STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365591	A. Building B. Wing	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Lawn Nursing Home	15028 Old Lincolnway East Dalton, OH 44618

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 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. Based on record review and interview the facility failed to ensure residents discharged from skilled services were provided appropriate notification in writing of services ending. This affected two Residents (Resident #77 and #229) of three residents reviewed for beneficiary notification. The facility census was 77. Findings include: 1. Review of the medical record for Resident #77 revealed an admission date of 12/01/24 and a discharge date of 02/21/25. Diagnoses included hyperlipidemia, dementia and hypertension. There was no evidence of a Notice for Medicare Non-coverage (NOMNC) provided to the resident. 2. Review of the medical record for Resident #229 revealed an admission date of 04/12/25.Diagnoses included hypertension. Morbid obesity, diabetes, kidney disease and dysphagia. There was no evidence of a NOMNC provided to the resident. Review of the beneficiary notice list provided by the facility revealed both Resident's #77 and Resident #229 had been discharged from a Medicare Part A covered stay in the last six months with benefit days remaining. There was no evidence a NOMNC form had been issued to either Resident #77 or Resident #229. Interview on 05/01/24 at 1:08 P.M. with the Social, Service Designee (SSD) #538 confirmed she had no evidence the NOMNC form had been issued to either Resident #77 or Resident #229.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of the medical record revealed Resident #40 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included traumatic brain injury, encephalopathy, cerebral infarction, tracheostomy, neuromuscular dysfunction of the bladder, conversion disorder with seizures or convulsions, acute respiratory failure, quadriplegia, and contractures of muscle. A plan of care dated 11/07/23 revealed Resident #40 was at risk for complications and/or aspiration related to tube feeding. Interventions included to administer tube feeding as ordered. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #40 had severe cognitive impairment. The MDS also revealed Resident #40 required a feeding tube. Review of physician orders revealed Resident #40 was ordered Nutren (Nutritional Supplement) 1.5 every shift at 60 milliliter/hour continuously. Observations on 04/28/25 at 11:22 A.M. and 2:02 P.M. revealed Resident #40's tube feeding pole had a dried brown substance, consistent with dried Nutren, on the four feet located at the bottom of the pole. An interview on 04/28/25 at 2:14 P.M. with family of Resident #40 revealed they had scraped dried substances off the floor next to the tube feeding pole. Observation on 05/01/25 at 7:25 A.M. revealed dried brown substance of the four feet located at the bottom of the tube feed pole. Licensed Practical Nurse (LPN) #540 verified there was a dried brown substance on the four feet at the bottom of the tube feeding pole. This deficiency represents non-compliance investigated under Complaint Number OH00164199. Based on observation, record review and interview the facility failed to maintain Resident #40's tube feeding pole and floor below his enteral pump in a clean and sanitary manner and failed to provide a smoke-free environment for Resident #58. This affected two residents (Resident #40 and #58) of 27 residents reviewed for homelike environment. The facility assessment was 77. Findings include: 1. Record review for Resident #58 revealed an admission date of 03/08/24. Diagnosis included paraplegia. Review of the admission MDS dated [DATE] revealed Resident #58 was cognitively intact. Resident #58 had impairment to both sides of the lower extremities, used a wheelchair for mobility, required substantial/maximal assistance for bed mobility and was dependent for chair/bed-to-chair transfer. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/30/25 at 2:03 P.M. with Resident #58 revealed the smoking area for residents was located outside her window. Residents smoked cigarettes frequently and when they smoked, the smell of the cigarettes came through the heating/air conditioner unit in her room. Resident #58 revealed she did not smoke and stated she could smell the smoke, it gets on her clothes and she even got black spots on her clothing. Resident #58 stated she told the Administrator and the Administrator said she would work on moving the residents who smoke down the courtyard, further away. Observation on 04/30/25 at 4:13 P.M. with Director of Social Services (DSS) #538 confirmed seven residents smoking near Resident #58's window, Resident #8, #10, #16, #21, #38, #59, and #129. DSS #538 revealed the Administrator requested the residents smoke at the other end of the courtyard, but the residents still smoke at this end. SSD #538 confirmed the smell of the cigarette smoke was strong due to residents standing next to each other. Observation and interview on 04/30/25 at 4:31 P.M. with Director of Maintenance #540 revealed the unit in Resident #58's room was a v-tack unit. The unit was located near Resident #58's window. When the unit was turned on for heat, air or ac, it sucks air in from the outside. Director of Maintenance #540 confirmed when the unit was turned on, if residents were smoking outside near the unit, it would suck in cigarette smoke and you would be able to smell the smoke.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, hospital record review, death certificate review, investigation review, drug information review, interview and policy review the facility failed to ensure staff belongings were properly secured to prevent access to Resident #11 and failed to ensure a condition change was timely reported to medical practitioners resulting in resident neglect. This resulted in Immediate Jeopardy and Actual Harm/subsequent death on [DATE] between 5:00 A.M. and 6:00 A.M. when Resident #11, who resided on a secured behavior unit and had a history of drug use and drug seeking behavior, accessed Certified Nurse Assistant (CNA) #120's purse (which was located at an unsecured nursing station) and obtained the prescription medication, Adipex (a stimulant). Resident #11 then ingested up to 20 37.5 milligram (mg) tablets that had been in the bottle without staff knowledge. At 7:40 A.M. Resident #11 was noted to be not acting right and at 8:56 A.M. Resident #11 developed a rapid pulse and confusion. Resident #11 (who was normally ambulatory) was unable to stand alone and was unable to walk with staff assistance. Physician Assistant (PA) #805 was notified and indicated she would be in to see Resident #11. At 11:17 A.M. PA #805 was notified Resident #11 was hypertensive (high blood pressure), required oxygen and an order was received to transfer the resident to the emergency room (ER) for evaluation of respiratory distress. While in the ER, Resident #11 required cardiopulmonary resuscitation (CPR) and intubation and was admitted to the intensive care unit (ICU) with amphetamines (stimulants) in her urine and pneumonia. The resident expired on [DATE] at a palliative care facility. A situation of neglect that did not rise to Immediate Jeopardy was identified when the facility failed to obtain and provide basic care, services and necessary equipment to meet the total care needs of Resident #70. This affected two residents (#11 and #70) of four residents reviewed for abuse/neglect. The facility census was 77. On [DATE] at 10:00 A.M. the Administrator (LNHA), Director of Nursing (DON), and Regional Director of Clinical Services (RDCS) #704 were notified Immediate Jeopardy began on [DATE] between 5:00 A.M. to 6:00 A.M. when Resident #11 accessed CNA #120's unsecured purse behind the nurses' station and ingested up to 20 37.5 mg tablets of Adipex (stimulant medication used for weight loss) resulting in a condition change that began at 7:40 A.M. The resident had confusion, hypertension, the inability to stand/walk, and rapid pulse before the resident was evaluated by the PA. The resident was not transferred to the ER until 11:37 A.M. for evaluation where she required CPR, intubation and was admitted to the ICU. The resident was comatose and never regained consciousness, subsequently expiring on [DATE]. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrections: • On [DATE] at 11:37 A.M., Resident #11 was transported to the emergency room by Emergency Medical Services (EMS) for evaluation. The resident was admitted to the hospital on [DATE] at 3:35 P.M. • (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:42 A.M. the Nurse Registered Nurse (RN) #500 attempted to notify Resident #11's guardian regarding the resident's condition and transport to the ER; however, there was no answer, and the nurse was unable to leave a voicemail. The resident's Emergency Contact #2 was notified and stated she would inform the resident's guardian. • On [DATE] at 11:01 A.M. Certified Nurse Assistant (CNA) #120 notified the Administrator, via phone, that a bottle of her prescription medication (Adipex) and a lighter were missing from her purse. • On [DATE] at 11:05 A.M. Resident #11's room was searched by Unit Manager #508 and an empty medication bottle labeled phentermine (Adipex) with CNA #120's name on it, a lighter and a bottle of esomeprazole (no name on the bottle) were found. The facility denied knowledge of how the resident obtained the bottle of esomeprazole. • On [DATE] at 11:29 A.M. the Unit Manager #508 notified an unidentified Intensive Care Unit nurse at the hospital of the empty Adipex bottle being found in Resident #11's room. • On [DATE] at 11:30 A.M. the Administrator and Regional Director of Operations #811 spoke with CNA #120. The employee reported that her medication and lighter were missing from her purse, but she could not remember if her purse was closed. The CNA #120 was suspended at approximately 11:35 A.M. • On [DATE] at 11:30 A.M. the Unit Managers #529 and #508 completed an observation of all four nursing stations to ensure that no personal items were kept there, unsecured. Employees on duty Registered Nurse (RN) #500, CNA #507, CNA #511, CNA #515, CNA #527, CNA #513, Licensed Practical Nurse (LPN) #540, CNA #541, CNA #560, CNA #604, CNA #620, and LPN #806 were instructed on where personal items were to be stored. Items must be stored on the units in the nurse aide rooms. • On [DATE] at 11:45 A.M. Regional Director of Operations #811 completed another environmental observation of Resident #11's room to ensure that no loose pills were in the room or that no items that could harm the resident were in the room. • On [DATE] at 11:54 A.M. the Unit Manager #508 spoke with CNA #120 and obtained a verbal statement. The employee reported she left her bag at the nurses' station and later noticed that her prescription pill bottle and lighter were missing. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	• On [DATE] at 12:00 P.M. the Management team including Unit Manager #508, Dietary Manager #517, Unit Manager #529, Director of Social Service #538, Minimum Data Set Nurse #543, Business Office Manager #556, Receptionist/Admin Assistant #591, and Admissions/Marketing #619 completed an environmental observation of 74 resident rooms to ensure there were no medications or items that could harm the residents. • On [DATE] at 12:00 P.M. Regional Nurse #704 began a medical record review that consisted of physician orders and notes, care plan, any behaviors, cognitive level and history with diagnosis for Resident #11. • On [DATE] at 12:30 P.M. Minimum Data Set (MDS) Nurse #543 reviewed Resident's #11's care plan. • On [DATE] at 1:30 P.M. Unit Managers #508 and #529 completed an observation of all residents in the facility (73) to ensure they displayed no change in condition. Observations were completed by 3:30 P.M. All resident progress notes were reviewed for condition changes not reported or addressed and all residents with a Brief Interview Mental Status (BIMS) score of eight to 15. In addition, Residents #3, #4, #5, #6, #8, #10, #12, #13, #14, #15, #16, #17, #18, #19, #22, #23, #24, #26, #27, #28, #29, #32, #34, #35, #37, #38, #39, #42, #43, #44, #45, #46, #48,#49, #50, #51, #52, #53, #54, #55, #58, #59, #61, #62, #63, #64, #65,#66, #67, #68, #69, #74, #76, #129, and #230 were interviewed related to care. • On [DATE] at 2:00 P.M. Regional Nurse #704 reviewed two additional resident records who were identified with a history of self-harm behaviors (Resident #16 and Resident #72) and one resident, (Resident #10) for drug seeking behaviors. No other residents were identified to meet the review criteria. • On [DATE] at 2:00 P.M. all (133) employees (2 activities, 1 Admissions director, 1 Business office, 1 Wellness Director, 20 LPNs, 7 RN'S, 60 CNA'S, 12 DIETARY, 9 Housekeepers, 7 Laundry, 1 HR/payroll, 1 PT, 2 PTAs, 1 OT, 4 OTA, 1 SLP, 2 Maintenance and 1 Medical Records) were educated on where they were to store their personal belongings, Residents' right to live in a safe environment, Abuse, Neglect and misappropriation policies. Education provided to all licensed nurses (20 LPNs and 7RNs), included medication storage and reporting changes in condition with emphasis on residents' behaviors and level of consciousness. Education was provided by the Administrator/designee in person or via phone. Any scheduled agency staff would be required to review the information in the Agency binder and sign that the information was reviewed before their scheduled shift. New hires would be educated during orientation by Human Resources Manager #512. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	• On [DATE] at 2:15 P.M. in person or via telephone education was provided by Unit Managers 3508 and #529 to (27) Nurses; staff were educated on the change in condition and documentation in the medical records policies. • On [DATE] at 2:25 P.M. the Administrator interviewed the nurse on duty, RN #500, related to resident's change in condition. RN #500 received education provided by the Administrator (the behavior unit) about documenting timely in the medical record including changes in condition. The education was provided verbally and in person. • On [DATE] at 2:30 P.M. the Administrator or designee began interviewing staff to determine if staff observed any changes in the resident's condition or were aware of any medications in her room. • On [DATE] at 2:30 P.M. Maintenance staff changed the lock to the designated area for staff to keep their belongings on Cherry Grove (the behavior unit) to a keypad. All 133 staff were provided with the code. • On [DATE] at 2:40 P.M. the Administrator initiated a self-reported incident (SRI) tracking number 258954 related to an allegation of neglect involving Resident #11. • On [DATE] at 5:05 P.M. an ad hoc Quality Assurance Performance Improvement meeting (QAPI) including Unit Manager #508, Unit Manager #529, Administrator, Director of Social Services #538, Receptionist #591, Regional Nurse #704, and Physician #812. QAPI was held to review the incident and the plan to prevent recurrence, Physician #812 attended via phone. The plan included interventions and system changes identified in this removal plan. • On [DATE] at 9:30 A.M. Maintenance Director #540 changed the gate to a half door. The mechanism to open the door was located on the inside of the door and not the outside which decreased access behind the nurses' station to like residents. • On [DATE] at 1:30 P.M. the Interdisciplinary Team (Unit Manager #508, Dietician #520, Unit Manager #529, Administrator # 537, Director of Social Services #538, MDS Nurse #543, Receptionist #591, and Regional Nurse #704) reviewed the incident in the facility's scheduled weekly risk meeting. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	• Beginning [DATE], the Administrator or designee would complete daily observations for five days then weekly for three weeks at varying times/shifts to verify that no employees' personal items were stored at the nurses' station or in areas accessible to residents. • Beginning [DATE] the DON or designee would complete an observation/assessment daily of each resident for changes in condition outside of their baseline and to ensure that changes in condition were documented in the resident's medical records. Reviews were to be completed daily for five days then weekly for four weeks. • Beginning [DATE], Ambassadors (Activity Director #506, Unit Manager #508, Maintenance #509, Human Resources Manager #512, Dietary Manager #517, Schedular #522, Unit Manager #529, Director of Social Services #538, Director of Maintenance #540, MDS Nurse #543, Activity Assistant #544, Business Office Manager #556, Receptionist #591, Medical Records #593, and Admissions/Marketing #619) or designee were to complete room checks at varying times/shifts to ensure no medications were stored in the residents' room and that the room does not have any unsafe items in them. Observations were to be conducted daily for five days in all resident rooms then weekly for four weeks. • Beginning [DATE], the Administrator or designee would complete an observation of the gate/door across the entrance to the nurses' station daily for five days, then weekly, for three weeks of the nursing station on Cherry Grove to ensure it was properly secured. • Beginning [DATE], the Administrator would review the audits weekly for four weeks to ensure they were completed, and any concerns would be addressed. Results of audits would be forwarded to the facility QAPI committee for further review and recommendations monthly for three months. The first review was completed [DATE]. Although the Immediate Jeopardy was removed on [DATE], the facility remains out of compliance at a Severity Level 2 (no actual harm with potential for more than minimum harm that is not Immediate Jeopardy) as the facility is in the process of implementing their corrective action plan and monitoring to ensure on-going compliance Findings include: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1.Review of the closed medical record for Resident #11 revealed the resident was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses including dementia, schizophrenia, borderline personality disorder, obsessive compulsive disorder, bipolar, anxiety, schizoaffective, auditory hallucination, major depressive disorder, dependent personality disorder, post-traumatic stress disorder, chronic kidney disease Stage 3, mild protein calorie malnutrition, drug use and viral hepatitis. Review of the medical record revealed behavior notes dated [DATE], [DATE], [DATE], and [DATE] indicating Resident #11 ambulated independently on the secured behavior unit. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #11 had severe cognitive impairment. The MDS revealed Resident #11 wandered one to three days during the assessment period. The wandering placed Resident #11 at significant risk of getting to a potentially dangerous place. The assessment revealed Resident #11 required supervision or touch assistance to ambulate. Review of a care plan dated [DATE] revealed Resident #11 had impaired cognitive process for daily decision making and was at risk for further decline in cognitive status. Interventions included to administer medications as ordered and observe for side effects (of medications). Review of a care plan dated [DATE] revealed Resident #11 would remain safe in the present environment, would adjust to the nursing home placement, would have opportunities for freedom of expression and movement in a safe environment, and would maintain her normal living patterns. Interventions included to allow Resident #11 to wander in acceptable areas and assist with ambulation as needed. Review of a care plan dated [DATE] revealed Resident #11 required secured unit placement related to a secondary diagnosis of elopement risk, bipolar disorder, dementia, psychosis, and schizophrenia. Interventions included to take the resident on walks or allow the resident to walk ad lib in the enclosed unit. Further review of the medical record revealed a general progress note dated [DATE] at 7:40 A.M. and authored by Registered Nurse (RN) #500 (created on [DATE] at 4:11 P.M. as a late entry) that revealed a CNA (unidentified) reported Resident #11 was not acting right. Resident #11 had a pulse of 104 beats per minute (bpm) (normal 60-90 bpm), a blood pressure was 129/89 millimeters of mercury (mmHg) (normal 120/80 mmHg) and oxygen saturation (the amount of oxygen in your blood with the normal level being greater than 92 percent) of 95 percent on room air. Resident #11 was alert with confusion. Resident #11 was unable to stand by herself and was unable to walk with staff (assistance). PA # 805 was notified and stated she would be in soon to see Resident #11. Review of a general progress note dated [DATE] at 10:11 A.M. and authored by RN #500 (created on [DATE] at 4:17 P.M. as a late entry) revealed a CNA (unidentified) reported Resident #11 only ate a couple bites of breakfast and was not able to feed herself. Resident #11's pulse was 102 bpm, blood pressure was 136/72 mmHg, and oxygen saturation was 93% on room air. Resident #11 was not able to sit up in a chair and the CNA put Resident #11 in bed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a general progress note dated [DATE] at 11:17 A.M. and authored by RN #500 (created on [DATE] at 4:31 P.M. as a late entry) revealed a CNA (unidentified) reported Resident #11 was short of breath and unable to stand or sit upright. Resident #11's pulse was 103 bpm, blood pressure was 159/108 mmHg, temperature of 99.5 degrees Fahrenheit (F), and oxygen saturation was 89 percent. PA #805 was called and stated she was in the building and on her way to evaluate Resident #11. Oxygen was placed on Resident #11 at two liters and oxygen saturation increased to 94 percent. New orders were received to send Resident #11 to the hospital for respiratory distress. 911 was called and an ambulance arrived within eight minutes to transport Resident #11 to the hospital. Resident #11 left the facility at 11:37 A.M. Further review of the medical record revealed a Situation, Background, Assessment, Recommendation (SBAR) Communication Form dated [DATE] and authored by RN #500 that revealed Resident #11 had abnormal vital signs, altered mental status, fever, functional decline, hypertension, and shortness of breath. The form indicated symptoms started on [DATE] and had gotten worse. Resident #11 had an altered level of consciousness, increased confusion or disorientation, memory loss, decreased mobility, more assistance needed for activities of daily living, and weakness. Resident #11 had labored/rapid breathing and shortness of breath, a resting pulse greater than 100 (bpm), distended abdomen, and Resident #11 reported no pain. There was no further documentation or assessment regarding the resident's labored/rapid breathing or her distended abdomen. Review of the transfer form dated [DATE] at 11:30 A.M. revealed Resident #11 usually ambulated independently and could follow simple instructions. Resident #11 was a full code (required life saving measures/CPR in the event of respiratory or cardiac arrest) and reported no pain. Review of a general progress note dated [DATE] at 3:35 P.M. and authored by RN #500 (created on [DATE] at 4:36 P.M. as a late entry) revealed Resident #11 had coded (required cardiopulmonary resuscitation) at the hospital and would be going to the intensive care unit (ICU) once all testing was completed. Review of emergency department documentation dated [DATE] at 4:19 P.M. revealed Resident #11 had no complaints. The Emergency Medical Service (EMS) stated Resident #11 had abdomen pain and (her) abdomen was distended. Resident #11 had a chest and abdominal computed tomography (CT) and had been on the monitor per nursing about 15 minutes prior to it being discovered that all of Resident #11's leads (heart monitor leads) were off and Resident #11 was unresponsive. Resident #11 did not have a pulse and cardiopulmonary resuscitation (CPR) was started. Nursing stated when Resident #11 was put back on the monitor the initial rhythm was bradycardic (heart rate less than 60 bpm) and in the range around 18 to 20 beats per minute. A resultant pulse was obtained, and Resident #11's pupils were eight (8)-millimeters (in diameter) and not responsive. The CT of the chest showed pneumonia and Resident #11 was ordered antibiotics. Resident #11's family was aware of the concern for hypoxic brain injury (lack of oxygen to the brain) and pneumonia. An addendum revealed the nursing facility staff reported Resident #11 pointed to her abdomen stating her belly hurt. When asked if abdomen hurt, Resident #11 stated yes and reported being short of breath. Resident #11 had generalized weakness along with hypoxia. Resident #11 was saturating at 88 percent at the nursing home and Resident #11 was placed on two liters and transported to the hospital. Resident #11 was able to get around on her own normally; however, the nursing staff were unable to get Resident #11 out of bed this morning. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Lawn Nursing Home	15028 Old Lincolnway East Dalton, OH 44618

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the hospital record revealed a toxicology report dated [DATE] at 4:23 P.M. that revealed Resident #11 was positive for amphetamines (stimulants). All other toxicology results were negative. Emergency Department (ED) documentation on [DATE] at 6:44 P.M. revealed Resident #11's family stated Resident #11 was sneaky with drugs at the nursing facility and wondered if there were any drugs in Resident #11's system. The family were told a drug screen could be ordered and the family would be notified of the results. The history and physical from the hospital dated [DATE] revealed EMS reported Resident #11 had abdominal pain and her abdomen was distended. Resident #11 had been transported to the ED for evaluation. Resident #11's family was notified by the nursing facility that patient was not her usual self. Upon arrival at the ED, Resident #11's temperature was 98.9 degrees F, heart rate was 88 bpm, blood pressure was 156/110 mmHg, and oxygen saturation was 94 % on two (2) liters (of oxygen) While on telemetry, Resident #11 was noted to become bradycardic into the 20's and unresponsive with subsequent pulseless electrical activity (PEA) for which CPR was initiated and Resident #11 was intubated. There was a question as to the length of downtime, with initial report of eight minutes of downtime; however, per review of telemetry monitor, downtime may have been as long as 15 minutes. The return of spontaneous circulation (ROSC) was reportedly achieved after five minutes. Resident #11 had decerebrate posturing (an involuntary, abnormal body posture characterized by rigid extension of the arms and legs, with toes pointed down, and the head and neck arched back. It is a strong indicator of severe brain damage) and non-purposeful movements. Resident #11 did open her eyes to sternal rub. Initially, pupils were reactive and brisk, but pupils were currently nonreactive. The urine drug screen was positive for amphetamines. A hospital progress note dated [DATE] revealed Resident #11's pulseless electrical activity arrest (PEA) arrest may be related to an overdose of Adipex. The history and physical from the hospital dated [DATE] revealed Resident #11's family requested to transition the resident to a Do Not Resuscitate Comfort Care (DNRCC) and to stop all interventions with terminal liberation from the ventilator (the process of withdrawing a patient from mechanical ventilation when they are no longer expected to recover). A hospital consultation note dated [DATE] revealed Resident #11 was a [AGE] year-old female with past medical history of mental illness including schizoaffective disorder, depression, anxiety, history of seizures, history of drug abuse, hypothyroidism, and hyperlipidemia. Resident #11 was not acting herself the morning of [DATE] and was running a fever. Resident #11 was transported to the emergency room. Resident #11 had bradycardia and thought to have pneumonia. Resident #11's urine was positive for amphetamines. Resident #11 developed PEA arrest resulting in anoxic brain injury, and at some point, had taken off her oxygen and cardiac monitor and required resuscitation with possibly five to eight minutes of downtime. Resident #11 was intubated and placed on hypothermic protocol and transferred to the ICU. Resident #11 was seen by neurology and had an abnormal electroencephalography (EEG), to record spontaneous electrical activity of the brain, with generalized periodic epileptiform discharges (abnormal electrical patterns). Resident #11 remained comatose, but did have a corneal and gag reflex. Resident #11's overall prognosis was significantly poor, and this was discussed with her family. Resident #11 was ultimately removed from the ventilator and transferred to the regular floor with palliative care to assist with end-of-life. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Hospital discharge documents dated [DATE] revealed Resident #11 was admitted [DATE] and discharged on [DATE] to the compassionate care center. Resident #11 presented to the emergency department from skilled nursing facility (SNF) due to a fever and not acting herself. In the ED, Resident #11 became bradycardic into the 20's and unresponsive with subsequent PEA and CPR was initiated. ROSC was achieved after five minutes. Resident #11 was found to have multifocal pneumonia and cystitis. An EEG showed generalized periodic epileptiform discharges and Resident #11 was started on Keppra. Resident #11 remained comatose despite an interruption of sedation. Resident #11's poor prognosis was discussed with Resident #11's family, and they decided on comfort care. Resident #11 was ultimately removed from the ventilator and transferred to the regular floor. Comfort medications were started, palliative care was consulted for discharge planning, and Resident #11 was discharged to the inpatient hospice unit. Review of a self-reported incident (SRI) Tracking Number 258954, created on [DATE] at 1:43 P.M. revealed a resident had a change in condition with an empty medication bottle found in the resident's room. On [DATE] CNA #120 called the Administrator to alert her that she was missing a prescription medication bottle from her purse and asked if the staff would look for it on the unit she was assigned [DATE]. Due to the call, the Administrator and nursing directors searched the behavior unit CNA #120 was working on during her [DATE] shift and searched all resident rooms. The empty medication bottle was found in the room of Resident #11. According to CNA #120, the bottle should have had 20 pills remaining in the bottle. The Administrator contacted the hospital where Resident #11 was located and alerted them Resident #11 could possibly have taken this medication, causing her condition change. The facility also alerted the guardian and physician. CNA #120 was suspended pending investigation. The SRI included Resident 311 had a history of psychiatric behaviors and resided on the behavioral unit (Cherry Grove) within the facility. Review of the facility investigation dated [DATE] revealed the following statements: Former Assistant Director of Nursing (ADON) #806 shared a nurse asked for assistance. Resident #11 was lying back in a wheelchair. PA #805 was assessing Resident #11. Resident #11's oxygen saturation was 88 percent on room air. ADON #806 applied oxygen at two liters to Resident #11. Resident #11's oxygen saturation increased to 97 percent and Resident #11 was sent to the hospital for evaluation. A statement by former CNA #544 revealed on [DATE] around 8:30 A.M. she said good morning to Resident #11. Resident #11 seemed different, and CNA #511 stated nursing staff was monitoring Resident #11. Resident #11 seemed weak and was not ambulating. Resident #11 was sent to the hospital. A statement by CNA #511 revealed Resident #11 was not acting right. The nurse checked Resident #11 and requested that staff monitor Resident #11. Resident #11 continued to fall asleep on and off. A statement by Unit Manager #508 revealed CNA #120 reported prescription medication and a lighter were missing from CNA #120's purse. An empty (prescription) bottle and lighter were found in Resident #11's room. Review of Resident #11's death certificate with a date of death [DATE] revealed the cause of death was anoxic brain injury after cardiac arrest and pneumonia. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 12:34 P.M., with CNA #511 revealed CNA #120 reported Resident #11 was up (moving around) on [DATE] around 5:30 A.M. CNA #511 went into Resident #11's room around 6:00 A.M. and Resident #11 was not standing properly. CNA #511 notified RN #500. Resident #11's vitals were okay. Resident #11 was brought into the common area so Resident #11 could be watched because something was not right. CNA #511 stated the nurse had to help get Resident #11 to the toilet and then about 45 minutes later, Resident #11 was slurring her words and her blood pressure, and heart rate were up. Resident #11 was sent to the hospital. CNA #511 stated she did not see a prescription bottle in Resident #11's room. Further interview with CNA #511 revealed CNA #120 reported, the next day ([DATE]), that her prescribed medication was missing. CNA #511 reported the prescription bottle was found in Resident #11's room. Interview on [DATE] at 5:43 P.M. with CNA #120 revealed she was an as needed employee and worked until 6:00 A.M. on [DATE]. CNA #120 stated she took Adipex, a prescribed medication for weight loss every morning at 5:00 A.M. before doing the last checks on the residents. CNA #120 stated she took the medication the morning of [DATE] and then put the bottle of pills back in the zipper part of her purse. CNA #120 stated she came out of a room near Resident #11's room and saw Resident #11 walking around. Further interview revealed she worked again on [DATE] beginning at 2:00 A.M. and saw Resident #11 had been transferred to the hospital for mental status change. While at work on [DATE], a resident asked to smoke and CNA #120 looked in her purse for a lighter, but she could not find the lighter and had to get a lighter from someone else. CNA #120 shared that on [DATE] around 5:00 A.M. several call lights were on so she did not take her medication at that time, and she went home and took a short nap after her shift. When she woke up, she looked in her purse for her weight loss medication but could not find it. CNA #120 called the facility on [DATE] between 11:00 A.M. to 12:00 P.M. and talked to RN #508 to see if anyone had found her prescription bottle but nothing had been reported at that time. RN #508 called about an hour later and asked if CNA #120 would write a statement about her medication. CNA #120 stated she would after she got off work at another place of employment. CNA #120 stated RN #508 and the Administrator called her back around 4:30 P.M. or 5:00 P.M. and the Administrator told her she was terminated because she had left a controlled medication unsupervised and the empty prescription bottle was found in a drawer in Resident #11's room. CNA #120 stated her purse was on the desk behind the nurse's station, next to the printer and there was a baby type gate that was hard to close, to keep residents from going behind the nurse's station. CNA #120 stated she was scheduled to work on another unit that night but had been moved to the behavioral unit due to a call off. CNA #120 shared there was nowhere to leave her belongings on the behavioral unit. On the unit there was a locked door indicating a medication room, and another locked door that had a sign that stated not to enter unless they were getting something for a resident. CNA #120 verified she did not have the codes to the doors, and she would not have asked for the code to the medication room because she was not a nurse. CNA #120 shared that she was the only staff member on the behavioral unit that night and if she cal[TRUNCATED]

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, investigation review, interview and policy review the facility failed to ensure medications were necessary prior to administration, failed to monitor the efficacy of psychotropic medications and failed to ensure residents were comprehensively assessed for side effects of psychotropic medications. This affected two residents (Resident #16, and #60) of five residents reviewed for psychotropic medications. The facility census was 77. Findings include: 1. Review of the medical record revealed Resident #60 was admitted on [DATE] with diagnoses that included major depressive disorder, dementia, hypertension, hypothyroidism, type 2 diabetes, malignant neoplasm of pituitary gland, dysphagia, anxiety, and anxiety disorder. The five-day Minimum Data Set (MDS) dated [DATE] revealed Resident #60 had severe cognitive impairment. The MDS also revealed Resident #60 had physical and verbal behaviors one to three days and other behaviors four to six days during the assessment period. A plan of care dated 03/27/25 revealed Resident #60 had the potential for mood and behavioral changes. Interventions included to administer medications as ordered and attempt non-pharmacological interventions such as one-on-one, change in position or scenery, bargaining, offering food and or fluids, redirection, activity of choice, toileting, and diversional activities. A physician order dated 05/05/25 at 7:13 P.M. revealed Resident #60 was ordered 0.5 milliliter of Ativan (antianxiety) two milligram/one milliliter to be injected intramuscularly every eight hours as needed for agitation/aggression for 14 days. Review of the medical record revealed no documentation of Resident #60 with behaviors on 05/05/25 or 05/06/25 and no documentation of Ativan being administered as ordered. The facility investigation contained a statement dated 05/06/25 by Certified Nursing Assistant (CNA) #589 that Licensed Practical Nurse (LPN) #815 reported administering Ativan to Resident #60. An interview on 05/07/25 at 12:47 P.M. CNA #589 revealed Resident #60 went to sleep about 20 minutes after LPN #815 stated she had medicated Resident #60. An interview on 05/07/25 at 1:38 P.M. with the Director of Nursing (DON) revealed the facility believed LPN #815 administered Ativan to Resident #60 sometime during the night of 05/05/25 and the early morning of 05/06/25. The DON verified there was no documentation in Resident #60's medical record of behaviors and of Ativan being administered to Resident #60. Review of the facility policy titled Use of Psychotropic Medications dated 03/01/25 revealed medication administered would be done so with adequate indication for use and the effects of the medication would be documented in the residents' medical record. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #16 revealed an admission date of 01/15/19. Diagnoses included depression, hypertension, diabetes, schizoaffective disorder, insomnia, sleep apnea and anxiety. Review of the Abnormal Involuntary Movement Scale (AIMS) evaluation history revealed Resident #16 had not been assessed since 08/27/24. This is a standardized tool used to assess abnormal involuntary movements , particularly movements associated with tardive dyskinesia (TD) which is a movement disorder that can be a side effect of certain medications, especially antipsychotic medications. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 was cognitively intact. He displayed behaviors including but not limited to hitting or scratching himself, throwing or smearing food or bodily wastes and screaming or other disruptive sounds. Review of the physician's orders for April 2025 revealed an order for Remeron (an antidepressant medication) 15 milligrams (mg) at bedtime for depression, Risperdal (an antipsychotic medication that has a potential side effect of TD) four (4) mg two times per day (BID) for schizoaffective disorder and Trazodone (an antidepressant medication) 150 mg at bedtime for insomnia. Review of the care plan dated 04/08/25 revealed Resident #16 had an alteration in behavior which included threatening staff and peers and physical attacks. Interventions included documenting behavior type, duration and precipitating events, intervening to protect others and informing the physician of increased behaviors. Interview on 05/01/25 at 9:26 A.M. with the Director of Nursing (DON) confirmed behavioral issues would be documented in the nursing progress notes. He confirmed there was not consistent evidence Resident #16's behaviors were being monitored to ensure efficacy of his medications. Interview on 05/01/25 at 1:24 P.M. with the DON confirmed Resident #16's AIMS had not been updated since 08/27/24 and should be done quarterly. Review of the facility policy titled Use of Psychotropic Medications dated 03/01/25 revealed medication administered would be done so with adequate indication for use and the effects of the medication would be documented in the residents' medical record. This deficiency represents non-compliance investigated under Complaint Number OH00165430.

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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** Based on record review, interview, and review of the facility policy, the facility failed to ensure care plans were reviewed and revised for activities. This affected two residents (Resident #10 and #16) of three residents reviewed. The facility census was 77. Findings include: 1. Record review for Resident #10 revealed an admission date of 03/15/19. Diagnosis included anxiety disorder. Review of the care plan for Resident #10 last updated 01/19/23 revealed Resident #10 needed encouragement to participate in activities of interest. The resident was dependent on staff for activities, cognitive stimulation, social interaction due to: current health conditions. Resident #10 attended activities on, and off her unit. Activity interests included cards/games, crafts/arts, exercise/sports, music, reading/writing, spiritual/religious, trips/shopping, TV/movies, socials/parties, resident council, coloring, puzzle books, cooking, and pets. Resident #10 worked at a bank, and she was also a computer programmer. Review of the Annual Minimum Data Set (MDS) dated [DATE] for Resident #10 revealed Resident #10 was cognitively intact. Resident #10 had impairment on one side of the upper and lower extremities, used a motorized wheelchair for mobility and required supervision or touch assistance with chair/bed to chair transfers. Books and newspapers were somewhat important, music was very important, and doing favorite activities was very important. Interview on 04/29/25 at 2:28 P.M. with Resident #10 revealed the facility had activities but the activities were not challenging, they did the same thing all the time over and over. Resident #10 shared she loved to go for drives, look at the scenery but she does not get to do that. Resident #10 shared she doesn't do many activities anymore because it's too much of the same thing. Interview on 04/29/25 at 4:37 P.M. with Activities Director #506 revealed there were no activities notes placed in any of the residents medical records including documentation of changes in participation or changes in likes or dislikes with activities. Activities Director #506 confirmed Resident #10's care plan had not been updated since January of 2023 to reflect new likes that may be more challenging for Resident #10 or dislikes and interventions to provide resident's likes. 2. Review of the medical record for Resident #16 revealed an admission date of 01/15/19. Diagnoses included depression, hypertension, diabetes, schizoaffective disorder, insomnia, sleep apnea and anxiety. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 was cognitively intact. He required partial to moderate assistance for showering and supervision for eating, toileting, dressing and personal hygiene. It was somewhat important for him to do his favorite activities and very important to go outside when the weather was good. (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 the care plan dated 10/18/22 revealed Resident #16 was dependent on staff for activities, cognitive stimulation and social interaction. He enjoyed pet visits, outings, going outside and fishing. Interventions included encouragement to participate in group activities, pet visits and reminders when activities were beginning. Interview on 05/01/25 at 1:55 P.M. with AD #506 revealed she updated care plans when there were changes and at scheduled care plan conferences. She confirmed Resident #16's care plan regarding activities was last updated on 10/18/22 and she could provide no evidence his care plan had been updated since that date. Review of the facility policy titled, Activities revised 06/01/24 revealed it is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan and preferences. Each resident's interest and needs will be assessed on a routine basis. The assessment shall include but not limited to: Activity assessment to include resident's interest, preferences, and needed adaptations. Activities will be designed with the intent to enhance a resident's sense of well-being, belonging, and usefulness; create opportunities for each resident to have a meaningful life and reflect choices of the resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of the medical record revealed Resident #70 was admitted on [DATE] with diagnoses that included lymphedema, autistic disorder, attention deficit hyperactive disorder, and expressive language disorder. A general progress note dated 10/24/24 at 4:52 P.M. revealed Resident #70 was alert and oriented times one and was primarily nonverbal. A general progress note dated 10/24/24 at 10:27 P.M. revealed four staff attempted to do a skin sweep on Resident #70. Resident #70 was impossible to turn. Resident #70's heart rate elevated to 100 to 130 beats per minute when attempting to move and Resident #70 became short of breath. A physician order dated 10/25/24 revealed Resident #70 was to be showered on day shift on Mondays and Thursdays. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #70 was cognitively intact and was dependent for activities of daily living. A nutrition/dietary note dated 03/04/25 at 1:33 P.M. revealed Resident #70's most recent weight was 544 pounds. Review of the shower documentation for the last 30 days revealed Resident #70 received a shower on 03/10/25 and 04/07/25. A physician order dated 04/01/25 revealed Resident #70 was to be showered on day shift on Mondays, Wednesdays, and Fridays. A general progress note dated 04/07/25 at 12:50 P.M. revealed Resident #70 complained of pain while being moved to bariatric shower bed. Resident #70's right leg had to be lifted around the doorway and Resident #70's lower limbs had to be hyperextended to maneuver Resident #70 in the doorways. Resident #70's anterior body could only be reached during the shower. The posterior portion of Resident #70's body was only accessible while Resident #70 was in bed. Doctor #500 was notified of the difficulty with transferring and showering Resident #70. A physician order dated 04/17/25 at 1:23 P.M. revealed Resident #70 was to be showered on day shift on Thursdays. An interview on 05/01/25 at 7:28 A.M. Licensed Practical Nurse (LPN) #540 verified multiple staff were needed to transfer Resident #70 to the shower bed. The doctor had ordered showers three times a week to help prevent skin breakdown. Resident #70 had shearing due to transferring to the shower bed so orders were changed to shower Resident #70 once a week. LPN #540 also verified the shower bed did not fit into the shower room correctly, and Resident #70 could not be turned on the shower bed for his backside to be washed. The LPN verified the resident did not receive his showers as ordered. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Activities of Daily Living revised 10/01/22 included care and services will be provided for bathing, dressing, grooming, and toileting. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The facility will maintain individual objectives of the care plan and periodic review and evaluation. Based on observation, interview, record review and review of the facility policy the facility failed to ensure residents were assisted with care needs to maintain adequate grooming and hygiene. This affected two (Residents #61 and #70) of three residents reviewed for activities of daily living. The facility census was 77. Findings include: 1. Record review for Resident #61 revealed an admission date of 09/26/24. Diagnosis included intracranial injury with loss of consciousness, unspecified psychosis, Alzheimer's disease, and need for assistance with personal care. Review of the care plan revised 09/26/24 revealed Resident #61 had impaired cognitive process for daily decision making. At risk for further decline in cognitive status. Interventions included to anticipate needs to keep resident clean, dry and comfortable every shift. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #61 was cognitively intact. Resident #61 was occasionally incontinent of bowel and bladder, had no impairment of the upper or lower extremities, required supervision or touching assistants with personal hygiene, toileting hygiene and ambulation. Behavioral symptoms not directed towards others occurred one to three days. Review of the medical record revealed no evidence of a care plan related to behaviors that affected resident care. Record review revealed on 04/26/25 Resident #61 moved from a semi-private room to a private room. Observation on 04/29/25 at 3:00 P.M. revealed Resident #61 was lying in bed. The room had an odor of stool. The sheets Resident #61 was lying on had multiple smears of stool with droplets of blood. The floor in front of the bed, leading to the bathroom, had multiple smears of stool with droplets of blood. Next to the bed on the floor was a clear disposable bag with stool on it. Next to the bag was a soiled brief filled with stool lying on the floor. The chair next to the bed had a large smear of stool on the seat. In the bathroom, the toilet bowl had stool smeared on the seat, outside the bowl, on the floor and in the sink. The floor and sink had multiple droplets of blood. Continued observation revealed Resident #61's bilateral arms had multiple circular open areas, the upper portion of her forehead also had multiple open areas, her hands had large plaques and open areas. Her nails, all 10 were fully impacted with a dark brown substance. Observation and interview on 04/29/25 at 3:02 P.M. with Certified Nursing Assistant (CNA) #615 confirmed the observation of Resident #61 and her room condition. CNA #615 shared Resident #61 was a picker, that was what caused the blood spots throughout the room and bathroom and Resident #61 changed herself when she went to the bathroom. CNA #615 confirmed Resident #61 fed herself meals and was last checked on at 12:30 P.M. to ensure her care needs were met. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Lawn Nursing Home	15028 Old Lincolnway East Dalton, OH 44618

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/30/25 at 1:56 P.M. revealed Resident #61 was lying in bed. The room had an odor of stool. There was a large smear of stool in front of the bed, multiple droplets of blood covering the sheets, pillow case, bedroom and bathroom floor. The toilet bowl inside and out, including the rim and seat, wall and floor had large smears of stool, the sink had droplets of blood and stool. Resident #61's nails, all 10 were impacted with a dark substance. Observation and interview on 04/30/25 at 1:58 P.M. with CNA #588 confirmed the condition of the room and Resident #61. CNA #588 shared Resident #61 went to the bathroom by herself. CNA #588 revealed Resident #61 was recently transferred from the 100 hall and she got nail care on Monday and Thursday, her shower days. Interview on 04/30/25 at 2:12 P.M. with Licensed Practical Nurse (LPN) #901 revealed Resident #61 was a picker, that was why she had so many sores on her hands, arms and forehead. LPN #901 shared Resident #61 moved over here because she had a roommate and she was getting stool/blood from picking everywhere. LPN #901 stated Resident #61 received a skin treatment daily, Chlorhexidine, she gets wiped down with it, but nothing is done for behaviors with her bowels and smearing stool. Interview on 04/30/25 at 2:20 P.M. with Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) #704 revealed Resident #61 recently moved to a different hall due to her roommate getting upset about the stool and blood. The DON confirmed Resident #61 did not have an individualized care plan for the behavior of picking her skin causing blood drops throughout the room and the behavior of smearing stool throughout the room. RDCS #704 revealed she would have housekeeping clean more frequently, more frequent hand hygiene and check and change more frequently as part of her care plan. Interview on 04/30/25 at 2:30 P.M. with Resident #179 confirmed she was Resident #61's roommate prior to her changing rooms. Resident #179 verified Resident #61 was her roommate but she wasn't very clean and got stool everywhere and picked her skin and got blood everywhere. Resident #179 also reported Resident #61 got into her drawers so she was placed in a private room. Observation on 04/30/25 at 2:34 P.M. with LPN #901 confirmed Resident #61's fingernails were still not cleaned, they were long and continued to be embedded with the dark brown substance.

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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** 2. Record review for Resident #10 revealed an admission date of 03/15/19. Diagnosis included anxiety disorder. Review of the care plan for Resident #10 last updated 01/19/23 revealed Resident #10 needed encouragement to participate in activities of interest. Dependent on staff for activities, cognitive stimulation, social interaction due to: current health conditions. Resident #10 attended activities on, and off her unit. Activity interests included cards/games, crafts/arts, exercise/sports, music, reading/writing, social smoking, spiritual/religious, trips/shopping, TV/movies, socials/parties, resident council, coloring, puzzle books, cooking, and pets. Resident #10 worked at a bank, and she was also a computer programmer. Review of the Annual MDS dated [DATE] for Resident #10 revealed Resident #10 was cognitively intact. Resident #10 had impairment on one side of the upper and lower extremities, used a motorized wheelchair for mobility and required supervision or touch assistants with chair/bed to chair transfers. Books and newspapers were somewhat important, music was very important, and doing favorite activities were very important. Review of the activity calendar for 04/29/25 revealed at 10:30 A.M. was game - scrabble, at 2:00 P.M. was game hi, low and at 3:30 P.M. was game euchre. Observation on 04/29/25 at 2:10 P.M. revealed there were no activities occurring for residents in the activity room. Interview on 04/29/25 at 2:28 P.M. with Resident #10 revealed the facility had activities but the activities were not challenging, they did the same thing all the time over and over. Resident #10 revealed she loved to go for drives, look at the scenery but she does not get to do that. Resident #10 shared she doesn't do many activities as they are all the same. Observation on 04/29/25 at 3:20 P.M. of the activities room revealed there were two residents in the room. The Activity Director had a deck of cards flipping a card for each resident and the resident would either say higher or lower than another card would be flipped. The game proceeded until the deck of cards was gone. Neither resident was smiling and there were no other residents present. Activities Director #506 confirmed this was the activity provided for the day. Interview on 04/29/25 at 4:37 P.M. with Activities Director #506 revealed there were no activities notes placed in any of the residents medical records including documentation of changes in participation or changes in likes or dislikes with activities. Activities Director #506 revealed she has not done that for years. Activities Director #506 revealed most residents who are one on one only like to watch TV or color and revealed she was the only activities person for 77 residents. Activities Director #506 revealed Resident #10 has not done crafts in a long time; she does not participate in activities as much as she use to. Activities Director #506 revealed she takes the residents that can walk on the outings. There was only one spot available on the bus for a wheelchair, electric wheelchairs could not go on outings unless they went in a regular chair but that would only be one person in a wheelchair that could go. Activities Director #506 confirmed the 10:30 A.M. activity was canceled, the 2:00 P.M. activity was moved to 3:15 P.M. and the 3:30 P.M. activity was canceled. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Activities revised 06/01/24 revealed it is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan and preferences. Facility sponsored group, individual and independent activities will be designed to meet the interest of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will be designed with the intent to enhance a resident's sense of well-being, belonging, and usefulness; create opportunities for each resident to have a meaningful life and reflect choices of the resident. Based on observation, record review, interview and policy review, the facility failed to ensure activities were offered to meet the individualized needs of residents. This affected two residents (Residents #10 and #16) of three reviewed for activities. The census was 77. Findings include: 1. Review of the medical record for Resident #16 revealed an admission date of 01/15/19. Diagnoses included depression, hypertension, diabetes, schizoaffective disorder, insomnia, sleep apnea and anxiety. Review of the care plan dated 10/18/22 revealed Resident #16 was dependent on staff for activities, cognitive stimulation and social interaction. He enjoyed pet visits, outings, going outside and fishing. Interventions included encouragement to participate in group activities, pet visits and reminders when activities were beginning. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 was cognitively intact. He required partial to moderate assistance for showering and supervision for eating, toileting, dressing and personal hygiene. It was somewhat important for him to do his favorite activities and very important to go outside when the weather was good. Interview on 04/29/25 at 4:37 P.M. with Activities Recreation Director (AD) #506 revealed she did not do one on one activities with residents. She confirmed the facility van could only accommodate one wheelchair at a time and outings were one to two times per month. She revealed she kept track of resident attendance in activities by writing resident names on a piece of paper. Interview on 05/01/25 at 1:55 P.M. with AD #506 revealed she did the shopping for Resident #16. She revealed most activities he participated in were food related but could provide no evidence Resident #16 had participated in any activity. She revealed they had gone to the park in the past, but confirmed no outside activities had occurred in the past three months and when the facility had an admission, the facility was not able to offer facility outings.

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F 0684 Level of Harm - 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** Based on closed medical record review, policy review and interview, the facility failed to timely identify and obtain medical intervention for Resident #77 following an acute change in condition. Actual harm occurred when the facility failed to provide timely intervention for Resident #77 following an acute change in condition. On 02/20/25 Resident #77, who had a physician order for comfort measures in the event of cardiac or respiratory arrest, was noted to have emesis, decreased fluid intake and adventitious lung sounds with no evidence the physician or family were notified or effective interventions initiated. On 02/21/25 at 1:07 A.M. Resident #77 developed a labored breathing with an increased respiratory rate of 39 breaths per minute (normal 16-20 breaths per minute), an oxygen saturation of 60% (normal 95 to 100%) while on oxygen, no obtainable blood pressure and a heart rate of 39 (normal between 60 and 100) beats per minute without medical practitioner notification for further intervention or additional intervention being provided. Resident #77 was discovered without vital signs at 6:15 A.M. This affected one resident (#77) of three residents reviewed for change in condition. The facility census was 77. Findings include: Review of Resident #77's closed medical record revealed an admission date of 01/06/25 and a discharge date of 02/21/25. Resident #77 had diagnoses including dysphagia, hypertension, and the need for assistance with personal care. Review of the care plan dated 01/16/25 revealed Resident #77 required (staff) assistance with activities of daily living (ADL). Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #77 had moderate cognitive impairment. The assessment revealed the resident used a walker for mobility, had no impairment to the upper or lower extremities and required supervision or touching assistance with eating. The resident did not have a condition or chronic disease that may result in a life expectancy of less than six months during the assessment period. Review of the physician's orders for Resident #77 revealed on 02/14/25 an order was received for Resident #77 to increase fluids every shift for dehydration. Review of the Skilled Summary/Services Provided dated 02/18/25 at 10:38 A.M. completed by Director of Nursing (DON) revealed to monitor fluid intake to prevent dehydration. Review of the medical record, including the Medication Administration Record (MAR), revealed the amount of fluids that Resident #77 was encouraged to consume was not documented. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the Health Status Note dated 02/20/25 at 9:05 A.M. completed by Registered Nurse (RN) #508 for Resident #77 revealed, This nurse notified in report that resident had an emesis two to three times on night shift, day shift aide reporting that resident has had one further emesis this shift. Further documentation included Resident #77 had a slight moist cough noted. The head of the bed was elevated to prevent aspiration from emesis. Review of physician orders for Resident #77 completed by RN #508 dated 02/20/25 at 9:30 A.M. included implementing oxygen at two liters via nasal cannula (NC) to keep oxygen saturation above 90% as needed, normal saline (ns) intravenous (IV) solution 0.9% administer 80 milliliters (ml) an hour (hr) every shift for hydration for one day 1000 ml only timed at 6:00 A.M. A second bag at 100 cc/hour was ordered after this bag had infused. Review of the Skilled Summary/Services Provided (progress note) dated 02/20/25 at 12:16 P.M. completed by the DON revealed to monitor fluid intake to prevent dehydration, respiratory regular rhythm, within normal limit lung sounds, normal breathing. Review of the medical record including the Medication Administration Record (MAR) revealed the amount of fluids for Resident #77 encouraged/consumed was not documented. Review of the General Progress note for Resident #77 dated 02/20/25 at 5:36 P.M. completed by RN #711 revealed staff reported the resident had two more emesis, unable to keep anything down. Certified Nurse Practitioner (CNP) #705 was notified. It was also reported Resident 377 had crackles throughout lung fields at this time and the resident may have aspirated. New orders were received or the anti-emetic medication Zofran four milligrams (mg) now, clear liquid diet for 24 hours, and when bag of 0.9% NS at 100 cc/hr was complete to change to D5% in 0.45% at 60 cc/hr. This nurse to call resident's daughter and ask if she wished for the resident to be kept comfortable, have a STAT (immediate) chest x-ray, or want her sent out (to the emergency room). The resident's daughter requested a chest x-ray be done at the facility. CNP #705 ordered STAT x-ray to rule out aspiration. Review of the General Progress note dated 02/21/25 at 1:07 A.M. completed by Licensed Practical Nurse (LP) #535 revealed results received from STAT chest x-ray performed. IMPRESSION: Bilateral pulmonary infiltrates are seen, cardiomegaly. The bones are osteopenic. Spondylotic changes. Results sent to physician (via fax) for review and placed in physician binder. Awaiting any new orders. Current vitals are as follows: respiratory rate 39 and labored, 97.7 temperature, 60% oxygen saturation on two liter (L) of oxygen and bumped up (the oxygen) to 3.5 L via nasal cannula. No blood pressure was able to be obtained, heart rate 39. Resident was still receiving IV fluids, site was clean/dry and intact. Resident resting comfortably at this time. At 1:13 A.M. LPN #535 documented the resident had voided and had a large loose bowel movement. No further emesis at this time. Record review revealed no documentation was completed on 02/21/25 between 1:13 A.M. and 6:02 A.M. Review of the Health Status note for Resident #77 dated 02/21/25 at 6:02 A.M. completed by LPN #610 revealed upon entering resident room, resident appears absent of vital signs, no pulse, no blood pressure, no respiration. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview on 04/30/25 at 12:01 P.M. with the DON revealed with any change in a resident's condition including abnormal vital signs, the nurse was expected to immediately contact the physician and update the family/POA. The DON reviewed Resident #77's medical record and confirmed the nurse did not call to notify Resident #77's family/POA or physician following the assessment on 02/21/25 at 1:07 A.M. and confirmed the nurse should have. The DON also confirmed the nurses were not monitoring/documenting each shift, Resident #77's fluid intake but should have to ensure hydration. Interview on 04/30/25 at 12:51 P.M. with Resident #77's daughter/Power of Attorney confirmed the facility did not notify her of any change in her mother's condition on 02/21/25 until the notification in the morning that her mother passed. Interview on 05/01/25 at 8:31 A.M. with CNP #705 confirmed she ordered a stat chest x-ray on 02/20/25 for Resident #77 and she would have expected to be updated as soon as the facility received the stat chest x-ray results. CNP #705 confirmed she did not get called about the results. CNP #705 also confirmed she was not notified of Resident #77's assessment documented on 02/21/25 at 1:07 A.M. and she would have expected the nurse to call her right away with that assessment. She would have instructed the nurse to A. Contact the family immediately and B. Called 911 immediately unless the family did not want that but ask them immediately Interview on 05/01/25 at 10:30 A.M. with Resident #77's Primary Care Physician (PCP) #712 revealed, if he had ordered an x-ray stat, he would expect to be notified as soon as the results were received but he wasn't called, the results were faxed to the office. PCP #712 also confirmed he was not notified of Resident #77's change in condition on 02/21/25 at 1:07 A.M. and revealed he would have expected for him or CNP #705 and the family to be immediately notified and he would have sent Resident #77 to the hospital. PCP #712 revealed any change in resident conditions, he would expect to be notified. During the onsite survey, three attempts each were made to contact LPN #535 and #610 via phone. No return calls were provided by either nurse. Review of the facility policy titled, Notification of Changes revised 09/30/22 revealed the purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Circumstances requiring notification include: Significant change in a resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status including life-threatening conditions; and circumstances that require a need to alter treatment. This deficiency represent non-compliance investigated under Complaint Number OH00164999 and OH00164534.

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F 0686 Level of Harm - 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** Based on observation, record review, interview, and policy review, the facility failed to develop and implement a comprehensive, effective and individualized resident centered pressure ulcer prevention and treatment program for Resident #46, Resident #48 and Resident #58 to prevent the development of pressure ulcers, to ensure treatments were completed as ordered and to promote timely and optimal healing of pressure ulcers. Actual Harm occurred on 05/06/25 when Resident #48, who was dependent on staff for bed mobility and toileting, and always incontinent of bowel and bladder, was assessed to have a dark purple, non-blanchable suspected deep tissue injury pressure ulcer (a localized area of discolored, intact skin or a blood-filled blister, often purple or maroon, due to damage of underlying soft tissue, typically from pressure or shear) to the right posterior thigh due to the resident's incontinence and use of incontinence briefs that were too small/tight for the resident when fastened. Actual Harm occurred on 03/14/25 when Resident #46, who was cognitively impaired, was assessed to have an unstageable pressure ulcer (a type of pressure ulcer where the base of the wound is obscured by slough or eschar, making it impossible to determine the true depth of the injury and thus the stage) to the right buttock without evidence of comprehensive, individualized and effective interventions being in place to prevent the development of the pressure ulcer. This affected three residents (#46, #48 and #58) of three residents reviewed for pressure ulcers. The facility identified four residents with pressure ulcers. Findings include: 1.Record review for Resident #48 revealed an admission date of 06/21/24 with diagnoses including morbid severe obesity and irritable bowel syndrome. Review of the weight for Resident #48 revealed a weigh range over the previous six months (October 2024 to April 2025) from 511.6 to 533.6 pounds with a height of 68 inches (five foot eight inches). Review of the care plan revised 02/10/25 for Resident #48 revealed the resident experienced bowel and bladder incontinence. Interventions included to provide incontinence care every two hours and as needed. Review of the care plan dated 03/19/25 revealed Resident #48 had an actual area of skin impairment related to incontinence associated dermatitis (IAD) to the right inner posterior thigh. Interventions included to initiate wound treatment, continue treatment as ordered, observe for clinical changes such as infection and or worsening of wound, and see at risk for skin breakdown. Review of the physician orders for Resident #48 revealed an order dated 03/20/25 for (incontinence) brief to remain unfastened when in bed every shift. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #48 was always incontinent of bowel and bladder, used a wheelchair for mobility and was dependent (on staff) for bed mobility and toileting hygiene. This assessment revealed Resident #48 had no pressure injuries, was at risk for pressure injuries, and had moisture associated skin damage. Review of the care plan revised 04/04/25 revealed Resident #48 had potential for alteration in skin integrity required protective/preventative skin care maintenance related to bladder incontinence, bowel incontinence, decreased mobility, and history of previous skin breakdown. Interventions included brief to remain unfastened when in bed dated 03/20/25 and inspect for any reddened areas during daily care. Additional interventions included assist in cleansing the peri area and apply house barrier protectant after each incontinence episode, encourage to turn and reposition every two hours, encourage to float heels, and pressure reducing mattress to bed and cushion to chair. Review of the physician orders dated 04/16/25 revealed a treatment for the IAD to the right inner posterior thigh which included to cleanse with normal saline, apply MediHoney and calcium alginate, cover with border foam daily and as needed. Record review of the Treatment Administration Record (TAR) for May 2025 for Resident #48 revealed the order for the (incontinence) brief to remain unfastened when in bed was signed each day by a nurse confirming the order was completed. Observation on 05/06/25 at 3:53 P.M. of incontinence care provided by Certified Nursing Assistant (CNA) #548 and #620 revealed Resident #48 was lying in bed wearing a fastened disposable incontinence brief that fit tightly in the resident's legs and groin areas. Multiple wounds to the right inner and posterior thigh were noted. There were multiple indentations from the brief going over the wounds, lining up with the wounds and surrounding the wounds and Resident #48 stated the wounds were painful. One small dressing was stuck to the left thigh where no wound was present. CNA #548 stated that it was the dressing that was originally on one of the wounds on the right thigh that had fallen off. CNA #548 and #620 stated Resident #48's briefs were too small causing the wounds and Resident #48 was provided the largest brief that the facility had for bariatric residents. Both CNAs shared residents were not measured for brief sizes but the CNAs would just look at the resident and guess the size of brief the resident needed. CNA #620 confirmed the facility did not provide larger briefs than the bariatric size that Resident #48 used but she stated she worked at other facilities and knew there were larger brief sizes available. Per CNA #548, when she worked with Resident #48 she would put Aquaphor salve on the wounds after incontinence care. CNA #548 and #620 revealed the wounds on Resident #48's thigh had been there for months, nearly as long as Resident #48 had been at the facility when she started wearing the facility briefs, The CNAs stated the wounds would improve and then decline. CNA #548 shared Resident #48 never refused incontinence care and confirmed she worked full time and was Resident #48's primary care staff during the shifts she worked. CNA #548 stated the other aides fastened the resident's incontinence brief in bed and she stated she believed the wounds were caused from her brief being too tight. On 05/06/25 at 4:14 P.M. Registered Nurse (RN) Wound Care Nurse #508 entered the room during incontinence care. RN Wound Care Nurse #508 shared Resident #48 constantly had wounds to her right inner thigh from her incontinence brief but starting today, the resident was no longer to wear incontinence briefs while in bed. The RN applied MediHoney, an alginate and a border gauze. The RN shared the resident had been seen today by the wound nurse Certified Nurse Practitioner (CNP). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A telephone interview on 05/06/25 at 4:50 P.M. with Wound Care Certified Nurse Practitioner (CNP) #801 revealed Resident #48 had a lot of wounds healing and opening to the inner thighs. Wound Care CNP #801 shared the resident being incontinent and wearing a brief that was too tight were contributing factors to the resident's wounds on her thighs. The CNP stated she had talked with the Director of Nursing (DON) about staff not fastening the resident's brief as incontinence briefs should not be tight. She shared the DON said he would look into it. The CNP verified at this time, the resident had a new pressure area to the right thigh (caused from the resident's brief being too tight and the resident's incontinence). Interview on 05/06/25 at 5:05 P.M. with Administrator, DON, and Wound Care Nurse #508 revealed they were unaware how staff measured for brief sizes. Review of the Skin Grid Pressure document for Resident #48 dated 05/06/25 at 7:07 P.M. completed by Wound Care Nurse #508 revealed the original date of the pressure area was 05/06/25 to the right posterior thigh identified as a suspected deep tissue injury (SDTI) measuring 0.5 centimeters (cm) in depth by 1.2 cm in length. The ulcer was described as dark purple, non-blanchable area. Review of the Skin Grid Non-Pressure for Resident #48 dated 05/06/25 at 7:01 P.M. completed by Wound Care Nurse #508 revealed Resident #48 had IAD acquired 03/18/25 to the right inner posterior thigh that measured 1.6 cm in length by 3.6 cm in width by 0.1 cm in depth. Interview on 05/07/25 at 10:00 A.M. with CNA #614 revealed she frequently worked with Resident #48 and prior to 05/06/25, no one told her the resident's brief wasn't to be fastened in bed. The CNA revealed staff always fastened the brief (when the resident was in bed). Interview on 05/07/25 at 10:41 A.M. with LPN #546 revealed she worked full time and was Resident #48's primary care nurse. LPN #546 confirmed she signed the order for Resident #48 on the days she worked confirming the brief was to remain unfastened when in bed. LPN #546 stated she signed the treatment administration record (TAR) indicating the brief was unfastened but stated she was not responsible for providing incontinence care to the resident, the CAN staff were. She stated she would complete the resident's treatment and leave the brief unfastened but she confirmed it was often fastened. On 05/07/25 at 3:30 P.M. a review of Resident #48's skin grids with Wound Care Nurse #508 revealed on 08/28/24 Resident #48 had documented moisture associated skin damage (MASD) to the right posterior thigh that was a new skin problem. On 09/04/24 the MASD healed. On 12/04/24 Resident #48 had an open lesion that was new to the right posterior thigh, an abrasion that was new to the right posterior thigh and a rash that was also new to the right posterior thigh. On 12/11/24 the skin condition healed. On 12/18/24 a new rash occurred to the right posterior thigh. On 01/08/25 the area healed. On 02/12/25 a new skin tear occurred to the right posterior thigh. On 03/18/25 IAD was identified to the right inner posterior thigh and on 05/06/25 the area continued with a new SDTI pressure wound to the right posterior thigh. Review of the Pressure Injury Prevention and Management policy revised on 06/01/23 revealed evidence-based interventions for prevention would be implemented for all residents who were assessed at risk or who had a pressure ulcer present. Evidence-based treatments in accordance with current standards of practice would be provided for all residents who had a pressure injury present. The attending physician would be notified of the presence of a new pressure injury upon identification. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Lawn Nursing Home	15028 Old Lincolnway East Dalton, OH 44618

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Basic or routine care interventions could include, but were not limited to provide appropriate, pressure - redistributing support surfaces. Minimize exposure to moisture and keep skin clean, especially of fecal contamination. Any changes to the facility's pressure injury prevention and management processes would be communicated to relevant staff in a timely manner. 2. Review of the medical record revealed Resident #46 was admitted on [DATE] with diagnoses that included hidradenitis suppurative, chronic lymphocytic leukemia of B-cell, adjustment disorder with depressed mood, and major depressive disorder. A skin/wound note dated 03/05/25 at 6:43 P.M. revealed Resident #46 was seen by the in-house wound nurse, Registered Nurse (RN) #508, for an abrasion to the right buttock. An order was initiated for skin prep (topical barrier to protect skin) and a foam dressing to be applied every night shift. A skin grid pressure form dated 03/14/25 at 1:36 P.M. revealed Resident #46 had a new unstageable (a type of pressure ulcer where the base of the wound is obscured by slough or eschar, making it impossible to determine the true depth and stage of the injury) pressure ulcer to right buttock that measured five centimeters (cm) long, 5.2 cm wide, and 0.1 cm deep. A skin and wound note authored by the Wound CNP dated 03/14/25 at 6:30 P.M. revealed Resident #46 had an unstageable pressure ulcer to right buttock that measured five cm long, 5.2 cm wide, and 0.1 cm deep. A sharp debridement was not performed due to this being the initial assessment of the wound. Treatment recommendations were made to cleanse the area with Dakins solution (a strong topical antiseptic to clean infected wounds), apply medical grade honey and calcium alginate with silver (highly absorbent wound dressing that releases silver ions to kill bacteria and promote healing) to the base of the wound, and then secure with a silicone bordered superabsorb dressing. The treatment was to be changed daily and as needed. Further review of the medical record revealed no evidence the treatment was ordered or implemented on 03/14/25. Staff continued to apply the skin prep as previously ordered. Record review revealed no evidence individualized, comprehensive and effective interventions were in place to prevent the development of the unstageable pressure ulcer for Resident #46 on 03/14/25. An order dated 03/18/25 at 12:30 P.M. revealed Resident #46's right buttock was to be cleansed with Dakins solution, with medihoney and calcium alginate with silver applied, and then covered with a silicone bordered dressing. A general progress note dated 03/18/25 at 12:39 P.M. revealed the area to Resident #46's right buttock previously noted to be an abrasion was now identified as an unstageable pressure ulcer. A general progress note dated 03/18/25 at 12:46 P.M. revealed Doctor #800 was updated that Resident #46 had a new pressure area. A skin grid pressure form dated 03/19/25 revealed Resident #46 had an unstageable pressure ulcer to the right buttock that measured five cm long, 5.8 cm wide, and 0.1 cm deep. The area was to be cleansed with Dakins solution, medihoney and calcium alginate silver were to be applied, and the wound covered with bordered foam. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the treatment administration record (TAR) revealed the treatment of Dakins solution, medihoney and calcium alginate silver, and bordered foam recommended on 03/14/25 was started on 03/19/25. Additionally, on 03/22/25, 03/28/25, and 03/31/25 the treatments were not completed as ordered. Review of the quarterly MDS assessment dated [DATE] revealed Resident #46 had cognitive impairment. The assessment revealed Resident #46 had an unstageable pressure ulcer that was not present upon admission. The resident was independent for activities of daily living and positioning. A skin and wound note by wound CNP dated 04/08/25 at 6:18 P.M. revealed the unstageable pressure ulcer to Resident #46's right buttock was now identified as a Stage III (a full-thickness skin loss where subcutaneous fat is visible) pressure ulcer to right buttock that measured 4.5 cm long, 5.5 cm wide, and 0.1 cm deep. The wound CNP debrided the wound. An interview on 05/01/25 at 3:25 P.M. with Registered Nurse (RN) #508 revealed she was an RN supervisor and facility wound nurse. RN #508 revealed the wound CNP usually visited the facility weekly on Tuesdays. RN #508 verified an area was discovered to Resident #46's right buttock on 03/05/25 and an order was put in place for skin prep to be applied to the area. RN #508 stated the wound CNP should have visited on 03/11/25 and did not know why the wound CNP did not see Resident #46 until 03/14/25. RN #508 verified an order recommended by the wound CNP on 03/14/25 was not ordered until 03/18/25. RN #508 stated she may have had to work some night shifts and may not have put the order in until 03/18/25. RN #508 verified the unstageable pressure to Resident #46's right buttock was now classified as a Stage III pressure ulcer. An interview on 05/06/25 at 11:11 A.M. with the Director of Nursing (DON) verified Resident #46, who was cognitively impaired, was assessed to have an unstageable pressure ulcer to the right buttock on 03/14/25. The DON also verified a review of the TAR and progress notes revealed the treatment to Resident #46's right buttock was not completed on 03/22/25, 03/28/25, or 03/31/25. Review of the Pressure Injury Prevention and Management policy revised on 06/01/23 revealed evidence-based interventions for prevention would be implemented for all residents who were assessed at risk or who had a pressure ulcer present. Evidence-based treatments in accordance with current standards of practice would be provided for all residents who had a pressure injury present. The attending physician would be notified of the presence of a new pressure injury upon identification. Basic or routine care interventions could include, but were not limited to provide appropriate, pressure - redistributing support surfaces. Minimize exposure to moisture and keep skin clean, especially of fecal contamination. Any changes to the facility's pressure injury prevention and management processes would be communicated to relevant staff in a timely manner. 3. Record review for Resident #58 revealed an admission date of 03/08/24 with diagnoses including paraplegia and obesity. Review of the care plan dated 03/08/24 for Resident #58 revealed the resident had an actual area of skin impairment related to a pressure ulcer to the left buttocks. Interventions included to initiate wound treatment. Continue treatment as ordered by physician (MD) and encourage resident to turn and reposition every two hours. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Skin Grid Pressure document dated 04/10/24 completed by RN #529 revealed Resident #58 had a new pressure area (originating 04/10/24) to the right gluteal fold measuring 6.5 cm by 5.5 cm by 0.1 cm in depth which was classified as a Stage II (partial thickness skin loss) pressure ulcer. The note also revealed a new pressure area was identified that was a suspected deep tissue injury to the resident's left Achilles that measured 1.2 cm by 1.5 cm that was discolored. The resident's left heel also had a new pressure ulcer that was a suspected deep tissue injury not present on admission (identified 04/06/24) that measured 1.6 cm by 1.5 cm and was discolored. Assessment of the resident's left buttocks pressure ulcer that was present on admission revealed the ulcer measured 4.5 cm by 5.0 cm with 5.8 cm depth which was classified as a Stage IV pressure ulcer (the most severe type, characterized by full-thickness skin and tissue loss, potentially exposing muscle, tendon, or bone) with heavy drainage and undermining at 12:00, 11:00, and 3:00. The wound had declined. . Review of the care plan dated 03/15/25 for Resident #58 revealed the resident had potential for alteration in skin integrity, required protective, preventative skin care maintenance related to bowel incontinence, decreased mobility and history of previous skin breakdown. Interventions included to administer supplements as ordered and record percent intake, provide peri care with each incontinent episode, and provide treatments as ordered. Interview on 04/30/25 at 5:03 P.M. with RN Wound Care Nurse #508 revealed Resident #58 now goes to the Wound Clinic for wound care. The RN revealed Resident #58 knows when her wound dressings were due to be changed, she is very on it and does not refuse the dressing changes. RN Wound Care Nurse #508 revealed Resident #58 did not set up in her chair for extended periods because she did not want the wounds to worsen. Review of the physician orders for May 2025 for Resident #58 revealed a treatment order for the sacrum - cleanse with soap and water, pat dry, apply Triad cream to open areas and peri wound skin, cover with bordered foam every day shift every other day. Record review revealed the treatment was due to be completed 05/01/25. Observation on 05/01/25 at 10:12 A.M. of preparation for wound care for Resident #58 with RN Wound Care Nurse #508 revealed the wound care supply - triad paste was not available for the treatment to Resident #58's sacrum. RN Wound Care Nurse #508 revealed the facility didn't have the treatment ordered and they were out of the paste. The nurse revealed central supply orders the supplies and the nurses add what is needed for the order but the nurses must not have ordered the paste since the facility was out. Interview on 05/01/25 at 10:58 A.M. with Cook/Central Supply #575 revealed the nurses were supposed to write down the supplies they needed on a list and she would place the order on Tuesdays. Observation with Cook/Central Supply #575 of the supply rooms confirmed there was no Triad cream available for use. Cook/Central Supply #575 revealed she could not always count on staff to write down what they needed and verified she had not ordered the Triad paste, but she stated that was due to not being aware it was supposed to be ordered. Interview on 05/01/25 at 11:10 P.M. with LPN #540 revealed she frequently ran out of wound care supplies and would order them herself from Amazon and pay for them herself so she would have them to care for her residents. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the May 2025 Treatment Administration Record (TAR) on 05/06/25 with RDCS #704 and Wound Care Nurse #508 revealed LPN #713 signed the TAR for Resident #58 reflecting the treatment to the sacrum to apply Triad cream was completed on 05/01/25 for Resident #58. However, Wound Care Nurse #508 confirmed that could not have been completed because the Triad cream was not available, an alternative treatment was applied that did not include Triad cream. RDCS #704 confirmed the nurse should not have signed the treatment was completed when it was not. Review of the Pressure Injury Prevention and Management policy revised on 06/01/23 revealed evidence-based interventions for prevention would be implemented for all residents who were assessed at risk or who had a pressure ulcer present. Evidence-based treatments in accordance with current standards of practice would be provided for all residents who had a pressure injury present. The attending physician would be notified of the presence of a new pressure injury upon identification. Basic or routine care interventions could include, but were not limited to provide appropriate, pressure - redistributing support surfaces. Minimize exposure to moisture and keep skin clean, especially of fecal contamination. Any changes to the facility's pressure injury prevention and management processes would be communicated to relevant staff in a timely manner. The deficiency represents non-compliance investigated under Complaint Number OH00165424 and Complaint Number OH00164199.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure exit doors were secured to prevent residents who were at risk for elopement from exiting the facility unassisted. This had the potential to affect ten residents (Resident #3, #12, #13, #17, #54, #55, #60, #61, #65, and #75) identified by the facility as being at risk for elopement and having access to an unsecured door. The facility census was 77. Findings include: Record review for Resident #60 revealed an admission date of 03/13/25. Diagnosis included unspecified dementia, unspecified severity with other behavioral disturbances. Review of the care plan dated 03/13/24 for Resident #60 revealed Resident #60 was at high risk for elopement. Interventions included to apply wanderguard (a device worn that will alert an alarmed door when a resident at risk for elopement is near an exit door) to reduce risk of elopement. Review of the physician orders for Resident #60 revealed an order dated 03/14/25 for wanderguard to the left ankle check placement every shift. Review of the Wander/Elopement assessment dated [DATE] completed by Licensed Practical Nurse (LPN) #514 revealed Resident #60 was cognitively impaired, ambulated independently, wandered aimlessly or non-goal directed, and had stated she wanted to leave the facility, packed belongings or stayed near a door to exit. Resident #60 was at risk for elopement. Review of the Medicare five-day Minimum Data Set (MDS) dated [DATE] revealed Resident #60 was severely cognitively impaired. Resident #60 had no impairment to the upper or lower extremities and ambulated with supervision or touch assistance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/07/25 at 8:06 A.M. Maintenance Assistant #509 and Maintenance Director #540 confirmed door number five located in the sunshine room (out of site from nursing stations or busy areas) was easily accessible to all residents located outside the secured unit. Observation with Maintenance Assistant #509 and Maintenance Director #540 revealed the door had a keypad to the left side and also a wanderguard unit. Observation revealed the door easily opened to the outside with no alarm sounding. Outside the door was the employee parking lot which also led to a busy highway. Maintenance Director #540 confirmed the door was supposed to be locked at all times and staff placed a code in the keypad to release the door to exit. The door for the keypad was not working for over a week. Maintenance Director #540 revealed the door was also alarmed with a wanderguard system. This was an additional alarm for exit doors used for residents who were at risk for elopement. The resident would have a bracelet on their person and when they were in close proximity to the door, the door would lock and if they pushed on the door, the door would alarm to notify the staff the resident was attempting to exit the facility unassisted. Observation with Maintenance Assistant #509 and Maintenance Director #540 using the wanderguard bracelet (the same as a resident would wear) revealed the door, (door #5) did not lock or alarm and freely opened to the unsecured parking lot. Maintenance Assistant #509 and Maintenance Director #540 confirmed the wanderguard system was not securing the door and a resident could have exited the facility undetected. A second attempt revealed the same door locked but when pressed/pushed on, did not alarm. Maintenance Director #540 confirmed the door was inconsistent opening at times without locking as it should and confirmed the door alarm was not working at all. Further observation on door #44 with the same alarm bracelet used for door five confirmed the bracelet functioned appropriately. Maintenance Assistant #509 and Maintenance Director #540 then exited the area with no staff present to monitor exit door #5. Observation on 05/07/25 at 9:24 A.M. with Maintenance Assistant #509 confirmed door #5 had not been repaired (was still not securing and the alarm was not sounding) and the door was not monitored by staff to assure residents who were at high risk for elopement was safe from exiting the facility unassisted. Interview on 05/07/25 at 9:44 A.M. with Director of Nursing (DON) confirmed door #5 was not working, the door was not being monitored by staff to prevent residents at risk for elopement from exiting the facility unassisted. DON confirmed there were 10 residents, Resident #3, #12, #13, #17, #54, #55, #60, #61, #65, and #75 residing outside the secured unit that were at risk for elopement. Interview on 05/07/25 at 12:08 P.M. with Certified Nursing Assistant #615 revealed Resident #60 ambulated independently throughout halls and in and out of residents' rooms, frequently going to exit doors attempting to open doors. Review of the facility policy titled, Elopements and Wandering Residents revised 10/01/22 revealed this facility ensures residents who exhibit wandering behavior and or at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The facility is equipped with door locks/alarms to help avoid elopements. Staff are to be vigilant in responding to alarms in a timely manner. The deficiency represents non-compliance investigated under Complaint Number OH00165424.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to provide comprehensive and individualized treatment and maintenance plans for residents with indwelling urinary catheters to prevent potential urinary tract infections. This affected two residents (Resident #33 and #43) of two residents reviewed for indwelling catheters. The census was 77. Findings include: Record review for Resident #33 revealed an admission date of 01/10/25. Diagnosis included retention of urine, cognitive communication deficit, muscle weakness, and need for assistants with personal care. Review of the Medicare five-day Minimum Data Set (MDS) dated [DATE] revealed Resident #33 was cognitively intact. Resident #33 had an indwelling catheter and required partial/moderate assistants with toileting hygiene and transfers. Review of the progress note for Resident #33 dated 02/28/25 at 12:00 P.M. completed by Registered Nurse (RN) #529 revealed Resident left at this time for a urology appointment. Review of the progress note for Resident #33 dated 02/28/25 at 2:47 P.M. completed by RN #529 revealed the resident returned at this time from the urology appointment. New order received: may place 16 F (French) Coude catheter if unable to void. Addendum: urology removed foley catheter. Discontinue foley catheter orders. Review of the physician orders for Resident #33 revealed an order dated 02/28/25 May place 16 f coude catheter if unable to void. Review of the Treatment Administration Record (TAR) for February, March, April, and May 2025 revealed the order dated 02/28/25 may place 16 f coude catheter if unable to void was not signed as completed or implemented at any time. Review of the physician orders for Resident #33 revealed no orders were present revealing an indwelling catheter had been implemented and or for care and treatment of an indwelling catheter. Review of the progress note for Resident #33 dated 03/01/25 at 4:54 P.M. completed by Licensed Practical Nurse (LPN) #610 included resident complained of pelvic tenderness, nausea, and pelvic area tender to touch, attempted to have resident urinate in urinal with approximately 30 ml (milliliters) output and then checked resident for residual, upon insertion resident had instant return, urine output above 350 ml, balloon inflated and placed, foley clamped off at 1,000 ml, returned in 20 minutes and unclamped for more return. Observation on 04/29/25 at 2:49 P.M. revealed Resident #33 was lying in bed. Observation revealed a catheter tubing with yellow urine and sediment. Resident #33 confirmed he had an indwelling catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 04/30/25 at 3:28 P.M. with LPN #546 confirmed Resident #33 had an indwelling catheter. There was no device securing the tubing for Resident #33 and the catheter insertion site was slightly red. LPN #546 verified there was no orders for the catheter care and treatment and there was no daily documentation of the urine output and confirmed there should be catheter care orders. Interview on 04/30/25 at 3:39 P.M. with Registered Nurse (RN) Unit Manager (UM) #508 confirmed Resident #33 had an indwelling catheter reinserted since 03/01/25 and had no orders for the care and treatment initiated and implemented for the indwelling catheter. RN UM #508 shared they were working the floor a lot, and couldn't complete floor work and paperwork. RN UM #508 confirmed Resident #33 should have orders for the care and treatment of the catheter. Interview on 04/30/25 at 3:45 P.M. with Regional Director of Clinical Services (RDCS) #704 revealed Resident #33 should have had orders for the care and treatment of the indwelling catheter. Output should also be measured every shift. The TAR should have been signed when the catheter was placed and the catheter should not have been clamped off after it was placed in Resident #33. 2. Review of Resident #43's medical record revealed the resident was admitted to the facility on [DATE]. Medical diagnoses include acute kidney failure (a sudden loss of kidney function), obstructive uropathy (urine is unable to flow through the urinary tract due to a blockage), reflux uropathy (urine flows backwards from the bladder into the kidneys), need for assistance with personal care, other specified disorders of the bladder, encounter for fitting and adjustment of urinary device (a tube inserted to drain the bladder and left in place to provide continuous bladder drainage), and urinary retention (the bladder does not empty completely after urinating). Review of the physician's orders revealed Resident #43 did not have any orders for catheter care. Review of the care plan dated 08/07/23 revealed Resident #43 was at risk for complications related to use of a suprapubic catheter (a tube that drains urine from the bladder through an incision in the belly that is left in place for continuous bladder emptying). Catheter care was absent from the care plan. Review of the Bowel and Bladder Catheter Care Task Sheet revealed the last entry for catheter care was 02/18/25 at 5:59 A.M. Review of the Minimum Data Set (MDS, a clinical assessment of a resident's functional capabilities) dated 03/09/25 revealed Resident #43 had no cognitive impairment. The MDS revealed during the assessment period the resident had an indwelling catheter (a tube inserted into the bladder and left in place to provide continuous emptying of the bladder) and was dependent on staff for toileting hygiene. Review of the Treatment Administration Record (TAR) for Resident #43 for the period of 04/01/25-04/30/25 revealed treatment for catheter care was absent. Interview on 05/01/25 at 11:26 A.M. with Unit Manager #529 verified that catheter care was absent from the physician's orders, care plan, and the last documentation on the catheter care task sheet was 02/18/25. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Catheter Care dated 03/02/22 revealed it is the policy of this facility that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. Catheter care will be performed every shift and as needed by nursing personnel. Privacy bags will be available and changed out when soiled with a catheter change or as needed, leg bags may be used, empty drainage bags when the bag is half full or every three to six hours and ensure the drainage bag is located below the level of the bladder. This deficiency represents non-compliance investigated under Complaint Number OH00164199.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Lawn Nursing Home	15028 Old Lincolnway East Dalton, OH 44618

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and policy review, the facility failed to administer oxygen per physician order for Resident #230. This affected one (Resident #230) of two residents reviewed for respiratory care. Facility census was 77. Findings include: Review of the medical record revealed Resident #230 was admitted on [DATE] with diagnoses that included acute and chronic respiratory failure with hypoxia, anxiety, congestive heart failure, and pneumonia. A physician order dated 04/04/25 at 5:54 P.M. revealed Resident #230 was ordered oxygen via nasal cannula at two to three liters per minute every shift. A plan of care dated 04/08/25 revealed Resident #230 had altered respiratory status and difficulty breathing. Interventions included to provide oxygen as ordered. A plan of care dated 04/23/25 revealed Resident #230 had signs and symptoms of pneumonia. Interventions included to obtain oxygen saturation and administer oxygen as ordered and indicated. Observations on 04/28/25 at 9:49 A.M., 04/29/25 at 8:17 A.M., and on 04/29/25 at 1:49 P.M. revealed Resident #230's oxygen was set at four liters. Interview on 04/29/25 at 1:49 P.M. with Licensed Practical Nurse (LPN) #567 verified Resident #230's oxygen was at four liters. LPN #567 also verified the physician order revealed Resident #230's oxygen should be at two to three liters. Review of Oxygen Administration policy dated 01/04/23 revealed oxygen is administered under orders of physician, except in the case of an emergency.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility investigation review, facility assessment review, time punch review, and interviews, the facility failed to maintain adequate staffing levels to meet the needs of residents related to medication administration. This affected three residents (Resident #26, #37 and #61) of nine residents reviewed for medication administration preferences. The facility census was 77. Findings include: 1. Review of a facility investigation revealed Licensed Practical Nurse (LPN) #815 was scheduled to work 05/05/25 from 6:00 P.M. to 6:00 A.M. Review of the time punches for Licensed Practical Nurse (LPN) #815 revealed she clocked in on 05/05/25 at 6:31 P.M. and clocked out on 05/06/25 at 1:09 A.M. LPN #815 was scheduled on 05/05/25 from 6:00 P.M. to 05/06/25 at 6:00 A.M. on Resident #26's unit. LPN #534 clocked in on 05/05/25 at 11:55 P.M. and clocked out on 05/06/25 at 6:56 A.M. Review of the facility investigation revealed a statement dated 05/06/25 by Certified Nursing Assistant (CNA) #589 that indicated LPN #815 stated she was going to the store (on 05/05/25). A statement by Scheduler #522 revealed the nursing agency company was notified that LPN #815 could not return to the facility due to not following policy and procedures and did not remain on the assigned hall for extended periods. It was reported LPN #815 was in her vehicle for extended periods of time. A statement by LPN #534 revealed they arrived to work on 05/06/24 around 12:00 A.M. LPN #534 was told LPN #815 had been off the unit for an extended amount of time. When LPN #815 was located, LPN #534 took the keys to the medication cart and sent LPN #815 home. An interview on 05/07/25 at 8:51 A.M. Director of Nursing (DON) verified an agency nurse that worked the night of 05/05/25 left the unit for extended amounts of time and was sent home on [DATE] around 1:00 A.M. The DON stated LPN #534 took the assignment LPN #815 had been assigned. An interview on 05/07/25 at 10:33 A.M. LPN #534 revealed she was scheduled on 05/06/25 at 12:00 A.M. to file papers. LPN #534 stated there had been complaints about LPN #815 leaving the unit. LPN #534 stated herself and LPN #610 went to LPN #815's car and told LPN #815 to go home. LPN #534 stated something seemed off with LPN #815 and LPN #815 had went to her car twice between midnight and 1:00 A.M. LPN #534 and LPN #610 did the narcotic count and LPN #534 finished the shift on the Beechwood unit where LPN #815 had been assigned. LPN #534 verified there were residents that had not received their medications. LPN #534 administered the medications around 1:00 A.M. to those residents that still had not received their scheduled evening medications. An interview on 05/07/25 at 12:47 P.M. CNA #589 revealed LPN #534 had been scheduled to come in around midnight to file papers. LPN #534 ended up working the Beechwood unit after LPN #815 was sent home. CNA #589 stated LPN #815 showed up late and only passed medications to the lower hall. LPN #815 left the Beechwood unit multiple times stating she was going to the store or to her car. CNA #589 stated LPN #534 administered the scheduled medications from 05/05/25 to the residents on the upper hall on 05/06/25 after 1:00 A.M. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record revealed Resident #26 was admitted on [DATE] with diagnoses that included multiple sclerosis, type 2 diabetes, hyperlipidemia, hypertension, and constipation. Review of physician orders revealed Resident #26 was ordered Simvastatin (for hyperlipidemia) 20 milligram (mg) at bedtime, Coreg (for hypertension) 25 mg upon rising and at bedtime (HS)/6:00 P.M., Glimepiride (anti-diabetic) one mg upon rising and at HS/6:00 P.M., magnesium (for hypomagnesemia) 400 mg upon rising and at HS/6:00 P.M., senna (laxative) 8.6 mg upon rising and at HS/6:00 P.M., clonidine (for hypertension) 0.3 mg at 6:00 A.M. 2:00 P.M. and 10:00 P.M., and baclofen (muscle relaxant) 10 mg scheduled at 6:00 A.M., 12:00 P.M., 6:00 P.M. and 10:00 P.M. Review of the medication administration record (MAR) revealed on 05/05/25 Resident #26's Simvastatin, Coreg, Glimepiride, magnesium, and senna scheduled for HS/6:00 P.M. were administered by Licensed Practical Nurse (LPN) #534. Resident #26's clonidine and baclofen scheduled for 10:00 P.M. were also administered by LPN #534 after 12:00 A.M. on 05/06/25. An interview on 05/06/25 at 3:52 P.M. Resident #26 verified it was around 1:00 A.M. on 05/06/25 when the evening medications for 05/05/25 were administered. Resident #26 stated she turned her call light on to ask about medications and a CNA stated the nurse was on break. Later another nurse brought medication and stated the agency nurse would not be back. The resident's medications had been provided much later than scheduled. 3. Review of the medical record revealed Resident #37 was admitted on [DATE] with diagnoses that included chronic kidney disease and type 2 diabetes. Review of physician orders revealed Resident #37 was ordered Lantus (insulin) 55 units at 9:00 P.M. Review of the MAR revealed on 05/05/25 Resident #37's Lantus scheduled for 9:00 P.M. was administered by LPN #534 (on 05/06/25). An interview on 05/06/25 at 3:56 P.M. Resident #37 verified a nurse did not come in until after 1:00 A.M. on 05/06/25 to administer the evening medication for 05/05/25. Resident #37 stated she did not go to sleep until after she received her medication. 4. Review of the medical record revealed Resident #61 was admitted on [DATE] with diagnoses that included intracranial injury, dementia, psychosis, restlessness and agitation, anxiety, and insomnia. Review of physician orders revealed Resident #61 was ordered vistaril (antihistamine also used to treat anxiety) 50 mg scheduled upon rising, at lunch, and at 6:00 P.M. and acetaminophen (for pain) 975 mg scheduled at 8:00 A.M., 2:00 P.M., and 10:00 P.M. Review of the MAR revealed Resident #61's vistaril scheduled for 6:00 P.M. and acetaminophen scheduled for 10:00 P.M. was administered by LPN #534. On 05/07/25 at 10:33 A.M. interview with LPN #534 verified she administered medications late since LPN #815 did not administer medications to some of the resident. She verified the nurse was in her car or off the floor for extended periods of time on 05/05/25 resulting in medications being administered late. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Master Complaint Number OH00165433, and Complaint Numbers OH00165430, and OH00165424.

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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** Based on record review, interview and facility assessment review the facility failed to ensure Resident #70 and the resident representative were provided timely and appropriate transition of care assistance from social services related to locating alternate placement better equipped to address Resident #70's medical and physical needs. This affected one resident (Resident #70) of two residents reviewed for discharge planning. The facility census was 77. Findings include: Review of the medical record revealed Resident #70 was admitted on [DATE] with diagnoses that included lymphedema, Milroy's disease (also known as primary congenital lymphedema, it is a rare, genetic condition that affects the lymphatic system and causes fluid build up in the legs. It is preset at birth and usually affects the tops of the feet. Symptoms include swelling in the legs (usually below the knees), prominent veins in the lower legs, slanted toenails, noncancerous growths and digestive issues. The severity of swelling can vary within and between families) autistic disorder, attention deficit hyperactive disorder, and expressive language disorder. A general progress note dated 01/22/25 at 4:17 P.M. revealed Doctor #800 requested referrals be made to other facilities closer to Cleveland Clinic. A health status note dated 02/07/25 at 5:19 A.M. revealed Resident #70's mother visited the beginning of the shift and requested updates regarding Resident #70's placement options. Resident #70's mother was notified there were no updates available related to lymphedema specialty nursing homes. An interview on 05/01/25 at 4:13 P.M.with Director of Social Services #538 verified Resident #70 needed to be at another facility that could provide more appropriate care and there was no evidence of referrals being made until 04/11/25, almost three months after the doctor requested referrals be made. Social Services did not provide additional information regarding why referrals were not sent sooner. An interview on 05/01/25 at 9:34 A.M. Doctor #800 verified Resident #70 needed to be at a facility that could provide transportation to doctor appointments and provide the care Resident #70 needed. An interview on 05/07/25 at 2:15 P.M. Resident #70's mother stated the facility told her they had sent referrals but had not heard from any of the other facilities. Resident #70's mother stated she would prefer a facility in the Akron/[NAME] area if possible but wanted Resident #70 at a facility that could transport me to appointments. Review of the Facility assessment dated [DATE] revealed the facility provided care for residents with conditions of morbid obesity and those that required bariatric care. This deficiency represents non-compliance investigated under Master Complaint Number OH00165433 and Complaint Number OH00164999.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure misappropriation of controlled medication did not occur when Resident #49's medication was administered to Resident #60. This affected one (Resident #49) out of five three residents reviewed for medication administration. Findings include: Review of the medical record revealed Resident #49 was admitted on [DATE] with diagnoses that included neurocognitive disorder with Lewy Bodies, anxiety, and depression. Review of physician orders revealed Resident #49 was ordered Ativan (antianxiety medication) one milliliter (ml) intramuscularly every three minutes as needed for seizures from 01/16/25 and discontinued on 01/30/25. The quarterly Minimum Data Set, dated [DATE] revealed Resident #49 was cognitively intact. Review of the controlled drug receipt/record/disposition sheet for Resident #49 revealed one ml of Ativan was administered on 05/06/25 at 6:00 A.M. Interview on 05/07/25 at 1:38 P.M. with the Director of Nursing (DON) verified Resident #49's Ativan was administered to Resident #60 on 05/05/25 or 05/06/25. The DON also verified there was nothing in Resident #49's or Resident #60's medical record about Ativan being taken from Resident #49's supply and administered to Resident #60. The DON verified he signed the Ativan out but did not administer the medication because it was reported that Licensed Practical Nurse (LPN) #815 administered it during her shift. The DON stated the narcotic count revealed Resident #60 did not have Ativan available and Resident #49 had a vial of Ativan missing. The DON verified vials of Ativan were available in the contingency box and LPN #815 should have obtained a vial from the contingency box and not from another resident. Review of Medication Administration policy dated 08/22/22 revealed medication source (bubble pack, vial, etc) is to be compared to the medication administration record (MAR) to verify resident's name, medication name, form, dose, route and time. Sign the MAR after administration. If the mediation is a controlled substance, in addition to signing the MAR, complete the control substance reconciliation sheet with the date/time of administration and a signature. If the medication is not available for administration, notify the physician that the medication is not available, utilize the contingency box if able. This deficiency represents non-compliance investigated under Master Complaint Number OH00165433 and Complaint Number OH00164999.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review the facility failed to ensure pharmacy recommendations were addressed in a timely manner. This affected one (Resident #60) of five residents reviewed for unnecessary medications. Facility census was 77. Findings include: Review of the medical record revealed Resident #60 was admitted on [DATE] with diagnoses that included major depressive disorder, dementia, hypertension, hypothyroidism, type 2 diabetes, malignant neoplasm of pituitary gland, dysphagia, anxiety, and vitamin D deficiency. A physician order dated 03/14/25 revealed Resident #60 was ordered Trazodone (antidepressant) 25 milligram (mg) at bedtime. Review of the pharmacy recommendation dated 03/21/25 revealed Trazodone 25 mg was ordered for insomnia. Resident #60 did not have a diagnosis of insomnia. The use of psychotropic medications required a specific condition as diagnosed and documented in the medical record. On 04/29/25 the physician agreed with the diagnosis of insomnia being added to Resident #60's medical record. Review of the medical record on 04/30/25 revealed the diagnosis of insomnia had not been added to Resident #60's medical record. An interview on 04/30/25 at 10:01 A.M. Registered Nurse (RN) #508 verified the pharmacy recommendation for Resident #60 was not addressed by the physician in a timely manner. RN #508 also verified the diagnosis of insomnia had not been added to Resident #60's medical record. Review of Medication Regimen Review policy dated 09/30/22 revealed facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities.

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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** Based on record review, interview, and review of the facility policy, the facility failed to assure one resident, Resident #10's psychotropic medication was decreased as ordered. This affected one Resident, Resident #10 of three residents reviewed for unnecessary drugs. The facility census was 77. Findings include: Record review for Resident #10 revealed an admission date of 03/15/19. Diagnosis included anxiety disorder. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #10 was cognitively intact. Resident #10 had anxiety disorder. Review of the physician orders for Resident #10 revealed an order dated 05/09/24 for Vistaril oral capsule (hydroxyzine pamoate) give 25 milligrams (mg) by mouth at bedtime for itching. Review of the medical record and progress notes for Resident #10 from 05/01/24 through 05/09/24 revealed no indication or observation of Resident #10 itching. Review of the Consultant Pharmacy Recommendation to Physician/Prescriber #900 printed 12/18/24 revealed Resident #10 received hydroxyzine (Vistaril) 25 mg po (by mouth) qhs (every night) for pruritic; last GDR (gradual dose reduction) attempted approximately greater than one year, please consider a possible gradual dose reduction while currently monitoring for any target and or withdrawal symptoms. Record review revealed below the recommendation, Physician #900 placed an x on the box stating, I accept the recommendations above with the following modifications, will wean down 12.5 mg po qhs for anxiety. The form was signed by physician and dated 01/07/25. Record review of the Medication Administration Record (MAR) for January and February 2025 for Resident #10 revealed Vistaril 25 mg was not decreased in January or February 2025 per the physicians order. The Vistaril was discontinued on 02/18/25. Interview and record review on 04/30/25 at 9:56 A.M. with the Director of Nursing (DON) verified Resident #10 had an order written and signed by Physician #900 on the Consultant Pharmacy Recommendation dated 01/07/25 to decrease the Vistaril for Resident #10 to 12.5 mg po qhs. The DON confirmed the Vistaril was not decreased per the physician order. The DON confirmed the Vistaril order should have been decreased on 01/07/25. Review of the facility policy titled, Use of Psychotropic Medications revised 03/01/25 revealed non-pharmacological approaches must be attempted, unless clinically contraindicated, to minimize the need for psychotropic medications, use the lowest possible dose, or discontinue the medication. Residents who use psychotropic drugs shall receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs.

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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. Based on observation, interview and review of the facility policy, the facility failed to ensure foods were appropriately stored and discarded when expired. This had the potential to affect 76 residents in the facility receiving food from the kitchen (Resident #40 was ordered nothing by mouth). Facility census was 77. Findings include: Observation on 04/28/25 from 8:36 A.M. to 9:12 A.M. with Dietary Manager (DM) #517 revealed in the walk-in cooler, there was a sheet pan with foil loosely placed over it exposing the contents to air. Beneath the foil was a cut of meat and writing on the foil identified the meat as pork and provided a date of 04/25/25. Continued observation of the walk-in cooler revealed four expired bags of carrots with dates of 02/10/25 or 03/13/25. Observation of the bread cart and an adjacent counter revealed an expired bag of English muffins dated 03/21/25 and an expired loaf of bread dated 04/26/25. Tour of the facility's nourishment refrigerators on the nursing units revealed on the Cherry Grove unit, there was a carton of Resource 2.0 supplement dated 11/02/24. Interviews with DM #517 verified the above expired foods and improperly wrapped pork at the time of observation. DM #517 confirmed foods were to be properly stored to prevent contamination and indicated all staff were to go through food stock daily to remove expired foods from use. DM #517 also shared unit refrigerators were to be checked once a week for expired foods. Review of the facility policy, Food Storage and Expired Food Policy, revised 02/22/25 revealed foods should be stored using the first in, first out (FIFO) method. Items should be rotated by staff when new items are received. Items that are expired or past the use by date must be discarded on the expired date. These items are not to be used for consumption after these dates.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, record review, job description review, and interview the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This had the potential to affect all 77 residents residing in the facility. Findings include: During the annual, complaint and extended survey, observations, record reviews, interviews, policy and facility assessment review resulted in concerns including but not limited to situations of neglect resulting in Immediate Jeopardy and actual harm to residents. Additional concerns included but were not limited to change in condition not being addressed and reported timely, staffing needs not being met resulting in a delay of care, not assisting residents to attend outside service appointments, not assisting residents with finding alternate placement when the facility identified their inability to meet the needs of a resident, infection control practices not being followed, equipment and supplies required for resident care not being available for staff to provide care, not providing comprehensive wound care, not providing appropriate care and services to bariatric residents despite being identified as a service the facility was able to provide according to the facility assessment. An interview on 05/07/25 between 10:00 A.M. and 11:00 A.M. the Administrator revealed she oversaw the day to day operations of the facility and was responsible for the day to day operations of the facility. The Administrator stated she was notified of all incidents and concerns at the facility. Review of the Administrator's personnel file revealed a hire date for administrator position of 08/07/24. Review of the facility Job Description for the Administrator dated 08/07/24 revealed assurance that all facility personnel, residents, visitors, etc. follow established safety regulations, to include fire protection/prevention, smoking regulations, and infection control. Ensure that the building and grounds are maintained in good repair. Review accident/incident reports and establish an effective accident prevention program and assure that the facility is maintained in a clean, safe, and sanitary manner. Ensure that all residents receive care in a manner and in an environment that maintains or enhances their quality of life without abridging the safety and rights of other residents. Ensure that each resident receives the necessary nursing, medical, and psychosocial services to attain and maintain the highest possible mental and physical functional status, as defined by the comprehensive assessment and care plan.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview and facility assessment review the facility failed to ensure residents were provided transportation to medical appointments as ordered. This affected one (Resident #70) of one residents reviewed for transportation. The facility census was 77. Findings include: Review of the medical record revealed Resident #70 was admitted on [DATE] with diagnoses that included lymphedema, Milroy's disease, autistic disorder, attention deficit hyperactive disorder, and expressive language disorder. The medical record revealed Resident #70 had an appointment with a cardiologist on 12/11/24 and a plastic surgeon on 01/15/25. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #70 was cognitively intact and was dependent for activities of daily living. A health status note dated 02/07/25 at 5:19 A.M. revealed Resident #70's mother visited the first part of the shift. The resident's mother reminded staff Resident #70 needed a signed referral sent to the Cleveland Clinic prior to Resident #70's appointment on 02/14/25. An interview on 05/01/25 at 7:15 A.M. with the Director of Nursing (DON) verified Resident #70 had not been transported to appointments because local transportation companies could not transfer bariatric residents. An interview on 05/01/25 at 9:34 A.M. Doctor #800 verified Resident #70 had not been to any outside appointments. Doctor #800 stated the DON said every company had been called and no one would transport Resident #70. An interview on 05/07/25 at 2:15 P.M. Resident #70's mother verified Resident #70 had not been transported to any outside appointments. Resident #70's mother stated she was concerned that Resident #70 could not attend any outside appointments and Resident #70 needed transferred to a facility that could offer transportation. Review of the Facility assessment dated [DATE] revealed the facility provided care for residents with conditions of morbid obesity and those that required bariatric care. This deficiency represent noncompliance investigated under Complaint Number OH00164199.

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	365591	A. Building B. Wing	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Lawn Nursing Home	15028 Old Lincolnway East Dalton, OH 44618

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure staff maintained infection control practices and failed to provide dedicated equipment for Resident #48 who was identified as being on isolation. This had the potential to affect all residents residing at the facility. The facility census was 77. Findings include: Record review for Resident #48 revealed an admission date of 06/21/24. Diagnosis included streptococcal pharyngitis dated 04/29/25. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #48 was cognitively intact. Resident #48 was dependent for bed mobility. Review of the care plan for Resident #48 dated 04/30/25 revealed Resident #48 required droplet isolation related to streptococcus pharyngitis. Interventions included isolation/quarantine maintained by staff during acute infection period. Review of the physician orders for Resident #48 revealed an order dated 04/30/25 for droplet precautions for strep throat. All meals, activities and therapies to be provided in the resident's room. Review of the list provided by the facility of residents residing in the facility requiring all types of isolation revealed 19 residents (Resident #3, #5, #22, #31, #32, #33, #38, #40, #43, #46, #48, #51, #54, #58, #61, #62, #63, #131, and #179). The DON confirmed the residents resided throughout the facility. Observation and interview on 05/01/25 at 10:58 A.M. with Cook/Central Supply #575 of the storage rooms revealed there were no storage of blood pressure cuffs, stethoscopes, thermometers, thermometer covers, or pulse oximeters. Cook/Central Supply #575 revealed she never ordered those supplies. Interview on 05/01/25 at 11:10 A.M. with Licensed Practical Nurse (LPN) #540 and #905 revealed they provided their own blood pressure cuffs, stethoscopes, thermometers, thermometer covers, and pulse ox revealing the facility never provided them for the nurses to use. LPN #540 and #905 shared if a resident was on isolation they would use their own then wipe them off. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation and interview on 05/01/25 at 12:26 P.M. of vital sign assessment for Resident #48 with Licensed Practical Nurse (LPN) #904 confirmed Resident #48 was on isolation/droplet precautions. Observation revealed Resident #48's door was open. LPN #904 removed a blood pressure cuff, thermometer, and stethoscope from her purse. LPN #904 shared the nurses have to provide their own blood pressure cuffs, stethoscopes, thermometers, thermometer covers, and pulse ox equipment. Observation revealed LPN #904 removed the thermometer and pulse ox from her shirt pocket, which was bulging from other items. LPN #904 donned a gown, gloves, and surgical mask and entered Resident #48's room. LPN #904 never cleaned any of the equipment prior to use with Resident #48. LPN #904 proceeded to assess Resident #48's blood pressure, pulse, oxygen saturation and temperature using all her own personal equipment including her stethoscope. LPN #904 then exited the room wearing all her Personal Protective Equipment (PPE), sat her equipment used to check Resident #48's vital signs on top of the isolation cart where a box of opened gloves and a box of opened face masks were located. The stethoscope and blood pressure cuff were directly on top of the boxes of face masks and gloves. LPN #904 then returned to the room, removed all her PPE, did not wash her hands or use hand sanitizer, went to her medication cart, removed her keys from her shirt pocket and opened the medication cart drawer. LPN #904 removed sani-wipes from the medication cart drawer, returned to the isolation cart where her personal vital sign equipment was located, quickly wiped off her thermometer and pulse ox and immediately returned them to her pocket then also and wiped the stethoscope and blood pressure cuff and placed them back in her purse,no more than 10 seconds of contact each with the Sani Wipe. LPN #904 did not allow any dry time after cleaning any of the equipment. LPN #904 did not wipe off the top of the isolation cart or remove the boxes of masks or gloves where she laid her soiled supplies. LPN #904 was not observed to wash her hands or use hand sanitizer and proceeded to the nurses station and sat at the desk and began documenting. LPN #904 verified the observations through interview. Interview on 05/01/25 12:43 P.M. with the Director of Nursing (DON) revealed Resident #48 was placed on droplet precautions for strep throat. Any resident on isolation should have their own equipment to monitor vital signs in their room and used only for them while they are on isolation. If a resident was on droplet precautions, their door to their room should be kept closed and all staff should doff (remove) PPE and wash their hands before leaving the room. Interview on 05/01/25 at 1:00 P.M. with Regional Director of Clinical Services (RDCS) Infection Preventionist (IP) #704 and Registered Nurse (RN) #529, who was in training for IP, confirmed if a resident was on isolation, the staff should keep the door closed. All equipment used for a resident, including vital sign equipment, should be provided by the facility and if used for residents on isolation, should be disposable and left in the residents' room. Staff were to doff PPE and wash their hands prior to leaving a residents room. RN #529 revealed when she worked on the floor, she used her own personal supplies to assess vital signs also. Interview on 05/01/25 at 4:30 P.M. with the Administrator revealed she found some stethoscopes for staff to use. Observation with the Administrator of the storage rooms confirmed there were no blood pressure cuffs, thermometers, thermometer covers, or pulse ox's for staff to use for residents' assessments. Review of the facility policy titled, Transmission Based Precautions revised 01/01/25 revealed use disposable or dedicated non-critical resident-care equipment (e.g., blood pressure cuff, bedside commode). If sharing noncritical equipment between residents, the equipment will be cleaned and disinfected following manufacturers instructions with an Environmental Protection Agency (EPA) -registered disinfectant after use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Manufacturer Directions for Sani wipes revealed to clean medical equipment with sani-cloth, first remove any visible soil with a fresh wipe then disinfect the surface using another fresh wipe, ensuring it stays visibly wet for the required contact time (two minutes). If necessary, use additional wipes to ensure the entire surface is covered and remains wet for the full contact time. Allow the surface to air dry before use. Always follow the manufacturer instructions and wear gloves. Review of the facility policy titled, Hand Hygiene revised 12/01/21 revealed all staff will perform hand hygiene procedures to prevent the spread of infections to other personnel, residents, and visitors. Staff will perform hand hygiene when indicated. Hand Hygiene Table included: between resident contacts, after handling contaminated objects, before applying and after removing PPE, including gloves, before performing resident care procedures, and before and after providing care to a resident in isolation. The deficiency represents non-compliance investigated under complaint number OH00164199.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview the facility failed to ensure Resident #64 was offered the influenza (flu) vaccine from 02/27/25 to 03/31/25. This affected one resident (#64) of five residents reviewed for influenza immunizations. The facility census was 77. Findings include: Record review revealed Resident #64 was admitted to the facility on [DATE]. Diagnoses include altered mental status, need for assistance with personal care, muscle weakness, cognitive communication deficit, and major depressive disorder. Review of the Minimum Data Set (MDS, a clinical assessment of a resident's functional capabilities) dated 03/07/25 revealed Resident #64 had intact cognition. Further review of the medical record revealed no evidence the resident was offered the influenza vaccine after admission. Interview on 04/30/25 at 1:40 P.M. with Regional Director of Clinical Services #704 revealed the facility was unable to locate any information regarding Resident #64's consent or refusal of the influenza immunization. Review of the influenza vaccine policy dated 10/01/22 revealed the flu vaccine will be offered annually October 1st through March 31st, the completed and signed consent or refusal will be filed in the individual's medical record, and the resident's medical record will include documentation the resident did or did not receive the vaccine.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview the facility failed to ensure the Covid-19 immunization was offered to residents. This affected four (#15, #58, #63, and #64) of five residents reviewed for Covid-19 immunizations. The facility census was 77. Findings include: 1. Record review for Resident #15 revealed an admission date of 02/26/25. Diagnoses include cerebral palsy (a group of disorders that impact movement, muscle tone, or posture), need for assistance with personal care, anxiety disorder, chronic obstructive pulmonary disease (COPD, a lung condition that limits airflow into and out of the lungs), heart failure, and type 2 diabetes mellitus. Record review of the Minimum Data Set (MDS, a clinical assessment of resident's functional capabilities) dated 03/13/25 revealed Resident #15 had intact cognition. Review of the medical record revealed no evidence the resident was offered the COVID-19 immunization. Interview on 04/30/25 at 1:40 P.M. with Regional Director of Clinical Services RDCS) #704 revealed the facility was unable to locate Resident #15's Covid-19 vaccine consent or refusal. 2. Record review for Resident #58 revealed an admission date of 03/08/24. Diagnoses include demyelinating disease of the central nervous system (condition that causes loss of fatty tissue that surrounds and protects nerve fibers), paraplegia, asthma, obesity, and neuromuscular dysfunction of bladder. Record review of the MDS dated [DATE] revealed Resident #58 had intact cognition. Review of the medical record revealed no evidence the resident was offered the COVID-19 immunization. Interview on 04/30/25 at 1:40 P.M. with RDCS #704 revealed the facility was unable to locate Covid-19 vaccine consent or refusal for Resident #58. 3. Record review for Resident #63 revealed an admission date of 01/31/25. Diagnoses include cellulitis (an infection of the skin and tissue beneath the skin), age related debility, methicillin resistant staphylococcus aureus infection (MRSA), aortic valve disorder, heart failure, COPD, and type 2 diabetes mellitus. Review of the MDS dated [DATE] revealed Resident #63 had intact cognition. Review of the medical record revealed no evidence the resident was offered the COVID-19 immunization. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/30/25 on 1:40 P.M. with RDCS #704 revealed the facility was unable to locate Covid-19 vaccine consent or refusal for Resident #63 4. Record review revealed Resident #64 was admitted to the facility on [DATE]. Diagnoses include altered mental status, need for assistance with personal care, muscle weakness, cognitive communication deficit, and major depressive disorder. Review of the MDS dated [DATE] revealed Resident #64 had intact cognition. Review of the medical record revealed no evidence the resident was offered the COVID-19 immunization. Interview on 04/30/25 at 1:40 P.M. with RDCS #704 revealed the facility was unable to locate Covid-19 vaccine consent or refusal for Resident #64 Review of the Covid-19 Vaccination policy dated 09/10/24 revealed the following: it is policy to offer residents the Covid-19 vaccine, residents will sign consent prior to administration that will be retained in the medical record, and the resident's medical record will include documentation of refusal.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to ensure Resident #70 was able to be transferred and evacuated from his room in the event of an emergency. This affected one (Resident #70) out of one reviewed for emergency transfer and evacuation. Facility census was 77. Findings include: Review of the medical record revealed Resident #70 was admitted on [DATE] with diagnoses that included lymphedema, Milroy's disease, autistic disorder, attention deficit hyperactive disorder, and expressive language disorder. A general progress note dated 10/24/24 at 4:52 P.M. revealed Resident #70 was alert and oriented times one and was primarily nonverbal. A bariatric mattress was provided but currently displayed error sounds due to the weight of Resident #70. Resident #70's weight was unable to be obtained due to Resident #70's weight exceeded the weight limit on the bariatric Hoyer (mechanical) lift. A general progress note dated 10/24/24 at 10:27 P.M. revealed four staff attempted to do a skin sweep on Resident #70. Resident #70 was impossible to turn. Resident #70's heart rate elevated to 100 to 130 beats per minute (normal 60-90 beats per minute) when attempting to move and Resident #70 became short of breath. Resident #70 was not appropriate for this facility. A care plan dated 10/25/24 revealed Resident #70 needed assistance with activities of daily living (ADL). Interventions revealed Resident #70 was totally dependent and did not participate in any aspect of the task for: bed mobility, grooming, dressing, toileting, and bathing. An interview on 05/01/25 at 7:15 A.M. the Director of Nursing (DON) verified that the facility had a bariatric Hoyer lift but did not have a lift pad to properly fit Resident #70. The DON verified Resident #70 was unable to get out of bed except when transferred to the shower bed. An interview on 05/01/25 at 7:28 A.M. with Licensed Practical Nurse (LPN) #540 verified the Hoyer lift could not be used for Resident #70 because the facility did not have the proper lift pad. LPN #540 verified Resident #70 could not be evacuated from his room if there was an emergency due to the bariatric bed could not fit through the doorway. Interview on 05/01/25 at 7:37 A.M. Certified Nursing Assistant (CNA) #515 verified the Hoyer lift could not be used for Resident #70. An interview on 05/01/25 at 9:34 A.M. with Doctor #800 verified the Hoyer lift could not be used to transfer Resident #70. An interview on 05/07/25 at 2:15 P.M. with Resident #70's mother verified Resident #70 was unable to get out of bed or out of his room. Resident #70's mother stated Resident #70's bed would not fit through the doorway. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 05/05/25 at 11:05 A.M. with Assistant Fire Chief #820 verified the facility would have to provide a mechanical lift if needed to lift Resident #70 from the floor to a cot or bed in the event of a fall. The AFC stated the department could use the resident's bed as a means to evacuate the resident but when it was identified the bed was too wide to fit through the doorway, the AFC stated the facility would need to create a plan to evacuate the resident in the event of an emergency. An interview and observation of measurements on 05/06/25 at 9:48 A.M. revealed the doorway opening to Resident #70's room measured 43 inches. Resident #70's bed measured 47.5 inches. Maintenance Director #540 verified Resident #70's bed would not fit through the doorway into the hall. This deficiency demonstrates non-compliance investigated under Complaint Numbers OH00165424, OH00164999 and OH00164199.