STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365584	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Healthcare of Rosemount Pavilion	20 Easter Drive Portsmouth, OH 45662

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	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** 34299 Based on observation, interview, medical record review, the facility failed to provide Resident #233 with a dignity bag for the indwelling foley catheter. This effected one (Resident #233) of three residents reviewed for indwelling foley catheter. The facility census was 78. Findings include: Review of the medical record for Resident #233 revealed an admitted [DATE] with diagnoses including complete amputation of right leg between the right hip and knee, complications of amputation stump, pressure ulcer of sacral area stage four, diabetes mellitus type two, hypotension, and sebhorrheic dermatitis. Review of the physician orders dated 05/25 revealed Resident #233 had an order for foley catheter care every shift. The physician orders did not include size of foley catheter or when to change it. Review of the Medicare five day admission Minimum Data Set (MDS) dated [DATE] revealed Resident #233 had cognitive impairment with inattention, disorganized thinking, delusions, and other behavioral symptoms directed towards others. Resident #233 was dependent on the staff to complete activities of daily living. Resident #233 had indwelling foley catheter for urination. Review of the plan of care initiated revealed Resident #233 had an indwelling foley catheter related to stage four pressure ulcer to sacrum. The goal stated Resident #233 would be free from catheter related trauma through review date. The interventions included the resident has a foley catheter, position the catheter bag and tubing below the level of the bladder and away from the entrance room door. The staff were to monitor and document intake and output per the facility policy, monitor for signs and symptoms of discomfort with urination, and monitor, record and report to the physician signs and symptoms of urinary tract infection such as pain, burning, blood tinged urine, cloudiness, no or decreased output, deepening of urine color, increased pulse, increased temperature, foul smelling urine, chills, altered mental status, change in behavior and or eating patterns. Observations on 05/12/25 at 3:29 P.M. and 05/15/25 at 8:09 A.M. revealed Resident #233 had indwelling foley catheter. The foley catheter drainage bag was not covered and lying on the floor. Interview on 05/15/25 at 8:10 A.M. with Certified Nursing Assistant (CNA) #101 confirmed Resident (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#233 foley catheter bag was not covered and lying on the floor. Review of the facility provided policy named Catheter Policy, revised on 04/28/25, did not address covering the indwelling foley catheter bag with a dignity bag to enhance the privacy of the resident.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on observations, interviews, and record reviews, the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected pressure relieving devices and mechanically altered diets. This affected three residents (#20, #39, and #233) out of the 20 residents whose MDS assessments were reviewed during the annual survey. The facility census was 78. Findings include: 1. Record review for Resident #39 revealed the resident was admitted to the facility on [DATE] and had diagnoses include pressure ulcer of the right heel, morbid obesity, and diabetes mellitus. Review of the quarterly MDS assessment, dated 04/20/25, revealed the resident was assessed to have intact cognition. The resident was assessed to have one stage three pressure ulcer which was present upon admission to the facility. The resident was assessed to not have pressure reducing devices in place to the bed or chair. Review of the facility Equipment Purchase/Rental List revealed a specialty mattress had been obtained for Resident #39 on 10/18/25. Review of the active physicians order, dated 04/28/25, revealed an order for a specialty mattress to be in place on the residents bed. Observation on 05/12/25 at 9:45 A.M. revealed Resident #39 was lying in bed on the left side. A specialty mattress was in place on the residents bed which provided pressure relieving measures. Interview with Resident #39 at the time of the observation confirmed the specialty mattress had been in place to the bed for several months. Interview with the Director of Nursing (DON) on 05/16/25 at 11:00 A.M. confirmed Resident #39 had a specialty, low air loss mattress in place to the bed since 10/18/24. The DON confirmed the MDS assessment dated [DATE] did not accurately reflect the use of a pressure reducing device to the residents bed. 34299 2. Review of the medical record for Resident #20 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, hypertension, protein calorie malnutrition, bipolar disorder, dementia, anxiety and hyperlipidemia. Review of a physician order dated 10/13/24 revealed Resident #20 was to receive a fortified foods diet, regular texture and thin liquids. Resident #20 also received a house supplement three times daily. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #20 was cognitively impaired with continuous inattention, disorganized thinking, had delusions and hallucinations and physical/verbal/other behavioral symptoms towards others. Resident #20 had impaired range of motion to bilateral lower extremities and was dependent upon staff to complete activities of daily living. Resident #20 was incontinent of bowel and bladder. Resident #20 had prognosis of life expectancy of less than six months. Resident #20 weight was 90 pounds with no weight loss of five percent in last month or 10 percent or more in six months. Resident #20 had no chewing or swallowing concerns and was not receiving a mechanically altered diet. Review of the nutritional assessment dated [DATE] revealed Resident #20 received fortified foods, regular diet, with double portions and house supplement three times daily. Resident #20 was dependent upon staff to eat her meals, and had no oral status concerns. Review of the plan of care revised 04/25/24 revealed Resident #20 had potential for alteration in nutrition/hydration status related to multiple chronic health issues, advanced age, supplement in place, variable oral intake with the need for fortified foods, a significant weight loss at 30 days, body mass index of less than 23 percent for her age. On 01/29/25 had a significant weight loss in 30 days, on 02/07/24 weight loss trend was more stable, on 02/19/24 significant weight gain following weight loss and on 04/24/24 started hospice care. The goal stated Resident #20 would remain comfortable as evidenced by no signs and symptoms of hunger or thirst through next review. The interventions included to administer medications as ordered, assess and report signs of edema to physician, assess resident for signs and symptoms of aspiration, assist resident with meals as needed, coordinate/collaborate care with hospice services, encourage family to bring in favorite foods from home, honor food preferences as able, monitor for signs and symptoms of dehydration, monitor labs as ordered, obtain food preferences, obtain weights as ordered, offer meal substitutions as needed, provide diet as ordered, provide snacks per facility policy and supplements as ordered. An observation on 05/15/24 at 12:10 P.M. of Resident #20 eating her lunch meal. Resident #20 daughter was in the facility assisting her mother to eat. Resident #20 meal ticket stated she received a mechanical soft diet, fortified foods (mashed potatoes), double portions of protein and thin liquids. Resident #20 food noted on her lunch tray consisted of mechanical soft hamburger meat-double portion of meat, mashed potatoes-fortified, and mixed vegetables. An interview on 05/15/25 at 2:01 P.M. with Dietary Manager #400 revealed Resident #20 received mechanical soft diet, double portions of protein and thin liquids. Dietary Manager #400 stated she received the order on a communication form provided by the nurses. Review of the communication form dated 03/22/25, unable to determine nurse signature, revealed Resident #20 had a diet change to mechanical soft meats. An interview on 05/15/25 at 12:06 P.M. with Registered Nurse (RN) MDS Coordinator #930 revealed she completed all MDS for the facility. RN MDS Coordinator #930 stated she reviewed the 24 hour report and orders every day to compile information and complete the MDS and care plans. RN MDS Coordinator #930 confirmed Resident #20 diet order was not mechanically altered per the MDS dated [DATE]. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 05/15/25 at 2:08 P.M. with Licensed Practical Nurse (LPN) #720 revealed she was not sure what Resident #20 diet order was and she would check the order. On 05/15/25 at 2:13 P.M. LPN #720 confirmed she changed the diet order in the electronic medical record to mechanical soft diet, double portions of protein and fortified mashed potatoes on this date from regular diet, regular texture, fortified foods, and thin liquids. LPN #720 did not state where or who she received the order from. An interview on 05/15/25 at 2:30 P.M. with the Director of Nursing (DON) revealed she would look in to the diet order and where it came from. The DON confirmed there was not any documentation related to diet order change on 03/22/25. 3. Review of the medical record for Resident #233 revealed an admitted [DATE] with diagnoses including complete amputation of right leg between the right hip and knee, complications of amputation stump, pressure ulcer of sacral area stage four, diabetes mellitus type two, hypotension, and sebhorrheic dermatitis. Review of the Medicare five day admission Minimum Data Set (MDS) dated [DATE] revealed Resident #233 had cognitive impairment with inattention, disorganized thinking, delusions, and other behavioral symptoms directed towards others. Resident #233 had impaired range of motion to bilateral upper and lower extremities and was dependent on the staff to complete activities of daily living. Resident #233 used a wheelchair for mobility. Resident #233 had indwelling foley catheter for urination and was incontinent of bowels. Resident #233 had a recent surgery (right above the knee amputation), a stage two pressure ulcer upon admission, a stage four pressure ulcer upon admission, and an unstageable/deep tissue injury upon admission. Resident #233 was provided pressure ulcer care and surgical wound care, however Resident #233 did not have a pressure reducing device for his chair or bed and was not scheduled for turning and repositioning. Review of the wound assessment dated [DATE] at 2:09 P.M. authored by Registered Nurse (RN) #103 revealed Resident #233 presented today with left foot second digit diabetic foot ulcer with partial thickness, measured 0.5 centimeters (cm) by 0.5 cm by 0.1 cm and was stable, left great toe diabetic foot ulcer with full thickness, measured 0.4 cm by 0.5 cm by 0.2 cm and was improving. The left ischial pressure ulcer, stage two, measured 2.4 cm by one cm by 0.2 cm and was improving and stable. The right iliac crest skin tear, partial thickness, measured 1.3 cm by three cm by 0.1 cm. The stage four pressure ulcer, present on admission, to the sacrum measured 17 cm by 13 cm by two cm. All as wound care and assessment was provided by in house wound care provider. Review of the plan of care dated 05/13/25 revealed Resident #233 had actual impairment to skin integrity related to area to left heel, sacral wound, surgical wound for amputation to right lower extremity, and the right hip. The goal stated the resident would have no complications through review date. The interventions included enhanced barrier precautions as ordered, follow facility protocols for treatment of injury, may see in house wound care as needed, to see outside provider for wound care and weekly treatment documentation to include measurement of each area of skin breakdown with width, length, type of tissue and exudate and any other notable changes or observations. Observations on 05/12/25 at 3:29 P.M., 05/14/25 at 10:19 A.M. and 05/15/25 at 8:09 A.M. revealed Resident #233 was lying in bed on a low loss air mattress, had a pressure relieving cushion to his chair, heel protector on left foot, and was positioned on his side. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 05/15/25 at 8:10 A.M. with Certified Nursing Assistant (CNA) #101 confirmed Resident #233 had a specialty air mattress, a pressure relieving cushion to chair, heel protector on left foot and was turned and repositioned. An interview on 05/15/25 at 12:06 P.M. with RN MDS Coordinator #930 revealed she completed all MDS for the facility. RN MDS Coordinator #930 stated she reviewed the 24 hour report and orders every day to compile information and complete the MDS and care plans. RN MDS Coordinator #930 confirmed Resident #233 MDS dated [DATE] did not indicate Resident #233 had a pressure relieving device to bed and or chair and no turning or repositioning.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on observations, interviews, and record reviews, the facility failed to ensure comprehensive, resident centered care plans were developed and implemented. This affected seven residents (#39, #48, #69, #74, #76, #78, and #233) out of the 20 residents whose comprehensive care plans were reviewed during the annual survey. The facility census was 78. Findings include: 1. Record review for Resident #39 revealed the resident was admitted to the facility on [DATE] and had diagnoses include pressure ulcer of the right heel, morbid obesity, and diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/20/25, revealed the resident was assessed to have intact cognition. The resident was assessed to have one stage three pressure ulcer which was present upon admission to the facility. Review of the active physicians orders for Resident #39 revealed orders for a specialty mattress to bed, house protein supplement two times a day, encourage to float heels, and resident to wear Prevalon boots to bilateral feet while in bed. Review of the care plan, most recently revised on 04/29/25, revealed the resident had actual impairment to skin integrity related to a right heel Deep Tissue Injury (DTI) and Moisture Associated Skin Damage (MASD). Interventions were limited to follow facility protocols for treatment of injury, weekly treatment documentation, and Enhanced Barrier Precautions (EBP) as ordered. Observation on 05/12/25 at 9:45 A.M. revealed Resident #39 was lying in bed on the left side. A specialty mattress was in place on the residents bed which provided pressure relieving measures. Interview with Resident #39 at the time of the observation confirmed the specialty mattress had been in place to the bed for several months. The resident confirmed staff assisted her to elevate her heels off the bed but she was not able to utilize Prevalon boots due to them not staying in place as they were intended to. Interview with the Director of Nursing (DON) on 05/16/25 at 11:00 A.M. confirmed the care plan for Resident #39 only contained generic interventions utilized for several residents with skin alterations and did not contain individualized interventions for the care of the resident. 2. Record review for Resident #48 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included Post Traumatic Stress Disorder (PTSD), insomnia, and Parkinson's disease. Review of the quarterly MDS assessment, dated 04/11/24, revealed the resident was assessed to be cognitively intact. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan, dated 01/24/25, revealed the resident displayed or had a diagnosis with mental disorder or psychosocial difficulty adjustment, or had a history of trauma/PTSD. The only intervention present was assist resident and family with access to psychiatry and psychosocial services. Interview with the DON on 05/16/25 at 11:00 A.M. confirmed the care plan for Resident #48 did not contain specific information regarding the cause of the residents PTSD, potential triggers for PTSD, or individualized interventions to assist in preventing re-triggering PTSD. 3. Record review for Resident #74 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included acute pain due to trauma, psychoactive substance abuse, and anxiety disorder. Review of the admission MDS assessment, dated 02/04/25, revealed the resident was assessed to have intact cognition. Review of the active care plan for Resident #74 revealed there was no care plan in place related to the residents history of trauma. Interview with Resident #74 ON 05/12/25 at 10:29 A.M. confirmed the residents son had committed suicide and the resident had hallucinations of him walking past the door to her room so she preferred to keep the door shut. The resident confirmed she had traumatic events which had occurred and loud noises such as guns firing, fireworks, and loud bangs set her off so she had headphones which she wore frequently to muffle the noises. Interview with the DON on 05/16/25 at 11:00 A.M. confirmed no care plan had been developed related to the residents history of trauma to include causes of the residents trauma, potential triggers for trauma, or individualized interventions to assist in preventing re-triggering of trauma. 34299 4. Review of the medical record for Resident #69 revealed an admitted [DATE] with diagnoses including unspecified fracture of left lower extremity, generalized anxiety disorder, major depressive disorder, congestive heart failure, atrial fibrillation, diabetes mellitus type two, and hypertension. Review of the physician orders dated 05/25 revealed Resident #69 was ordered the following medications and treatments: blood glucose before meals and at bedtime, notify physician if blood sugar less than 60 or above 400, oxycodone hydrochloride five milligrams (mg) by mouth every six hours for pain, Metoprolol tartrate 50 mg by mouth two times daily for hypertension-hold if systolic blood pressure less than 120 milliliters of mercury (mmHg) or pulse less than 60 beats per minute (bpm), Sertraline hydrochloride 100 mg by mouth once daily for depression, buspirone hydrochloride 10 mg by mouth three times daily for anxiety and Midodrine hydrochloride 10 mg by mouth three times daily for hypotension-hold if systolic blood pressure greater than 120 mmHg. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #69 was cognitively intact with no mood symptoms or behaviors. Resident #69 had impaired range of motion to bilateral lower extremities. Resident #69 required substantial-maximum assistance from staff to complete activities of daily living. Resident #69 was incontinent of bowel and bladder. Resident #69 did not have any pain, falls or skin impairment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the nursing progress notes dated 05/13/25 at 5:28 P.M. the nurse noted a conversation with the Nurse Practitioner (NP) concerning the resident received scheduled Midodrine 10 mg by mouth three times daily related to hypotension and Lopressor 50 mg by mouth two times daily related to hypertension and atrial fibrillation. New orders received to continue the Lopressor as scheduled and change the perimeters to hold the medication if pulse was less than 60 beats per minute. A order to taper the Midodrine off at this time at a slow pace due to risk of arrhythmia if medication was stopped to suddenly. The resident was updated on the orders given. Review of the monthly medication review by the pharmacy revealed a recommendation on 03/04/25, that was signed by physician on 03/08/25: please consider adding parameters to Midodrine hydrochloride 10 mg by mouth three times daily for hypotension and hold if systolic blood pressure was greater than 120 mmHg. Review of the plan care initiated on 05/13/25 revealed Resident #69 had hypotension and atrial fibrillation. The goal stated Resident #69 would be free of signs and symptoms of hypotension through review date. The interventions included: give medications as ordered, monitor for side effects and effectiveness, monitor/document/report to the physician as needed any signs and symptoms of hypotension (dizziness, fainting, syncope, blurred vision, lack of concentration, nausea, fatigue, and or cold clammy pale skin), and obtain and monitor lab/diagnostic work as ordered, report the results to physician and follow up as indicated. Review of the plan of care initiated on 05/13/25 revealed Resident #69 was at risk for alteration in mood and behavior related to anxiety and depression, makes statements to therapy such as I don't need to know how to walk my boyfriend will carry me wherever I want when he gets out of prison, prefers to stay in her room and chooses not to get up out of bed. The goal stated Resident #69 would have reduced number of mood indicators or reduced instances of mood indicators. The interventions included to administer medications per order, encourage loved ones to contact/visit, and observe and report any changes in mental status. The plan of care did not address any cardiovascular diseases such as congestive heart failure or hypertension. Interview with Director of Nursing 05/16/25 at 12:20 P.M. confirmed care plans were not completed to meet all the needs of the resident. 5. Review of the medical record for Resident #76 revealed an admitted [DATE] with diagnoses including dysarthria, neuromuscular dysfunction of bladder, transient ischemic attack (TIA), cirrhosis of liver, benign prostate hypertrophy (BPH), insomnia, viral Hepatitis B, hypertension and major depression. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician orders dated 05/25 revealed Resident #76 was ordered the following medications and treatments: 16 French indwelling foley catheter with 10 milliliter (ml) balloon to catheter bag drainage system related to neurogenic bladder, change indwelling foley catheter monthly and as needed, monitor urinary output related to foley catheter every shift, irrigate bladder three times per week with normal saline, Furosemide 40 mg by mouth daily for edema, potassium chloride extended release 10 milliequivalents (mEq) by mouth daily as supplement, Trazadone hydrochloride 150 mg by mouth at bedtime related to major depressive disorder, buspirone hydrochloride 10 mg by mouth two times daily for anxiety, Eliquis 5 mg by mouth daily, and enhanced barrier precautions due to foley catheter. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #76 was cognitively intact with little interest or pleasure in doing things, feeling down, depressed and or hopeless, had trouble with sleeping, and feeling tired, feeling bad about self and trouble concentrating 12-14 days of look back period. Resident #76 had no impaired range of motion. Resident #76 required substantial to maximum assistance with toileting and personal hygiene, partial to moderate assistance with transfers and was dependent on the staff for showers and bathing. Resident #76 had an indwelling catheter for urinary output, and was occasionally incontinent of bowel. Resident #76 had no falls or skin impairment. Observations on 05/12/25 at 10:20 A.M., 05/12/25 at 3:46 P.M. and 05/15/25 at 2:38 P.M. revealed Resident #76 seated in the chair in his room with the indwelling foley catheter bag lying on the floor with no dignity bag cover. Interview on 05/12/25 at 3:49 P.M. with Licensed Practical Nurse (LPN) #620 confirmed Resident #76 indwelling foley catheter bag was lying on the floor with no dignity bag. LPN #620 stated Resident #76 likes to drag the bag around on the floor wherever he goes. Review of the plan of care initiated 02/24/25 and revised on 05/14/25 revealed Resident #76 was not compliant with showers/bathing, not letting indwelling foley catheter bag hang, not keeping the cover on his indwelling foley catheter bag and taking medications. The goat stated Resident #76 would verbalize understanding of education. The interventions included: document educational attempts with resident and family related to non compliance, educate resident and family on adverse effects of non compliance, and notify the physician of non compliance. Review of the plan care for Resident #76 initiated 02/24/25 revealed no plan of care related to viral Hepatitis B, cirrhosis of liver, hypertension, depression, dysarthria, edema, blood thinner medication or enhanced barrier precautions. Interview with Director of Nursing 05/16/25 at 12:20 P.M. confirmed care plans were not completed to meet all the needs of the resident. 6. Review of the medical record for Resident #78 revealed an admitted [DATE] with diagnoses including fracture of body of sternum, displaced fracture of olecranon process without extension of right ulna, unspecified fracture of lower end of right femur, major depressive disorder, insomnia, anxiety and severe pain. (all related to motor vehicle accident) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #78 was cognitively intact with little interest or pleasure in doing things two to six days of look back period, feeling down, depressed or hopeless two to six days of look back period and had no social isolation or behaviors. Resident #78 had impaired range of motion to one side of upper extremities and to both lower extremities. Resident #78 was dependent on the staff for toileting hygiene, and required substantial to maximum assistance of staff for showers/bathing, personal hygiene and transfers. Resident #78 had scheduled pain medication with non pharmacological interventions with almost constant severe pain. Resident #78 was at risk for pressure ulcers, had surgical wounds and wound care. The assessment did not have Resident #78 using a pressure reducing device for chair or bed, turning and repositioning or nutritional interventions. Review of the physician orders dated 05/25 revealed Resident #78 was ordered the following medications: Baclofen 10 milligrams (mg) by mouth three times daily for muscle spasms, Mirtazapine 30 mg by mouth at bedtime for insomnia, Prazosin hydrochloride one mg by mouth at bedtime for hypertension-hold if systolic blood pressure was less than 120 millimeters of mercury (mmHg) or pulse less than 60 beats per minute and notify provider-, Sertraline 75 mg by mouth daily for depression, Fenofibrate micronized 200 mg by mouth daily for hyperlipidemia, buspirone hydrochloride 5 mg by mouth every 12 hours for anxiety, Eliquis 5 mg by mouth two times daily for deep vein thrombosis, Gabapentin 100 mg by mouth three times daily for nerve pain, Hydroxyzine Pamoate 50 mg by mouth three times daily for anxiety, oxycodone hydrochloride 5 mg by mouth give two tablets every six hours for pain, tramadol hydrochloride 50 mg by mouth every six hours for breakthrough pain, monitor for bleeding, and assess residents pain every shift. Review of the psychosocial assessment completed on admission by Social Services #175 dated 03/21/25 revealed Resident #78 was involved in a horrific event-a car accident, reported anxiety and depression and became tearful when talking about his circumstances. Resident #78 was sitting up in bed, alert, oriented, pleasant and cooperative despite pain. Resident #78 reported he did not sleep at all due to his pain last night. Resident #78 became tearful when speaking about his motor vehicle accident. Resident #78 was independent prior and working full time. Psychiatric services offered but resident declined. No further investigation into Resident #78 trauma, triggers or symptoms, or plan to advert the triggers. Review of the progress note dated 05/15/25 at 12:59 A.M. authored by the Nurse Practitioner (NP) revealed Resident #78 was seen for follow up visit. The NP noted Resident #78 was healing from multiple fractures and surgeries after motor vehicle collision. The NP noted Resident #78 diagnoses included insomnia, essential hypertension, acute pain due to trauma, multiple fractures of ribs, unspecified fracture of shaft of right femur and presence of right artificial knee joint. Review of the plan of care initiated on 04/02/25 revealed Resident #78 had potential for alteration in comfort as evidenced by verbalization, facial expression and body language related to multiple recent surgical repairs. The goal stated Resident #78 would display or express signs of comfort by next review date. The interventions included administer medications as ordered, attempt non pharmacological interventions (none listed) and pain assessment per facility policy. (continued on next page)

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Ayden Healthcare of Rosemount Pavilion	20 Easter Drive Portsmouth, OH 45662

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the plan of care initiated on 04/02/25, revised on 04/25/25, revealed Resident #78 had potential impairment to skin integrity related to co morbidities and history of multiple surgical incisions. The goal stated Resident #78 would have no complications through review date. The interventions included follow facility protocols for treatment of injury and weekly treatment documentation to include measurement of each skin breakdown, type of tissue and exudate and any other changes. (Plan did not address pressure reducing device to chair and bed or turning and repositioning) Review of the plan of care dated 04/02/25 revealed Resident #78 was at risk for alteration in mood and behavior related to anxiety, depression, little interest or pleasure in doing things and tearful at times. The goal stated Resident #78 would have reduced number of mood indicators or reduced instances of mood indicators. The interventions included to administer medications per order, encourage loved ones to visit and observe and report any changes in mental status. The plan of care for Resident #78 did not address trauma, care of including triggers and interventions, insomnia, muscle spasms, deep vein thrombosis, hypertension or hyperlipidemia. Interview with Director of Nursing 05/16/25 at 12:20 P.M. confirmed care plans were not completed to meet all the needs of the resident. 7. Review of the medical record for Resident #233 revealed an admitted [DATE] with diagnoses including complete amputation of right leg between the right hip and knee, complications of amputation stump, pressure ulcer of sacral area stage four, diabetes mellitus type two, hypotension, and sebhorrheic dermatitis. Review of the physician orders dated 05/25 revealed Resident #233 was ordered the following treatments: apply Dakins solution to a four by four or Keflex roll and use to pack wound with a damp dressing, cover with abdominal pads and secure with medipore tape, negative pressure wound therapy-wound vac type of filler dressing was black foam, wound bed preparation, wound vac pressure settings of 125 milliliters of mercury (mmHg) pressure, continues, change three times weekly. catheter care every shift, cleanse left heel with wound cleanser and apply heel protector to left foot and oxygen at one liter per minute via nasal cannula. Review of the Medicare five day admission Minimum Data Set (MDS) dated [DATE] revealed Resident #233 had cognitive impairment with inattention, disorganized thinking, delusions, and other behavioral symptoms directed towards others. Resident #233 had no impaired range of motion to bilateral upper extremities or bilateral lower extremities and used a wheelchair for mobility. Resident #233 was dependent on the staff to complete activities of daily living. Resident #233 had indwelling foley catheter for urination and was incontinent of bowels. Resident #233 diagnoses included coronary artery disease, diabetes mellitus, complete traumatic amputation at level between right hip and knee, stage four pressure ulcer to sacral region. Resident #233 had frequent mild pain with as needed pain medications. Resident #233 had recent weight loss while not on a prescribed weight loss regimen. Resident #23 had one stage two pressure ulcer on admission, one stage four pressure ulcer on admission, and one unstageable/deep tissue injury upon admission. The assessment did not not Resident #233 had a pressure reducing device for chair or bed and no turning or repositioning. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the progress note dated 05/03/25 at 12:59 A.M. authored by Nurse Practitioner (NP) for routine visit revealed Resident #233 had traumatic amputation of the right hip and knee, sacral region stage four pressure ulcer, chronic obstructive pulmonary disorder, diabetes mellitus type two, hypotension, primary osteoarthritis and non ST segment myocardial infarction (NSTEMI). Resident #233 wears oxygen at one to two liters per minute via nasal cannula and has a foley catheter. Review of the plan of care revised 05/13/25 revealed Resident #233 had actual skin impairment to skin integrity related to area to left heel, sacral wound, surgical wound to amputee right lower extremity, and right hip. The goal stated Resident #233 would have no complications through review date. The interventions included the following: enhanced barrier precautions, follow facility protocols for treatment of injury, may see in house wound care as needed, may see local wound care provider, and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Review of the plan of care initiated on 05/08/25 revealed Resident #233 had indwelling foley catheter related to stage four pressure ulcer to sacrum. The goal stated Resident #233 would be free from catheter related trauma through review date. The interventions included position catheter bag and tubing below the level of the bladder and away from the entrance room door, monitor and document intake and output per facility policy, monitor for signs and symptoms of discomfort on urination and frequency, and monitor, document and report to physician any signs and symptoms of urinary tract infection. (pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse and temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status and change in behavior. The plan of care did not address hypotension, NSTEMI, diabetes mellitus type two, osteoarthritis or oxygen use. Interview with Director of Nursing 05/16/25 at 12:20 P.M. confirmed care plans were not completed to meet all the needs of the resident.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 42728 Based on observation, interviews, and record reviews, the facility failed to ensure fall interventions on resident care plans were reviewed and revised to ensure accuracy. This affected one resident (#48) out of the two residents whose care plans were reviewed for fall interventions during the annual survey. The facility census was 78. Findings include: Record review for Resident #48 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included Post Traumatic Stress Disorder (PTSD), insomnia, and Parkinson's disease. Review of the quarterly minimum data set (MDS) assessment, dated 04/11/24, revealed the resident was assessed to be cognitively intact. Review of the care plan, dated 01/14/21, revealed the resident was at risk for falls and potential injury. Interventions included a commode or urinal at bedside. Observation on 05/12/25 at 3:30 P.M. revealed Resident #48 was lying in bed. No commode or urinal were present at the residents bedside. Interview with Licensed Practical Nurse (LPN) #300 on 05/13/25 at 4:38 P.M. confirmed there was not a commode or urinal present at Resident #48's bedside. Interview with the Director of Nursing (DON) on 05/16/25 at 11:00 A.M. confirmed the care plan intervention for Resident #48 to have a commode or urinal present at bedside was no longer appropriate and had been removed from the residents care plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on observations, interviews, record reviews, and review of facility policy, the facility failed to ensure wound care treatments were provided as ordered by the physician. This affected one resident (#15) out of the two residents who were reviewed for non-pressure skin conditions during the annual survey. The facility census was 78. Findings include: Record review for Resident #15 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included diabetes mellitus, chronic kidney failure, and pruritis (itching). Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/07/25, revealed the resident was assessed to have intact cognition. Review of the care plan, most recently revised on 05/12/25, revealed the resident had eczematous areas all over body and skin tears to right wrist and top of forehead. Interventions included treatments as ordered. Review of the active physician order, dated 05/01/25, revealed an order to cleanse left shoulder with soap and water, pat dry, apply Triad cream, and leave open to air daily and as needed. Review of the active physician order, dated 05/01/25, revealed an order to cleanse left arm with soap and water, pat dry, apply Triad cream, and leave open to air daily and as needed. Review of the active physician order, dated 05/01/25, revealed an order to cleanse the right forearm with soap and water, pat dry, apply Xeroform, apply a non-adherent dressing, and wrap with gauze. Change daily and as needed. Further review of the active physicians orders for Resident #15 revealed no orders in place for an Optifoam bandage to be applied to the arm below the right elbow. Observation on 05/12/25 at 9:21 A.M. revealed Resident #15 was lying in bed and had an Optifoam bandage in place to the arm below the right elbow which contained staff initials and a date of 05/10/25. The resident had Kerlix to the right and left lower arms which was hanging loosely by the residents wrists, was saturated with blood, and had tape in place which contained staff initials and a date of 05/10/25. The resident had an Optifoam bandage in place to the left shoulder which was not dated or initialed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of wound care treatment completed by Licensed Practical Nurse (LPN) #185 for Resident #15 on 05/12/25 at 3:15 P.M. revealed LPN #185 removed the old bandages from the left arm, left shoulder, and right arm of Resident #15. LPN #185 then removed old gloves, completed hand hygiene, and put on new gloves. LPN #185 then cleansed the right arm and left arm of Resident #15 with wound cleanser and patted the areas dry. LPN #185 then removed old gloves, completed hand hygiene, and put on new gloves. LPN #185 then applied a clean Optifoam bandage to the residents right arm below the elbow, wrapped the residents right arm with Kerlix and secured it with tape, and wrapped the residents left arm with Kerlix and secured it with tape. LPN #185 then removed gloves, completed hand hygiene, and disposed of old bandages appropriately. Interview with LPN #185 at the time of the observation confirmed the Optifoam bandage to the residents right arm below the elbow and the Kerlix to the residents right and left arms were heavily saturated with dried blood and fresh blood and were dated as being changed last on 05/10/25 (two days prior). LPN #185 confirmed the Optifoam bandage to the residents left shoulder had not been initialed or dated. LPN #185 confirmed dressings were to be dated and initialed by the person completing the dressing change at the time wound care was completed. Interview with LPN #185 on 05/13/25 at 10:35 A.M. confirmed the wound care treatment she had completed for Resident #15 on 05/12/25 was not done as ordered by the physician. LPN #185 confirmed there had not been an order in place for an Optifoam bandage to be applied to the residents right arm below the elbow or to the residents left shoulder. LPN #185 confirmed Xeroform and a non-adherent bandage should have been applied to the residents right arm and the left arm should have had Triad cream applied then been left open to air. Review of the facility policy titled Wound Care, reviewed 04/28/25, revealed the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. Physicians orders for the procedure were to be verified, treatments were to be applied as indicated, then the wounds were to be dressed as ordered. [NAME] tape or dressings with initials, time, and date and apply to dressing.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on interview and record review the facility failed to ensure the physician order for pressure ulcer care contained sufficient information to provide adequate care. This effected one resident (Resident #233) of four reviewed for pressure ulcer care. The facility census was 78. Findings include: Review of the medical record for Resident #233 revealed an admitted [DATE] with diagnoses including complete amputation of right leg between the right hip and knee, complications of amputation stump, pressure ulcer of sacral area stage four, diabetes mellitus type two, hypotension, and sebhorrheic dermatitis. Review of the Medicare five day admission Minimum Data Set (MDS) dated [DATE] revealed Resident #233 had cognitive impairment with inattention, disorganized thinking, delusions, and other behavioral symptoms directed towards others. Resident #233 had no impaired range of motion to bilateral upper extremities or bilateral lower extremities and used a wheelchair for mobility. Resident #233 was dependent on the staff to complete activities of daily living. Resident #233 had indwelling foley catheter for urination and was incontinent of bowels. Resident #233 diagnoses included coronary artery disease, diabetes mellitus, complete traumatic amputation at level between right hip and knee, stage four pressure ulcer to sacral region. Resident #233 had frequent mild pain with as needed pain medications. Resident #233 had recent weight loss while not on a prescribed weight loss regimen. Resident #23 had one stage two pressure ulcer on admission, one stage four pressure ulcer on admission, and one unstageable/deep tissue injury upon admission. The assessment did not include that Resident #233 had a pressure reducing device for chair or bed and no turning or repositioning. Review of the physician orders dated 05/25 revealed Resident #233 was ordered the following treatments: apply Dakins solution to a four by four or Kerlix roll and use to pack wound with a damp dressing, cover with abdominal pads and secure with medipore tape, negative pressure wound therapy-wound vac type of filler dressing was black foam, wound bed preparation, wound vac pressure settings of 125 milliliters of mercury (mmHg) pressure, continues, change three times weekly, catheter care every shift, cleanse left heel with wound cleanser and apply heel protector to left foot and oxygen at one liter per minute via nasal cannula. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note authored by wound care provider Nurse Practitioner (NP) dated 05/05/25 at 3:16 P.M. revealed Resident #233 wound assessment as follows: wound #1 stage two pressure ulcer present on admission with no odor, measurements were 1.3 centimeters (cm) by 3 cm by 0.1 cm. The wound base was 100 percent epithelial, wound edges attached, peri-wound intact, light amount of serosanguineous exudate. Wound #2 deep tissue injury present on admission, measurements were 3.5 cm by 7 cm by 0 cm. The wound base was 100 percent epithelial,wound edges attached, with no odor. Wound #3 stage four pressure ulcer present on admission with no odor, measurements were 17 cm by 13 cm by 2 cm and tunneling undefined o'clock of 2.2 cm. The wound base was 10 percent epithelial, 50 percent granulation, 30 percent slough and 10 percent eschar. The periwound was intact with heavy amount of serosanguineous exudate, and rated pain at six of 10. The wound care provider debrided the wound to the sacrum. The plan stated to complete medications-labs-imaging procedures, add protein supplement, prostate, multivitamin and vitamin C for wound healing. Apply foam booties and low air loss mattress to the bed to reduce pressure on wounds. All the above was discussed with facility nursing staff. Review of a nursing progress note authored by Licensed Practical Nurse (LPN) #620 dated 05/13/25 revealed Resident #233 had an appointment at local wound care provider center. Resident #233 returned with new order to change sacral wound daily; apply Dakins solution to a four by four or Kerlix roll and use to pack the wound with a damp dressing. Cover with abdominal pad and secure with medipore tape. The order was updated in point click care (electronic health record system) Review of the plan of care revised 05/13/25 revealed Resident #233 had actual skin impairment to skin integrity related to area to left heel, sacral wound, surgical wound to amputee right lower extremity, and right hip. The goal stated Resident #233 would have no complications through review date. The interventions included the following: enhanced barrier precautions, follow facility protocols for treatment of injury, may see in house wound care as needed, may see local wound care provider, and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Observations on 05/12/25 at 3:29 P.M., 05/14/25 at 10:19 A.M., and 05/15/25 at 8:09 A.M. revealed Resident #233 had a low air loss specialty mattress to his bed, a pressure reducing cushion to chair and was positioned on his side. Interview on 05/15/25 at 12:35 P.M. with the Director of Nursing (DON) confirmed the physician order for wound was not complete or adequate to provide care for Resident #233 wounds. Also confirmed the wound NP recommendations for protein supplement prostat, Vitamin C and a multivitamin for wound healing was not transcribed to physician orders. The facility did not provide a policy for wound care orders and treatment.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on observations, interviews, record reviews, and review of facility policy, the facility failed to ensure smoking assessments were accurately completed for residents who smoked at the facility. This affected one resident (#39) out of the two residents reviewed for safe smoking practices during the annual survey. The facility identified 11 residents who were smokers. The facility census was 78. Findings include: Record review for Resident #39 revealed the resident was admitted to the facility on [DATE] and had diagnoses include pressure ulcer of the right heel, morbid obesity, and diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/20/25, revealed the resident was assessed to have intact cognition. Review of the care plan, initiated on 10/20/24, revealed the resident was at risk for injury related to smoking. Interventions included supervision at all times for smoking and smoking items to be kept at the nurses station. Review of the facility Smoking and Safety assessments, dated 01/13/25 and 04/18/25, revealed the resident was assessed to not smoke. Review of the list of residents who smoked provided by the facility revealed Resident #39 was listed to be a supervised smoker. Interview with Resident #39 on 05/14/25 at 12:35 P.M. confirmed staff assisted her outside to smoke cigarettes usually once a day at 1:00 P.M. The resident confirmed she had smoked cigarettes since being admitted to the facility though not as frequently as she wanted to due to her physical limitations. Observation on 05/14/25 at 1:05 P.M. revealed Resident #39 was outside smoking a cigarette in the designated smoking area with supervision from staff. Interview with the Director of Nursing (DON) on 05/16/25 at 11:00 A.M. confirmed the facility Smoking and Safety assessments for Resident #39 completed on 01/13/25 and 04/18/25 were inaccurate as the resident was a supervised smoker. Review of the facility policy related to smoking, not titled and reviewed most recently in 07/2024, revealed residents in the nursing center who smoke tobacco-cigarettes will be assessed using a smoking assessment. Residents are to smoke in outside designated smoking areas if determined to be a safe smoker as assessed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on observation, interview and record review the facility failed to ensure resident meals were as ordered by the physician. This effected one (Resident #20) of two residents reviewed for nutrition. The facility census was 78. Findings include: Review of the medical record for Resident #20 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, hypertension, protein calorie malnutrition, bipolar disorder, dementia, anxiety and hyperlipidemia. Review of a physician order dated 10/13/24 revealed Resident #20 was to receive a fortified foods diet, regular texture and thin liquids. Resident #20 also received a house supplement three times daily. Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #20 was cognitively impaired with continuous inattention, disorganized thinking, had delusions and hallucinations and physical/verbal/other behavioral symptoms towards others. Resident #20 had impaired range of motion to bilateral lower extremities and was dependent upon staff to complete activities of daily living. Resident #20 was incontinent of bowel and bladder. Resident #20 had prognosis of life expectancy of less than six months. Resident #20 weight was 90 pounds with no weight loss of five percent in last month or 10 percent or more in six months. Resident #20 had no chewing or swallowing concerns and was not receiving a mechanically altered diet. Review of the plan of care revised 04/25/24 revealed Resident #20 had potential for alteration in nutrition/hydration status related to multiple chronic health issues, advanced age, supplement in place, variable oral intake with the need for fortified foods, a significant weight loss at 30 days, body mass index of less than 23 percent for her age. On 01/29/25 had a significant weight loss in 30 days, on 02/07/24 weight loss trend was more stable, on 02/19/24 significant weight gain following weight loss and on 04/24/24 started hospice care. The goal stated Resident #20 would remain comfortable as evidenced by no signs and symptoms of hunger or thirst through next review. The interventions included to administer medications as ordered, assess and report signs of edema to physician, assess resident for signs and symptoms of aspiration, assist resident with meals as needed, coordinate/collaborate care with hospice services, encourage family to bring in favorite foods from home, honor food preferences as able, monitor for signs and symptoms of dehydration, monitor labs as ordered, obtain food preferences, obtain weights as ordered, offer meal substitutions as needed, provide diet as ordered, provide snacks per facility policy and supplements as ordered. Review of the nutritional assessment dated [DATE] revealed Resident #20 received fortified foods, regular diet, with double portions and house supplement three times daily. Resident #20 was dependent upon staff to eat her meals, and had no oral status concerns. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 05/15/24 at 12:10 P.M. of Resident #20 eating her lunch meal. Resident #20 daughter was in the facility assisting her mother to eat. Resident #20 meal ticket stated she received a mechanical soft diet, fortified foods (mashed potatoes), double portions of protein and thin liquids. Resident #20 food noted on her lunch tray consisted of mechanical soft hamburger meat-double portion of meat, mashed potatoes-fortified, and mixed vegetables. An interview on 05/15/25 at 2:01 P.M. with Dietary Manager #400 revealed Resident #20 received mechanical soft diet, double portions of protein and thin liquids. Dietary Manager #400 stated she received the order on a communication form provided by the nurses. Review of the communication form dated 03/22/25, unable to determine nurse signature, revealed Resident #20 had a diet change to mechanical soft meats. Review of the nursing progress notes revealed the notes were silent related to diet order change dated 03/22/25. An interview on 05/15/25 at 12:06 P.M. with Registered Nurse (RN) MDS Coordinator #930 revealed she completed all MDS for the facility. RN MDS Coordinator #930 stated she reviewed the 24 hour report and orders every day to compile information and complete the MDS and care plans. RN MDS Coordinator #930 confirmed Resident #20 diet order was not mechanically altered per the MDS dated [DATE]. An interview on 05/15/25 at 2:08 P.M. with Licensed Practical Nurse (LPN) #720 revealed she was not sure what Resident #20 diet order was and she would check the order. On 05/15/25 at 2:13 P.M. LPN #720 confirmed she changed the diet order in the electronic medical record to mechanical soft diet, double portions of protein and fortified mashed potatoes. LPN #720 did not state where or who she received the order from. An interview on 05/15/25 at 2:30 P.M. with the Director of Nursing (DON) revealed she would look in to the diet order and where it came from. The DON confirmed there was not any documentation related to diet order change on 03/22/25. The facility did not provide a policy related to dietary orders.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33023 Based on record reviews and interviews, the facility failed to ensure a resident with Post Traumatic Stress Disorder (PTSD) was appropriately assessed to identify the cause of the residents PTSD and minimize triggers and/or re-traumatization. This affected five residents (#36, #48, #69, #74, and #78) out of five residents identified by the facility as having PTSD/trauma. The facility census was 78. Findings include: 1. Record review for Resident #36 revealed the resident was admitted to the facility on [DATE] and had diagnoses including diabetes mellitis type II, cataracts, benign neoplasm of the chorioid, hypertensive retinopathy, dementia, chronic obstructive pulmonary disease, hypertension, neuropathy, contractures, hemiplegia and hemiparesis, congestive heart failure, cerebral infarction, dysphagia, aphagia, epilepsy, post-traumatic stress disorder(08/23/21), chronic pain, atrial fibrillation, anxiety, and muscle weakness. Review of the admission Minimum Data Set (MDS) assessment, dated 03/03/25, revealed this resident was assessed to have severely impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 99. This resident was assessed to have an active diagnosis of PTSD. Review of the active care plans for Resident #36 revealed no plan of care was in place addressing the cause of PTSD, triggers which may cause re-traumatization, or interventions to reduce the risk of re-traumatization and provide care for PTSD. Further record review for this resident revealed no assessment had been completed to identify the cause of PTSD for Resident #36 and to identify potential triggers which may cause re-traumatization. Interview with the Director of Nursing (DON) on 05/16/25 at 11:26 A.M. verified an assessment of the cause of PTSD and possible triggers for Resident #36 had not been completed and additionally verified there had not been a plan of care implemented for Resident #36 to minimize the risk of re-traumatization. 34299 2. Review of the medical record for Resident #69 revealed an admitted [DATE] with diagnoses including unspecified fracture of left lower extremity, generalized anxiety disorder, major depressive disorder, congestive heart failure, atrial fibrillation, diabetes mellitus type two, and hypertension. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #69 was cognitively intact with no mood symptoms or behaviors. Review of the trauma informed care assessment dated [DATE] revealed Resident #69 was asked if anything unusually frightening, horrible or traumatic had happened to her. Resident #69 replied she had been constantly on guard, watchful and felt startled. Resident #69 stated she felt numb, detached from people, activities and or surroundings. Resident #69 was unable to identify any triggers. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The plan of care initiated on 05/13/25 did not address Resident #69 trauma or interventions for staff as needed for adverse reactions. Interview on 05/12/25 at 12:20 P.M. with the Director of Nursing (DON) confirmed Resident #69 was not assessed appropriately for trauma informed care and did not have a plan of care that included cause of trauma, triggers and interventions. Interview on 05/12/25 at 2:43 P.M. with Resident #69 revealed her nerves were shot. Resident #69 stated she takes medication but does not feel it is helping. 3. Review of the medical record for Resident #78 revealed an admitted [DATE] with diagnoses including fracture of body of sternum, displaced fracture of olecranon process without extension of right ulna, unspecified fracture of lower end of right femur, major depressive disorder, insomnia, anxiety and severe pain. (all related to motor vehicle accident) Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #78 was cognitively intact with little interest or pleasure in doing things two to six days of look back period, feeling down, depressed or hopeless two to six days of look back period and had no social isolation or behaviors. Review of the psychosocial assessment completed on admission by Social Services #175 dated 03/21/25 revealed Resident #78 was involved in a horrific event-a car accident, reported anxiety and depression and became tearful when talking about his circumstances. Resident #78 was sitting up in bed, alert, oriented, pleasant and cooperative despite pain. Resident #78 reported he did not sleep at all due to his pain last night. Resident #78 became tearful when speaking about his motor vehicle accident. Resident #78 was independent prior and working full time. Psychiatric services offered but resident declined. No further investigation into Resident #78 trauma, triggers or symptoms, or plan to advert the triggers. Review of the plan of care initiated on 4/2/25 revealed no plan of care related to trauma including triggers or symptoms, or plant to advert triggers. Interview on 05/13/25 at 10:27 A.M. with Resident #78 revealed he was driving home from work and was hit head on by a drunk driver. Resident #78 stated his whole life changed in the blink of an eye and he will never be able to run again or climb a tree. Resident #78 became teary eyed and shaky voice talking about it. Resident #78 was traumatized by the incident and will always be disabled. Interview on 05/12/25 at 12:20 P.M. with the Director of Nursing (DON) confirmed Resident #69 was not assessed appropriately for trauma informed care and did not have a plan of care that included cause of trauma, triggers and interventions. 42728 4. Record review for Resident #48 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included Post Traumatic Stress Disorder (PTSD), insomnia, and Parkinson's disease. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly MDS assessment, dated 04/11/24, revealed the resident was assessed to be cognitively intact. Review of the care plan, dated 01/24/25, revealed the resident displayed or had a diagnosis with mental disorder or psychosocial difficulty adjustment, or had a history of trauma/PTSD. The only intervention present was assist resident and family with access to psychiatry and psychosocial services. No causes or potential triggers for the residents PTSD were identified. Review of facility assessments for Resident #48 revealed no assessment of the potential causes or triggers of the residents PTSD were present. Interview with the Director of Nursing (DON) on 05/16/25 at 11:00 A.M. confirmed Resident #48 had not been adequately assessed for causes and potential triggers of PTSD to prevent possible re-triggering. 5. Record review for Resident #74 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included acute pain due to trauma, psychoactive substance abuse, and anxiety disorder. Review of the admission MDS assessment, dated 02/04/25, revealed the resident was assessed to have intact cognition. Review of the active care plan for Resident #74 revealed there was no care plan in place related to the residents history of trauma. Interview with Resident #74 ON 05/12/25 at 10:29 A.M. confirmed the residents son had committed suicide and the resident had hallucinations of him walking past the door to her room so she preferred to keep the door shut. The resident confirmed she had traumatic events which had occurred and loud noises such as guns firing, fireworks, and loud bangs set her off so she had headphones which she wore frequently to muffle the noises. Interview with the DON on 05/16/25 at 11:00 A.M. confirmed Resident #48 had not been adequately assessed for causes and potential triggers of PTSD to prevent possible re-triggering.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on observations, interview and record review the facility failed to ensure Resident #20 family concerns of being overmedicated were timely and appropriately assessed. This effected one of one residents reviewed for opioid medication side effects. The facility census was 78. Findings include: Review of the medical record for Resident #20 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, hypertension, protein calorie malnutrition, bipolar disorder, dementia, anxiety and hyperlipidemia. Review of the physician orders dated 05/25 revealed Resident #20 was ordered the following medications: Tylenol eight hour extended release 650 milligrams (mg) by mouth every eight hours as needed for pain, tramadol hydrochloride 50 mg by mouth two times daily for pain, and attempt non pharmacological interventions as resident allows such as reposition for comfort, massage, diversion/guided imagery, music and relaxation techniques. Review of the Medication Administration Record (MAR) dated 04/25 and 05/25 revealed Resident #20 received tramadol 50 mg by mouth two times daily. Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #20 was cognitively impaired with inattention, disorganized thinking, had hallucinations and delusions and physical, verbal and other behavioral symptoms towards others. Resident #20 had impaired range of motion and was dependent on staff to complete activities of daily living. Resident #20 had no pain identified and a prognosis of less than six months life expectancy. Resident #20 received opioid medication and was on hospice services. Review of the pain assessment completed 05/14/25 revealed Resident #20 had no pain. Review of the plan of care imitated 04/09/25 revealed Resident #20 had potential for alteration in comfort related to generalized pain as evidenced by advanced age and frailty. The goal stated Resident #20 would display or express signs of comfort through review date. The interventions included the following: attempt non pharmacological interventions if resident allows, coordinate and collaborate care with hospice provider, monitor for increased levels of pain and notify the physician and pain assessment per facility policy. Observations of on 05/13/25 at 9:44 A.M. and on 05/15/25 at 1:17 P.M. revealed Resident #20 was sleeping and hard to arouse to verbal stimuli. Interview on 05/13/25 at 9:44 A.M. with Resident #20's daughter revealed the resident was sleeping a lot. The daughter comes in every day to feed her mother lunch. At times she would not wake up and eat and lost weight. The daughter stated the nurses were giving Resident #20 pain medicine two times a day and she can not handle that. The daughter stated she had asked the facility to only give her the night time dose to help her sleep and the other dose if she complained or appeared to be in pain. The daughter stated she was not sure the facility had done that yet. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/16/25 at 10:28 A.M. with Licensed Practical Nurse (LPN) #620 confirmed Resident #20 continued to receive her pain medication tramadol two times a day. LPN #620 stated the daughter had not told her that personally but the nurse was told by another nurse. Interview on 05/16/25 at 10:33 A.M. with the Director of Nursing (DON) stated she had seen a nursing note about too much pain medication and sleeping but had not spoke to Resident #20's daughter. DON stated if Resident #20 was oversedated and or the daughter had concerns we could certainly change the dosage. The facility did not have a policy related to opioid medication/over sedation.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on interview and medical record review the facility failed to ensure blood pressure medications were held per the physician parameters. This effected one (Resident #69) of one reviewed for significant medication errors. The facility census was 78. Findings include: Review of the medical record for Resident #69 revealed an admitted [DATE] with diagnoses including unspecified fracture of left lower extremity, generalized anxiety disorder, major depressive disorder, congestive heart failure, atrial fibrillation, diabetes mellitus type two, and hypertension. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #69 was cognitively intact with no mood symptoms or behaviors. Resident #69 had impaired range of motion to bilateral lower extremities. Resident #69 required substantial-maximum assistance from staff to complete activities of daily living. Resident #69 was incontinent of bowel and bladder. Resident #69 did not have any pain, falls or skin impairment. Review of the monthly medication review by the pharmacy revealed a recommendation on 03/04/25, that was signed by physician on 03/08/25: please consider adding parameters to Midodrine hydrochloride 10 mg by mouth three times daily of hold if systolic blood pressure greater than 120 mmHg. Review of the physician orders dated 05/25 revealed Resident #69 was ordered the following medications and treatments: blood glucose before meals and at bedtime, notify physician if blood sugar less than 60 or above 400, oxycodone hydrochloride five milligrams (mg) by mouth every six hours for pain, dated 4/7/25 Metoprolol tartrate 50 mg by mouth two times daily for hypertension-hold if systolic blood pressure less than 120 milliliters of mercury (mmHg) or pulse less than 60 beats per minute (bpm) added on , Sertraline hydrochloride 100 mg by mouth once daily for depression, buspirone hydrochloride 10 mg by mouth three times daily for anxiety and Midodrine hydrochloride 10 mg by mouth three times daily for hypotension-hold if systolic blood pressure greater than 120 mmHg. Review of the Medication Administration Record (MAR) dated 05/25 revealed the medication Metoprolol tartrate 50 mg by mouth two times daily with parameters to hold if systolic blood pressure than 120 mmHg or pulse less than 60 beats per minutes was not held on the following dates when systolic blood pressure was less than 120 mmHg: 05/01/25 evening dose, 05/02/25 morning dose, 5/3/25 morning dose, 5/7/25 morning dose, evening dose, 5/8/25 morning dose, 5/89/25 morning and evening dose, 5/10/25 morning and evening dose, 5/11/25 evening dose. The medication Midodrine hydrochloride 10 mg by mouth three times daily with parameters to hold when systolic blood pressure was greater than 120 mmHg was not held on the following dates when systolic blood pressure was greater than 120 mmHg: 5/1/25 morning and afternoon dose, 5/3/25 night dose, 5/6/25 night dose, and 5/12/25 night dose. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing progress notes dated 05/13/25 at 5:28 P.M. the nurse noted a conversation with the Nurse Practitioner (NP) concerning the resident received scheduled Midodrine 10 mg by mouth three times daily related to hypotension and Lopressor 50 mg by mouth two times daily related to hypertension and atrial fibrillation. New orders received to continue the Lopressor as scheduled and change the perimeters to hold the medication if pulse was less than 60 beats per minute. A order to taper the Midodrine off at this time at a slow pace due to risk of arrhythmia if medication was stopped to suddenly. The resident was updated on the orders given. Review of the plan care initiated on 05/13/25 revealed Resident #69 had hypotension and atrial fibrillation. The goal stated Resident #69 would be free of signs and symptoms of hypotension through review date. The interventions included: give medications as ordered, monitor for side effects and effectiveness, monitor/document/report to the physician as needed any signs and symptoms of hypotension (dizziness, fainting, syncope, blurred vision, lack of concentration, nausea, fatigue, and or cold clammy pale skin), and obtain and monitor lab/diagnostic work as ordered, report the results to physician and follow up as indicated. Interview on 05/13/25 at 3:45 P.M. with Licensed Practical Nurse (LPN) #620 confirmed Resident #69 had orders for both Metoprolol tartrate and Midodrine. LPN #620 stated you should hold one or the other based on the residents blood pressure reading. Interview on 05/14/25 at 10:00 A.M. with the Director of Nursing (DON) and facility Nurse Practitioner (NP) confirmed Resident #69 received both Metoprolol tartrate 50 mg by mouth two times daily and hold if systolic blood pressure was less than 120 mmHg or pulse was less than 60 beats per minute for hypertension and received Midodrine hydrochloride 10 mg by mouth three times daily and hold if systolic blood pressure was greater than 120 mmHg for hypotension. The NP stated one or the other of the medications would be held based on blood pressure. The DON confirmed Resident #20 received medications Metoprolol tartrate and Midodrine hydrochloride when parameters to hold were met.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728 Based on record reviews and staff interviews, the facility failed to ensure laboratory testing was performed as ordered by the physician. This affected one resident (#39) out of the five residents reviewed for unnecessary medications during the annual survey. The facility census was 78. Findings include: Record review for Resident #39 revealed the resident was admitted to the facility on [DATE] and had diagnoses include pressure ulcer of the right heel, morbid obesity, and diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/20/25, revealed the resident was assessed to have intact cognition. Review of the active physicians order, dated 12/10/24, revealed the resident was to have a Complete Blood Count (CBC) with differential, and Basic Metabolic Panel (BMP), and a Hemoglobin(Hgb) A1C level drawn and resulted every three months in January, April, July, and October. Review of the laboratory results for Resident #39 from 10/11/24 through 05/14/25 revealed no CBC, BMP, or HgbA1C levels were obtained from 01/2025 through 05/2025. Interview with Licensed Practical Nurse (LPN) #300 on 05/15/25 at 10:50 A.M. confirmed the order for a CBC, BMP, and HgbA1C for Resident #39 had not been obtained as ordered in 01/2025 or 04/2025.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on observation and interview the facility failed to ensure indwelling foley catheter drainage bags were off the floor. This effected two residents (Resident #76 and #233) of three residents reviewed for indwelling foley catheters. The facility census was 78. Findings include: 1. Review of the medical record for Resident #76 revealed an admitted [DATE] with diagnoses including dysarthria, neuromuscular dysfunction of bladder, transient ischemic attack (TIA), cirrhosis of liver, benign prostate hypertrophy (BPH), insomnia, viral Hepatitis B, hypertension and major depression. Review of the physician orders dated 05/25 revealed Resident #76 was ordered the following medications and treatments: 16 French indwelling foley catheter with 10 milliliter (ml) balloon to catheter bag drainage system related to neurogenic bladder, change indwelling foley catheter monthly and as needed, monitor urinary output related to foley catheter every shift, irrigate bladder three times per week with normal saline and enhanced barrier precautions due to foley catheter. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #76 was cognitively intact with little interest or pleasure in doing things, feeling down, depressed and or hopeless, had trouble with sleeping, and feeling tired, feeling bad about self and trouble concentrating 12-14 days of look back period. Resident #76 had no impaired range of motion. Resident #76 required substantial to maximum assistance with toileting and personal hygiene, partial to moderate assistance with transfers and was dependent on the staff for showers and bathing. Resident #76 had an indwelling catheter for urinary output, and was occasionally incontinent of bowel. Resident #76 had no falls or skin impairment. Observations on 05/12/25 at 10:20 A.M., 05/12/25 at 3:46 P.M. and 05/15/25 at 2:38 P.M. revealed Resident #76 seated in the chair in his room with the indwelling foley catheter bag lying on the floor with no dignity bag cover. Interview on 05/12/25 at 3:49 P.M. with Licensed Practical Nurse (LPN) #620 confirmed Resident #76 indwelling foley catheter bag was lying on the floor with no dignity bag. LPN #620 stated Resident #76 likes to drag the bag around on the floor wherever he goes. Review of the plan of care initiated 02/24/25 and revised on 05/14/25 revealed Resident #76 was not compliant with showers/bathing, not letting indwelling foley catheter bag hang, not keeping the cover on his indwelling foley catheter bag and taking medications. The goat stated Resident #76 would verbalize understanding of education. The interventions included: document educational attempts with resident and family related to non compliance, educate resident and family on adverse effects of non compliance, and notify the physician of non compliance. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #233 revealed an admitted [DATE] with diagnoses including complete amputation of right leg between the right hip and knee, complications of amputation stump, pressure ulcer of sacral area stage four, diabetes mellitus type two, hypotension, and sebhorrheic dermatitis. Review of the physician orders dated 05/25 revealed Resident #233 was ordered to have foley catheter care every shift only. The physician orders did not include size of foley catheter or when to change it. Review of the Medicare five day admission Minimum Data Set (MDS) dated [DATE] revealed Resident #233 had cognitive impairment with inattention, disorganized thinking, delusions, and other behavioral symptoms directed towards others. Resident #233 had no impaired range of motion to bilateral upper extremities or bilateral lower extremities and used a wheelchair for mobility. Resident #233 was dependent on the staff to complete activities of daily living. Resident #233 had indwelling foley catheter for urination and was incontinent of bowels. Resident #233 diagnoses included coronary artery disease, diabetes mellitus, complete traumatic amputation at level between right hip and knee, stage four pressure ulcer to sacral region. Resident #233 had frequent mild pain with as needed pain medications. Resident #233 had recent weight loss while not on a prescribed weight loss regimen. Resident #23 had one stage two pressure ulcer on admission, one stage four pressure ulcer on admission, and one unstageable/deep tissue injury upon admission. Review of the plan of care initiated on 05/08/25 revealed Resident #233 had indwelling foley catheter related to stage four pressure ulcer to sacrum. The goal stated Resident #233 would be free from catheter related trauma through review date. The interventions included position catheter bag and tubing below the level of the bladder and away from the entrance room door, monitor and document intake and output per facility policy, monitor for signs and symptoms of discomfort on urination and frequency, and monitor, document and report to physician any signs and symptoms of urinary tract infection. (pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse and temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status and change in behavior. Observations on 05/12/25 at 3:29 P.M. and 05/15/25 at 8:09 A.M. revealed Resident #233 had indwelling foley catheter. The foley catheter drainage bag was not covered and lying on the floor. Interview on 05/15/25 at 8:10 A.M. with Certified Nursing Assistant (CNA) #101 confirmed Resident #233 foley catheter bag was not covered and lying on the floor. Review of the facility policy titled Infection Control revised on 08/24 did not address infection prevention related to foley catheters. Review of the facility policy titled Catheter Care revised on 04/28/25 did not address infection prevention related to foley catheters.