of native coronary artery without angina pectoris. Review of the quarterly MDS assessment dated [DATE] revealed the resident had a BIMS score of 15 out of 15 and was cognitively intact. Resident #42 required substantial assistance for oral hygiene, toileting, shower/bath, and dressing. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident care plan meeting documentation revealed the last care plan meeting for Resident #42 was completed on 09/13/23. There was no documented evidence of any additional care conference being conducted. Interview on 03/28/24 1:55 P.M., with SSD #916 confirmed quarterly care plan meetings had not been conducted for Resident #42. Interview with the Administrator and Director of Nursing (DON) on 03/28/24 at 2:00 P.M. revealed that the facility did not have a care planning policy but stated the facility follows state rules regarding care planning. Interview on 04/02/24 at 2:18 P.M. with Resident #42 who reported that he was unable to recall ever having had a care plan meeting.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565 Based on record review and interview the facility failed to obtain written and witnessed authorizations to manage resident funds. This affected four residents (#18, #34, #38, and #291) of eight residents reviewed for facility fund management. The facility census was 86. Findings include: 1. Review of the medical record for Resident #18 revealed an admitted [DATE]. Significant diagnoses included acute kidney failure, unspecified dementia, and adult failure to thrive. Resident #18 had a court appointed guardian. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 had a BIMS score of three of 15, indicating severe cognitive deficit. A review of the resident fund management authorization form dated 08/22/23 revealed it was signed by Resident #18. There was no witness signature and no signature by the guardian. On 03/27/24 at 1:50P.M. an interview with Business Office Manager (BOM) #710 who manages resident funds verified there was no witness signature and no signature of the guardian. She stated she only obtained a witness signature when a resident signed with an X. 2. Review of the medical records for Resident #34 revealed an admitted [DATE]. Significant diagnoses included chronic obstructive pulmonary disease and vascular dementia. Resident #34 was listed as his own guarantor. Review of the quarterly MDS assessment dated [DATE] revealed a BIMS score of six of 15, indicating severe cognitive impairment. A review of the resident fund management authorization form for Resident #34 revealed no signed authorization for the facility to manage personal funds. On 03/27/24 at 1:50P.M. an interview with BOM #710 who manages resident funds verified there was no written authorization for funds for Resident #34. 3. Review of the medical record for Resident #38 revealed an admitted [DATE] and a discharge date of [DATE]. Significant diagnoses included chronic obstructive pulmonary disease, atrial fibrillation, depression, anxiety, and a dependence on dialysis. Resident #38 was listed as her own guarantor. Review of the annual MDS assessment dated [DATE] revealed a BIMS score of 10 of 15, indicating mild cognitive impairment. A review of the resident fund management authorization form dated 04/18/23 revealed it was signed by Resident #38. There was no witness signature. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 03/27/24 at 1:50P.M. an interview with BOM #710 who manages resident funds verified there was no witness signature. She also stated she only obtained a witness signature when a resident signed with an X. 4. Review of the medical record for Resident #291 revealed an admitted [DATE] and a discharge date of [DATE]. Significant diagnoses included acute and chronic respiratory failure, anxiety, morbid obesity. and hypertension. Resident #291 was listed as own guarantor per face sheet. Review of the annual MDS assessment dated [DATE] revealed a BIMS score was not assessed. A quarterly MDS dated [DATE] revealed a BIMS score of 14 of 15, indicating the resident was cognitively intact. Review of the resident fund management authorization form for Resident #34 revealed no signed authorization for facility to manage personal funds. On 03/27/24 at 1:50P.M. an interview with BOM #710 who manages resident funds verified there was no written authorization for the facility to manage funds for Resident #34.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565 Based on record review and staff interview the facility failed to ensure funds were conveyed within 30 days upon death for Resident #292 and failed to notify two residents (#8 and #34) when their personal funds account balance was within two hundred dollars of the state allowed limit. This affected three residents (#292, #8 and #34) of eight residents reviewed for personal funds. The facility census was 86. Findings include: 1. Review of the medical record for Resident #292 revealed an admitted [DATE] and a discharge of 11/10/23. Significant diagnoses included metabolic encephalopathy, adult failure to thrive, anxiety, and acute respiratory failure. A review of closed resident funds for Resident #292 revealed a check in the amount of $200.54 was issued on 12/31/23. Interview on 03/27/24 at 1:50 P.M. with Business Office Manager (BOM) #710 verified the check amount and check date which was more than 30 days after death. 2. Review of the medical record for Resident #8 revealed an admitted [DATE]. Significant diagnoses included unspecified dementia, depression, and anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Resident #8 had a court appointed guardian. Resident #8 was on Medicaid as a payor source. A review of resident account balances as of 03/27/24 revealed Resident #8 had $2405.63 in a resident fund account. On 03/27/24 at 1:50P.M. an interview with BOM #710 who manages resident funds revealed she makes phone calls to notify residents, powers of attorneys, or guardians of a need to spend down monies to ensure continued Medicaid benefits. She stated she would call families if listed if the resident is cognitively impaired. She stated she does not give written notifications of a need for spend down and was unable to verify notification of the guardian for Resident #8 regarding spend down. 3. Review of the medical record for Resident #34 revealed an admitted [DATE]. Significant diagnoses included chronic obstructive pulmonary disease and vascular dementia. Resident #34 was listed as his own guarantor. Review of the quarterly MDS assessment dated [DATE] revealed a BIMS score of six of 15, indicating severe cognitive impairment. A review of resident accounts revealed Resident #34 had an account balance of $2321.45 on 03/27/24. (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of authorization forms for Resident #34 revealed no signed authorization for the facility to manage personal funds. On 03/27/24 at 1:50P.M. an interview with BOM #710 who manages resident funds revealed she makes phone calls to notify residents, powers of attorneys, or guardians of a need to spend down monies to ensure continued Medicaid benefits. She would call families if the resident was cognitively impaired. She does not give written notifications of a need for spend down and she would talk to Resident #34 in regard to a spend down of monies to ensure continued Medicaid benefits.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565 Based on record review, observation, interview, and review of the facility policy the facility failed to ensure a clean environment with walls in good repair for Resident #12. The facility did not ensure an environment free of broken window blinds for Residents #48 and #71. The facility did not ensure a room with comfortable temperatures for Residents #54 and #64. This affected five residents (#12, #48, #71, #54 and #64) of 34 residents observed for environment who resided on the Dogwood and Crab Apple units. The facility census was 86. Findings include: 1. Review of the medical record for Resident #12 revealed an admitted [DATE]. Significant diagnoses included diabetes mellitus type II, morbid obesity, weakness, mood disorder, schizophrenia, anxiety, major depressive disorder, and bipolar disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 of 15, indicating Resident #12 was cognitively intact. On 03/25/24 at 11:03 A.M. an observation of Resident #12 revealed a room with a dirty floor and a foul odor. There were food crumbs under the head of the bed on the floor. The corner of the wall next to the bathroom had missing plaster. On 03/26/24 at 4:30 P.M. an observation of Resident #12 revealed a room with a dirty floor and a foul odor. There were food crumbs under the head of the bed on the floor. The corner of the wall next to the bathroom had missing plaster. On 03/27/24 at 7:50 A.M. observation of Resident #12 revealed a room with a dirty floor and a foul odor. There were food crumbs under the head of the bed on the floor. The corner of the wall next to the bathroom had missing plaster. An interview with Occupational Therapist #867 at the time of the observation verified the findings. Occupational Therapist #867 stated the room was filthy. On 03/27/24 at 9:35 A.M. an interview with Housekeeper (HK) #831 revealed resident rooms were cleaned daily and deep cleaning of rooms was done monthly. HK #831 was unaware of any resident refusals regarding room cleaning. On 03/28/24 at 9:00 A.M. an interview with Housekeeping Manager (HKM) #834 revealed resident rooms were cleaned daily and deep cleaning of rooms was done monthly. HKM #834 was unaware of any resident refusals regarding room cleaning. HKM #834 also verified the missing plaster on the corner of the wall by the bathroom for Resident #12. HKM #834 stated when there was disrepair in a resident room, she reports it to maintenance. HKM #834 could not verify if the missing plaster was reported to maintenance for repair. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the undated document titled Room Cleaning revealed high touch surfaces, bathrooms, and the floor are to be cleaned daily. A review of the undated document titled Deep Cleaning Check Off List revealed a signature line for resident refusals of cleaning. 2. Review of the medical record for Resident #48 revealed an admitted [DATE]. Significant diagnoses included end stage renal disease, diabetes mellitus type II, neuropathy, malignant neoplasm of the prostrate, malignant neoplasm of the bladder, metabolic encephalopathy, and dependence on renal dialysis. Review of the quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 of 15, indicating Resident #48 was cognitively intact. On 03/25/24 at 11:25 A.M. an observation of Resident #48's room revealed broken window blinds. An interview with Resident #48 at the time of the observation revealed the window blinds have been broken since admission. On 03/28/24 at 9:00 A.M. an interview with HKM #834 revealed housekeepers report any disrepair in resident rooms to maintenance. HKM #834 could not verify if any broken blinds were reported. On 04/01/24 at 10:00 A.M. an interview with State tested Nurse Aide (STNA) #964 verified the window blinds for Residents #48 and #71 were broken. 3. Review of the medical record for Resident #71 revealed an admitted [DATE]. Significant diagnoses included, traumatic brain Injury, acute respiratory failure, diabetes mellitus type II, hypertension, chronic pancreatitis, and protein calorie malnutrition. Review of the quarterly MDS assessment dated [DATE] revealed a BIMS score of 99, indicating staff was unable to evaluate cognition. On 03/25/24 at 11:25 A.M. an observation of Resident #71's room revealed a broken window blind. On 03/28/24 at 9:00 A.M. an interview with HKM #834 revealed housekeepers report any disrepair in resident rooms to maintenance. HKM #834 could not verify if any broken blinds were reported. On 04/01/24 at 10:00 A.M. an interview with STNA #964 verified the window blinds for Residents #48 and #71 were broken. 4. Review of the medical record for Resident #54 revealed an admitted [DATE]. Diagnoses included Lewy body dementia, diabetes mellitus type II, and secondary Parkinsonism. Review of the admission MDS assessment dated [DATE] revealed a BIMS score of 10 of 15, indicating moderate cognitive impairment. On 03/26/24 at 12:10 P.M. observation of room temperatures as taken by the life safety code surveyor revealed a wall temperature of 67 degrees Fahrenheit (F) and a floor temperature of 65 degrees F. Resident #54 was observed sitting on the side of his bed with his coat on. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/26/24 at 12:13 P.M. an interview with Resident #54 revealed he had asked for his door to be kept open for the heat and, they always close it. 5. Review of the medical records for Resident #64 revealed an admitted [DATE]. Significant diagnoses included malignant neoplasm of the brain, respiratory failure, atresia of the esophagus, dysfunction of the bladder and depression. Review of the quarterly MDS assessment revealed a BIMS score of 9 of 15, indicating moderate cognitive impairment. On 03/26/24 at 12:10 P.M. observation of room temperatures as taken by the life safety code surveyor revealed a wall temperature of 67 degrees Fahrenheit (F) and a floor temperature of 65 degrees F. A thermometer on the bedside table of Resident #64 revealed a room temperature of 68 degrees F. On 03/26/24 at 12:30 P.M. an interview with the mother of Resident #64 revealed the room was cold, and she would be willing to have a room change now. She also stated the facility had someone look at the heat in February of this year, but nothing was done. On 03/26/24 at 12:30 P.M. an interview with the [NAME] President of Operations (VPO) #716 and the mom of Resident #64 revealed the heat in the room had been an ongoing problem. VPO #716 asked Resident #64's mother to verify that she had refused to move rooms due to the heat. Resident #64's mother stated she could not recall having such conversations. On 03/26/24 at 1:00 P.M. a review of a proposal from a local heating and air conditioning company dated 02/20/24 revealed the heat was functioning properly in the room for Residents #54 and #64 but due to there being two outside walls it was proposed to run another unit in the room. On 03/26/24 at 1:15 P.M. an interview with VPO #716 revealed the facility did not act on the proposal to add an additional heating unit to the room of Residents #54 and #64 as the proposal stated the heating unit was functioning properly. On 04/01/24 at 9:00 A.M. an interview with the Administrator revealed there was no policy for a comfortable environment.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Nursing & Rehab	2473 North Rd NE Warren, OH 44483

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on interview, observation, and record review the facility did not ensure staff were knowledgeable regarding how to locate baseline care plans and/ or had Kardex's (communication tool that identifies care and services residents require) in place to ensure staff were aware what care and services residents were to receive on admission. This affected two residents (#76 and #82) out of two residents reviewed for baseline care plan. The facility census was 86. Findings include: 1. Review of the medical record for Resident #82 revealed an admitted [DATE] with diagnoses including myelodysplastic syndrome (disorder of the blood cell formation in the bone marrow), diabetes, hypertension, and osteoarthritis. Review of the Admission/ Readmission Packet- V2 dated 02/14/24 and completed by Licensed Practical Nurse (LPN) #838 revealed Resident #82 was alert and oriented times three, communicated verbally with clear speech. The Braden Scale for Predicting Pressure Ulcer Risk was completed and noted Resident #82 to be at risk as his sensory perception was limited, he was very moist, he was bedfast, he had limited mobility, and he had a problem with friction and shear. Review of the Kardex for Resident #82 revealed he did not have one in place from the date of admission, 02/14/24, to date it was brought to the attention of the Director of Nursing (DON), 04/03/24 including no interventions in place to prevent pressure ulcers/ skin impairment and/or activities of daily living (ADL) care. Review of Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #82 had intact cognition. He was dependent on staff assist for toileting, sitting to lying, lying to sitting, and transfers. He required substantial to maximum assistance of staff to roll left and right and oral care. Interview and observation on 03/25/24 at 9:54 A.M. with Resident #82 revealed he had not brushed his teeth since admission (02/14/24). Resident #82 revealed he did not have a bathroom in his room so the only place a toothbrush would be was in his nightstand but he had not seen one. Observation of Resident #82's teeth appeared to have a white yellow coating with food particles. Observation of his nightstand in the top drawer contained a wash basin that contained a toothbrush in a plastic wrapper that was unused/ unopened. Interview with the Administrator and DON on 03/28/24 at 2:00 P.M. revealed that the facility did not have a care planning policy but stated the facility followed state rules regarding care planning. Interview on 04/01/24 at 10:42 A.M. with Resident #82 revealed they had washed him up this morning in bed, but he still had not brushed his teeth. Observation of his teeth continued to have a white yellow coating to his teeth. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 04/01/24 at 11:43 A.M. with State tested Nursing Assistant (STNA) #947 revealed that Resident #82 was already washed up and had a new gown on before she came on duty at 6:30 A.M. She revealed she was unsure if he had received oral care. Observation with STNA #947 revealed Resident #82 continued to have a toothbrush in a plastic wrapper that was unopened/ unused in his top drawer of his nightstand. She verified he did not have a bathroom in his room and that the only toothbrush she had seen was the one in his nightstand unopened/ unused. Upon observation she stated, by the looks no oral care was done as she revealed Resident #82 had food particles and a white film coating/ covering his teeth. Review of the baseline care plan dated 02/14/24 (provided on 04/03/24) for Resident #82 revealed Resident #82 had an activities of self-care performance deficit. Interventions included the resident was totally dependent on staff for repositioning and transfers. He utilized a mechanical lift for transfers. (The baseline care plan was provided on 04/03/24 as the DON did not know where to locate it in the electronic record when first requested on 04/02/24). Review of baseline care plan dated 02/14/24 (provided on 04/03/24) for Resident #82 revealed Resident #82 had a pressure ulcer or potential for a pressure ulcer. Interventions included turning and repositioning every two hours or more often as needed, bed flat as possible to reduce shear, assess, record, monitor wound healing, and moisturizer to his skin. (The baseline care plan was provided on 04/03/24 as the DON did not know where to locate it in the electronic record when first requested on 04/02/24). Interview on 04/02/24 at 9:05 A.M. with the DON revealed she was unable to locate a baseline care plan for Resident #82 regarding prevention of pressure ulcers and interventions. She verified the first care plan regarding interventions was on his comprehensive care plan on 03/07/24. Interview on 04/03/24 at 11:25 A.M. with the DON revealed she did not realize when asked previously where Resident #82's baseline care plan was as she stated there was an area in his electronic medical record that a person reviewing had to go under the trigger a button to view. She verified she was not familiar with where to locate the baseline care plan since she was hired as she had not been shown on orientation; therefore, had not been educating the nurses on the location of the baseline care plan. Interview on 04/03/24 at 12:00 P.M. with LPN #854 (currently assigned to Resident #82) revealed she had worked at the facility since November 2023 and was not familiar with how to locate a baseline care plan in the electronic record. She was unable to show this surveyor where Resident #82's baseline care plan was, including interventions to prevent pressure ulcers and ADL care and services except on the comprehensive care plan dated 03/07/24. Interview on 04/03/24 at 12:08 P.M. with STNA #940 (currently assigned to Resident #82) revealed she had worked for approximately four years at the facility. She revealed she was not aware how to access any care plans but revealed she utilized the Kardex for each resident regarding interventions related to their care. STNA #940 showed this surveyor how she looked up each resident's Kardex by the electronic record and verified Resident #82 did not have a Kardex in place; so therefore, she was not aware what interventions he had in place regarding prevention of pressure ulcers and or ADL care needed. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 04/03/24 at 1:40 P.M. with the DON verified the STNA's utilized the Kardex to know what interventions to follow especially in relation to the prevention of pressure ulcers and ADL care. She verified Resident #82 did not have a Kardex in place. Interview on 04/03/24 at 12:13 P.M. with Registered Nurse (RN) #902 revealed she did not know where to locate the baseline care plans and/ or interventions for a resident newly admitted . 2. Review of medical record for Resident #76 revealed an admitted [DATE] with diagnoses including cerebral infarction, acute kidney failure, pressure ulcer of his sacral region, and tracheostomy. Review of the Admission/ Readmission Packet-V2 dated 02/06/24 completed by LPN #704 revealed a skin assessment was completed on admission, and Resident #76 had a pressure ulcer to his coccyx. On admission a Braden Scale for Predicting Pressure Sore Risk was also completed, and Resident #76 was at risk due to limited sensory perceptions, he was occasionally moist, he was chairfast, he was completely immobile, and he had a problem with friction and shear. Review of Medicare five-day MDS assessment dated [DATE] revealed Resident #76 was rarely and/ or never understood. He was dependent on staff for his ADL including bed mobility, toileting, and transfers. Interview with the Administrator and DON on 03/28/24 at 2:00 P.M. revealed that the facility did not have a care planning policy but stated the facility followed state rules regarding care planning. Review of baseline care plan dated 02/06/24 (provided on 04/03/24) revealed Resident #76 had potential for impairment of skin integrity. Interventions included moisture barrier after each incontinent episode, floating heels while in bed, encouraging to turn and reposition in bed every two hours, and checking and changing every two to three hours. (The baseline care plan was provided on 04/03/24 as the DON did not know where to locate it in the electronic record when first requested on 04/02/24). Review of Kardex dated 02/06/24 to 04/03/24 revealed Resident #76 only had interventions related to safety regarding seizure precautions. He did not have any interventions on his Kardex regarding the prevention of pressure ulcers and/ or any other care and services for the STNAs to follow. Interview on 04/03/24 at 10:33 A.M. with the DON verified she was unable to locate a baseline care plan for Resident #76 regarding prevention of pressure ulcers and interventions until his comprehensive care plan on 03/03/24. Interview on 04/03/24 at 11:25 A.M. with the DON revealed she did not realize when asked previously where Resident #76's baseline care plan was as she stated there was an area in his electronic medical record that a person reviewing had to go under the trigger a button to view. She verified she was not familiar with where to locate the baseline care plan since she was hired as she had not been shown on orientation; therefore, had not been educating the nurses on the location of the baseline care plan. Interview on 04/03/24 at 12:13 P.M. with RN #902 (assigned to Resident #76) revealed she did not know where to locate the baseline care plans and/ or interventions for a resident newly admitted on ly the comprehensive care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 04/03/24 at 12:15 P.M. with STNAs #939 and #963 (assigned to Resident #76) revealed they did not know where to find baseline care plans, they utilized the Kardex's to know how to care for a resident and see what interventions they had. They showed this surveyor Resident #76's Kardex only had interventions regarding seizure precautions and that he did not have any interventions regarding prevention of pressure ulcers. Interview on 04/03/24 at 1:41 P.M. with the DON verified the Kardex for Resident #76 that the STNA's utilize for care/ interventions only had interventions for seizure precautions and nothing regarding pressure ulcer prevention/ management or ADL care. Review of the undated facility policy labeled, Pressure Ulcer Prevention and Risk Identification revealed the facility would assess each resident for risk of pressure ulcer development to establish measures to prevent the development of pressure ulcers within the facility or to prevent further decline of already existing pressure ulcer. The policy revealed preventative measures would be implemented based upon the residents assessed need and risk score. Review of facility policy labeled, Activities of Daily Living (ADL), supporting, dated March 2018, revealed residents would be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADL. The policy revealed appropriate care and services would be provided in accordance with the plan of care.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39973 48565 49774 Based on record review and interview the facility failed to ensure resident care plans were updated to reflect the physician's orders. This affected two residents (#42 and #66) of six residents reviewed for care plans. The facility census was 86. Findings include: 1. Review of the medical record for Resident #42 revealed an admitted [DATE]. Significant diagnoses included congestive heart failure, edema, diabetes mellitus type II and chronic kidney disease. Significant orders included monitor weight monthly, fluid restriction of 2000 milliliters a day broken down as 860 milliliters for day shift, 300 milliliters for night shift and 840 milliliters for dietary. Other orders included Lasix 40 milligrams (mg) (diuretic) two times daily and potassium 20 milliequivalents (mEq) (supplement) daily. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15 of 15, indicating Resident #42 was cognitively intact. Review of the care plan dated 02/26/24 revealed Resident #42 was at risk for dehydration or potential fluid deficit related to diuretic use. Interventions included documenting intake and output per facility policy dated 08/13/20. Resident #42 had a nutrition and hydration risk related to a history of weight fluctuations with edema. Interventions included a fluid restriction per medical doctor order. There were no intake and output records to review within Resident #42's medical record. On 04/02/24 at 9:15 A.M. an interview with the Director of Nursing (DON) verified no intake and outputs were monitored as this was put on care plan in 2020 and was no longer ordered by the physician. 2. Review of the medical record for Resident #66 revealed an admitted [DATE]. Significant diagnoses included chronic obstructive pyelonephritis, chronic kidney disease stage III, and dependence on renal dialysis. Significant orders included dialysis five times a week, enhanced barrier precautions, trazadone 50 mg (antidepressant) at bedtime, diphenhydramine 50 mg (antihistamine) by mouth in the afternoon every Monday, Tuesday, Wednesday, Thursday, and Friday for itching. Give 30 minutes before dialysis, Nephro vitamins oral tablet 0.8 mg (supplement) daily, Oxycodone 5 mg (opioid pain medication) every eight hours as needed for pain, escitalopram 10 mg (antidepressant) daily, and Gabapentin 200 mg (anticonvulsant and nerve pain medication) three time daily. Review of the quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 of 15, indicating Resident #66 was cognitively intact. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan dated 02/21/24 revealed a need for hemodialysis related to chronic kidney disease stage III. Interventions included assess resident upon return from dialysis, dialysis in house Monday through Friday, monitor central venous catheter site for infection, bleeding, dislodging and check that dressing is dry and intact every shift, change dressing per orders and monitor intake and output. Review of the medical record revealed there were no intake and output records to review. On 04/03/24 at 10:00 A.M. an interview with the DON verified there were no intake and output records for Resident #66. The DON stated the intake and output intervention on the care plan was carried over from previous care plans and was no longer ordered by the physician.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on interview, observation, record review, and review of the facility policy the facility failed to ensure residents who were dependent on staff for assistance with activities of daily living (ADL) including hygiene, fingernail care, and oral care were provided with adequate care. This affected three residents (#51, #71, and #82) out of six residents reviewed for ADL care. This had the potential to affect 67 residents (#1, #3, #4, #6, #7, #8, #9, #11, #12, #14, #15, #19, #21, #22, #23, #25, #26, #27, #28, #29, #30, #32, #33, #34, #35, #36, #37, #39, #40, #42, #44, #45, #46, #47, #48, #49, #51, #50, #53, #54, #55, #57, #59, #60, #63, #64, #65, #66, #67, #70, #71, #72, #73, #74, #77, #79, #80, #81, #82, #83, #187, #237, #238, #287, #288, #289, and #290) who required assistance with ADL. The facility census was 86. Findings include: 1. Review of the medical record for Resident #82 revealed an admitted [DATE] with diagnoses including myelodysplastic syndrome (disorder of the blood cell formation in the bone marrow), diabetes, hypertension, and osteoarthritis. Review of the Kardex for Resident #82 revealed he did not have one in place from date of admission 02/14/24 to date brought to attention of the Director of Nursing (DON), 04/03/24, including no interventions in place regarding ADL, including oral care. Review of the care plan dated 03/07/24 revealed Resident #82 had a self-care deficit related to multiple comorbidities and weakness. Interventions included assisting with ADL as needed, encouraging the resident to do for self as able, and monitoring for fatigue. Review of the care plan dated 03/07/24 revealed Resident #82 had an actual/ potential for oral/ dental health problems. Interventions included mouth care with ADL personal hygiene, coordinate arrangements for dental care, and transportation as needed. Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #82 had intact cognition. He required substantial to maximum staff assistance for oral care. He was dependent on staff assist for sitting to lying, lying to sitting, and transfers. Interview and observation on 03/25/24 at 9:54 A.M. with Resident #82 revealed he had not brushed his teeth since admission (02/14/24). Resident #82 revealed he did not have a bathroom in his room so the only place a toothbrush would be was in his nightstand but he had not seen one. Observation revealed the resident's teeth appeared to have a white yellow coating with food particles. Observation of his nightstand in the top drawer revealed a wash basin that contained a toothbrush in a plastic wrapper that was unused/unopened. Interview on 04/01/24 at 10:42 A.M. with Resident #82 revealed they had washed him up this morning in bed but still had not brushed his teeth. Observation revealed his teeth continued to have a white yellow coating. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/01/24 at 11:43 A.M. with State tested Nursing Assistant (STNA) #947 revealed that Resident #82 was already washed up and had a new gown on before she came on duty at 6:30 A.M. She revealed she was unsure if he had received oral care. Observation with STNA #947 revealed Resident #82 continued to have a toothbrush in a plastic wrapper that was unopened/ unused in the top drawer of his nightstand. She verified he did not have a bathroom in his room and that the only toothbrush she had seen was the one in his nightstand unopened/ unused. Upon observation, she stated, by the looks no oral care was done as she revealed he had food particles and a white film/ coating his teeth. Interview on 04/03/24 at 12:08 P.M. with STNA #940 (currently assigned to Resident #82) revealed she had worked for approximately four years at the facility. She revealed she was not aware how to access any care plans but revealed she utilized the Kardex for each resident regarding interventions related to their care. STNA #940 showed this surveyor how she looked up each resident Kardex in the electronic record and verified Resident #82 did not have a Kardex in place; so therefore, she was not aware what interventions he had in place regarding ADL, including oral care. Interview on 04/03/24 at 1:40 P.M. with the DON verified the STNA's utilized the Kardex to know what interventions to follow especially in relation to ADL. She verified Resident #82 did not have a Kardex in place. 45441 2. Review of the medical record for Resident #51 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), kidney disease, hypertension, and diabetes. Review of the MDS assessment dated [DATE] revealed Resident #51 was cognitively intact. He required supervision or touch assistance for oral hygiene, toileting, personal hygiene and partial or moderate assistance for showering. Interview on 03/25/24 at 9:45 A.M. with Resident #51 revealed no one at the facility would help him shave or clean and trim his fingernails. Observation at the time of the interview revealed his fingernails were approximately 1/4 to 1/2 inch long with a brown substance beneath the end of each nail. His face was unshaven with his hair unkempt and uncombed. Interview on 03/25/24 at 10:06 A.M. with STNA #922 confirmed Resident #51's nails were long with a brown substance under them, his hair was unkempt, and his face was unshaven. She revealed she did not think staff were able to clip the resident's fingernails because he was diabetic. Surveyor: Ahlswede, [NAME] 48565 3. Review of the medical record for Resident #71 revealed an admitted [DATE]. Significant diagnoses included diffuse traumatic brain injury, acute respiratory failure, diabetes mellitus type II, chronic pancreatitis, protein calorie malnutrition, fracture of orbital floor left side, and tracheostomy status. Significant orders included nothing by mouth, low air mattress, house barrier cream after each incontinent episode, cleanse gastric-tube site with soap and water, pat dry, leave open to air every day, elevate the head of bed at 30 degrees at all times, and cleanse right lateral foot with saline wound cleanser, apply betadine (antiseptic), leave open to air, weekly skin check. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS assessment dated [DATE] revealed severe cognitive impairment. Resident #71 was always incontinent of bowel and bladder and had a tube feed on admission. Review of the care plan dated 03/21/24 revealed Resident #71 was not care planned for ADL. Shower sheets dated 02/26/24, 03/04/24, 03/07/24, 03/11/24, 03/14/24, 03/18/24, 03/21/24, and 03/25/24 revealed bed baths were given. On 03/25/24 at 11:25 A.M. observation of Resident #71 revealed disheveled hair and dry flaking skin on face. The flakes of dry skin were noted to be in Resident #71's hair. On 04/01/24 at 10:00 A.M. observation of Resident #71 revealed the resident in bed on his back. His face was dirty with dry skin flakes noted. Dry flakes of skin were also going into his hair. On 04/01/24 at 10:05 A.M. the above findings were confirmed by STNA #964. STNA#964 stated that resident's faces are washed while bathing and Resident #71 gets bathed three times a week. STNA #964 also stated resident's faces were washed as needed. A review of the policy titled, Activities of Daily Living (ADL), Supporting, dated March 2018, revealed appropriate care and services will be provided for residents who are unable to carry out ADL independently, with consent of the resident and in accordance with the plan of care. This deficiency represents non-compliance identified under Complaint Number OH00151709.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, interview, and record review the facility did not ensure Resident #53's concern regarding hearing and/or request for hearing aids were timely met. This affected one resident (#53) out of one resident reviewed for hearing and had the potential to affect six residents (#6, #15, #30, #51, #53, and #69) identified as hard of hearing. The facility census was 86. Findings include: Review of the medical record for Resident #53 revealed an admitted [DATE] with diagnoses including diabetes, hypertension, congestive heart failure, and chronic obstructive pulmonary disease. Review of the care plan dated 09/26/23 revealed Resident #53 had a risk for communication problems related to hearing deficit. Interventions included anticipating and meeting needs, referring to audiology for hearing consult as ordered, allowing adequate time to respond, repeating (if necessary), do not rush, face when speaking, and using simple brief consistent words. Review of the Ear Nose Throat (ENT) Nurse Practitioner (NP) #708 progress note dated 06/16/23 revealed Resident #53 was seen, and Resident #53 was requesting hearing aids due to hearing loss. An audiogram was completed and recommended a hearing aid for the left ear. (There was no documented evidence in the medical record regarding any follow-up for a hearing aid from 06/16/23 to 10/10/23). Review of the in-house Ear Care Exam dated 10/10/23 and completed by NP #705 revealed Resident #53 was referred by the facility for cerumen removal. He complained of not being able to hear out of his right ear for one year now as he stated it was clogged up. He revealed he had constant ringing in his ears and that he had a hearing evaluation approximately two to three months ago and was told a hearing aid would not help his right ear but would his left ear. NP #705 completed an ear care procedure to remove the cerumen. Resident #53 was diagnosed with unspecified hearing loss and referred to an audiologist due to the hearing loss and ringing in his ears. She revealed Resident #53 was interested in getting a hearing aid. Review of progress note dated 12/06/23 and completed by ENT #707 revealed Resident #53 needed medical clearance due to hearing loss, pain, ringing in bilateral ears, and dizziness. An audiometric test was completed and revealed Resident #53 had dizziness and pain in ears. The report revealed he was placed in a nursing home due to hearing loss and wanted to investigate getting a hearing aid. The audiometric test noted hearing loss and recommended Resident #53 to be fitted with hearing aid after medical clearance. Review of the physician order dated 01/04/24 and completed by Primary Care Physician #706 revealed Resident #53 may have a consult with an audiologist due to hearing loss, pain, and dizziness. (There was no other medical clearance noted in the medical record just the above order). Review of quarterly Minimum Data Set, dated dated dated [DATE] revealed Resident #53 was cognitively intact as his brief interview for mental status (BIMS) score was a 15 of 15. He had moderate difficulty with hearing and had no hearing aids. (continued on next page)

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	365539	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Nursing & Rehab	2473 North Rd NE Warren, OH 44483

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 03/25/24 at 10:44 A.M. revealed Resident #53 was lying in bed and was hard of hearing. The surveyor had to speak loudly and repeat sentences in the interview. There was no other form of communication such as communication board in the room. He revealed he had been waiting for a long time for a hearing aid and that he still had not received one. He had an appointment last month, but the facility had forgotten about the appointment, so he missed it. The facility would tell him they would take care of it and get him seen for a hearing aid but then nothing ever happened, and it had been almost a year that he had been waiting. He revealed he cannot hear, and it made it hard to communicate with staff and others. He then stated, I never feel I will get hearing aids while I am alive. He had spoken to the ombudsman several times about the concern and was unsure what good that did as he still had no hearing aid. Interview on 03/27/24 at 10:03 A.M. with Social Service Designee (SSD) #916 revealed she was responsible for setting up residents to see the in-house ENT that comes to the facility approximately every three to four months. She revealed they had sent her a list of residents that they had scheduled, and she added any residents that needed to be seen. Resident #53 was seen by the in-house ENT on 10/10/23, and she believed he was seen at an outside ENT, but she was unsure what transpired as nursing sets up any follow-up appointments. She was unsure if Resident #53 was getting a hearing aid or what was going on regarding his request for one. Interview on 03/28/24 at 2:15 P.M. and on 04/01/24 at 9:39 A.M. with Ombudsman #715 revealed she had an ongoing open case since 03/28/23 regarding Resident #53's complaint of hearing loss and request for a hearing aid that she felt the facility had not timely addressed. She revealed one factor was the turnover in management staff including the Administrator and Director of Nursing (DON) that affected the follow-through of the concern. She revealed on 03/28/23 Resident #53 had reported to her that he had ear pain and they had communicated the concern to the Former DON #717 and Former Administrator (now in corporate role at the facility) #716. She revealed on 05/10/23 Resident #53 continued to state he was having ear pain and that he had not seen anyone for the concern. They had sent a request for an update regarding the concern to Former DON #717 and Former Administrator #716. She revealed on 05/22/23 she had not received a response back so requested to speak with Owner of the Facility #718 and Former Administrator #716 regarding the concern and that the concern was not being followed up on. On 05/25/23 she met with management including the Owner of the Facility #718 and Former Administrator #716 who verified they had not set up a hearing consult but stated they would. She revealed she followed up 05/30/23 and 06/02/23 and had not heard any update. On 06/05/23 she received notification that Resident #53 was to have an appointment on 06/16/23. On 06/06/23 she saw Resident #53 and now he was complaining of not only pain to his ears but hearing loss. He was requesting a hearing aid. She stated on 07/27/24 she met with Resident #53 who stated he went to the appointment, and they recommended a hearing aid. She attempted to follow up with administration including Former DON #717 and Former Administrator #716 on 07/27/23, 08/31/23, 09/29/23, 10/06/23, and 10/13/23 regarding an update regarding Resident #53's hearing aid but did not get any follow up. On 11/08/23 they finally received an update from Former DON #717 that Resident #53 had seen in-house NP #705 for ear care who recommended a hearing aid and referred Resident #53 to an audiologist. She followed up on 12/21/23 for an update, and the facility could not provide one. On 01/02/24 she sent the facility a breakdown of all the dates and how long Resident #53 was waiting for a hearing aid. On 02/08/24 she requested an update, but nothing was received. On 02/15/24 she met with the new DON regarding Resident #53's concern, and she had stated he was set up for an appointment on 02/21/24. On 03/21/24 she found out Resident #53 missed his appointment. Resident #53 had showed significant frustration throughout the process as he had filed the case on 03/28/23, and it was still ongoing. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/01/24 at 9:17 A.M., 04/01/24 at 9:43 A.M., and 04/04/24 at 10:00 A.M. with the DON revealed she started in February of 2024 and was unsure of where Resident #53 was in the process of getting a hearing aid. She verified it appeared per the medical record the resident was seen 06/16/23 per ENT NP #708 who noted in her progress note Resident #53 was requesting a hearing aid and she completed an audiogram with a recommendation for a hearing aid for the left ear. She verified there was no other records regarding the hearing aid until 10/10/23 when the in-house NP #705 completed an ear care exam and diagnosed Resident #53 with unspecified hearing loss and referred the resident to an audiologist due to the hearing loss and ringing in his ears. She revealed he was interested in getting a hearing aid. She verified he was seen by ENT #707 on 12/06/23 who also noted Resident #53 wanted a hearing aid but had ordered medical clearance to be done due to due to hearing loss, pain, ringing in bilateral ears, and dizziness then he would be fitted for a hearing aid. She revealed on 01/04/24 Primary Care Physician #706 wrote an order may have consult with audiologist due to hearing loss, pain, and dizziness but per the medical record no other form of medical clearance was noted. She revealed Resident #53 had an appointment on 02/21/24 with ENT #707 but it was cancelled as she believed due to lack of transportation. She revealed his next appointment was scheduled for 04/12/24 with ENT #707. She verified Resident #53 had first requested a hearing aid on 06/16/23. She revealed the facility did not have a policy regarding hearing.

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, record review, facility policy review and interview, the facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention program to prevent the development of pressure ulcers, ensure timely and accurate assessments were completed, ensure treatments were completed as ordered and/or to ensure staff were knowledgeable of care planned interventions for Resident #76 and Resident #82. Actual Harm occurred on 02/22/24 when Resident #82 who required substantial to maximum staff assistance with bed mobility and was totally dependent on staff with transfers and toileting was found per Wound Physician #703 progress note to have an unstageable (full-thickness pressure ulcer in which the base was obscured by slough and/ or eschar (dead skin) pressure ulcer to his right buttock and an unstageable deep tissue pressure ulcer to his left heel (this was the first time these two areas were documented per the medical record) eight days after admission. The facility failed to provide evidence of effective interventions being in place prior to the development or evidence the pressure ulcers were identified before being found as unstageable pressure ulcers. This affected two residents (#76 and #82) of four residents reviewed for pressure ulcers. The facility identified 13 residents (#8, #19, #44, #46, #70, #76, #82, #83, #70, #187, #192, #287, #288) with pressure ulcers. Findings include: 1.Review of the medical record for Resident #82 revealed an admitted [DATE] with diagnoses including myelodysplastic syndrome (disorder of the blood cell formation in the bone marrow), diabetes, hypertension, and osteoarthritis. Review of the Admission/ Readmission Packet- V2 dated 02/14/24 and completed by Licensed Practical Nurse (LPN) #838 revealed Resident #82 was alert and oriented times three, communicated verbally with clear speech. The skin assessment was completed on admission that noted he had a left elbow abrasion, scabbed over area to left outer forearm, left great toe joint under nail was red and swollen, and bilateral upper extremities were edematous. The assessment revealed an intact clear blister to the sacrum area that measured 2.0 centimeters (cm) in length, 2.0 cm in width, and 0.5 cm in depth, open area 2.0 cm in length by 2.0 cm in width and a blister 4.5 cm in length and 1.5 cm in width. There were no pressure areas noted to the right buttock and/ or left heel noted on admission. Review of the Kardex for Resident #82 revealed he did not have one in place from date of admission, 02/14/24, to the date it was brought to the attention of the Director of Nursing (DON), 04/03/24, including no documented evidence of interventions in place to prevent pressure ulcers/ skin impairment. Review of the baseline care plan dated 02/14/24 for Resident #82 revealed Resident #82 had an activities of self-care performance deficit. Interventions included the resident was totally dependent on staff for repositioning and transfers. He utilized a mechanical lift for transfers. (However, this baseline care plan was not provided until 04/03/24 as the DON did not know where to locate it when first requested on 04/02/24). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the baseline care plan (dated 02/14/24) for Resident #82 revealed Resident #82 had a potential for pressure ulcer development. Interventions included turning and repositioning every two hours or more often as needed, bed flat as possible to reduce shear, assess, record, and monitor wound healing, and moisturizer to his skin. (However, this baseline care plan was not provided until 04/03/24 as the DON did not know where to locate it when first requested on 04/02/24). The Braden Scale for Predicting Pressure Ulcer Risk was completed and noted Resident #82 to be at risk (for pressure ulcer development) as his sensory perception was limited, he was very moist, he was bedfast, he had limited mobility, and he had a problem with friction and shear. Review of the physician's orders for February 2024 through April 2024 revealed on 02/15/24 there was an order to cleanse the open area to resident's sacrum with normal saline, apply collagen sheet (encourages cell proliferation, angiogenesis, and collagen deposition to the wound bed) and dressing every night shift Monday, Wednesday, and Friday. Review of an Initial Wound Evaluation and Management Summary dated 02/22/24 and completed by Wound Physician #703 revealed Resident #82 had an unstageable pressure ulcer to his sacrum that measured 6.0 cm in length, 4.0 cm in width and 0.2 cm in depth and contained 40 percent thick adherent necrotic tissue. He had an unstageable pressure ulcer to his right buttock that measured 12.0 cm in length, 13.0 cm in width, and 0.2 cm in depth and contained 50 percent thick adherent necrotic tissue. He ordered leptospermum honey (MediHoney) applied three times per week and cover with composite dressing (provides bacterial barrier, absorption, and adhesion) to his right buttock. The note also revealed Resident 382 had an unstageable deep tissue injury to his left heel that measured 2.4 cm in length, 2.0 cm in width and depth unable to be determined. The heel was purple/ maroon in color. On 02/23/24 Resident #82 was ordered a treatment to his left heel to cleanse with normal saline, apply betadine (topical antiseptic), pad, and protect with abdominal pad and wrap with Kerlix gauze. On 02/23/24 he was also ordered a pressure relieving boot to his left heel (after the deep tissue pressure injury was identified). On 02/27/24 there was an order to cleanse the open area on the resident's sacrum and right buttock with normal saline, apply Medihoney (supports the removal of necrotic tissue and aides in wound healing) and dressing every night shift (this was the first date referenced for a treatment to his right buttock). Review of the comprehensive care plan dated 03/07/24 revealed Resident #82 had impaired skin impairment related to bowel and bladder incontinence, diabetes, impaired mobility, and pressure injury present. Interventions included assisting with hygiene and general skin care, consulting with the wound physician, pressure reducing mattress to bed, and educating the resident on need to reposition to side. Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #82 had intact cognition. The assessment revealed the resident was dependent on staff assist for toileting, sitting to lying, lying to sitting, and transfers. He required substantial to maximum assistance of staff to roll to the left and right. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 03/21/24 the treatment order to the resident's sacrum and right buttock changed to cleanse open area on sacrum and right buttock with normal saline, apply black foam to wound bed and cover with wound vac at 125 millimeters of mercury (mmHg) to continuous suction and change every Tuesday, Thursday, and Saturday. Review of the Wound Evaluation and Management Summary dated 03/21/24 and completed by Wound Physician #703 revealed Resident #82's pressure wound to his sacrum was now a Stage IV (full thickness skin loss) that measured 7.2 cm in length, 5.0 cm in width, and 3.3 cm in depth. The wound bed contained 60 percent granulating tissue, 30 percent necrotic tissue, and 10 percent slough. His right buttock pressure ulcer was now classified as a Stage III (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining and tunneling) pressure ulcer that measured 8.8 cm in length, 7.4 cm in width, and 0.2 cm in depth with 40 percent necrotic tissue. His left heel continued to be an unstageable deep tissue injury that measured 2.0 cm in length, 1.5cm in width, and depth was unable to be measured. The area continued to remain intact with purple/ maroon discoloration. Interview on 04/01/24 at 1:44 P.M. with LPN/ Infection Control Preventionist #970 revealed she also followed all the wounds at the facility. She revealed the first date she saw Resident #82's wounds were on 02/22/24 on Wound Physician #703's initial wound evaluation as she completed rounds with him. She verified on the resident's admission assessment dated [DATE], LPN #838 had documented Resident #82 had an intact clear blister to his sacrum area that measured 2.0 cm in length, 2.0 cm in width, and a depth of 0.5 cm, an open area measuring 2.0 cm in length by 2.0 cm in width and another blister 4.5 cm in length and 1.5 cm in width. She revealed how the areas were documented and it appeared all three were on his sacrum. There were no pressure areas noted to the right buttock and/or left heel noted on admission. She verified the first documentation that Resident #82 had a pressure area to his right buttock was when Wound Physician #703 had consulted on 02/22/24 and the area was documented as unstageable. She also verified the first time Resident #82 had any documentation regarding his deep tissue pressure injury to his left heel was also on 02/22/24, and it was also found unstageable. Interview on 04/02/24 at 9:05 A.M. with the DON revealed she was unable to locate a baseline care plan for Resident #82 regarding prevention of pressure ulcers and interventions. She verified the first care plan regarding interventions was on his comprehensive care plan on 03/07/24. Observation on 04/02/24 at 10:45 A.M. of wound care completed by LPN/ Infection Control Preventionist #970, LPN #845 and State tested Nursing Assistant (STNA) #927 revealed Resident #82 continued to have the pressure ulcer to his sacrum that contained approximately 80 percent yellow slough and 10 percent eschar, pressure wound to his right buttock that was described as beefy red containing yellow slough, and a deep tissue pressure injury to his left heel that was approximately a quarter in size and covered in hard eschar. The treatments were completed as ordered. Interview on 04/03/24 at 11:25 A.M. with the DON revealed she did not realize that when asked previously where Resident #82's baseline care plan was as she stated there was an area in the electronic medical record that a person reviewing had to go under the trigger button to view. She verified she was not familiar with this since she was hired as she had not been shown that on orientation; therefore, had not been educating the nurses on the location of where to find the baseline care plan. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 04/03/24 at 12:00 P.M. with LPN #854 (currently assigned to Resident #82) revealed she had worked at the facility since November 2023 and was not familiar with how to locate a baseline care plan in the electronic record. She was unable to show this surveyor where Resident #82's baseline care plan including his interventions to prevent pressure ulcers, except in the comprehensive care plan dated 03/07/24. Interview on 04/03/24 at 12:08 P.M. with STNA #940 (currently assigned to Resident #82) revealed she had worked for approximately four years at the facility. She revealed she was not aware how to access any care plans but revealed she utilized the Kardex for each resident regarding interventions related to their care. STNA #940 showed this surveyor how she looked up each resident's Kardex in the electronic record and verified Resident #82 did not have a Kardex in place; so therefore, was not aware what interventions he had in place regarding prevention of pressure ulcers. Interview on 04/03/24 at 1:40 P.M. with the DON verified the STNA's utilized the Kardex to know what interventions to follow especially in relation to the prevention of pressure ulcers. She verified Resident #82 did not have a Kardex in place. Interview on 04/03/24 at 12:13 P.M. with Registered Nurse (RN) #902 revealed she did not know where to locate the baseline care plans and/ or interventions for a resident newly admitted . Review of the undated facility policy labeled, Pressure Ulcer Prevention and Risk Identification revealed the facility would assess each resident for risk of pressure ulcer development in an effort to establish measures to prevent the development of pressure ulcers within the facility or to prevent further decline of already existing pressure ulcer. The policy revealed preventative measures would be implemented based upon the residents assessed need and risk score. The nurse would perform a head-to-toe assessment on admission and every seven days thereafter to identify any new skin areas and document in the medical record. 2. Review of the medical record for Resident #76 revealed an admitted [DATE] with diagnoses including cerebral infarction, acute kidney failure, pressure ulcer of his sacral region, and tracheostomy. Review of the Admission/ Readmission Packet-V2 dated 02/06/24 completed by LPN #704 revealed a skin assessment was completed on admission, and Resident #76 had a stage four pressure ulcer to his coccyx that measured 10.0 cm in length, 6.0 cm in width and 6.0 cm in depth. There were no other skin impairment issues noted including on his right ear. On admission, a Braden Scale for Predicting Pressure Sore Risk was also completed, and he was at risk due to limited sensory perceptions, he was occasionally moist, he was chairfast, he was completely immobile, and he had a problem with friction and shear. Review of baseline care plan dated 02/06/24 revealed Resident #76 had potential for impairment of skin integrity. Interventions included moisture barrier after each incontinent episode, floating heels while in bed, encouraging turning and repositioning in bed every two hours, and checking and changing every two to three hours. Review of the Kardex dated 02/06/24 to 04/03/24 revealed Resident #76 only had interventions related to safety regarding seizure precautions. He did not have any interventions on his Kardex regarding the prevention of pressure ulcers for the STNAs to follow. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Wound Physician #703's progress note dated 02/08/24 revealed Resident #76 had a Stage II (partial thickness loss of dermis) pressure ulcer to the right ear that measured 3.3 cm in length, 0.5 cm in width and 0.1 cm in depth. He also had a Stage IV pressure ulcer to his sacrum that measured 9.0 cm in length, 6.5 cm in width and 2.9 cm in depth with 10 percent necrotic tissue and 10 percent slough. Review of Medicare five-day Minimum Data Set, dated dated dated [DATE] revealed Resident #76 was rarely and/ or never understood. He was dependent on staff for activities of daily living including bed mobility, toileting, and transfers. Review of March 2024 Treatment Administration Record (TAR) revealed Resident #76 had an order to cleanse the right ear with normal saline and apply collagen paste and band-aid every night shift on Tuesday, Thursday, and Saturday. The TAR had blanks on 03/09/24 and 03/12/24 indicating the treatment was not completed as ordered. He also had an order to cleanse his sacrum wound with normal saline, apply oil emulsion into wound bed over bone, apply black foam, and wound vac as 125 mmHg continuously every Tuesday, Thursday, and Saturday. The TAR was blank on 03/09/24, 03/12/24, and 03/26/24 indicating the treatments were not completed as ordered on these dates. Review of the comprehensive care plan dated 03/03/24 revealed Resident #76 had the potential for impairment of skin integrity related to incontinence, impaired mobility, and pressure injury that was present. Interventions included assisting with hygiene and general care, keeping skin clean and dry, consulting wound physician, pressure reducing mattress, and treatment as ordered. Review of Wound Physician #703 progress note dated 03/28/24 revealed Resident #76 continued to have a Stage II pressure ulcer to his right ear that measured 1.0 cm in length, 0.4 cm in width and the depth was not measurable as it had dried exudate (scab). He also continued to have a Stage IV pressure ulcer to his sacrum that measured 7.8 cm in length, 9.0 cm in width and 3.3 cm in depth as the wound bed contained 20 percent necrotic tissue and 10 percent slough. Interview on 04/03/24 at 10:33 A.M. with the DON verified there were blanks on the March 2024 TAR indicating the treatment was not completed as ordered. She revealed she was unable to locate a baseline care plan for Resident #76 regarding prevention of pressure ulcers and interventions until his comprehensive care plan on 03/03/24. Interview on 04/03/24 at 11:25 A.M. with the DON revealed she did not realize that when asked previously where Resident #76's baseline care plan was as she stated there was an area in the electronic medical record that a person reviewing had to go under the trigger button to view. She verified she was not familiar with this since she was hired as she had not been shown that on orientation; therefore, had not been educating the nurses on the location of where to find the baseline care plan. Observation of the wound to Resident #76's right ear on 04/03/24 at 11:22 A.M. with RN #902 revealed Resident #76's ear lobe was described as a scabbed area to the center of the wound with brownish/ white tissue surrounding the scabbed area with drainage. Upon observation, the resident was completely dependent on staff to reposition his head to the side to observe the wound. Interview on 04/03/24 at 12:13 P.M. with RN #902 (assigned to Resident #76) revealed she did not know where to locate the baseline care plans and/ or interventions for a resident newly admitted , only the comprehensive care plan. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 04/03/24 at 12:15 P.M. with STNA #939 and #963 (assigned to Resident #76) revealed they did not know where to locate the baseline care plans. They utilized the Kardex to know how to care for a resident and what interventions they had. They showed this surveyor Resident #76's Kardex which only had interventions regarding seizure precautions. There were no interventions regarding prevention of pressure ulcers. Interview on 04/03/24 at 1:41 P.M. with the DON verified the Kardex for Resident #76 that the STNA's utilize for care/ interventions only had interventions for seizures and nothing regarding pressure ulcer prevention and/ or management. Review of the undated facility policy labeled, Pressure Ulcer Prevention and Risk Identification revealed the facility would assess each resident for risk of pressure ulcer development in an effort to establish measures to prevent the development of pressure ulcers within the facility or to prevent further decline of already existing pressure ulcer. The policy revealed preventative measures would be implemented based upon the residents assessed need and risk score. The nurse would perform a head-to-toe assessment on admission and every seven days thereafter to identify any new skin areas and document in the medical record. This deficiency represents non-compliance investigated under Complaint Number OH00151709.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565 Based on observation, interview, record review, and review of the facility policy the facility failed to change nasal cannula oxygen tubing in a timely manner. This affected two residents (#6 and #289) of 34 residents utilizing oxygen. The facility census was 86. Findings include: 1. Review of the medical record for Resident #6 revealed an admitted [DATE]. Significant diagnoses included chronic obstructive pulmonary disease, morbid obesity, diabetes mellitus, and heart failure. Significant orders included oxygen at three liters per minute via nasal cannula, nasal cannula ear cushions, and change oxygen tubing weekly. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 was moderately impaired cognitively. Review of the care plan dated 12/13/23 revealed Resident #6 was at risk for altered respiratory status and oxygen should be delivered as ordered. A review of the Treatment Administration Record (TAR) revealed oxygen tubing was changed 03/06/24, 03/13/24, 03/20/24. On 03/25/24 at 10:23 A.M. an observation of Resident #6 revealed the resident in bed with oxygen running at three liters per minute continuously via nasal cannula. The nasal cannula was dated 02/07/24. An interview with State tested Nurse Aide (STNA) #949 at the time of the observation verified the date on the nasal cannula tubing as 02/07/24. 2. Review of the medical record for Resident #289 revealed an admitted [DATE]. Significant diagnoses included acute respiratory failure, chronic obstructive pulmonary disease, cryptogenic organizing pneumonia, and pulmonary fibrosis. Significant orders included change oxygen tubing every week. Review of the five-day MDS assessment dated [DATE] revealed Resident #289 was cognitively intact. On 03/25/24 at 11:10 A.M. observation of Resident #289 revealed the resident resting in bed with oxygen on at four liters per minute via nasal cannula. The oxygen tubing was undated. On 03/25/24 at 11:15 A.M. an interview with Licensed Practical Nurse (LPN) #972 verified there was no date on the oxygen tubing for Resident #282. LPN #972 stated that oxygen tubing is to be changed weekly. A review of the facility policy titled, Oxygen Administration, dated October 2010, did not reveal frequency of oxygen tubing change.

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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** 48565 Based on interview, observation, record review, and review of self-reported incident (SRI) the facility did not ensure Resident #6's behavior plan of care was followed by staff. This affected one resident (#6) out of one resident reviewed for behavioral health services. The facility census was 86. Findings include: Review of the medical record for Resident #6 revealed an admitted [DATE] with diagnoses including atrial fibrillation, morbid obesity, chronic obstructive pulmonary disease, heart failure, chronic pain, and anxiety. Review of the care plan dated 09/11/23 revealed Resident #6 had the potential to be verbally aggressive, throw objects, make false allegations due to ineffective coping skills. Interventions included assess understanding of the situation, allow time to express self and feelings towards the situation, and give as many choices as possible about care. The care plan revealed when she becomes agitated intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, and staff to walk calmly away and approach later. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 had impaired cognition as her Brief Interview for Mental Status (BIMS) score was a 12 of 15. She was incontinent of bowel and bladder. Review of SRI tracking number #245690 completed on 03/27/24 revealed the facility filed an SRI for an allegation of staff-to-resident physical abuse. The SRI revealed that while staff, State tested Nurse Aide (STNA) #956 and Agency STNA #701, were completing care Resident #6 became physically aggressive towards staff. The SRI revealed Resident #6 had gotten irritated because she was developing pain and started hitting Agency STNA #701. Resident #6 was assisted on her side and continued to hit staff. Resident #6 started to swing her arms again, and STNA #956 told Agency STNA #701 to just back up because she was trying to hit only Agency STNA #701. Agency STNA #701 grabbed Resident #6's wrists trying to block the hits. The SRI revealed following the incident Resident #6 had skin tears on her arms. Review of nursing note dated 03/27/24 at 1:10 P.M. and completed by Licensed Practical Nurse (LPN) #702 revealed Resident #6 had showed her both arms which had a skin tear on her right arm and a scab had been removed on the left arm. The note revealed both arms were actively bleeding. There were no measurements regarding the areas. Review of the witness statement dated 03/27/24 and completed by Agency STNA #701 revealed she and STNA #956 tried to change Resident #6 earlier, but she refused. She then asked STNA #956 and herself to pull her up, and at that time noticed she needed a total bed change and explained this to Resident #6. The statement stated she immediately started grabbing, hitting, and punching them. She revealed they turned her on her side towards the wall and Agency STNA #701 wiped the bowel movement off her and then she began swinging and trying to fight. STNA #956 went to the door and called for the nurse and that was when she saw the skin tears on her arms. (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.	Review of the witness statement dated 03/27/24 and completed by Resident #6 revealed she was getting her incontinence product changed and Agency STNA #701 began to turn her back and forth roughly until she got sores on both her arms. She revealed STNA #956 was trying to keep her off her and Agency STNA #701 got rougher. The statement revealed she had never been abused before and that she did not want Agency STNA #701 caring for her again. Review of the witness statement dated 03/27/24 and completed by STNA #956 revealed she had gone in to answer Resident #6's call light and Resident #6 informed her that she needed her incontinence product changed. She had Agency STNA #701 assist her by at first pulling her up in bed. The statement revealed Agency STNA #701 was wiping the resident because she had bowel movement on her, and Resident #6 became irritated as she was developing pain being on her side. Resident #6 then began hitting Agency STNA #701 and flailing her arms. The statement revealed when Resident #6 began to swing her arms around again she told Agency STNA #701 to just back up because Resident #6 was trying to hit her, but Agency STNA #701 grabbed her wrists trying to block the hits. Interview on 04/02/24 at 2:22 P.M. with Resident #6 revealed on 03/27/24 STNA #956 and Agency STNA #701 were assisting in providing incontinence care. She revealed they had turned her on her side towards STNA #956 and as Agency STNA #701 was cleaning her up she reached her hand back to have her watch the dressing that was in place on her butt. She revealed Agency STNA #701 hit her arm hard causing her arm to move forward and blood was running down both her arms from the incident. She revealed she had grabbed Agency STNA #701 since she hit her, and she hit Agency STNA #701 back. She revealed the facility suspended or fired Agency STNA #701 because of the incident. She then proceeded to lift her right arm and showed this surveyor she had a bandage wrapped with Kling wrap gauze to the lower part of her arm. Interview on 04/03/24 at 2:30 P.M. with STNA #956 revealed she and Agency STNA #701 pulled up Resident #6 in bed and noticed that she needed changed. She revealed Resident #6 rolled towards her in the bed and Agency STNA #701 started to clean her, but Resident #6 was specific on how she liked to be cleaned as she liked to be patted not wiped as she was tender in the area. She revealed Agency STNA #701 wiped her instead and Resident #6 got upset and started hitting Agency STNA #701. She revealed she felt if Agency STNA #701 was patient and gave Resident #6 some time and space there would not have been any incident. Instead, she stated Agency STNA #701 continued to wipe her and then Resident #6 continued to hit out at Agency STNA #701. STNA #701 then grabbed Resident #6's wrist to have her stop hitting her. She revealed she felt the incident would have been prevented if Agency STNA #701 had just backed away from the bed when Resident #6 became upset and started hitting out instead of continuing to provide care. She revealed she had told Agency STNA #701 to back away and stop but that she did not listen to her. She revealed she felt most likely the skin tear to her arm was caused by Agency STNA #701 grabbing her wrist/ arm. She revealed she did not inform Agency STNA #701 how Resident #6 preferred to be patted instead of wiped during incontinence care as she stated, I am only [AGE] years old, so a lot of people don't listen. She revealed she reported the incident to LPN #702, Unit Manager #972, and the Director of Nursing. (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.	Interview on 04/03/24 at 2:44 P.M. with the Director of Nursing revealed in her interviews Agency STNA #701 did grab Resident #6's wrist to prevent Resident #6 from hitting her. She verified Resident #6 was in bed and if Agency STNA #701 would have stepped back and stopped providing care that then Resident #6 would have stopped hitting her and the incident would not have proceeded on to her needing to grab her wrist. She revealed she had attempted to interview Agency STNA #701 further about the incident, but that Agency STNA #701 stated she was not going to discuss the incident with her as she already wrote a witness statement. The Director of Nursing verified in Resident #6's care plan when Resident #6 was agitated staff was to intervene before agitation escalated, guide away from source of distress, engage calmly in conversation, and staff was to walk calmly away and approach later. Interview on 04/03/24 at 2:56 P.M. with Agency STNA #701 revealed Resident #6 was incontinent of bowel and that she had written on her communication board that she needed changed. She revealed she and STNA #956 pulled her up in bed and noticed that she required a complete bed change because she was incontinent of bowel. She revealed Resident #6 was combative as she was fighting them during her care as they were trying to change her. She revealed Resident #6 did not want to be changed but that she needed changed. She revealed she did not grab her at any time, including her arms. She verified she did not walk away when the incident escalated per the plan of care. She stated if in their right mind they would not want to be left like that so yeah I did, I am not going to lie I did keep cleaning her despite Resident #6 being combative and indicating she did not want changed further. She revealed she was unsure how Resident #6 received her two skin tears on her bilateral arms as she left the room once the nurse, LPN #702 had arrived at the room.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on interview and record review the facility did not ensure Resident #13's lab work was obtained as ordered by the physician. This affected one resident (#13) out of five residents reviewed for unnecessary medications including lab work. The facility census was 86. Findings include: Review of medical record for Resident #13 revealed an admitted [DATE] with diagnoses including schizophrenia, bipolar disorder, and morbid obesity. Review of annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 had impaired cognition. She displayed hallucinations and delusions. Review of the March 2023 physician's order revealed Resident #13 had an order dated 05/05/20 to have a glycated hemoglobin test (hbA1c) (a lab to obtain an overall picture of what the average blood sugar level was over the past three months) every three months. She also had an order for Risperdal (antipsychotic medication which can increase the risk of impaired glucose metabolism). Review of the lab work revealed there was no evidence a hbA1c level was completed as ordered by the physician. Interview on 03/27/24 at 1:13 P.M. with the Director of Nursing (DON) verified she had no record Resident #13 received an hbA1c as ordered since 05/05/20. Interview on 04/04/24 at 12:59 P.M. with the DON revealed the facility did not have a lab policy.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565 Based on observation and interview, the facility failed to store tortillas, cheese, salami, and turkey in a manner to prevent food borne illness and contamination. This had the potential to affect all 69 residents residing in the facility who were receiving food from the kitchen. There were 15 residents (#7, #33, #44, #55, #67, #69, #70, #71, #72, #76, #77, #79, #81, #83, and #238) who were identified by the facility as receiving nothing by mouth. The facility census was 86. Findings include: On [DATE] at 9:30 A.M. a tour of the dry storage area of the kitchen revealed a 36-count package of tortillas with a use by date of [DATE]. Interview with Dietary Manager (DM) #823 verified the use by date at the time of the observation. On [DATE] at 10:00 A.M. an inspection of the snack refrigerator located in the kitchen revealed a 160 count, open package of American cheese that was undated. There were also two packages of approximately 20 slices each of American cheese that was wrapped in plastic and undated. There was a 16-ounce package of [NAME] Genoa salami slices that was opened and undated and a 32-ounce package of [NAME] O smoked sliced turkey breast that was opened and undated. The opened and undated cheese, salami and turkey was verified by DM #823 at the time of the observation. Review of the policy titled, Food Storage, dated [DATE], revealed all products should be inspected for safety and quality and be dated upon receipt, when open, and when prepared. Any outdated or expired food products should be discarded.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 39973 Based on observation, record review, job description review, and interview the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This had the potential to affect all 86 residents residing in the facility. Findings include: Review of the facility job description labeled Administrator revealed the Administrator had signed the job description on 11/01/23. The description revealed the Administrator would lead, direct, and manage the overall operations of the nursing facility in accordance with facility policies and procedures, resident, and family needs and both state and federal guidelines. The description revealed he was to monitor each department's activities ensuring that each department attained and maintained compliance with state and federal regulation. He was to monitor that each manager received training needed to be successful in their job. He was to exhibit and promote a positive customer service relationship to both internal and external customers. Also, he was to round frequently throughout the facility to monitor the delivery of nursing care, overall cleanliness, and appearance of the facility. Review of facility job description labeled Director of Nursing revealed the Director of Nursing (DON) had signed the job description on 02/05/24. The description revealed the facility was to be managed in accordance with the nurse practice act, state and federal regulations, and policies and procedures. The DON was to facilitate meetings and committees to address resident care issues, investigate and resolve resident concerns, and assures that all clinical protocols and nursing policies and procedures were followed. During an interview and review on 04/04/24 at 11:10 A.M. with the Administrator and DON regarding the identified survey findings, the administrative staff was asked if they were currently working on any Quality Assurance Performance Improvement (QAPI) projects in these areas. The Administrative staff indicated they had not identified the below concerns and/ or had not developed any type of quality improvement plans in these areas. During the annual and complaint surveys, observations, record reviews and interviews resulted in concerns related to the overall operation of the facility including but not limited to treatment of pressure ulcers, lack of facility transfer agreement, care planning, environmental concerns, ADL care, treatment to maintain hearing, lab work, antibiotic stewardship, and pneumococcal and influenza vaccines. The facility failed to provide evidence administrative staff, including the Administrator and/or DON had effective systems in place to timely identify and correct quality, care and environmental concerns. a. The facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention program to prevent the development of pressure ulcers, ensure timely and accurate assessments were completed, ensure treatments were completed as ordered and/or to ensure staff were knowledgeable of care planned interventions for Resident #76 and Resident #82. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	b. The facility failed to ensure Resident #13, #18, #25, #42, and #56 and/or their responsible parties were offered the opportunity to participate in quarterly care plan meetings. Interviews between 03/27/24 at 10:03 A. M. and 03/28/24 at 1:55 P.M. with the Social Service Designee (SSD) #916, confirmed the care plan meetings for the above residents were not performed timely or on a quarterly schedule. Interview on 03/27/24 at 10:03 A.M. with Social Services Designee (SSD) #916 revealed she had worked at the facility since July 2023. SSD #916 revealed she had never received any training upon hire that care conferences needed to be held on admission and quarterly. Interview on 04/04/24 at 11:10 A.M. with the Administrator revealed he was not aware care conferences were not being held on a quarterly basis. The Administrator verified SSD #916 was not trained upon hire and stated it was her responsibility to ensure they were conducted. c. The facility did not ensure a clean, safe, homelike environment for Resident #12. On 03/25/24 at 11:03 A. M., 03/26/24 at 4:30 P.M., and 03/27/24 at 7:50 A.M. an observation of Resident #12 revealed a room with a dirty floor and a foul odor. An interview with Occupational Therapist #867 at the time of the observation verified the findings. Occupational Therapist #867 stated the room was filthy. A review of the undated document titled Room Cleaning revealed high touch surfaces, bathrooms, and the floor were to be cleaned daily. d. The facility did not ensure a clean, safe, homelike environment for Residents #48 and #71. On 03/25/24 at 11:25 A.M. an observation of Resident #48's room revealed broken window blinds. An interview with Resident #48 at the time of the observation revealed the window blinds have been broken since admission (09/28/23). On 03/25/24 at 11:25 A.M. an observation of Resident #71's room revealed a broken window blind. On 03/28/24 at 9:00 A.M. an interview with HKM #834 revealed housekeepers report any disrepair in resident rooms to maintenance. HKM #834 could not verify if any broken blinds were reported. On 04/01/24 at 10:00 A.M. an interview with STNA #964 verified the window blinds for Residents #48 and #71 were broken. e. The facility did not ensure a clean, safe, homelike environment for Residents #54 and #64. On 03/26/24 at 12:10 P.M. observation of room temperatures as taken by the life safety code surveyor revealed a wall temperature of 67 degrees Fahrenheit (F) and a floor temperature of 65 degrees F. Resident #54 was observed sitting on the side of his bed with his coat on. On 03/26/24 at 12:13 P.M. an interview with Resident #54 revealed he had asked for his door to be kept open for the heat and, they always close it. On 03/26/24 at 12:30 P.M. an interview with the mother of Resident #64 revealed the room was cold. She also stated the facility had someone look at the heat in February of this year, but nothing was done. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	On 03/26/24 at 12:30 P.M. an interview with the [NAME] President of Operations (VPO) #716 and the mom of Resident #64 revealed the heat in the room had been an ongoing problem. f. The facility failed to ensure ADL care for Resident #82 who substantial to maximum staff assistance for oral care. Interview and observation on 03/25/24 at 9:54 A.M. with Resident #82 revealed he had not brushed his teeth since admission (02/14/24). Resident #82 revealed he did not have a bathroom in his room so the only place a toothbrush would be was in his nightstand but he had not seen one. Observation revealed the resident's teeth appeared to have a white yellow coating with food particles. Observation of his nightstand in the top drawer revealed a wash basin that contained a toothbrush in a plastic wrapper that was unused/unopened. A follow-up interview on 04/01/24 at 10:42 A.M. with Resident #82 revealed they had washed him up this morning in bed but still had not brushed his teeth. Observation revealed his teeth continued to have a white yellow coating. Upon observation and interview on 04/01/24 at 11:43 A.M. with STNA #947, she stated, by the looks no oral care was done as she revealed he had food particles and a white film/ coating his teeth. g. The facility failed to ensure ADL care for Resident #51 who required touch assistance with hygiene. Interview on 03/25/24 at 9:45 A.M. with Resident #51 revealed no one at the facility would help him shave or clean and trim his fingernails. Observation at the time of the interview revealed his fingernails were approximately 1/4 to 1/2 inch long with a brown substance beneath the end of each nail. His face was unshaven with his hair unkempt and uncombed. Interview on 03/25/24 at 10:06 A.M. with STNA #922 confirmed Resident #51's nails were long with a brown substance under them, his hair was unkempt, and his face was unshaven. She revealed she did not think staff were able to clip the resident's fingernails because he was diabetic. h. The facility failed to ensure ADL care for Resident #71 who had severe cognitive impairment and was not care planned for ADL care. On 03/25/24 at 11:25 A.M. observation of Resident #71 revealed disheveled hair and dry flaking skin on face. The flakes of dry skin were noted to be in Resident #71's hair. On 04/01/24 at 10:00 A.M.follow-up observation of Resident #71 revealed the resident in bed on his back. His face remained dirty with dry skin flakes noted. Dry flakes of skin were also going into his hair. On 04/01/24 at 10:05 A.M. the above findings were confirmed by STNA #964. STNA#964 stated that resident's faces are washed while bathing and Resident #71 gets bathed three times a week. STNA #964 also stated resident's faces were washed as needed. A review of the policy titled, Activities of Daily Living (ADL), Supporting, dated March 2018, revealed appropriate care and services will be provided for residents who are unable to carry out ADL independently, with consent of the resident and in accordance with the plan of care. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	i. The facility did not ensure Resident #53's concern regarding hearing and/or request for hearing aids were timely met. Interview on 03/28/24 at 2:15 P.M. and on 04/01/24 at 9:39 A.M. with Ombudsman #715 revealed she had an ongoing open case since 03/28/23 regarding Resident #53's complaint of hearing loss and request for a hearing aid that she felt the facility had not timely addressed. She revealed one factor was the turnover in management staff including the Administrator and Director of Nursing (DON) that affected the follow-through of the concern as either the facility did not return the Ombudsman #715's call/ email, respond to how they were going to address the concern and/ or follow up with what they had stated they would do. j. The facility did not ensure behavioral health care plans were followed for Resident #6. Review of SRI tracking number 245690 completed on 03/27/24 revealed the facility filed an SRI for an allegation of staff-to-resident physical abuse. The SRI revealed that while staff, STNA #956 and Agency STNA #701, were completing care Resident #6 became physically aggressive towards staff. The SRI revealed Resident #6 had gotten irritated because she was developing pain and started hitting Agency STNA #701. Resident #6 was assisted on her side and continued to hit staff. Resident #6 started to swing her arms again, and STNA #956 told Agency STNA #701 to just back up because she was trying to hit only Agency STNA #701. Agency STNA #701 grabbed Resident #6's wrists trying to block the hits. The SRI revealed following the incident Resident #6 had skin tears on her arms. Interview on 04/03/24 at 2:44 P.M. with the DON revealed in her interviews Agency STNA #701 did grab Resident #6's wrist to prevent Resident #6 from hitting her. She verified Resident #6 was in bed and if Agency STNA #701 would have stepped back and stopped providing care that then Resident #6 would have stopped hitting her and the incident would not have proceeded on to her needing to grab her wrist. The Director of Nursing verified in Resident #6's care plan when Resident #6 was agitated staff was to intervene before agitation escalated, guide away from source of distress, engage calmly in conversation, and staff was to walk calmly away and approach later. j. The facility did not ensure Resident #13's lab work was obtained as ordered by the physician. Review of the March 2023 physician's order revealed Resident #13 had an order dated 05/05/20 to have a glycated hemoglobin test (hbA1c) (a lab to obtain an overall picture of what the average blood sugar level was over the past three months) every three months. She also had an order for Risperdal (antipsychotic medication which can increase the risk of impaired glucose metabolism). Review of the lab work revealed there was no evidence a hbA1c level was completed as ordered by the physician. Interview on 03/27/24 at 1:13 P.M. with the DON verified she had no record Resident #13 received an hbA1c as ordered since 05/05/20. k. The facility did not ensure they had an effective antibiotic stewardship program that monitored antibiotic use including reducing the risk of adverse effects of the development of antibiotic resistant organisms from unnecessary or inappropriate antibiotic use for Resident #10, #16, #29, #30, #31, #38, #40, #44, #47, #51, #53, #55, #59, #63, #68, #73, #75, #77, #80, #83, #189, #190, #191, #238, #287, #288, #290 and #337. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Interview on 03/26/24 at 11:46 A.M. and 04/02/24 at 3:11 P.M. with Licensed Practical Nurse (LPN)/ Infection Control Preventionist #970 revealed at the end of each month she sent the log to Director of Nursing and Administrator but that they do not review and/or discuss the log including at an Infection Control Meeting and/or Quality Improvement and Performance Improvement (QAPI) meeting. She revealed she felt some of the residents did not meet the criteria (for antibiotic use) due to lack of documentation in the nursing notes as she was unable to find where residents displayed certain symptoms to justify the antibiotic use. She revealed she had not brought up this concern to the DON and/ or Administrator as well as she had not in-serviced the nurses on the importance of documentation regarding meeting criteria for antibiotic use. Interview on 04/04/24 at 11:10 P.M. with the Administrator and Director of Nursing revealed LPN/ Infection Control Preventionist #970 turned in the antibiotic summary logs monthly. They were not aware that most the residents receiving antibiotics did not meet the McGreer's criteria for use and/ or that one of the reasons LPN/ Infection Control Preventionist #970 had provided was that the nursing documentation was lacking especially regarding symptoms. The Director of Nursing stated, there will be a lot of changes moving forward. I. The facility did not ensure Residents #39, #61, #80 had received and/or the facility had documented evidence that residents were offered the pneumococcal and influenza vaccines.

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. 48565 Based on record review and interview the facility failed to have an updated and signed transfer agreement in place to accommodate residents in the event of an emergency. This affected 10 residents (#31, #33, #39, #44, #57, #67, #70, #73, #38 and #76) of 10 residents located on the 500 unit and identified by the facility to be ventilator dependent and had the potential to affect all 86 residents residing in the facility. Findings include: The facility utilized mechanical Ventilation, Oxygen, Cough, Suction, and Nebulizer (VOCSN) therapies in one compact, portable, lightweight device with an 8-hour internal back up battery, along with two 1.5 hour external (interchangeable batteries) for a total of up to 11 hours of battery backup per ventilator. Each ventilator resident also had a backup ventilator in house with up to another 11 hours of battery backup for a total of 22 hours. The facility identified 10 residents (#31, #33, #39, #44, #57, #67, #70, #73, #38 and #76) that were ventilator dependent. On 03/25/24 at 5:14 P.M., a review of the document titled, Transfer Agreement revealed it was last updated July 2020 and was not signed by the local hospital listed in the agreement. A new updated signed transfer agreement for a facility that had ability to care for all facility ventilator residents was requested from Administrator #807. Interview with the Administrator verified the July 2020 date of the unsigned transfer agreement at the time of the document review. On 03/25/24 at 6:55 P.M. a signed transfer agreement contract with a facility capable of providing ventilator care was provided by the Administrator to evacuate ventilator dependent residents in the event of a power outage.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on record review, interview, and review of the facility policy the facility did not ensure they had an effective antibiotic stewardship program that monitored antibiotic use including reducing the risk of adverse effects of the development of antibiotic resistant organisms from unnecessary or inappropriate antibiotic use. This affected 28 residents (#10, #16, #29, #30, #31, #38, #40, #44, #47, #51, #53, #55, #59, #63, #68, #73, #75, #77, #80, #83, #189, #190, #191, #238, #287, #288, #290 and #337) out of 34 residents identified as ordered antibiotics during the months of February 2024 and March 2024. The facility census was 86. Findings include: 1. Review of the form labeled, Date reported to QA/ RM Committee and dated 03/01/24 revealed the facility tracked residents that had received antibiotics for the month of February 2024. The form included the resident name, admitted , onset of infection date, site of infection, pathogen, antibiotic that was ordered, if isolation was ordered, if the infection was healthcare associated, the date the infection resolved, and if the infection met McGreer criteria (infection surveillance definitions for long term facilities for antibiotic use). The form revealed for the month of February 2024 there were 27 occurrences of residents requiring antibiotic use, and 25 residents did not meet the McGreer criteria for antibiotic use. The following residents were identified on the log of not meeting the criteria: A. Resident #80 with an admitted [DATE] was ordered Levaquin (antibiotic) on 02/07/24 for a possible lower respiratory infection. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. B. Resident #51 with an admitted [DATE] was ordered Fosfomycin (antibiotic) and Macrodantin (antibiotic) on 02/07/24 for a urinary tract infection (UTI). The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. C. Resident #59 with an admitted [DATE] was ordered Diflucan (antifungal) on 02/08/24 due to irritation. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. D. Resident #47 with admitted [DATE] was ordered Ceftin (antibiotic) on 02/11/24 for a possible UTI. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. E. Resident #53 with an admitted [DATE] was ordered fluconazole (antifungal) on 02/11/24 for a possible UTI. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	F. Resident #77 with an admitted [DATE] was ordered Bactrim (antibiotic) and meropenem (antibiotic) on 02/11/24 for a lower respiratory infection. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. G. Resident #68 with an admitted [DATE] was ordered Augmentin (antibiotic) on 02/12/24 for a sinus infection. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. H. Resident #190 with an admitted [DATE] was ordered doxycycline (antibiotic) on 02/14/24 for a wound infection. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. I. Resident #75 with an admitted [DATE] was ordered cefdinir (antibiotic) on 02/15/24 for a UTI. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. J. Resident #83 with an admitted [DATE] was ordered Tazicef (antibiotic) on 02/15/25) for a lower respiratory infection. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. K. Resident #189 with an admitted [DATE] was ordered cefdinir (antibiotic) on 02/15/24 for a UTI. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. L. Resident #16 with an admitted [DATE] was ordered amoxicillin and clarithromycin (antibiotic) on 02/17/24 due to a gastroenterology mass. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. M. Resident #10 with an admitted [DATE] was ordered Keflex (antibiotic) and cipro (antibiotic) 02/18/24 for infection in the finger. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. N. Resident #238 with an admitted [DATE] was ordered Bactrim DS (antibiotic) on 02/20/24 for a lower respiratory infection. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. O. Resident #191 with an admitted [DATE] was ordered daptomycin (antibiotic) on 02/23/24 for a wound infection. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	P. Resident #44 with an admitted [DATE] was ordered Levaquin (antibiotic) on 2/25/24 for a lower respiratory infection. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. Q. Resident #73 with an admitted [DATE] and was ordered Keflex (antibiotic) on 02/22/24 for cellulitis. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. R. Resident #288 with an admitted [DATE] was ordered Bactrim DS (antibiotic) on 02/28/24 for a UTI. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. S. Resident #55 with an admitted [DATE] was ordered Fosfomycin (antibiotic) on 02/28/24 for a UTI. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. T. Resident #38 with an admitted [DATE] and was ordered Cipro (antibiotic) and Flagyl (antibiotic) on 02/29/24 for a gastroenterology infection. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. 2. Review of for labeled, Date reported to QA/ RM Committee and dated 04/01/24 revealed the facility list of residents that had been ordered antibiotics for the month of March 2024. The form revealed for the month of March 2024 there were 21 occurrences of residents requiring antibiotic use and 14 residents did not meet the McGreer criteria for antibiotic use. The following residents were identified on the log of not meeting the criteria: A. Resident #337 with an admitted [DATE] was ordered levofloxacin (antibiotic) on 03/01/24 for a blood infection. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. B. Resident #40 with an admitted [DATE] and was ordered clindamycin (antibiotic) on 03/04/24 for dental. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. C. Resident #83 with an admitted [DATE] was ordered colistin (antibiotic) on 03/06/24 for a lower respiratory infection and Bactrim (antibiotic) for skin infection. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated both of the antibiotics did not meet the criteria for antibiotic use. D. Resident #287 with an admitted [DATE] was ordered daptomycin (antibiotic) on 03/10/24 for a skin infection and piperacillin (antibiotic) and Bactrim (antibiotic) for a UTI. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated all of the antibiotics did not meet the criteria for antibiotic use. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	E. Resident #288 with an admitted [DATE] was ordered meropenem (antibiotic) on 03/13/24 for a UTI. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. F. Resident #73 with an admitted [DATE] was ordered doxycycline (antibiotic) on 03/14/24 for a lower respiratory infection. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. G. Resident #290 with an admitted [DATE] was ordered Bactrim (antibiotic) on 03/18/24 for a UTI. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. H. Resident #63 with an admitted [DATE] was ordered clindamycin (antibiotic) on 03/21/24 for a dental infection. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. I. Resident #31 with an admitted [DATE] was ordered doxycycline (antibiotic) on 03/22/24 for a lower respiratory infection. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. J. Resident #30 with an admitted [DATE] was ordered penicillin (antibiotic) on 03/25/24 for a dental infection. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. K. Resident #29 with an admitted [DATE] was ordered Augmentin (antibiotic) on 03/26/24 as a preventative for skin infection. The antibiotic log and the individual form titled Revised McGreer Criteria for Infection Surveillance Checklist stated the antibiotic did not meet the criteria for antibiotic use. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 03/26/24 at 11:46 A.M. and 04/02/24 at 3:11 P.M. with Licensed Practical Nurse (LPN)/ Infection Control Preventionist #970 revealed she reviewed all residents that were on antibiotics and completed an individual McGreer Citeria form for each resident on an antibiotic to determine if the antibiotic met or did not meet the criteria. She revealed she then placed that information on the antibiotic log and the individual form if they did or did not meet the criteria. If the resident did not meet the criteria, she did not do anything else except mark that it did not meet the criteria including she did not contact the medical director, physician, pharmacist and/ or discussed it with the Administrator/ Director of Nursing/ Interdisciplinary Team. She felt some of the residents did not meet the criteria due to lack of documentation in the nursing notes as she was unable to find where residents displayed certain symptoms to justify the antibiotic use. She had not brought this concern to the Director of Nursing and/or Administrator. She had not in-serviced the nurses on the importance of documentation regarding meeting criteria for antibiotic use. She verified the antibiotic log for the month of February 2024 had 27 occurrences of residents that received antibiotics/ antifungal medications, and 25 of those residents did not meet the McGreer criteria for antibiotic/ antifungal use. She also verified for the month of March 2024 there were 21 occurrences of residents receiving antibiotics and 14 of those residents did not meet the McGreer criteria for antibiotic use. She stated at the end of each month she sent the log to the Director of Nursing and Administrator but that they did not review and/or discuss the log including at an Infection Control Meeting and/or Quality Improvement and Performance Improvement (QAPI) meeting. Interview on 04/04/24 at 11:10 P.M. with the Administrator and Director of Nursing revealed LPN/ Infection Control Preventionist #970 turned in the antibiotic summary logs monthly. They were not aware that most the residents receiving antibiotics did not meet the McGreer's criteria for use and/ or that one of the reasons LPN/ Infection Control Preventionist #970 had provided was that the nursing documentation was lacking, especially regarding symptoms. The Director of Nursing stated, there will be a lot of changes moving forward. Review of the facility policy labeled Antibiotic Stewardship, dated February 2019, revealed widespread use of antibiotics had resulted in an alarming increase in antibiotic-resistant infections. The policy revealed providers would utilize the McGreer's criteria when considering initiation of antibiotics. The policy revealed when infection was suspected review with the physician the criteria that was met for use of the antibiotic. The outcome data would be compiled monthly and the Infection Control Preventionist would interpret monthly the data and define any necessary action steps.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49774 Based on interview and record review the facility failed to ensure residents had received and/or the facility had documented evidence that residents were offered the pneumococcal and influenza vaccines. This affected three residents (#39, #61, #80) of the five residents reviewed for immunizations. The facility census was 86. Findings include: 1. Review of the medical record for Resident #39 revealed an admitted [DATE] with diagnoses including myotonic muscular dystrophy, chronic obstructive pulmonary disease (COPD), morbid obesity with alveolar hypoventilation, congestive heart failure (CHF), unspecified atrial fibrillation, dependence on respirator status, and tracheostomy status. Review of immunizations in the electronic medical record did not reflect the pneumococcal vaccine had been administered. Review of the consent form for Pneumococcal and Influenza Vaccines revealed Resident #39 signed the consent requesting the vaccine on 09/20/23. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39's cognition is intact. Interview with Licensed Practical Nurse (LPN)/ Infection Control Preventionist #970 on 03/26/24 at 12:08 P. M. confirmed the facility had no documented evidence in the electronic medical record Resident #39 and had been administered the pneumococcal vaccine despite having a signed consent dated 09/20/23. The signed consent form for influenza and pneumococcal vaccines were provided on 3/28/24 and were signed and dated by Resident #39 on 09/20/23. The consent forms were provided after the concern was brought to the attention of the facility. 2. Review of medical record for Resident #80 revealed an admitted [DATE] with diagnoses including epilepsy, other sequelae of cerebral infarction, chronic respiratory failure with hypoxia, COPD, and alcoholic cirrhosis of liver with ascites. Review of the quarterly MDS assessment dated [DATE] revealed Resident #80's short term memory was mildly impaired. Review of the immunizations in the electronic medical record revealed the influenza and pneumococcal vaccines were not administered and/or offered to Resident #80. Interview with LPN/ Infection Control Preventionist #970 on 03/26/24 at 12:08 P.M. confirmed the facility had no documented evidence in the electronic medical record that Resident #80 had received the influenza or pneumococcal vaccines. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The consent form for the influenza vaccine was received and dated for 03/28/24 and was not signed by Resident #80. The form reflected Resident #80 gave verbal consent for the vaccine. The consent form for the pneumococcal vaccine was also received on 03/28/24 and was dated 03/27/24. The consent forms were provided after the concern was brought to the attention of the facility. 3. Review of medical record for Resident #61 revealed an admitted [DATE] with diagnoses including acute diastolic (congestive) heart failure, COPD, pleural effusion, atherosclerotic heart disease of native coronary artery without angina pectoris, and paroxysmal atrial fibrillation. Review of the immunizations in the electronic record revealed the influenza and pneumococcal vaccines were not administered and/or offered to Resident #61. Review of the quarterly MDS assessment dated [DATE] revealed Resident #61's cognition was intact. Interview with LPN/ Infection Control Preventionist #970 on 03/26/24 at 12:08 P.M. confirmed the facility had no documented evidence in the electronic medical record Resident #61 had received the influenza or pneumococcal vaccines. The consent forms for the influenza and pneumococcal vaccines were provided on 03/28/24. The influenza consent was dated 03/07/24 (but was not administered upon consent). The pneumococcal consent was dated 03/27/24. The consent forms were provided after the concern was brought to the attention of the facility. Review of the undated facility policy labeled Pneumococcal Vaccine revealed the facility would offer all residents pneumococcal vaccines to aid in preventing pneumococcal infection unless medically contraindicated. The policy revealed the resident's vaccination status will be assessed within five working days of the resident's admission if not conducted prior to admission. The policy revealed if the residents refused, appropriate entries would be documented in the resident's medical record and, for those residents who received the vaccine, it also would be documented per the medical record. Review of the facility policy labeled Influenza Vaccine, revised October 2019, revealed the facility will offer the vaccine annually to promote the benefits associated with fighting against influenza. The facility would offer the vaccine between October 1st and March 31st to residents unless medically contraindicated. The policy revealed if the residents refused appropriate entries would be documented in the resident's medical record and, for those residents who received the vaccine, it also would be documented per the medical record.