STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365604	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Meadows Skilled Nursing and Rehab	7770 Columbus Road NE Louisville, OH 44641

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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 - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observations, interviews, record reviews, and facility policy, the facility failed to ensure the E wing (memory care unit) was homelike by having a basin on the hallway floor outside of Resident #55's room to collect water from a ceiling leak for an extended period of time and by having walls in disrepair in 9 resident's (#24, #35, #54, #62, #63, #76, #78, #335, and #336) rooms. This affected 10 residents (#24, #35, #54, #55, #62, #63, #76, #78, #335, and #336) out of 26 residents who resided on the E wing (memory care unit). Findings include: 1. Review of medical record for Resident #55 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease (COPD), unspecified dementia, malignant neoplasm of bladder (bladder cancer), benign prostatic hyperplasia (BPH) with lower urinary tract symptoms (enlarged prostate), and major depressive disorder. The resident was at moderate risk of falling. Review of Resident #55's quarterly Material Data Set (MDS) assessment revealed the resident was severely impaired cognitively; exhibited inattention behavior, which was continuously present and did not fluctuate; rejected care daily; used a walker and could walk up to 150 feet with supervision or touch assistance from staff; and had no falls since prior assessment. Observation on 02/03/25 at 10:09 A.M. revealed a yellow square plastic basin sitting on the floor of the hallway with a wet floor sign sitting next to the basin, which was blocking part of Resident #55's doorway. The basin appeared to be collecting water from a ceiling leak. Interview on 02/03/25 at 12:32 P.M. with Responsible Party of Resident #55 revealed the last time she visited the resident about two weeks ago, there was a basin on the floor collecting water outside his room. Observation on 02/04/25 at 11:04 A.M. revealed the yellow plastic basin remained on the hallway floor with a caution wet floor sign observed sitting to the left of the sign right outside Resident #55's door. Interview on 02/04/25 at 2:17 P.M. with Certified Nursing Assistant (CNA) #433 revealed the drip pan had been there for months and having a basin collecting water from a ceiling leak was not homelike. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/04/25 at 11:31 A.M. with Licensed Practical Nurse (LPN) #347 revealed the basin had been there for a couple months. Observation on 02/05/25 at 11:31 A.M. revealed the yellow basin and the wet floor sign had been removed from the hallway floor outside Resident #55's doorway. Interview at the time of observation with Resident #55 revealed he was unsure how long the yellow basin and wet floor sign had been outside his room. He stated at his home he wouldn't have had a bucket collecting water from a leak in the ceiling for a long time. Observations on 02/05/24 during an environmental tour from 1:35 P.M. to 1:47 P.M. with Maintenance Supervisor (MS) #373 and the Administrator revealed the yellow basin and wet floor sign had been removed from the hallway outside Resident #55's room. Interview at the time of observation with MS #373 confirmed the yellow basin and wet floor sign had been removed that morning since the ceiling was no longer leaking. He stated the roof above the hallway outside Resident #55's room had sprung a small leak, which he thought he had fixed but the leak continued. He stated he never called a roofer to come in and fix the leak and the leak had been going on and off for about a month or two. He confirmed having a basin collecting water from a leak in the ceiling for an extended period was not homelike. 2. Interview on 02/05/24 at 1:00 P.M. with family of Resident #336 revealed the gouges behind the bed and the condition of the wall was not homelike, and they wouldn't have had a wall like that at home. Environmental tour on 02/05/24 from 1:35 P.M. to 1:47 P.M. with Maintenance Supervisor #373 and Administrator revealed the following concerns on the E wing (the memory care unit): -On the right wall directly behind Resident #76's headboard was one circular softball sized black mark and 14 black linear marks varying in width from pencil thin to approximately one inch wide and approximately one to three inches long, and three linear gouge marks which caused the paint to be removed. -On the right wall directly behind Resident #35's headboard were 10 black pencil thin linear lines, approximately two feet long, and a large area, approximately two feet wide and one feet long, with many linear gouge marks, which caused areas of the paint to be removed. -On the left wall directly behind Resident #78's headboard and to the right of the headboard were 21 gouged areas varying from pencil thin to one half inch wide and one inch long, which caused areas of paint to be removed -On the right wall behind Resident #24's headboard and two feet on each side of the headboard was extensive damage to the wall with multiple gouged marks, which caused paint to be removed or peeled back, and multiple black linear marks. -On the left wall directly behind Resident #336's headboard were many gauge marks approximately one inch wide by four inches long, which caused areas of paint on the wall to be removed or peeled back (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On the right wall to the right side of Resident #62's headboard were four circular quarter sized indentations in a line from the floor to halfway up the wall, and there was an abundance of linear gauge marks directly behind the headboard and behind the bedside table to the left of the headboard, which caused areas of the paint to be removed. -On the left wall directly behind and to the right of Resident #335's headboard was a large area with multiple gouged areas in the wall which had removed some of the paint. -On the right wall directly behind Resident #54's headboard were many gouged marks, which had caused the paint to be removed. -On the left wall directly behind Resident #63's headboard were many black linear marks and gouge marks in the wall which had removed or peeled back the paint. Interview on 02/05/24 with MS #373 during an environmental tour from 1:35 P.M. to 1:47 P.M. confirmed the areas of concern and stated maintenance didn't tour the facility for concerns and was only made aware of maintenance concerns through TELS (a platform used by maintenance staff for work orders). He stated he was responsible for many items in the facility, and it was hard to get everything done. Review of facility policy Resident Rights, revised September 2022, revealed a resident has a right to a dignified existence. This deficiency represents non-compliance investigated under Complaint Number OH00161856.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on review of the closed medical record, review of facility investigation, interview and review of the facility policy the facility failed to ensure Resident #82 was free from physical restraints. This affected one resident (Resident #82) of three reviewed for accidents. Findings included: Review of the closed medical record revealed Resident #82 was admitted to the facility on [DATE]. Diagnoses included metabolic encephalopathy, respiratory failure, iron deficiency anemia, kidney disease, non-ST elevation myocardial infarction, diabetes, pulmonary edema, diabetic neuropathy, hypertension, glaucoma, hyperlipidemia, insomnia, and anxiety disorder. Review of the plan of care dated 11/21/24 with a revision dated of 02/06/25 revealed Resident #82 was at risk for falls related to incontinence, decreased strength and endurance, history of falls, need for activity of daily living assistance, poor balance, and unsteady gait. Interventions included bed alarm, bariatric bed, clear pathways, educate resident and family to call for assistance before transferring, environmental intervention, food and fluids within reach, bed in the lowest position, left chair remote in the pocket to discourage resident from adjusting (approved by the wife), call light within reach, maintain needed items within reach, mat ot the floor beside the bed when occupied, mattress to the open side of the bed, and bolsters to bed to define perimeters. Review of the Five-Day Medicare Minimum Data Set assessment dated [DATE] revealed Resident #82 had intact cognition. He required substantial/maximum assistance for turning and transfers. Physical Therapy Notes dated 01/17/25 revealed Resident #82 was a fall risk. He was legally blind and was weight bearing for only transfers due to bilateral heel ulcers and left toe gangrene. He actively participated with bed mobility. Review of the progress note dated 01/18/25 at 1:00 P.M. revealed staff was passing by the room of Resident #82 and his lift chair was in the high position. Resident #82 was sitting on the floor in front of the chair with the controller in his hand. His range of motion was within normal limits and he denied pain. The staff used a Hoyer lift to put him back to bed. His power of attorney was notified and requested he be sent to the emergency room for a mental status change. Review of the fall occurrence note dated 01/18/25 at 1:06 P.M. revealed Resident #82 was sitting on the floor in front of his lift chair with the recliner in the high position and the controller was in his right hand. The resident stated he did not know what he was doing. The new intervention was to place the lift chair remote in the pocket to discourage him from adjusting. Further review of the medical record revealed no documentation of a restraint assessment for taking the lift chair remote from Resident #82 for a fall intervention. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/10/25 at 11:40 A.M. an interview with the Director of Nursing revealed Resident #81's behaviors varied from day to day. She stated he had delusions and tremors on some days and would be able to have a conversation with him other days. She stated they tried several interventions with him, like bringing him out to the nurses station but he would get upset and want to go back to his room. She stated his wife could normally get him to calm down by talking to him but there were days he would not even talk to her. He stated he was able to move himself in the bed and he had therapy services the whole time he was at the facility. She stated he had a lift chair per the wife's request and they did not have any other recliners. She verified they took the remote away for him as an intervention due to he used it to position himself straight up and down in the recliner and he slid to the floor because he did not have the strength to keep himself in the recliner. She stated they would put the remote control in the side pocket on the side of the chair. She stated she did not believe it was a restraint but an interventions to keep him safe from falling out. She stated he was always in the recliner and hardly ever got into his bed. Review of the facility policy titled, Use of Restraints, dated 09/21 revealed restraints would not be used for the safety and well being of the residents and only after other alternatives had been tried unsuccessfully. Residents would only be used to treat the resident's medical conditions and never for disciple or staff convenience or for the preventions of falls. A physical restraint was defined as any manual method, physical, or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restraints normal access to one's body.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on review of a Self Reported Incident (SRI) with the facility's investigation, policy review, medical record review, and interview, the facility failed to ensure protection of a resident during an investigation of emotional/verbal abuse and the facility failed to ensure a thorough investigation was completed into allegations of verbal/emotional abuse. This affected one (Resident #188) of two residents reviewed for abuse. Findings include: Review of Resident #188's closed medical record revealed diagnoses including systemic lupus erythematosus (lupus that affects multiple organs and systems), osteomyelitis (infection of the bone) of the left ankle and foot, right sided weakness following a stroke, stage four kidney disease and heart disease. An admission Minimum Data Set (MDS) dated [DATE] indicated Resident #188 was able to make himself understood, was able to understand others, was cognitively intact, and exhibited no behavioral symptoms. A nursing note dated 09/25/24 at 4:50 A.M. indicated a phlebotomist reported Resident #188 was aggressive with her when attempting to draw blood. The phlebotomist reported Resident #188 requested she use a butterfly needle and she explained he did not need a butterfly needle. Resident #188 yelled at the phlebotomist and used explicit language. The note indicated Registered Nurse (RN) #439 attempted to discuss the importance of lab tests and Resident #188 responded he did not need to have the laboratory tests done. Review of SRI #252856 revealed on 10/11/24 at approximately 7:00 A.M. a state survey agency surveyor reported Resident #188 alleged verbal abuse, telling the surveyor a nurse (later identified as RN #439) told him to stop being a cry baby. The report indicated the nurse was not in the facility at the time of the allegation. Registered Nurse (RN) #439 was contacted and immediately suspended pending investigation. Review of the facility's investigation revealed a typed statement signed by the Director of Nursing (DON) which indicated RN #439 was interviewed on 10/11/24 and stated on 09/25/24 Resident #188 could be heard yelling profanities down the hallway. Upon entering the room, Resident #188 was yelling at the phlebotomist to get out of his room and stating the phlebotomist was not going to touch him. Resident #188 proceeded to yell and be verbally aggressive with RN #439 when attempting to redirect and calm him. RN #439 stated she left the room after ensuring Resident #188 was safe. RN #439 denied calling Resident #188 a cry baby or speaking disrespectfully to him. Review of time punches and schedules revealed RN #439 worked night shift on 10/11/24, 10/12/24, and 10/13/24. Review of typed statements dated 10/16/24 indicated Certified Nursing Assistant (CNA) #356 and CNA #398 were interviewed because they worked the shift RN #439 identified during her interview. Both statements revealed they had not witnessed RN #439 call Resident #188 a cry baby or be verbally abusive to him. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The final report of the facility's investigation was dated 10/16/24. On 02/06/25 at 3:28 P.M., RN #439 stated she was interviewed regarding anything unusual that occurred with Resident #188 and she reported Resident #188 refused to have his blood drawn for laboratory tests and he got belligerent with her. RN #439 stated she was also trying to obtain vital signs for dialysis. RN #439 stated she was encouraging Resident #188 to have the blood drawn and Resident #188 got upset and kicked her out of his room. A couple weeks later after Resident #188 filed a complaint was when management counseled her not to argue with residents and she was told not to interact with Resident #188. RN #439 stated she believed Resident #188 might have misinterpreted something that was said. RN #439 stated she reported the incident to the Director of Nursing (DON) right after the situation occurred. RN #439 denied she was suspended or missed any work but was counseled before her shift started. On 02/10/25 at 9:59 A.M., the Administrator stated after the allegation was reported on 10/11/24 the DON spoke to Resident #188 and he denied abuse although no statement was written regarding an interview being conducted. The Administrator verified RN #439 was permitted to work on 10/11/24, 10/12/24 and 10/13/24 while she waited for the certified nursing assistants to call back and provide witness statements. Review of the facility's Abuse Investigation and Reporting policy (dated September 2021) revealed the Administrator would suspend immediately any employee who had been accused of resident abuse, pending the outcome of the investigation. b. During the entrance conference held with the Administrator and Director of Nursing (DON) on 02/03/25 the facility's investigation into the allegation was requested. Review of the facility investigation information provided revealed a copy of the SRI, a copy of Resident #188's face sheet, a print out of nursing notes on 09/25/24 at 12:15 A. M, 12:34 A. M, and 4:50 A. M, a printed statement for an interview of RN #439 signed by the DON and 13 forms indicated residents were interviewed to ask if they knew who RN #439 was and if they had any issues with her. There was no documented interview of Resident #188 or other staff who could have potentially been a witness or the phlebotomist. On 02/05/25 at 1:55 P.M., the Administrator stated she had attempted to call Laboratory representative #503 so she could interview the phlebotomist but never got a response. The Administrator verified she had documented no attempts to contact the lab and could not provide any dates or times. On 02/05/25 at 2:07 P.M., a message was left for Laboratory Representative #503 requesting a return call. A return call was received at 3:26 P.M. Laboratory Representative #503 reported the phlebotomist who visited the facility to draw labs on 09/25/24 no longer worked for the lab but was a mandated reported and she was not aware of any reports of abuse against the facility. However, she would not get the reports directly. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/05/25 at 4:45 P.M. the DON was interviewed regarding the lack of interviews of any additional staff who may have been potential witness to abuse being interviewed. The DON stated she spoke with the Administrator who stated she needed time to search through other SRIs to determine if staff interviews might have been placed in the wrong folder. On 02/05/25 at 5:13 P.M., the DON provided undated papers she stated were sign in sheets for education done after the incident was reported and typed statements indicating Certified Nursing Assistants (CNAs) #356 and #398 were interviewed. Neither of the CNA interviews were signed. On 02/05/25 at 5:17 P.M., the Administrator stated she took CNA #356 and CNA #398's statements over the phone. The Administrator stated she generally spoke to staff and wrote their statements out for them because some staff did not write well. The Administrator verified the statements were not reviewed by staff or signed by them to verify accuracy. On 02/06/25 at 9:45 A.M., the Administrator verified there was no documentation of an interview with Resident #188 being conducted but stated she knew the DON had spoken to Resident #188. On 02/06/25 at 12:46 P.M., CNA #356 reported Resident #188 and RN #439 got into it at various times, one time regarding medication. Resident #188 could be very stern. CNA #356 denied anybody had ever questioned her about Resident #188 or RN #439. CNA #356 denied any knowledge of abuse. On 02/06/25 at 12:58 P.M., the DON stated after receiving the allegation of abuse, she went and spoke with Resident #188. When asked if he had problems with RN #439, Resident #188 responded no black person was going to draw his blood and RN #439 was telling him he just needed to let the phlebotomist draw his blood. On 02/10/25 at 9:07 A.M., the Administrator verified the lack of documentation of an interview with Resident #188 made it difficult to verify the incident occurred at the time of the phlebotomist blood draw or if it was an entirely separate incident in which a staff member called Resident #188 a cry baby. The Administrator verified she had not had staff review/sign their statements and did not interview any additional staff to determine if they had any additional information. Review of the facility's Abuse Investigation and Reporting policy (dated September 2021) indicated all reports of resident abuse or mistreatment should be promptly reported to local, state and federal agencies and thoroughly investigated by facility management. If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source was reported, the Administrator would assign the investigation to an appropriate individual. The policy indicated the individual conducting the investigation would, at a minimum, interview any witness to the incident, interview the resident, and interview staff members on all shifts who had contact with the resident during the period of the alleged incident. Witness reports would be obtained in writing. Either the witness would write his/her statement and sign and date it, or the investigator might obtain a statement, read it back to the member and have him/her sign and date it. This deficiency represents non-compliance investigated under Complaint Number OH00161264.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on review of the medical record, review of the facility bed hold notices and interview with staff the facility failed to ensure bedhold notices were given to Resident #52 and #82 before a hospital transfer. This affected two residents (Resident #52 and #82) of three reviewed for hospitalization . Findings included: 1. Review of the medical record revealed Resident #82 was admitted to the facility on [DATE]. Diagnoses included metabolic encephalopathy, respiratory failure, iron deficiency anemia, kidney disease, non-ST elevation myocardial infarction, diabetes, pulmonary edema, diabetic neuropathy, hypertension, glaucoma, hyperlipidemia, insomnia, and anxiety disorder. Further review of the medical record revealed Resident #82 was discharged to the hospital on 12/20/24, 01/06/25, 01/18/25, and 01/31/25 with no evidence of a bedhold notice was given to the resident or his legal representative. On 02/06/25 at 2:20 P.M. an interview with Business Office Manager #387 revealed Resident #82 was never given a bedhold notice because he was not Medicaid. She stated she only gave bed hold notices to Medicaid residents. On 02/10/25 at 2:30 P.M. an interview with Family Member # 502 revealed she did not remember receiving a bedhold notice any time he was sent out to the hospital. 44808 2. Review of the medical record for Resident #52 revealed an admitted [DATE] with diagnoses including end-stage renal disease, type two diabetes mellitus, dependence on renal dialysis, and heart failure. Resident #52 was transferred to the hospital on 11/20/24. Review of the transfer notice documentation for 11/20/24 revealed there was no evidence that a bed hold notice was provided to Resident #52. On 02/06/25 at 2:45 P.M., an interview with Business Office Manager (BOM) #387 verified Resident #52 did not receive a bed hold notice at the time of transfer on 11/20/24. Review of the facility's policy for bed holds, dated 09/2021, indicated the facility would provide a copy of the bed hold policy to the resident and immediate family member or legal representative before and when a resident was transferred for hospitalization or therapeutic leave.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on review of the medical record and interview with the staff the facility failed to ensure a Significant Change assessment was completed for Resident #2 after initiating hospice services. This affected one resident (Resident #2) of 26 residents reviewed for comprehensive assessments. Findings included: Review of the medical record revealed Resident #2 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, protein-calorie malnutrition, history of falling, kidney disease, vitamin D deficiency, hypothyroidism, hypertension, atherosclerotic heart disease, hyperlipidemia, osteoarthritis, hypotension, depression, anxiety disorder, heart failure, anemia, and edema. Review of the February 2025 physician's orders revealed Resident #2 had an order for hospice dated 01/12/25. Further review of the medical record revealed there was no evidence of a Significant Change Minimum Data Set assessment completed within 14-days of receiving hospice services for Resident #2. On 02/10/25 at 10:08 A.M. an interview with the Director of Nursing confirmed there was no significant change Minimum Data Set assessment completed within 14-day of hospice initiation for Resident #2.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on review of the medical record and interview with the staff the facility failed to ensure the comprehensive assessment accurately reflected a pressure ulcer for Resident #82 and correct hearing status and anti-anxiety medication use for Resident #44. This affected two residents (Resident #44 and #82) of 26 residents reviewed for comprehensive assessments. Findings included: 1. Review of the medical record revealed Resident #82 was admitted to the facility on [DATE]. Diagnoses included metabolic encephalopathy, respiratory failure, iron deficiency anemia, kidney disease, non-ST elevation myocardial infarction, diabetes, pulmonary edema, diabetic neuropathy, hypertension, glaucoma, hyperlipidemia, insomnia, and anxiety disorder. Review of the wound evaluation note dated 11/21/24 at 2:14 P.M. revealed Resident # 82 was admitted with a Stage III pressure ulcer to the sacrum. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #82 did not have a pressure ulcer. Review of the Discharge Medicare MDS assessment dated [DATE] revealed Resident #82 did not have a pressure ulcer. On 02/06/25 at 3:20 P.M. an interview with the Director of Nursing confirmed the Admission Minimum Data Set (MDS) assessment dated [DATE] and the Discharge MDS assessment dated [DATE] were coded incorrectly indicating Resident #82 did not have a pressure ulcer despite having a pressure ulcer present on admission and discharge. 51514 2. Review of the medical record for Resident #44 revealed the resident was admitted to the facility on [DATE]. Medical diagnoses included recurrent major depressive disorder, anxiety disorder, mild neurocognitive disorder due to known physiological condition with behavioral disturbance, and end stage renal disease. Review of an audiology consult note dated 03/06/24 revealed Resident #44 was referred by the facility due to decreased hearing. The audiology note stated Resident #44's right ear had profound hearing loss and the left ear had moderately severe high frequency sensorineural hearing loss (a type of hearing loss that occurs due to inner ear damage or auditory nerve issues). Review of Resident #44's physician's orders identified orders for Ativan (lorazepam) 0.5 milligram (mg) one tablet by mouth in the morning every Monday, Wednesday, and Friday, for anxiety/agitation related to anxiety disorder (ordered 10/23/24). Review of Resident #44's medication administration record (MAR) revealed Ativan was administered on 12/18/24, 12/20/24, and 12/23/24, (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) 3.0 assessment, dated 12/23/24, indicated Resident #44 did not receive any anti-anxiety medication and hearing was assessed as adequate. Interview on 02/03/25 10:34 A.M. with Resident #44 stated they were having increased hearing difficulties. Interview on 02/06/25 at 3:22 P.M. with the Director of Nursing (DON) verified Resident #44's MDS assessment did not accurately reflect the resident taking an anti-anxiety medication or reflect the resident's hearing loss that was indicated on the audiology notes.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on record review and interview, the facility failed to develop a comprehensive care plan to include hearing loss and monitoring the correct dialysis access for Resident #44, constipation and diarrhea for Resident #71, and oxygen use for Resident #67. This affected three residents (#44, #67, and #71) of 26 resident records reviewed. The facility census was 89. Findings include: 1. Review of the medical record for Resident #67 revealed an admitted [DATE] with diagnoses including pulmonary embolism, heart failure, hypertension, and type two diabetes mellitus. Review of the physician's orders for February 2025 identified no orders for oxygen use or maintenance of oxygen equipment. Review of Resident #67's care plan, last reviewed 12/10/24, revealed there was no plan of care for oxygen use. On 02/03/25 at 11:04 A.M., observation of Resident #67 revealed he was receiving oxygen via nasal cannula. On 02/03/25 at 11:06 A.M., interview with Licensed Practical Nurse (LPN) #384 confirmed Resident #67 was receiving oxygen. On 02/04/25 at 10:46 A.M., observation of Resident #67 revealed he was receiving oxygen via nasal cannula. On 02/10/25 at 11:12 A.M., interview with the Director of Nursing (DON) confirmed there were no orders or care plan for oxygen use for Resident #67. 22653 2. Review of Resident #71's medical record revealed diagnoses including cerebral infarction, type two diabetes mellitus, depression, migraine, hypertension, hyperlipidemia, hypothyroidism, anxiety disorder, delusional disorder, osteoporosis, and constipation. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #71 was cognitively intact and able to make herself understood. Review of physician orders revealed the following medications for constipation and/or diarrhea were ordered: -miralax 17 grams every 24 hours as needed for constipation with a start date of 06/04/24. The January 2025 Medication Administration Record (MAR) revealed one dose was administered on 01/18/25. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-milk of magnesia 30 milliliters every 24 hours as needed for constipation at bedtime if no bowel movement in three consecutive days with a start date of 09/27/24. The January 2025 MAR revealed one dose was administered on 01/14/25 which was ineffective. -bisacodyl laxative suppository 10 milligrams (mg) every 24 hours as needed for constipation at bedtime if no bowel movement after Milk of Magnesia was administered with a start date of 05/30/24 -mineral oil enema 118 milliliters (ml) every 24 hours as needed for constipation every day if no bowel movement after receiving a suppository. If no bowel movement within one hour of receiving the enema notify the physician. The start date was 05/30/24. - imodium A-D two tablets every six hours as needed for diarrhea with two caplets administered after the first loose stool, one caplet after each subsequent loose stool but no more than four caplets in 24 hours with a start date of 01/08/25. The January 2025 MAR revealed one dose was administered on 01/08/25. The February 2025 MAR revealed one dose was administered on 02/01/25 and on 02/02/25. No care plan was located regarding constipation. On 02/03/25 at 1:49 P.M., Resident #71 reported she had problems with constipation and sometimes went four to six days before she was able to have a bowel movement . Resident #71 stated this was not a new problem. While at home she used a little round pill. On 02/06/25 at 7:53 A.M., Certified Nursing Assistant (CNA) #436 stated Resident #71 required assistance to stand and pivot as she did not have use of one side of her body. Resident #71 also required assistance with toileting and was able to wipe herself. However, staff had to finish cleaning her. Resident #71 complained diarrhea at times and would ask for medicine to help her bowels move then Resident #71's daughter would request she be given medication for diarrhea. On 02/10/25 at 10:15 A.M., the Director of Nursing (DON) verified although Resident #71 had complaints of constipation and diarrhea, there was no care plan addressing gastrointestinal concerns (constipation and/or diarrhea). 51514 3. Review of Resident's #44 medical record revealed the resident was admitted to the facility on [DATE]. Medical diagnoses included recurrent major depressive disorder, anxiety disorder, mild neurocognitive disorder due to known physiological condition with behavioral disturbance, and end stage renal disease. Review of the audiology notes revealed Resident #44 had impacted (hard) ear wax removal from the right ear on 08/10/23, impacted ear wax removal from both ears on 10/16/23, profound hearing loss in the right ear on 03/26/24, and moderately severe high frequency sensorineural hearing loss (a type of hearing loss that occurs due to inner ear damage or auditory nerve issues) in the left ear on 03/26/24. Review of Resident #44's care plan, last reviewed on 01/09/25, revealed no focus areas, goals, or interventions for hearing loss or reversible hearing loss. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the care plan revealed a goal for monitoring a dialysis catheter port for signs and symptoms of infection and there was no goal for monitoring the left upper arm fistula (a type of dialysis access which is a surgical joining of a vein and an artery). Review of the dialysis communication report dated 02/02/25 indicated Resident #44 had a left upper arm fistula that was the dialysis access site in use. Interview on 02/03/25 10:34 A.M. with Resident #44 stated they were having increased hearing difficulties. During the interview, the resident frequently was unable to hear questions and needed multiple questions repeated due to not being able to hear the questions. Interview on 02/05/25 at 3:21 P.M. with the Director of Nursing (DON) verified Resident #44's hearing impairment wasn't addressed in the comprehensive care plan. The DON confirmed Resident #44's care plan indicated the resident had a dialysis catheter and did not include monitoring the left upper arm fistula for signs and symptoms of infection. Interview on 02/06/25 at 3:29 P.M. with the DON verified Resident #44 had a left upper arm fistula and did not have a dialysis catheter. Interview on 02/10/25 at 10:44 A.M. with Assistant Director of Nursing #336 confirmed the audiology notes indicated Resident #44 had profound hearing loss and multiple procedures for impacted ear wax removal.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observations, interviews, record review, and facility policy review, the facility failed to ensure Resident #55's doorway was free from potential fall hazards. This affected one (#55) resident of three residents reviewed for accidents. The facility census was 89. Findings include: Review of medical record for Resident #55 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease (COPD), unspecified dementia, malignant neoplasm of bladder (bladder cancer), benign prostatic hyperplasia (BPH) with lower urinary tract symptoms (enlarged prostate), and major depressive disorder. The resident was at moderate risk of falling. Review of Resident #55's quarterly Material Data Set (MDS) assessment revealed the resident was severely impaired cognitively; exhibited inattention behavior, which was continuously present and did not fluctuate; rejected care daily; used a walker and could walk up to 150 feet with supervision or touch assistance from staff; and had no falls since prior assessment. Further review of Resident #55's medical record revealed a psychiatric note, dated 12/03/24, which indicated the resident was in his room most of the time, but he would come out to walk with his walker at times. Review of Resident #55's care plan, initiated on 06/20/23, revealed the resident was at risk for falls related to incontinence at times, COPD, BPH, depression, would forget to ring the call light, and had an unsteady gait with a goal to minimize risk for falls/minimize injuries related to falls through next review. Interventions included implement preventative fall interventions/devices. Observation on 02/03/25 at 10:09 A.M. revealed a yellow square plastic basin sitting on the floor of the hallway with a wet floor sign sitting next to the basin, which was blocking part of Resident #55's doorway. The basin appeared to be collecting water from a ceiling leak. Interview on 02/03/25 at 12:32 P.M. with Responsible Party of Resident #55 revealed the last time she visited the resident about two weeks ago, there was a basin on the floor collecting water outside his room. Observation on 02/04/25 at 11:04 A.M. revealed the yellow plastic basin remained on the hallway floor with a caution wet floor sign observed sitting to the left of the sign right outside Resident #55's door. Interview on 02/04/25 at 11:31 A.M. with Licensed Practical Nurse (LPN) #347 revealed the basin had been there for a couple months and confirmed Resident #55 would come out of his room with his rollator and the basin on the floor outside of Resident #55's room was a fall hazard, but no residents had tripped on it. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/04/25 at 2:17 P.M. with Certified Nursing Assistant (CNA) #433 revealed the drip pan had been there for months. She stated Resident #55 used a rollator and would have to maneuver the rollator around the yellow basin to leave his room. Observation on 02/05/25 at 11:31 A.M. revealed the yellow basin and the wet floor sign had been removed from the hallway floor outside Resident #55's doorway. Interview at the time of observation with Resident #55 revealed he was unsure how long the yellow basin and wet floor sign had been outside his room. He stated he was able to leave his room by maneuvering his rollator around the sign and basin, which had been sitting on the hallway floor just outside his room. Observations on 02/05/24 during an environmental tour from 1:35 P.M. to 1:47 P.M. with Maintenance Supervisor (MS) #373 revealed the yellow basin and wet floor sign had been removed from the hallway outside Resident #55's room. Interview at the time of observation with MS #373 confirmed the yellow basin and wet floor sign had been removed that morning since the ceiling was no longer leaking. He stated the roof above the hallway outside Resident #55's room had sprung a small leak, which he thought he had fixed but the leak continued. He stated he never called a roofer to come in and fix the leak and stated the leak had been going on and off for about a month or two. Review of facility policy Falls, dated September 2021, revealed the staff would identify interventions to reduce the risk of falls. This deficiency represents non-compliance investigated under Complaint Number OH00161264.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation, interviews, record review, manufacturer's instructions, and facility policy review, the facility failed to ensure Resident #42 received nectar thick liquids as ordered. This affected one resident (#42); however, it had the potential to affect seven residents (#1, #30, #35, #42, #43, #50, #63) the facility identified as being on a thickened liquids. The facility census was 89. Findings include: Review of medical chart for Resident #42 revealed an admitted [DATE]. Diagnoses included altered mental status, oropharyngeal dysphagia (difficulty swallowing), dementia, schizophrenia (a mental health condition which may result in a mix of hallucinations, delusions, disorganized thinking and behavior), and legal blindness. Review of speech therapy evaluation and plan of treatment for Resident #42, signed 05/15/24, revealed the resident had been referred to speech therapy due to coughing/choking during oral intake, pneumonia, prolonged mastication with solids, and signs/symptoms of dysphagia. Clinical bedside assessment of swallowing revealed Resident #42 coughed one time on thin liquids and swallowing status was normal for mildly thick liquids. Review of care plan, created on 05/15/24, revealed Resident #42 was at altered nutritional status related to dementia and schizophrenia. Interventions included provide meals/snacks/fluids based on resident preferences and physician orders. Review of Resident #42's physician orders revealed an order dated 06/24/24 for regular diet, mechanical soft texture, nectar thick consistency diet. Review of speech therapy discharge summary for Resident #42, signed 06/28/24, revealed the resident had received speech therapy services from 05/15/24 to 06/28/24 and it was recommended the resident receive minced and moist diet consistency and slightly thick liquids (nectar thick). Review of Resident #42's quarterly Minimum Data Set (MDS) assessment, dated 11/15/24, revealed the resident was severely impaired cognitively, exhibited inattention and disorganized thinking behavior continuously which did not fluctuate, required supervision or touch assistance from staff for eating, and was on a mechanically altered diet. Review of Hormel Thick and Easy factory instructions printed on the canister revealed to achieve a mildly thick (nectar consistency) for eight ounces of coffee, two tablespoons and one and a half teaspoons of the product should be added to the liquid. Staff should then stir with a spoon or fork for approximately 15 to 30 seconds and allow one to four minutes for the beverage to reach desired thickness. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/03/25 at 11:29 A.M. revealed the coffee on Resident #42's lunch's meal tray was not nectar thick consistency, it was too thin. Certified Nursing Assistant #368 confirmed she had added one and a half tablespoons of thickener to Resident #42's eight ounce mug of coffee and after reading the manufacturer's thickening chart on the canister, she confirmed she hadn't added enough thickening product to the coffee to achieve nectar consistency and then proceeded to add additional thickener to the coffee to achieve the appropriate nectar consistency. Interview on 02/04/25 at 10:21 A.M. with Speech Language Pathologist (SLP) #445 revealed the staff would need to follow the directions on the back of the Hormel Thick and Easy container for mildly thick liquids to achieve a nectar thick consistency. She indicated if the liquids were not thick enough for a resident requiring nectar thick liquids, the resident could develop potential signs and symptoms of pharyngeal dysphagia. Interview on 02/04/25 at 11:26 A.M. with Certified Nursing Assistant (CNA) #390 revealed she also had been adding one and a half tablespoons of the thickening powder to a mug of coffee to achieve nectar thick consistency. Interview on 02/04/25 at 4:44 P.M. with Licensed Practical Nurse (LPN) #347 revealed Resident #42 was on nectar thick liquids. Most of the nectar liquids came from the kitchen prethickened; however, the staff on the floor had to thicken the coffee. After reviewing the Hormel Thick and Easy thickener mixing chart on 02/06/25 at 11:46 A.M. with SLP #444, the speech therapist stated for an eight-ounce cup of coffee, two tablespoons and one and a half teaspoons of the thickener powder would be needed to achieve nectar consistency. She confirmed using one and a half tablespoons of thickener for eight ounces of coffee would achieve a liquid consistency too thin to be considered nectar thick. Review of facility policy Therapeutic Diets, dated 09/01/21, revealed mechanically altered diets, as well as diets modified for medical or nutritional needs, would be considered therapeutic diets, and the facility would ensure each resident received the diet as ordered. This deficiency represents non-compliance investigated under Complaint Number OH00161651.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on observation, record review, and interview, the facility failed to ensure Resident #67 had physician's orders for oxygen use, oxygen tubing was dated at the time it was changed, and administration of oxygen was documented in the medical record at the time of each administration and Resident #2's oxygen cannula was stored properly. This affected two residents (#2 and #67) of three residents reviewed for respiratory care. The facility census was 89. Findings include: 1. Review of the medical record for Resident #67 revealed an admitted [DATE] with diagnoses including pulmonary embolism, heart failure, hypertension, and type two diabetes mellitus. Review of Resident #67's care plan, last reviewed 12/10/24, revealed there was no plan of care for oxygen use. Review of the physician's orders for February 2025 identified no orders for oxygen use or maintenance of oxygen equipment. Review of the medication administration record, vital signs, assessments, and progress notes for February 2025 revealed there was no documentation for the administration of oxygen via nasal cannula on 02/03/25 and 02/04/25. On 02/03/25 at 11:04 A.M., observation of Resident #67 revealed he was receiving oxygen via nasal cannula and the oxygen tubing was not dated. On 02/03/25 at 11:06 A.M., interview with Licensed Practical Nurse (LPN) #384 confirmed Resident #67 was receiving oxygen and there was no date on the oxygen tubing to indicate when it was changed. On 02/04/25 at 10:46 A.M., observation of Resident #67 revealed he was receiving oxygen via nasal cannula. On 02/10/25 at 11:12 A.M., interview with the Director of Nursing (DON) confirmed there were no orders or care plan for oxygen use for Resident #67. Review of the facility's policy for oxygen administration, dated 09/2021, revealed the need for oxygen would be determined by a physician's order. 35765 2. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, protein-calorie malnutrition, history of falling, kidney disease, vitamin D deficiency, hypothyroidism, hypertension, atherosclerotic heart disease, hyperlipidemia, osteoarthritis, hypotension, depression, anxiety disorder, heart failure, anemia, and edema. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/03/35 at 10;20 A.M. revealed the portable oxygen tank nasal cannula was hanging on the back of the wheelchair for Resident #2 not in a protective bag. On 02/03/25 at 10:30 A.M. an interview with the Director of Nursing verified the portable oxygen tank nasal cannula was hanging on the back of the wheelchair for Resident #2 not in a protective bag.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on record review, review of the facility's dialysis contract, and interview, the facility failed to monitor vital signs and weights before and after dialysis for Residents #52 and #239, and failed to maintain adequate communication with the outside dialysis center for Resident #239. This affected two residents (#52 and #239) of three reviewed for dialysis. The facility census was 89. Findings include: 1. Review of the medical record for Resident #52 revealed an admitted [DATE] with diagnoses including end-stage renal disease, type two diabetes mellitus, dependence on renal dialysis, and heart failure. Review of the physician's orders for February 2025 identified orders for hemodialysis three times weekly on Monday, Wednesday and Friday at the in-facility dialysis center. Review of the dialysis communication reports for Resident #52 revealed pre-dialysis vital signs were not documented on 03/20/24, there was no dialysis communication form for 04/08/24, post-dialysis vital signs were not documented on 04/19/24, pre-dialysis weight and post-dialysis weight were not documented on 04/26/24, pre-dialysis vital signs were not documented on 06/10/24, pre-dialysis vital signs were not documented on 08/14/24, pre-dialysis vital signs were not documented on 08/28/24, pre-dialysis vital signs were not documented on 09/25/24, pre-dialysis vital signs were not documented on 10/28/24, and pre-dialysis vital signs were not documented on 12/24/24. Review of the vital signs recorded in the electronic health record revealed the following: - On 03/20/24, there was no documented oxygen saturation level, pulse, respiration rate, temperature, or weight. - On 04/08/24, there was no documented oxygen saturation level, pulse, respiration rate, temperature, weight, or pre-dialysis blood pressure. - On 04/19/24, there was no documented oxygen saturation level, pulse, respiration rate, temperature, or weight. - On 04/26/24, there was no documented weight. - On 06/10/24, there was no documented oxygen saturation level, pulse, respiration rate, temperature, weight, or blood pressure. - On 08/14/24, there was no documented oxygen saturation level, pulse, respiration rate, temperature, weight, or blood pressure. - On 08/28/24, there was no documented oxygen saturation level, pulse, respiration rate, temperature, weight, or blood pressure. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 09/25/24, there was no documented oxygen saturation level, pulse, respiration rate, temperature, weight, or blood pressure. - On 10/28/24, there was no documented oxygen saturation level, pulse, respiration rate, temperature, weight, or blood pressure. - On 12/24/24, there was no documented oxygen saturation level, pulse, respiration rate, temperature, weight, or blood pressure. On 02/05/25 at 9:04 A.M., interview with the Director of Nursing (DON) verified vital signs were not documented on every dialysis day for Resident #52. Review of the facility's dialysis services and coordination agreement, dated 09/01/22, revealed facility staff were required to provide a dialysis communications form upon bringing residents to the dialysis center. Facility staff were required to list the resident's most recent vital signs, current weight, mental status, any change in condition since the previous dialysis treatment, and new medications. 2. Review of the medical record for Resident #239 revealed an admitted [DATE] with diagnoses including end-stage renal disease, type two diabetes mellitus, dependence on renal dialysis, and hypertension. Review of the physician's orders for February 2025 identified orders for dialysis every Tuesday, Thursday and Saturday and to obtain vital signs prior to and upon return from dialysis. Review of the dialysis communication forms revealed there was pre-dialysis weight or post-dialysis vitals recorded on 01/14/25, and there were no communication forms between the facility and the outside dialysis center on 01/18/25, 01/21/25, 01/23/25, 01/25/25, 01/28/25, and 01/30/25. Review of the vital signs recorded in the electronic health record revealed the following: - On 01/18/25, there was no documented pre-dialysis oxygen saturation level, pulse, respiration rate, temperature, weight, or blood pressure. - On 01/21/25, there was no documented pre-dialysis weight. - On 01/23/25, there was no documented pre-dialysis or post-dialysis weight. - On 01/25/25, there was no documented pre-dialysis or post-dialysis weight, and no documented post-dialysis oxygen saturation level, pulse, respiration rate, temperature, weight, or blood pressure. - On 01/28/25, there was no documented pre-dialysis oxygen saturation level, pulse, respiration rate, temperature, weight, or blood pressure, and no documented post-dialysis weight. - On 01/30/25, there was no documented pre-dialysis or post-dialysis blood pressure or weight, and there was no documented post-dialysis oxygen saturation level, pulse, respiration rate, or temperature. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes for January 2025 and February 2025 revealed two progress notes, dated 02/04/25 at 8:35 A.M. and 02/04/25 at 9:26 A.M., that the dialysis center was notified Resident #239 was being transferred to the hospital and would not be attending dialysis that date. There was no other documented communication between the facility and the dialysis center. On 02/05/25 at 3:55 P.M., interview with the Director of Nursing (DON) stated Resident #239's dialysis center did not always send the dialysis communication forms back to the facility. On 02/05/25 at 4:40 P.M., interview with the DON verified the facility did not have dialysis communication forms for Resident #239 for all dialysis days. On 02/06/25 at 9:56 A.M., interview with Dialysis Administrative Assistant #520 stated dialysis communication forms were not always sent with residents to dialysis and even if they were, they were not always completed by dialysis staff after each dialysis treatment.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 46195 Based on review of employee files and staff interviews, the facility failed to consistently complete staff evaluations for two Certified Nursing Assistants (CNA). This was identified in two personnel files (CNA #367 and #370) out of five employee files reviewed and had the potential to affect all residents except the 26 residents (#12, #17, #18, #20, #24, #29, #30, #35, #42, #45, #48, #49, #53, #54, #55, #59, #61, #62, #63, #66 #76, #78, #79, #335, #336, #337) on the E wing where CNA #367 and #370 had not worked. Findings include: 1. An interview on 02/05/25 at 11:48 A.M. with CNA #367 revealed she was not receiving evaluations on a consistent basis. Review of CNA #367's employee file revealed a hire date of 11/09/22. There was no 90 day or yearly evaluation for 2023. There was a yearly evaluation dated 11/14/24. Interview on 02/10/25 at 9:05 A.M. and again at 10:42 A.M. with Human Resources (HR) /Personnel Manager #316 confirmed the only evaluation in Resident #367's employee file was dated 11/14/24, and she should have had a 90 day and a yearly evaluation in 2023. HR/Personnel #316 was not sure why the evaluations had been missed. 2. Reveiw of CNA #370 revealed a hire date of 10/07/24. There was no 90-day evaluation in her employee file. Interview on 02/10/25 at 10:42 A.M. with Human Resources (HR) /Personnel #316 confirmed a 90 evaluation had not been completed for CNA #370 and HR/Personnel #316 was not sure why it had been missed.

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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** 46195 Based on record review, interviews, and facility policy review, the facility failed to ensure narcotic pain medications were provided according to physician orders and non-pharmacologic pain relief interventions were encouraged prior to medication administration. This affected one resident (#14) of five residents reviewed for unnecessary medications. The facility census was 89. Findings include: Review of medical record for Resident #14 revealed an admitted [DATE]. Diagnoses included end stage renal disease (ESRD) with dependence on dialysis, muscle weakness, spondylolisthesis of thoracolumbar region(a condition where a vertebra slips out of alignment and presses on the vertebra below it which can put pressure on nerves around spine and cause back pain), osteoarthritis (a condition where the protective cartilage that cushions the end of bone wears down over time which can cause pain) of right knee, hydronephrosis with renal and ureteral calculous obstruction (a condition where urine builds up in a kidney stone due to a blockage), generalized osteoarthritis, and chronic gout (a form of arthritis characterized by sudden, severe attacks of pain, swelling, redness and tenderness in one or more joints). Review of care plan initiated on 10/23/22 revealed Resident #14 had a potential for pain related to end stage renal disease with dialysis status. Interventions included administering medications per physician orders. Review of Resident #14's modification of annual Minimum Data Set (MDS), dated [DATE], revealed the resident was cognitively intact, and during the assessment reference period had not received routine pain medications but had received non pharmacological interventions and as needed pain medications and had occasional pain level of five, which had affected her sleep and day to day activities. Review of Resident #14's physician orders revealed an order dated 12/24/24 for hydrocodone-acetaminophen tablet 5-325 milligram (mg), give one tablet every six hours as needed for a pain level between five and ten, with ten being the worst pain possible. Review of Resident #14's January 2025 Medication Administration Record (MAR) revealed the resident had received one tablet of hydrocodone-acetaminophen 5-325 mg for a pain level less than five on the following days : on 01/04/25 at 8:56 P.M. for a pain level of three, on 01/05/25 at 7:04 P.M. for a pain level of zero, on 01/06/25 at 8:33 P.M. for a pain level of three, on 01/08/25 at 4:37 A.M. for a pain level of three and again at 8:49 P.M. for a pain level of three, on 1/09/24 at 9:47 P.M. for a pain level of four, on 01/11/25 at 7:42 P.M. for a pain level of zero, on 01/12/25 at 7:38 P.M. for a pain level of zero, on 01/13/25 at 6:43 P.M. for a pain level of three, on 01/14/25 at 8:25 P.M. for a pain level of three, on 01/17/25 at 7:47 P.M. for a pain level of two, on 01/18/25 at 8:43 P.M. for a pain level of three, on 01/20/25 at 6:52 A.M. for a pain level of three and again at 8:39 P.M. for a pain level of three, and on 01/21/25 at 7:37 P.M. for a pain level of three. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 02/10/25 at 8:15 A.M. with the Director of Nursing (DON) revealed Resident #14 was to receive one tablet hydrocodone-acetaminophen 5-325 mg when the resident was experiencing pain levels between five and ten scale. After reviewing the January 2025 MAR for Resident #14, the DON confirmed hydrocodone-acetaminophen 5-325 mg had been given to Resident #14 with pain levels less than five and stated she shouldn't have been given hydrocodone-acetaminophen 5-325 mg with pain levels less than five. The DON verified the nurse is to try non-pharmacologic interventions for pain and document those interventions tried in the progress notes or on the MAR. The DON confirmed there was no evidence to support the interventions were tried/offerred. Review of facility policy Pain Assessment and Management, dated September 2021, revealed pain management includes effectively recognizing the presence of pain, developing and implementing approaches to pain management, identifying and using specific strategies for different levels of pain. The nurses were to implement the medication regimen as ordered. Review of facility policy Administering Medications, undated, revealed medications must be administered in accordance with the orders. This deficiency represents non-compliance investigated under Complaint Number OH00161651.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 35765 Based on observations, review of the medical record and interview with staff the facility failed to ensure multi-dose insulin pens were dated as to when they were first accessed. This affected three residents (Resident #11,#25 and #242) of 24 residents prescribed insulin. Findings included: 1. Observation of medication administration with Licensed Practical Nurse (LPN) #385 on 02/05/25 at 7:45 A.M. revealed a humulin 70/30 multi-dose Kwikpen for Resident # 242 and a Lantus multi-dose SoloStat pen for Resident #25 that were not dated as to when they were first accessed. On 02/05/25 at 7:50 A.M. an interview with LPN #385 verified the multi-dose insulin pens were not dated as to when the insulin were first accessed. 2. Observations of medication administration with LPN #384 on 02/05/25 at 8:05 A.M. revealed a Novolin 70/30 multi-dose FlexPen for Resident #11 was not dated as to when it was first accessed. On 02/05/25 at 8:15 A.M. an interview with LPN #384 verified there was no dated as to when the multi-dose insulin pen was first accessed. Review of the undated facility policy titled, Administering Medications, revealed medications should be administered in a safe and timely manner and as prescribed. The expiration or beyond use date on the medication label must be checked prior to administration. When using a multi-dose container the date opened should be recorded on the container.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on medical record review and interview, the facility failed to ensure a physician order was written prior to obtaining a laboratory test. This affected one (Resident #71) of five residents reviewed for medication use. Findings include: Review of Resident #71's medical record revealed diagnoses including type two diabetes mellitus and stroke. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #71 was usually able to understand others and was cognitively intact. Review of Resident #71's physician orders revealed medication orders for the management of the diabetes mellitus. On 09/28/24 an order was written for metformin Extended Release 1000 milligrams (mg) twice a day. An order dated 12/18/24 was written for insulin NPH isophane and regular suspension pen 70/30 with a concentration of 100 units per milliliter. Ten units were ordered every day. A pharmacy recommendation dated 07/26/24 revealed a request for monitoring HgbA1c (laboratory test that measured the average amount of sugar in one's blood over the last two to three months) every three months. A HgbA1c level was obtained on 10/10/24. Additional HgbA1c results were obtained on 11/21/24 and 12/03/24. On 02/05/25 at 3:53 P.M., the Director of Nursing (DON) was interviewed regarding why HgbA1c levels were obtained in October, November and December 2024. The DON stated Resident #71 saw multiple doctors and sometimes they gathered lab tests outside the office and sent them or order the lab tests so they were available at the time of the visit. On 02/10/25 at 11:05 A.M., the DON verified she had been unable to locate an order for the HgbA1c obtained in December 2024.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on observation, record review and interview, the facility failed to ensure medical records were complete and accurate for Residents #3, #44, and #71. This affected three (#3, #44, and #71) of 26 resident records reviewed. The facility census was 89. Findings include: 1. Review of the medical record for Resident #3 revealed an admitted [DATE] with diagnoses including quadriplegia, personal history of traumatic brain injury, contracture of the right knee, contracture of the left knee, calcification and ossification of muscle, contracture of the right foot, contracture of the left foot, and chronic pain due to trauma. Review of the comprehensive care plan for activities of daily living (ADLs), initiated 10/21/22, revealed Resident #3 had an ADL self-care deficit related to quadriplegia. Interventions included mechanical lift for transfers. Review of therapy screenings dated 01/22/24, 07/15/24, and 12/12/24 revealed Resident #3 was dependent on staff for ADLs and was unable to perform any transfer or walking activities. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/09/24, indicated Resident #3 was cognitively intact and was dependent on staff for all ADLs including transfers and bathing. Review of the nurse aide task documentation indicated Resident #3 independently performed a chair/bed to chair transfer on 01/25/25 and 02/02/25, and independently performed bathing on 01/15/25, 01/17/25, and 01/20/25. On 02/04/25 at 3:44 P.M., interview with the Director of Nursing (DON) verified the above nurse aide tasks were inaccurately documented as completed independently for Resident #3. 22653 2. On 02/03/25 at 1:49 P.M., Resident #71 reported she had problems with constipation and sometimes went four to six days before she was able to have a bowel movement . Resident #71 stated this was not a new problem. While at home she used a little round pill. Review of Resident #71's medical record revealed diagnoses including cerebral infarction, type two diabetes mellitus, depression, migraine, hypertension, hyperlipidemia, hypothyroidism, anxiety disorder, delusional disorder, osteoporosis, and constipation. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #71 was cognitively intact and able to make herself understood. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During review of bowel movement records from 01/07/25 to 02/05/25 with the Director of Nursing (DON) on 02/10/25 at 10:09 A.M., the DON verified although there were periods of time greater than three days (01/08/25-01/12/25) when there was no evidence of Resident #71 having a bowel movement, the records were incomplete as there was one shift on 01/08/25, 01/10/25 and 01/11/25 with no documentation. 51514 3. Review of Resident #44's medical record revealed the resident was admitted to the facility on [DATE]. Medical diagnoses included recurrent major depressive disorder, anxiety disorder, mild neurocognitive disorder due to known physiological condition with behavioral disturbance, and end stage renal disease. Review of Resident #44's physician's orders identified orders for Tramadol (pain reliever) 50 milligram (mg) tablet every six hours as needed for pain with instructions to attempt and document non-pharmacological interventions (ordered 07/05/24), and Tylenol (pain reliever) 325 mg two tablets by mouth every six hours as needed for pain with instructions to attempt and document non-pharmacological interventions (ordered 01/18/25). Review of Resident #44's medication administration record (MAR) revealed Tramadol was administered on 01/12/25, 01/19/25, 01/27/25, 01/30/25, 02/03/25, and 02/05/25, and Tylenol was administered on 02/03/25. The MAR documentation did not specify what non-pharmacological interventions were attempted prior to administration of pain medications. Review of Resident #44's progress notes revealed there was no documentation of the specific non-pharmacological interventions that were attempted prior to administration of pain medications. Interview on 02/05/25 at 1:44 P.M. with Licensed Practical Nurse (LPN) #384 and Assistant Director of Nursing (ADON) #336 stated the non-pharmacological interventions attempted for pain management should be documented in the progress notes. Interview on 02/05/25 at 2:37 P.M. with ADON #336 verified that specific non-pharmacological interventions attempted were not documented in the progress notes linked to pain medication administration.

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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 0867 Level of Harm - Potential for minimal harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 22653 Based on policy review and interview, the facility failed to establish comprehensive written policies and procedures related to the Quality Assurance (QA) process. This had the potential to affect all 89 residents. Findings include: Review of the Quality Assessment and Assurance policy (dated September 2021) revealed the committee would consist of the Administrator, the Director of Nursing Services, a physician designated by the facility and other facility staff members. The committee shall be responsible for identifying issues needing action that affect quality of care and services provided to residents. The committee shall meet at least quarterly to identify quality assessment and assurance issues, and to develop and implement or oversee implementation of, appropriate plans for identified quality deficiencies. The facility would expand and develop the Quality Assurance (QA) Committee to meet the requirement of the Quality Assurance and Quality Improvement Committee. Issues of quality concerns that rise to a level that demonstrated a lapse in the facility standards or has the potential to fall below those standards may be processed through the Quality Assurance team, which may include the development of a corrective plan to be monitored over time. The Quality Assessment and Assurance policy was missing information including the role/participation of the Infection Control Preventionist (ICP). The policy did not address procedures for feedback, data collection system and monitoring, including adverse event monitoring. The policy lacked information regarding how actions taken to ensure performance improvement would be evaluated and tracked to ensure the improvements were realized and sustained. On 02/10/25 at 2:40 P.M., the Director of Nursing verified the facility did not have any additional policies regarding QA. The policy which was provided from September 2021 was a corporate policy. On 02/10/25 at 3:06 P.M., the Administrator verified the Quality Assessment and Assurance policy did not address the role/participation of the ICP in the QA process and verified the facility's policy did not contain required information.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 22653 Based on review of Quality Assurance (QA) committee meeting attendance sheets, policy review and interview, the facility failed to ensure a QA meeting was held the first quarter of 2024. This had the potential to affect all 89 residents. Findings include: Upon entrance with the Administrator and Director of Nursing (DON), sign in sheets for quality assurance meetings held in the year 2024 were requested. There were no attendance sheets provided for a meeting in the first quarter of 2024. Review of the Quality Assessment and Assurance policy (dated September 2021) revealed the committee shall meet at least quarterly to identify quality assessment and assurance issues, and to develop and implement or oversee implementation of, appropriate plans for identified quality deficiencies. On 02/10/25 at 2:40 P.M., the DON verified there was no documentation/attendance sheets which revealed a QA meeting was held the first quarter of 2024. On 02/10/25 at 3:13 P.M., the Administrator verified she had no evidence a QA meeting was held the first quarter of 2024. The records before she was employed were not available to her.

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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** 43061 Based on record reviews, observations, interviews, facility policy review, and review of Centers for Disease Control (CDC) Guidelines, the facility failed to ensure a comprehensive infection control program was maintained to ensure the health and safety of all residents in the facility including timely notification of the local health department (LHD) regarding positive cases of Coronavirus (COVID-19), failed to have a procedure in place to address staff illness, failed to ensure a comprehensive water maintenance program was continuously implemented, failed to clean the rubber stopper of a multi-use insulin pen and failed to track and trend potential outbreak illness in the facility. This affected Resident #23, #35, #69, #71, #73, #186, #187 and #235 but had the potential to affect all 89 residents residing in the facility. Findings include: 1.Review of the medical record for Resident #235 revealed an admitted [DATE] with diagnoses including type II diabetes, end stage renal disease, cellulitis of right lower limb, dependence on renal dialysis, and hypertension (HTN), Review of the physician orders for January 2025 revealed an order for droplet precautions. Review of the minimal data system (MDS) quarterly assessment dated [DATE] revealed Resident #235 had intact cognition. Review of the progress note dated 01/25/25 11:42 .M. revealed Resident #235 tested positive for COVID on 01/26/25 per facility protocol. Review of the e-mail dated 02/04/25 from the DON to the LHD revealed the DON notified the health department of Resident #235 testing positive for COVID-19. Interview on 02/06/25 at 10:30 A.M. via phone with Registered Nurse (RN) #500 and RN #501 (from the LHD) revealed COVID cases are to be reported by the end of the next business day to the LHD. RN #500 and RN #501 confirmed they didn't receive notification of the COVID-19 case until 02/04/25 via email from the facility. Further interview revealed they received the email nine days after confirmation and the facility is a little behind in reporting to them. Interview on 02/10/25 at 8:54 A.M. with the Director of Nursing (DON) revealed the facility to report new COVID-19 cases as soon as possible to the health department. The DON confirmed the email dated 02/04/25 was the facility reporting the COVID-19 case to the LHD. The DON stated she called the LHD and reported the case to them but she was unable to provide evidence of the call made. 2.Interview on 02/06/25 at 9:30 A.M. with the Administrator revealed a management staff had been up all night vomiting and the Administrator was unsure if the staff person would be in (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 02/06/25 at 9:39 A.M. with the Administrator revealed she did not feel comfortable speaking regarding symptoms in which a staff member is to stay home. The Administrator reported if staff vomited all night she would encourage them to stay home for 24 hours. The Administrator verified there was no facility policy regarding staff illness. Interview on 02/06/25 at 10:30 A.M. via phone with RN #500 and RN #501 revealed best practice for sick staff is to stay home for at least 24 hours and free of symptoms. Both RN #500 and #501 stated the facility should follow their employee illness policy but this was the first time they had heard of a provider not having a policy or procedure regarding staff illness. Interview on 02/06/25 at 11:30 A.M. with Staffing Scheduler #440 revealed staff vomiting all night would not be permitted to work and would be sent home and would need to remain home for 48 hours before returning to work. Interview on 02/06/25 at 2:13 P.M. with the Assistant Director of Nursing (ADON) #336 revealed she would not permit a staff member to work if they vomited the night but the facility did not have an employee illness policy and procedure so the facility would follow the CDC guidelines which is 48 hours after symptoms are relieved. Review of the Center for Disease Control (CDC) guidelines for sick employees revealed all employees should stay home if they are sick until at least 24 hours, both are true: their symptoms are getting better overall, and they have not had a fever* (temperature of 100 degrees Fahrenheit or 37.8 degrees Celsius or higher) and are not using fever-reducing medication. There was no policy for staff illness. 3. Review of the facility water management program revealed the facility did not have water management logs for 2023. Interview on 02/10/25 at 8:54 A.M. with Maintenance Director #373 revealed he had no water management logs for the year 2023. Maintenance Director #373 reported they are to be done throughout the week, but he did not complete them in 2023. 35765 4. Observation of medication administration on 02/05/25 at 12:35 P.M. revealed Licensed Practical Nurse (LPN) #347 did not clean the rubber seal/needle access prior to placing the needle on the humolog KwikPen for Resident #35. On 02/05/25 at 12:40 P.M. an interview with LPN #347 verfied she had not cleaned the rubber seal/needle access prior to placing the needle on the humolog KwikPen for Resident #35. 22653 5. During the onsite survey, the following information was obtained: (continued on next page)

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	365604	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Meadows Skilled Nursing and Rehab	7770 Columbus Road NE Louisville, OH 44641

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a.Review of Resident #187's medical record revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, chronic pain syndrome, heart disease, obstructive sleep apnea, and orthopedic aftercare. A nursing note dated 01/27/25 at 6:41 P.M. indicated the nurse received a call from Resident #187's daughter stating Resident #187 told her she had a cough and was coughing up yellow sputum. The nurse advised Resident #187's daughter that the resident did not present with a cough throughout the day as she had been there since 5:45 A.M. and Resident #187 had not complained of respiratory concerns. Resident #187's daughter became very argumentative and belligerent, demanding Resident #187 be sent to the emergency room for evaluation. The assistant director of nursing and certified nurse practitioner were notified of Resident #187's daughter's demands. A change in condition nursing note dated 01/27/25 at 6:55 P. M. indicated family was demanding Resident #187 be sent to the hospital. Resident #187's temperature was 97.7, respirations were 18, and blood pressure was 155/78. Oxygen saturation levels were 92% on room air. A nursing note dated 01/28/25 at 3:08 A.M. revealed Resident #187 returned from the hospital with a diagnosis of influenza A. On 02/03/25 at 10:49 A.M., Resident #187 was observed with isolation signs on her door. Certified Nursing Assistant (CNA) #367 reported Resident #187 was on isolation due to influenza A. b. On 02/03/25 at 10:48 A.M., Resident #186 was observed lying in bed with a basin at the foot of the bed. Resident #186 stated she was recovering from the flu and that was the first morning she had not vomited. Review of Resident #186's medical record revealed diagnoses including traumatic subdural hemorrhage, displaced fracture of the first cervical vertebra, multiple fractures of ribs on the right side, gastro-esophageal reflux disease, generalized anxiety disorder, fibromyalgia, and mild cognitive impairment. An admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #186 was cognitively intact. A nursing note dated 02/01/25 at 3:30 P.M. indicated Resident #186's family reported to the nurse that Resident #186 voiced her stomach was upset, then had an emesis. Resident #186 verified she had an emesis but denied headache, chest pain, and shortness of breath. Mylanta was administered and Resident #186 was encouraged to rest. A nursing note dated 02/01/25 at 5:08 P.M. indicated staff reported Resident #186 had another large emesis. Resident #186 reported an upset stomach and Resident #186 had another extra large emesis in front of the nurse which was yellow bile in color. Resident #186 also complained of a headache from all this throwing up. Resident #186 refused dinner and was encouraged to increase fluid intake. A nursing note dated 02/02/25 at 12:21 P.M. indicated Resident #186 refused both breakfast and lunch. Resident #186 had two additional emesis and complained of a queasy stomach. An electronic Medication Administration Record (eMAR) note dated 02/02/25 at 7:26 P.M. revealed senna-plus was held due to diarrhea. A nursing note dated 02/03/25 at 12:41 A.M. revealed a COVID test was negative. (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 progress notes on 02/02/25 indicated Resident #73 had diarrhea and vomiting requiring her to be changed eight times, complained of a headache and feeling sick to her stomach. The February 2025 MAR revealed imodium AD was administered on 02/03/25 at 3:14 A.M. for loose stools. f. On 02/03/25 at 10:51 A.M., Resident #23 was observed lying in bed with the head of her bed raised. Resident #23 stated she was vomiting that morning and felt chilled. Review of Resident #23's medical record revealed diagnoses including non-pressure chronic ulcer of the right foot, cerebral infarction, acute pulmonary edema, type two diabetes mellitus, chronic respiratory failure, chronic obstructive pulmonary disease, morbid obesity, asthma, heart disease and dependence on renal dialysis. A modification of a quarterly MDS dated [DATE] indicated Resident #23 was cognitively intact. Nursing notes on 02/03/24 revealed general complaints about not feeling well. Resident #23 was sent to the hospital from the wound care center on 02/04/25 and diagnosed with cellulitis. On 02/03/25 after resident interviews between 10:33 A.M. and 1:10 P.M. revealed multiple residents reported flu symptoms and were not noticed in isolation, the Director of Nursing (DON) was interviewed and stated the residents mentioned were a group of friends who talk and convince one another of ailments. The DON denied any of the residents had flu except Resident #187. On 02/23/25 at 10:57 A.M., Certified Nursing Assistant (CNA) #367 stated she had noticed an increase of residents with flu-like symptoms with abnormal vomiting and diarrhea and complaints of overall not feeling well. On 02/06/25 (time withheld to aid in maintaining confidentiality) a certified nursing assistant who requested anonymity stated she had noticed multiple residents on B hall had flu-like symptoms and it continued to spread. CNA #436 stated she did not believe the facility was testing symptomatic residents. On 02/06/25 at 11:00 A.M., the DON indicated although multiple residents had emesis, diarrhea and other symptoms from 01/27/25 to 02/02/25, Resident #71 had a history of nausea, vomiting and diarrhea. Resident #23 frequently complained of not feeling well and skipped appointments and treatment due to such so it was not a new onset illness. No explanation was provided as to the reason multiple residents had issues with similar symptoms within a day or two of one another other than the facility had an ill population. The DON stated she did not suspect an infectious outbreak because no residents had an elevated temperature. Lastly, the DON shared no tracking or increased precautions were needed.