STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365588	A. Building B. Wing	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Valley Skilled Nursing and Rehabilitation	25675 East Main Street Coolville, OH 45723

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, review of beneficiary protection notification review form, interview, and policy review, the facility failed to ensure Resident #40 and #41 were provided appropriate liability notices when cut from Medicare Part-A services with benefit days remaining and remained in the facility. This affected two residents (#40 and #41) of two residents reviewed who remained in the facility after being cut from Medicare Part-A services. Findings included: 1. Record review revealed Resident #40 was admitted to the facility on [DATE] with diagnoses including acute bronchitis, need for assistance with personal care, muscle weakness, pain in thoracic spine, difficulty in waking, and altered mental status. Review of the beneficiary protection notification review form (undated) revealed Resident #40 was discharged from Medicare Part A with benefit days remaining on 02/18/24 and remained in the facility. The resident did not receive an Advance Beneficiary Notice (ABN) form CMS-10055 due to the facility did not issue one. 2. Record review revealed Resident #41 was admitted to the facility on [DATE] with diagnoses including multiple sclerosis, cellulitis, muscle weakness, muscle wasting and atrophy, osteoarthritis, restless leg syndrome, and spinal stenosis. Review of the beneficiary protection notification review form undated revealed Resident #41 was discharged from Medicare Part A with benefit days remaining on 04/20/24 and remained in the facility. The resident did not receive an Advance Beneficiary Notice (ABN) form CMS-10055 due to the facility did not issue one. Further view of the beneficiary protection notification review form revealed the last time a resident was discharged from Medicare Part A with benefit days remaining was resident R#41 on 04/20/24. (continued on next page)

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/20/24 at 8:42 A.M. with the Administrator, who was also the Business Office Manager (BOM) and responsible for the liability notices, revealed there was some miscommunication between the therapy department and the facility on who was responsible for completing the ABN form. Therapy was originally completing the forms and then felt it should be the facility responsibility per the Administrator. The Administrator reported on Monday 05/13/24, after the survey team had entered, she had developed a quality assurance/performance improvement (QAPI) plan for ABN's. The Administrator provided the surveyor with a copy of the QAPI plan and the supporting documentation. The Administrator confirmed the QAPI plan only had one intervention to audit all cut notices from skilled services weekly to determine if ABN was required and if the ABN was required to note the date ABN was issued. There was no evidence that a house audit was completed, staff educated, or when the audits would be evaluated. The Administrator provided additional emails dated 04/25/24 and 05/13/24 confirming with therapy that the facility was responsible for completing the ABN's and discussing the service rate to document on the form. The QAPI plan also included one audit that was completed on 05/14/24 (the second day of the survey). The Administrator confirmed she provided the surveyor with all the QAPI information which included the plan, emails, one audit dated 05/14/24 with that included three residents' names, if an ABN was required, and date issues, and a copy of the beneficiary notice guidelines. The Administrator confirmed the QAPI plan did not include an initial audit or staff education, however she felt the emails discussing the rate and who was responsible for providing the ABN was her education. Review of the facility policy titled Skilled Nursing Facility Advanced Beneficiary Notices and Advanced Beneficiary Notice Standard of Practice (dated 04/01/18) revealed the CMS-10055/ABN was a written notice that would be provided to the resident or representative two days prior to services being terminated The purpose of the form was to inform the resident that the services may not be paid for and to let them make an inform decision if they would like to continue services that they may have to pay for out of pocked or through other insurance. The resident or representative must sign the box acknowledging that they have read and understood the notice.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on interviews and record review, the facility failed to ensure residents had privacy while in their room. This affected one resident (#38) of one resident reviewed for privacy. The facility census was 42. Findings included: Record review revealed Resident #38 was admitted to the facility on [DATE] with diagnoses including hyperkalemia, gastrointestinal hemorrhage, acute kidney failure, and type II diabetes. Review of a quarterly minimum data set completed on 03/22/24 revealed Resident #38's cognition remained intact and she had no behaviors. 1. Review of a nursing note dated 04/11/24 at 11:06 A.M. by Director of Nursing (DON) revealed Resident #38 had declined a room change after being kept awake the previous night by her roommate. Review of an undated page of interventions for Resident #38's roommate revealed no interventions to prevent rummaging through Resident #38's belongings. Review of an updated sticky note revealed interventions for Resident #38's privacy to be maintained included cups with lids, pulling the privacy curtain, and a child lock for the closet was discussed the previous day. Interview on 05/13/24 at 3:40 P.M. with Resident #38 revealed her roommate would rummage through her belongings, and she was concerned what would be misplaced due to just returning from the hospital. Interview on 05/16/24 at 8:15 A.M. with Resident #38 revealed her roommate was still getting into her belongings and a few items were missing. Resident #38 stated her roommate had even came over and tried to put her hands on her food before. Resident #38 stated she feels like a babysitter for her roommate and has to stay up with her all night. Interview on 05/16/24 at 10:52 A.M. with Licensed Practical Nurse (LPN) #126 revealed Resident #38's roommate did often go through her personal belongings but would be redirected by staff. LPN #126 stated the misplaced items are usually found, but the rummaging could impede on Resident #38's privacy. State tested Nursing Assistant (STNA) #100 present during conversation and nodded her head enthusiastically when asked if Resident #38's roommate impeded on her privacy. LPN #126 stated Resident #38's roommate rummaged throughout the whole building every few days, especially during the nights since she used to work nightshift. LPN #126 stated Resident #38 had been offered room changes multiple times but declined. Interview on 05/16/24 at 12:27 P.M. with STNA #101 revealed Resident #38's roommate did pilfer through her belongings. STNA #101 stated it is an invasion of privacy for another resident to go through Resident #38's belongings. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/16/24 at 12:54 P.M. with the director of nursing (DON) revealed Resident #38 did have concerns with her roommate when her roommate first moved in together but declined a room change because she knew it was a disease process and not intentional. The DON stated another room change was offered to Resident #38 last week but she will not move. The DON stated it would be detrimental to the roommate to have a room change due to her declined cognitive status but stated due to the decline, she likely won't be around much longer. Interview on 05/20/24 at 2:01 P.M. with the DON confirmed apart from offering room changes, no additional interventions were implemented to safeguard Resident #38's privacy. 2. Observation on 05/13/24 at 3:05 P.M. revealed no staff in the vicinity of the nurses station while a script for Resident #38 for Lyrica 100 milligrams one tablet by mouth three times a day and a script for oxycodone 5 milligrams every 8 hours as needed were sitting on the nurses station, face up, with Resident #38's information visible. After approximately three minutes, Medication Aide #136 confirmed the scripts for controlled substances were left unsupervised on the nurses station and they should not be left out. Interview on 05/13/24 at 3:11 P.M. with DON revealed new scripts are usually placed facing down on a clip attached to the edge of the nurses station until pharmacy can come pick them up. A policy related to privacy was requested but not provided by the facility.

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F 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 47985 Based on personnel file review, policy review, and interview, the facility failed to ensure the facility implemented their policy and failed to ensure all staff were checked against the Nurse Aide Registry (NAR) for history of abuse. This had the potential to affect 42 of 42 residents at the facility. Findings included: 1. Review of personnel file for Dietary Cook #117 revealed no evidence he was checked against the NAR for history of abuse. 2. Review of personnel file for Licensed Practical Nurse (LPN) #126 revealed no evidence he was checked against the NAR for a history of abuse. Interview on 05/20/24 at 11:24 A.M. with Human Resources Manager #135 confirmed there was no evidence Dietary Cook #117 and Licensed Practical Nurse #126 were checked against the NAR for a history of abuse. Immediately after the facility was notified regarding the lack of all staff being checked against the NAR, Dietary Cook #117 and LPN #126 were checked against the NAR with no negative findings. Review of an undated policy titled Licensing Requirements revealed all required checks, including the Ohio Nurse Aide Registry and Office for Inspector General will be completed on anyone the facility is considering hiring.

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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** 47985 Based on record review and interview, the facility failed to ensure residents were invited to participate in care planning upon admission and quarterly reviews. This affected two residents (#15 and #22) of three residents reviewed for care planning. The facility census was 42. Findings included: 1. Record review revealed Resident #22 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, type II diabetes, and congestive heart failure. Review of an admission minimum data set (MDS) revealed Resident #22's cognitive function remained intact and she had no behaviors. Review of a Multidisciplinary Care Conference assessment dated [DATE] revealed a care conference was held via telephone and participants included administration, social worker, and Resident #22's family/friend. Interview on 05/13/24 at 11:29 A.M. with Resident #22 revealed she had not been invited to participate in a care conference and was not aware the facility had a social worker. Interview on 05/14/24 at 4:14 P.M. with Social Services Designee (SSD) #141 revealed care plan meetings are held within 72 hours of admission to the facility, quarterly, annually, and with a significant change in status. Care plan meetings are completed in conjunction with the MDS schedule. Interview on 05/16/24 at 12:49 P.M. with Behavioral Health Social Worker #312 revealed Resident #22 is alert and oriented, has no hallucinations or delusions, has a goal of completing rehab then discharging home, and maintained a logical thought process. Interview on 05/20/24 at 1:23 P.M. with the Director of Nursing (DON) confirmed Resident #22 was not invited to the admission care plan meeting. Review of an undated policy titled Care Plan and Advanced Care Plan Process revealed the interdisciplinary care team and resident will meet and review the care plan upon admission. 32801 2. Record review revealed Resident #15 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, cerebral infarction, protein-calorie malnutrition, muscle wasting and atrophy, mild cognitive impairment, need for assistance with personal care, muscle weakness, mood disorder, impulse disorder, cannabis and alcohol abuse, dysphagia, injury of right wrist, hand, and finger(s), history of falling, and peripheral vascular disease. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #15's medical record (paper and electronic) revealed the last care conference was held on 01/04/24 and the only people in attendance were Resident #15 and Licensed Practical Nurse (LPN) #112. The LPN reviewed ancillary services, physician orders, preferences, advance directives, and discharge planning. The resident reported he had no problems or issues at this time. Further review revealed no evidence a care plan meeting was held after 01/04/24. Interview on 05/13/24 at 10:13 A.M., with Resident #15 revealed he was not included in his care plan and doesn't know if his family or friends were involved in any care conferences. Interview on 05/16/24 at 8:26 A.M., with the Director of Nursing (DON) revealed there was no documented evidence a care plan meeting was held after 01/04/24 and the resident should have had a care plan meeting in April 2024. The DON reported there was no staff in social service in April 2024 to do care conference due to the facility was in transition. Review of the facility policy titled Continuing Healthcare Solutions Care Plan and Advanced Care Plan Process undated, revealed the interdisciplinary team along with the resident would meet and review the care plan quarterly. The team directs care planning towards achieving and maintaining the highest practicable physical, psychosocial, functional status including advance directives, and signs the approved plan of care.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on record review, observation, interview, and policy review the facility failed to ensure residents were assessed and provided activities per preference. This affected one resident (#247) of one reviewed for activities. Findings included: Record review revealed Resident #247 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including malignant neoplasm of bone, type two diabetes, diabetic retinopathy with macular edema unspecified eye, visual loss, anxiety, depression, spinal stenosis, arthritis, sleep disorder, and heart disease. Review of Resident #247's activity participation review dated 03/15/24 revealed the resident's activity preference was blank. The Minimum Data Set (MDS) assessment section indicated the resident was interviewed and it was somewhat important to do her favorite activities. Further review of Resident #247's medical record (paper and electronic) revealed no evidence the resident's activity preferences were reviewed or evidence a new assessment was completed on the resident re-admission on 05/06/24. Review of Resident #247's activity participation dated 04/17/24 to 05/16/24 revealed the only activity the resident participated in was daily chronicle, one birthday party, one craft, one bingo, two special cart items, one game, and one food event. Review of Resident #247's visual plan of care dated 03/15/24 revealed the resident had alteration on vision as related to diabetes and decreased vision. Interventions included to adapt environment, ensure glass were clean, in good repair, appropriate and being worn by resident, monitor eye infection, obtain eye exam consultation, position window blinds to decrease glare, and provide well-lit environment for reading and daily activity. There was no evidence of providing large print materials. Review of Resident #247's activity (personal and cultural preferences) plan of care dated 03/15/24 and revised 03/25/24 revealed to honor activity daily living preferences, food preferences, other preferences, resident preferred to rise in morning and go to bed at night. There was no evidence of resident's individualized activity preference. Observation on 05/15/24 from 9:50 A.M. to 2:07 P.M. revealed the resident was in bed all day. There was no evidence of large print reading materials in the resident's room. Interview on 05/15/24 at 11:58 A.M., with Corporate Nurse #300 confirmed the current Activity Director (AD) #142 was not qualified per the regulation. The Corporate Nurse reported the AD was also the facility Dietary Manager (DM). Interview on 05/15/24 at 2:05 P.M., with Resident #247 revealed she had vision impairment and needs reading material in larger print. The facility was not currently providing her with large, printed reading materials. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/16/24 at 9:44 A.M., with AD #142 confirmed she started to complete the admission activity assessment however the resident was not feeling well, and she didn't complete the entire evaluation and didn't follow up with resident. The AD #142 reported she was aware of the resident visual impairment and didn't think about providing her with large print items. The AD reported the resident had refused activities however she doesn't document resident refusals. The AD reported she tries to go from room to room and invite residents and has two volunteers that help her twice a week. The AD reported she was also the dietary manager and depends on the volunteers to help. AD #142 confirmed she told the facility she was not qualified as AD per the job description she signed on 02/09/23 and the facility was supposed to set her up with training over a year ago, but the training was never set up until yesterday. Interview on 05/16/24 at 10:18 A.M. and 11:00 A.M., with the Director of Nursing (DON) confirmed the resident would need large print items because she had vision impairment. The DON confirmed the resident would not be able to read the daily chronicle due to the chronicle not being large print. The DON confirmed the resident admission activity assessment was not comprehensive and the activity plan of care was not individualized. The DON confirmed the resident was not reassessed for activities on re-admission (05/06/24) per the policy. Review of the facility policy and procedure titled Assessment Schedule (undated) revealed activities assessment should be completed with on all resident on admit, with re-admission, and annually, with a quarterly progress note that summarizes needs identified and facility actions over the quarter. A short term stay activity assessment may be completed for admits and re-admits what are anticipated to be short term in nature. Assessments in PCC should be completed on admission, quarterly with sign change and annually in accordance with the MDS schedule. Review of the facility policy and procedure titled Care plan and advance care plan process (undated) revealed the interdisciplinary team would coordinate with the resident and/or their responsible party if the resident was unable to participate in appropriate care plan for the resident's needs or wishes specific to the person-centered care based on the assessment and reassessment process within the required time frames.

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F 0680 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on review of personnel files, review of the facility assessment, and interviews the facility failed to ensure the activities director was qualified. This had the potential of affect all 42 of 42 residents residing in the facility. Findings included: Review of Activity Director (AD) #142's personnel file revealed the AD was hired on 02/14/22 and signed the activity director job description on 02/09/23. The job description indicated the qualifications for the AD were to be qualified therapeutic recreation specialist and/or activities professional who was licensed by the state and is eligible for certification as recreation specialist or as an activities professional or must have two year experience in a social or recreation program within the last five years, one of which was a full-time in a patient activities program in a health care setting; or must have completed a training coarse approved by the state. There was no evidence AD #142 met the qualifications listed in the job description and regulation. Review of the facility assessment dated [DATE] revealed AD #142 was listed on the phone list as the facility Activity Director. Interview on 05/15/24 at 11:58 A.M., with Corporate Nurse #300 revealed the DM was also the AD and she was not qualified to be the AD per the regulation. The facility set her up today for training. Interview on 05/16/24 at 8:32 A.M., with AD #142 confirmed she was hired on 02/14/22 as the Dietary Manager and then asked to be the AD on 02/09/23. The AD confirmed when she signed the AD job description, she told the facility she was not qualified, and the facility offered to provide her with training. The AD confirmed the facility never provided her with the training but did register her yesterday (05/15/24) for the training. As of today, AD #142 confirmed she was not qualified to be the AD according to the job description and regulation.

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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** 32801 Based on record review, observation, interview, and policy review the facility failed to ensure fall interventions were in place per the resident plan of care. This affected one resident (#10) of one reviewed for falls. Findings included: Record review revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including muscle weakness, dementia, macular degeneration, difficulty walking, lack of coordination, and fracture of right humerus. Review of Resident #10's nurses notes dated 05/2023 to 05/2024 revealed Resident #10 had fallen 07/17/23, 09/01/23, 01/20/24, and 04/25/24. Review the Resident #10's quarterly Minimum Data Set (MDS) dated [DATE] to 10/03/23 revealed no evidence the falls that occurred on 07/17/23 or 09/01/23 were captured on the MDS assessment. Review of Resident #10's fall plan of care initiated on 01/01/23 and revised on 01/18/24 revealed on 03/14/22 an intervention was added to have a low bed with mat on floor. On 02/15/22 a new intervention was added to place the resident in a room closer to the nurse's station. On 11/30/23 a new intervention was added to have nonskid socks on at all times. On 01/20/24 a new intervention was added to use bright colored tape to the call light for a visual reminder to use the call light. Review of Resident #10's current orders dated 05/2024 revealed mat to floor at bedside to assist with safety and nonskid socks on at all times. Review of Resident census dated 03/01/23 to 05/20/24 revealed the resident has resided in the same room. Observation on 05/13/24 at 4:15 P.M., 05/14/24 at 9:53 A.M., 05/15/24 at 12:35 P.M., and 05/16/24 at 12:36 P.M., of Resident #10 revealed no evidence the resident had mats at the bedside. Observation on 05/20/24 at 9:50 A.M. of Resident #10 with State tested Nurse's Aide (STNA) #301 and Licensed Practical Nurse (LPN) #139 confirmed the resident did not have mats on the floor, the call light did not have bright colored tag, the resident did not have nonskid socks in-place, nor was the resident's room close to the nurse's station per the resident's plan of care. The STNA reported the resident roommates call light had bright colored tag, however the resident's (#10) did not have bright colored tag and the resident refuses to wear non-skid socks. The LPN confirmed the non-skid socks was not an appropriate intervention since the resident refuses to wear them. Both STNA and the LPN reported Resident #10 had been in the same room since they have worked there and there were several rooms that were closer to the nurse's station. Observation on 05/20/24 10:26 AM revealed Resident #10's room was on the end of the hallway and furthest from the nurse station. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/20/24 at 12 :15 P.M., with the Director of Nursing (DON) confirmed the falls that occurred on 07/17/23 and 09/01/23 were not captured on the next MDS completed on 10/03/23. Review of the facility policy titled Fall Management (undated) revealed the facility would identify each resident who was at risk for falls and would develop a plan of care and implement intervention to manage falls. The interdisciplinary team would review the falls routinely to determine the most appropriate intervention to be implemented to attempt in preventing the future incidents from occurring. The care plan would be updated routinely and with significant changes in the resident conditions.

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Arcadia Valley Skilled Nursing and Rehabilitation	25675 East Main Street Coolville, OH 45723

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, observations, review of a resident's meal ticket, staff interview, and policy review, the facility failed to ensure a resident, who had a history of a significant weight loss, received nutritional interventions as ordered. This affected one resident (#35) of three residents reviewed for nutrition. Findings include: Review of Resident #35's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included morbid obesity, moderate protein-calorie malnutrition, muscle wasting and atrophy, dysphagia (difficulty swallowing), mild cognitive impairment of unknown etiology, schizo-affective disorder, heart failure, and major depressive disorder. Review of Resident #35's physician's orders revealed her diet included a consistent carbohydrate diet, regular texture, and regular consistency. She was also to receive super cereal and super potatoes (higher calorie foods) every day. Review of Resident #35's care plans revealed she had a care plan in place for the potential for an alteration in nutrition related to chronic disease, being nutritionally at risk, and having a history of a significant weight loss. The goal was for the resident to be adequately nourished with no significant weight changes. Interventions included honoring her food preferences as able and for a registered dietitian referral as needed. Review of Resident #35's progress notes revealed a weight warning note from the facility's contracted dietitian dated 04/10/24 at 5:19 P.M. that indicated the resident's weight was 232.6 pounds. It was a 27.4 pound/ 10.5% loss and was considered a significant weight loss. The dietitian recommended super cereal and super mashed potatoes to be provided to the resident once a day. On 05/15/24 at 12:30 P.M., a meal observation was made for the lunch meal served to the resident in the dining room. She was served an egg salad sandwich, beets, cucumbers, and grapes. She was not noted to have received any mashed potatoes that would have been the super mashed potatoes recommended by the dietitian in response to a significant weight loss on 04/10/24. Further observations of Resident #35's dinner meal, served to her in her room on 05/15/24 at 4:58 P.M., revealed the resident was given chicken parmesan over noodles and a breadstick. Her husband was in the room visiting at the time the evening meal was served. Again, the resident did not receive any mashed potatoes that would have been the super mashed potatoes recommended by the dietitian for the resident's significant weight loss. Review of a meal ticket that was on Resident #35's tray identified her diet as being a regular, consistent carbohydrate diet with thin liquids. There was nothing on the meal ticket to reflect the resident was supposed to receive super cereal once a day or super mashed potatoes once a day as was ordered for the resident. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/15/24 at 5:04 P.M., an interview with the Director of Nursing (DON) verified Resident #35 was to receive super cereal and super mashed potatoes as was included in her diet orders. She confirmed the facility's dietitian added super cereal and super mashed potatoes as a nutrition intervention on 04/10/24 in response to the resident's identified significant weight loss. She denied the facility would have documented the resident receiving the super cereal or super mashed potatoes, as it was just part of her diet. She acknowledged the resident was observed for two meals and did not receive super mashed potatoes with her lunch or dinner meal. She further acknowledged the resident's meal ticket did not reflect the super cereal or the super mashed potatoes that she was ordered to have. On 05/15/24 at 5:05 P.M., an interview with Dietary Manager #142 revealed, if a resident was on super cereal, it would be given with breakfast as cream of wheat. If a resident was on super mashed potatoes, it would be given with the lunch meal. She confirmed Resident #35's meal ticket did not identify her as being on either and the resident had not been receiving those as a nutritional intervention, after they had been recommended by the dietitian on 04/10/24. Review of the facility's policy on Immediate Temporary Interventions for Unintended Significant Weight Loss revealed individuals with unintended significant weight loss would receive immediate nutrition interventions to prevent further weight loss, stabilize weight, and/ or assist the individual to regain weight as appropriate. Facility staff would request temporary nutrition interventions as appropriate for significant weight loss. Food and nutritional services would be notified using facility procedures (communication form or electronic communication as appropriate) to request the temporary intervention.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review, observation, and interview, the facility failed to ensure medically related social services were provided to residents to monitor behavioral health concerns. This affected one resident (#10) of two residents reviewed for behaviors. The facility census was 42. Findings included: Record review revealed Resident #10 admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, major depressive disorder, anxiety disorder, chronic obstructive pulmonary disease. Review of a quarterly minimum data set completed 04/03/24 revealed Resident #10 had moderately impaired cognitive skills, verbal behaviors one to three days, other behaviors one to three days, and refused care one to three days. Review of a care plan revealed Resident #10 had a behavior problem related to Alzheimer's disease, depression, and anxiety, is followed by [NAME] psych for frequently yelling out; Resident #10 has an alteration in mood with depression, anxiety, related to anxiety disorder with target behaviors of crying, tearfulness, decreased socialization, withdrawal from activities and socialization, difficulty sleeping, insomnia, easily annoyed, angered by placement and care, Ativan (an anti-anxiety medication) per orders, stop sign on door; Resident #10 has an alteration in cognitive function related to diagnosis of Alzheimer's, depression, anxiety, inattention and disorganized thinking fluctuate, verbal behaviors and rejection of care. Review of assessments revealed the last Social Service History assessment was completed 09/27/23. Review of progress notes revealed no evidence of medically related social services being provided to Resident #10 since 10/07/22. Observation on 05/13/24 at 11:00 A.M. revealed Resident #10 calling out and yelling for help constantly. Observation on 05/15/24 at 2:17 P.M. revealed Resident #10 could be heard yelling out from the nurse's station. Observation on 05/20/24 at 8:24 A.M. revealed Resident #10 was in her room and could be heard yelling for help because she did not know where she was from the nurse's station. Therapy staff were nearby and walked into the therapy gym without acknowledging Resident #10's calls for help. Interview on 05/20/24 at 8:26 A.M. with Licensed Practical Nurse (LPN) #139 revealed if Resident #10 gets up in the wheelchair, her behaviors of yelling out become worse. Resident #10 will tell staff she wants up and as soon as she is in the wheelchair, Resident #10 will scream I want back in bed. LPN #139 stated behaviors are usually addressed by offering food or drink, then offering anxiety medication or pain medication. LPN #139 stated she informed the activities department of Resident #10's behaviors and they were planning to sit one-on-one with her. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/20/24 at 9:04 A.M. with the Director of Nursing (DON) revealed there is a behavior binder in place for nursing and activity staff to provide interventions with Resident #10, but nothing social services related. Interventions included talking to her favorite aide, having visitors, having coffee, and getting her nails painted. The DON stated social services had not had consistent staffing in a while. Interview on 05/20/24 at 12:34 P.M. with the Administrator revealed social service assessments should be completed quarterly. The Administrator confirmed if the last social services assessment was completed in September 2023, two more should have been completed since then. The Administrator confirmed a social worker would be an integral part of behavior management for those who are easily calmed by having someone to talk to. Review of an undated policy titled Behavior and Psychoactive Management Program revealed social service support should be provided as needed. A social service representative familiar with the resident will evaluate the resident who is experiencing any changes in behaviors, will document in the medical record, and communicate with the Behavior Committee. The Behavior Committee should include the social worker.

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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** 28923 Based on record review, family interview, and staff interview, the facility failed to ensure narcotic pain medication ordered on an as needed (prn) basis included parameters to direct the nurses on when to administer it and failed to administer another controlled narcotic medication for the reason it was ordered for. This affected one resident (#26) of five residents reviewed for unnecessary medications. Findings include: Review of Resident #26's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included Parkinson's disease, congestive heart failure (CHF), unspecified dementia without behavioral disturbances, emphysema, anxiety disorder, schizophrenia, unspecified psychosis, and psychotic disorder with delusions. Review of Resident #26's physician's orders revealed she had an order to receive Norco (controlled narcotic pain medication used for the treatment of moderate to severe pain) 5-325 milligrams (mg) by mouth (po) every four hours prn for pain. She also had an order to receive Acetaminophen 650 mg po every four hours as needed for pain/ fever. There were no parameters included in the physician's order that directed the nurses on when to give the prn Acetaminophen or the prn Norco for pain. Further review of the physician's orders noted an order for Morphine Sulfate 20 mg/ milliliter (ml) with directions to give 0.5 ml po every 30 minutes prn for dyspnea (shortness of breath). The prn Norco and the prn Morphine Sulfate had an order date of 11/15/23 and the prn Acetaminophen had been ordered since 01/11/22. Review of Resident #26's medication administration record (MAR's) for April 2024 revealed the resident was given the prn Norco eight times that month for pain levels between 3 to 5 on a 1-10 scale. She was given the prn Norco on 04/01/24 at 11:09 A.M. and again on 04/20/24 at 7:27 P.M. for a reported pain level of 5 on a 1-10 scale. She was given the prn Norco on 04/09/24 at 8:46 P.M. for a pain of a 3 on a 1-10 scale. The prn Acetaminophen had not been used at all that month for the resident's complaints of pain. The resident was also noted to have been given Morphine Sulfate that was ordered on a prn basis 20 times. The prn Morphine Sulfate was ordered to be given every 30 minutes as needed for shortness of breath. Nineteen of the 20 doses, the nurse administering the prn Morphine Sulfate documented a pain level on the MAR at the time of its administration, even though the Morphine Sulfate was not ordered to be given for pain. Four of the 19 times the prn Morphine Sulfate was given, the resident's pain level was below a 6 on 1-10 scale. On 04/04/24 at 8:44 A.M., Morphine was given for a pain level of 3 on 1-10 scale. On 04/26/24 at 4:16 P.M., 04/26/24 at 5:29 P.M., and 04/28/24 at 3:33 P.M., the Morphine Sulfate was given for recorded pain levels of a 5 on a 1-10 scale. Review of the MAR's for May 2024 revealed Resident #26 was given prn Norco six times that month. On 05/06/24 at 9:00 A.M., the resident's pain level was a 5 when the prn Norco was given. Again, the prn Acetaminophen had not been used on an as needed basis for pain. The resident was given Morphine Sulfate 11 times that month. The nurse administering the prn Morphine Sulfate recorded a pain level 10 out of the 11 times the Morphine Sulfate was given that month. The other time the nurse gave the Morphine they recorded a pain level as 0. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #26's progress notes confirmed the Morphine Sulfate that was ordered on an as needed basis for shortness of breath was being used for pain and not shortness of breath as it was ordered for. There was no indication of the resident having complaints of dyspnea/ shortness of breath. On 05/14/24 at 2:30 P.M., an interview with Resident #26's Power of Attorney (POA) revealed the resident received pain medication for generalized arthritic pain. She would complain of pain in her legs and in her back. She had a history of some compression fractures in her back that resulted in chronic pain. She denied the resident was known to have shortness of breath on a regular basis, unless she had some respiratory infection going on and that did not happen that often. On 05/14/24 at 3:45 P.M., an interview with Regional Quality Assurance Nurse #300 confirmed Resident #26's Norco order did not include parameters in which it should be used. She acknowledged the resident was being given prn Norco for pain levels between 3 and 5 on a 1-10 scale. She also confirmed the resident's Morphine Sulfate was ordered to be given prn for dyspnea and the nurses had been administering the Morphine Sulfate for pain. She further acknowledged the Morphine Sulfate had been given to the resident for pain levels between 3 and 5 on a 1-10 scale.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on record review, observation, interview, and policy review the facility failed to ensure the medication error rate was less than 5%. There were 26 opportunities for error and two observed errors resulting in the medication error rate of 7.69 percent. This affected one resident (#33) of three residents observed for medication administration. Findings included: Record review revealed Resident #33 was admitted to the facility on [DATE] with diagnoses including hypothyroidism, low back pain, chronic pain, and fractures of the left femur, humerus, and sacrum. Review of Resident #33's current order dated 05/2024 revealed on 04/08/24 new orders were received to administer Synthroid 125 micrograms (mcg) early (4:00 A.M. to 6:00 A.M.) on Monday, Wednesday, and Friday. Further review revealed to administer Diclofenac Sodium external gel 1% four grams (gm) to knees, ankles, foot topically every shift for pain. Observation of Resident #33's medication administration with Licensed Practical Nurse (LPN) #126 on 05/15/24 at 8:11 A.M., revealed the LPN administered Synthroid 125 mcg and applied the Diclofenac only to the residents' knees and upper back. Interview on 05/15/24 at 11:04 A.M. and 11:10 A.M., with LPN#126 confirmed the Synthroid was administered at 8:11 A.M. and the order was for 4:00 A.M. to 6:00 A.M. and the Diclofenac order indicated to apply to the knees, ankles, and foot and he didn't administer the gel to the ankles and feet. The LPN confirmed the order for the Diclofenac gel didn't not include the upper back and he had applied the gel to the upper back without an order. Review of the facility policy titled Medication Administration Schedule (dated 07/2016) revealed no evidence what early times indicated, however indicated the physician order for specific times supersedes any routine schedule. Review of the facility policy titled Medication Administration (dated 10/2007) revealed to administer medication in an organized and safe manner. Apply topical treatment per physician order.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on record review, observation, interview, review of medication administration records, review of the pharmacy list for expiration dates for insulin, and policy review the facility failed to ensure medications were stored properly and medications were not expired. This affected one resident (#38) residing on the East unit. Finding included: Review of Resident #38's medical record revealed the resident was admitted to the facility on [DATE] with a diagnosis including type two diabetes. Review of Resident #38's orders and medication administration record dated ,d+[DATE] revealed on [DATE] the resident's insulin order was changed to Humalog pen inject per sliding scale. If blood sugar ,d+[DATE] no insulin required, blood sugar ,d+[DATE] give four units, blood sugar ,d+[DATE] give six units. Check blood sugar before meals and at bedtime. The resident did not receive the Humalog from [DATE] to [DATE]. Observation and interview on [DATE] at 2:21 P.M. and 3:00 P.M. of East medication cart with Licensed Practical Nurse (LPN)# 126 revealed there was 15 loose identified pills in the medication cart drawers and a Humalog pen (Resident #38 pen) that was opened on [DATE]. LPN #126 reported he did not know how long the Humalog was good for once it was opened and he would have to get back to the surveyor. The LPN gathered the 15 loose pills and placed them in a chemical to destroy them. At 3:00 P.M. the LPN confirmed the Humalog was only good for 28 days after it was open per the pharmacy. The LPN confirmed Resident #38's Humalog pen should have been discarded two days ago. Review of the pharmacy list of expiration dates for insulin's undated revealed Humalog expires 28 days after opening. Review of the medication storage policy titled Medication Storage (dated ,d+[DATE]) medication and biological are stored properly, following manufactures, or provided pharmacy recommendation, to maintain their integrity and to support safe effective drug administration. Insulin products should be stored in the refrigerator until opened. Note the date on the label for insulin vials and pens when first used. The opened insulin vial may be stored in the refrigerator or at room temp. Opened insulin opens must be stored at room temp. Medication storage should be kept clean, well lit, organized, and free of clutter.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47985 Based on observation and interview, the facility failed to store and prepare food in a sanitary manner. This had the potential to affect 42 of 42 residents at the facility. Findings included: Observation during an initial tour of the kitchen with Dietary Manager (DM) #142 on 05/13/24 at 8:54 A.M. revealed two bags of salad with a best by date of 05/12/24 in the refrigerator. DM #142 confirmed findings. Continuous observations of the lunch tray line were made on 05/15/24 from 12:14 P.M. to 12:44 P.M. revealed: 1. Dietary Aide (DA) #109 used the back of her right wrist to rub her nose. DA #109 did not change her gloves or wash her hands. 2. Seven trays were sent out to be served on the [NAME] hallway with bowls of grapes left open to air. 3. Dietary Cook (DC) #123 sorted meal tickets to be placed on trays. While sorting, DC #123 licked her fingers to help separate papers. The tickets then went onto resident trays. 4. DA #109 took her right glove off, wiped her right hand on her pants, then applied a new glove without performing hand hygiene. 5. DA #109 used the back of her right wrist to wipe her forehead and did not change gloves or perform hand hygiene. Interview on 05/15/24 at 2:54 P.M. with DM #142 confirmed the findings of the lunch tray line. Observation on 05/16/24 at 7:53 A.M. revealed the freezer temperature from two internal thermometers was reading 14 degrees Fahrenheit. DC #123 confirmed the temperature of the freezer. Review of a policy titled General Food Preparation and Handling (dated 2021) revealed employees should wash their hands prior to putting on gloves and after taking them off. Review of a policy titled Food Storage (dated 2021) revealed all foods should be consumed by their safe use by dates, frozen, or discarded.

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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** 32801 Based on record review, observation, interview, and policy review the facility failed to maintain infection control practice while administering eye drops. This affected one resident (#6) of two observed for administration of eye drops. Finding included: Record review revealed Resident #6 was admitted to the facility on [DATE] with diagnoses including macular degeneration and dry eyes. Review of Resident #6's orders and medication administration records dated 05/2024 revealed to instill one drop of Artificial Tear Solution 1% in both eyes twice daily. Observation on 05/15/24 at 8:43 A.M. of Licensed Practical Nurse (LPN) #139 administering eye drops to Resident #6 revealed the LPN washed hands and applied gloves and administered artificial tears to Resident #6's left eye. The LPN removed her gloves and applied a new pair of gloves without performing hand hygiene. The LPN administered artificial tears to the right eye and removed her gloves and left the room without performing hand hygiene after removing the gloves or exiting the resident's room. Interview on 05/15/24 at 8:54 A.M., with LPN #139 confirmed she did not perform hand hygiene after changing her gloves or before exiting Resident #6 room. Review of the facility policy titled Hand Washing (dated 03/2020) revealed staff were to use alcohol hand sanitizer before exiting a resident's room. Review of the facility policy titled Medication Administration (dated 10/2007) revealed to administer ophthalmic solution into eye in a safe and accurate manner. The equipment required was gloves, however the policy didn't include when to apply the gloves or remove them. The only indication the policy addressed for hand hygiene was after returning the medication container to the medication cart for storage then perform hand hygiene.