STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365612	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Acres Nursing Home	44565 Sunset Road Caldwell, OH 43724

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50538 Based on observation, interview, self reported incident review, and record review the facility failed to treat residents in a dignified manner as evidenced by one resident being told to stay in her damn room and two residents being assisted with their meals by Certified Nursing Assistants who were standing above them. This affected three of six residents (#33, #36 and #57) reviewed for dignity. The facility census was 84. Findings include: 1. Review of Resident #33's medical record revealed an admitted [DATE] and diagnoses including Wernicke's encephalopathy, hyperlipidemia, anxiety, major depressive disorder, and alcohol abuse in remission. Review of Resident #33's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of zero indicating severe cognitive impairment and wandering behavior for one to three days of the review period. Further review revealed Resident #33 was independent with ambulation and transfers. Review of Resident #33's behavior plan of care revealed Resident #33 exhibited the behavioral symptoms of verbal aggression, wandering- wandering into other resident rooms, cursing at staff, taking other resident's food and drinks, aggravating other residents, not leaving other resident's personal items alone, rummaging, tearful, and unplugging equipment. Interventions for Resident #33 include redirecting her from other resident's rooms, removing her from overly stimulating situations, taking her for a walk in the facility, and offering to take her to smoke at scheduled smoke break times. Review of the facility self-reported incident investigation started on 02/03/25 at 6:36 P.M. revealed that on 02/03/25 at 6:00 P.M. Certified Nursing Assistant (CNA) #307 was witnessed to have one hand on Resident #33's back and one hand on her arm and was pushing/guiding her fast, almost like running from another resident's room to her room across the hall. CNA #307 stated to Resident #33 stay in your damn room and slammed the door shut. This was witnessed by Licensed Practical Nurse (LPN) #126 and CNA #309. LPN #126 reported the incident to the administrator and CNA #307 was suspended pending investigation. A head-to-toe assessment was completed of Resident #33 and no concerns were noted. Resident #33 did not remember the incident and did not appear to have any harm or distress. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #33 throughout the survey revealed the resident was moving about the secure unit and interacting with the facility staff and her peers. Resident #33 showed no signs of fear or distress. In an interview on 05/20/25 at 2:12 P.M. LPN #126 stated on 02/03/25 she was working on the secure unit and had stepped off the unit to fax something and was returning when she saw CNA #307 with her hand on Resident #33's arm and her other hand on her back pushing her out of another resident's room and across the hall to her own room. Once Resident #33 was in the room CNA #307 told the resident to stay in her damn room. She immediately sent CNA #307 home and notified the administrator of the incident. LPN #126 assessed Resident #33 and found no physical injuries. LPN #126 stated that Resident #33 has dementia and is not really aware of what happened and was not upset by the incident. LPN #126 stated that Resident #33 did not change from her baseline. LPN #126 further stated that an alert resident would have been very upset with the treatment Resident #33 received from CNA #307. LPN #126 did not feel Resident #33 was treated with dignity and respect in the situation. She would have been upset if she was spoken to that way or if it had been her family member who was spoken to that way. LPN #126 stated she wants the residents she cares for to be cared for like she would want her family to be cared for. In an interview on 05/20/25 at 2:49 P.M. Speret Hall Program Director LPN #178 revealed she did not feel Resident #33 had been treated with dignity during the 02/03/25 incident when CNA #307 told her to stay in her damn room. She would not have wanted to be treated that way if it was her. 28923 2 a.) On 05/18/25 11:58 A.M., an observation during the lunch meal service for the residents eating in their rooms on Unit 2 noted Certified Nursing Assistant (CNA) #187 to be feeding Resident #36, while the resident was in her bed. CNA #187 was standing at the side of the bed while feeding the resident. She was not noted to be sitting in a chair at the bedside to provide the resident with a dignified dining experience. 2 b.) On 05/18/25 at 12:00 P.M., an observation during the lunch meal service for the residents eating in their rooms on Unit 2 noted CNA #500 to be feeding Resident #57, while the resident was in her bed. CNA #500 was standing at the side of the bed while feeding the resident. She was not noted to be sitting in a chair at the bedside to provide the resident with a dignified dining experience. On 05/18/25 at 12:10 P.M., an interview with CNA #187 and CNA #500 confirmed they did feed Resident #36 and #57 in bed, while they stood at the residents' bedside. CNA #187 stated they stood while feeding the residents because it was easier for them to feed the residents while standing. They denied they were standing while feeding those residents for any reason that was beneficial to the residents. When asked why they were not sitting at the side of the bed to feed the residents to promote a more dignified eating experience, CNA #187 reported they were not trained that way to do so. They acknowledged it was considered a dignity issue to stand over a resident while feeding them. They further acknowledged they should be sitting in a chair beside the bed at the resident's eye level to promote a more dignified dining experience. CNA #187 was noted to leave Unit 2 returning a short time later with a folding chair. She provided the folding chair to CNA #500, so CNA #500 could continue to assist Resident #57 with her meal while in a seated position. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy on Meal Service updated 05/01/25 revealed it was the facility's policy to serve nutritional meals promptly and to provide meal assistance as needed. Residents requiring feeding assistance would be provided assistance at the time they received their meal. Staff providing assistance would be seated next to the resident and engaging in conversation with the resident or offering cueing during the meal.

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F 0600 Level of Harm - Minimal harm or potential for actual harm 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** 32801 Based on review of self-reported incident (SRI), review of the facility's investigation, interviews, and policy review the facility failed to prevent resident neglect. This affected one resident (#73) of one resident reviewed for abuse. Findings included: Record review revealed Resident #73 was admitted to the facility on [DATE] with diagnoses including cardiac arrhythmia, heart failure, muscle weakness, abnormalities of gait and mobility, weakness, retention of urine, right knee pain, benign prostatic hyperplasia without lower urinary tract symptoms, obstructive and reflux uropathy, and reduced mobility. Review of Resident #73's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident's Brief Interview for Mental Status (BIMS) was 11. The resident was dependent for toiling. He required partial to moderate assistance for personal hygiene, dependent for sitting to lying, lying to sitting, sitting to stand, chair to bed, toilet, and shower transfer. He required substantial/maximal assist to roll left to right. He was always incontinent of urine and bowel. He was not on a toileting program. No rejection of care noted. Review of Resident #73's urinary incontinence plan of care dated 05/29/24 revealed to check and provide incontinence care as needed. Maintain dignity when checking/providing incontinence care for the resident. Review of the facility investigation SRI #258993 revealed Resident #73 was interviewed by the Administrator on 04/04/25. The resident reported he had trouble getting someone to answer his call light. The first female (staff) hit the button but did not change him as asked. She said she would be right back but never returned to his room. Another female (staff) and a co-worker changed his wet under pad sometime around 4:00 P.M. He told the Administrator he pushed his call light three times to get help. The Administrator asked if he had a sore bottom or butt area and the resident said no. The Nurse completed a physical assessment on the resident with no excoriation places or pain. Review of a handwritten sheet authored by the Administrator undated revealed Agency Certified Nursing Aide (CNA) #303 name and phone number was on the top of the paper. The first question asked was who she had worked with on Thursday (04/03/25), and the CNA responded CNA #102. The second question asked was why she went in and shut the resident's call light off. The response was he (the resident) was a two person assist. The third question was not answered. Question four asked was why did you go out to your car for an extended amount of time. The answer was she was on the phone Grandpa- surgery. Question five was asked why she was seen by various employees hanging out in the activity room. The answer was a number 1. Question six was not answered. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of CNA #102's written statement dated 04/03/25 revealed at about 4:45 P.M., she went into Resident #73's room, and he told her a blonde girl came into his room and shut off the call light three times when he told her he needed to be changed. When the CNA changed his brief it nearly disintegrated and he was brinking on a major blowout. The only blonde girl we had was the Agency CNA #303 and she was barely doing anything all night. Review of handwritten sheet authored by the Administrator undated revealed CNA #102's name and number was on the top of the sheet of questions. CNA #102 reported the Agency CNA #303 told her she had turned off Resident #73's call light without providing care to the resident. CNA #102 reported to Licensed Practical Nurse (LPN) #129 that the Agency CNA didn't do anything all night around 9:45 P.M. She had witnessed CNA #303 loafing in the activity room for 30 minutes. There were additional comments on the bottom of the sheet that the CNA #303 walked past call lights and went to others, took 1.5-to-two-hour break, would tell her to do things and she would give attitude. It was too late for LPN #129 to talk to her. Review CNA #193's written statement dated 04/03/25 revealed she witnessed CNA #303 standing in the activities room from 7:45 P.M. till 9:30 P.M., then proceeded to continue outside for 15 minutes. Review of CNA#184's written statement dated 04/03/25 revealed CNA #303 was on Home B. There was multiple instances of her walking past lights, walking past people yelling out the door, telling residents that she would be back to help them and turning their lights off and then not coming back, staying in the activity room for very long periods of time. Just overall acts of neglecting residents. We ended up leaving without all residents in bed because we did not have the help we would expect from having another aide on staff. Review of the Administrator's handwritten letter undated revealed CNA #184's name and number was on top of the letter and phone number. CNA #184 reported CNA #303 had walked past Resident #73's and #17's call light and she dropped Resident #35 hard. CNA #303 told Resident #73 she would be back. When asked which residents were neglected there was an arrow and comment to see statement. Three residents were left up and night shift took out the trash. The CNA reported the incident to LPN #129 and Registered Nurse (RN) #170. Review of the Administrator's handwritten letter undated revealed LPN #129's name and phone number was on the top of the letter. The LPN reported that all three staff reported the incident to him around 9:45 P.M. The LPN reported he was not aware CNA #303 was walking pass call lights, and she was off the unit most of the shift and he told her late in the shift. CNA #184 did not use the term neglect when reporting CNA #303's poor job performance and he was unaware the staff thought it was neglect. The LPN reported he had staff write statements but never read them and gave them to someone else to pass on to the Administrator. The LPN never said anything to CNA #303 due to it being late in the shift and he was not aware of the neglect. Review of an email from the agency staffing company dated 04/04/25 at 1:06 P.M. revealed the staffing company was thankful for the information and was going to suspend the CNA (#303). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the investigation revealed there was a copy of Resident #73's face sheet, a progress note from 04/04/25 at 3:07 A.M. that revealed episodes of incontinence reported last night. Follow up this morning with skin check. No areas noted. Resident stated that his bottom feels fine. Incontinence care provided. Resident resting in recliner. Call light and fluids remain in reach. There was a follow note dated 05/07/25 that indicated a follow up from the SRI (04/04/25) regarding call light being turned off. Resident reported there were no further issues or concerns related to his call light being turned off and he notes that it is being answered timely. He was satisfied with resolution. Resident's wife in room and agrees. There was no documented evidence that the additional resident mentioned in the SRI was interviewed or assessed. There was no statement from RN #170 who staff indicated they reported the incident to and there was no evidence residents on Home B, the unit the CNA was assigned to, were interviewed or assessed. Interview on 05/19/25 at 3:29 P.M. with Resident #73, revealed call lights not answered timely was still an issue on second shift. Sometimes he has to wait up to an hour for someone to answer his call light. Interview on 05/19/25 at 3:40 P.M., with the Administrator confirmed the surveyor had the complete investigation for Resident 73's SRI and there was no additional information. The surveyor reviewed the information in the folder with the Administrator. The Administrator confirmed he did not interview other residents on the unit or residents' staff had mentioned during the investigation to ensure they were not affected. The Administrator reported he was just focused on Resident #73 because he was upset about the incident. The Administrator could not recall why he wrote Resident #35 was dropped hard. The Agency CNA #303 confirmed she was outside for extended period of time but had permission due she was outside on the phone because her grandfather had surgery. The Administrator reported that the CNA was in the activity room watching residents play pool, however the resident didn't require supervision, and she should have been on the floor assisting residents. The Administrator confirmed he notified the staffing agency to ensure she was not providing care to other facility residents during the investigation. Interview on 05/02/25 at 1:58 P.M., with Resident #73 and his daughter revealed he felt he was neglected when the agency staff member left him in a saturated depends (incontinence brief) and didn't return to provide incontinence care timely. Follow up interview on 05/21/25 at 7:54 A.M., with the Administrator to confirm timeline of events on 04/03/25 revealed the Agency CNA (#303) worked 2:00 P.M. to 10:00 P.M. on 04/03/25. The resident reported he started to ring his light around 4:00 P.M. The Agency CNA answered the call light three times, however, didn't communicate the need of two people to provide the care and it frustrated the resident. The Administrator reported he was unsure of the time the two CNAs ended up providing care to the resident. The Administrator was not sure of the times the Agency CNA was off the floor for lunch, when she went to her car, or when she was in the activity room. The Agency CNA confirmed she was off the floor for extended amounts of time because she was worried about her grandfather, however he explained to her she still had job duties to perform. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/21/25 at 10:19 A.M., with CNA #184 and #102 via phone revealed they felt the Agency CNA #303 had neglect Resident #73. The surveyor reviewed the facility's definition of neglect with the CNAs, and they agreed the Agency CNA did not provide a good or service to the resident by turning off his call light several times and not returning to provide care, which resulted in mental anguish to the resident. The CNA's reported the resident usually doesn't get upset and he was upset that night and feared staff would not return to provide care. CNA #102 reported she tried to reassure the resident she would return. CNA #102 reported that she worked 2-10 P.M., on 04/03/25 and there were several residents upset about the care they received or didn't receive from Agency CNA #303. She had gone to Resident #73's room between 4:30 P.M. to 5:00 P. M. and he was upset. Resident #73 reported Agency CNA #303 had come in his room [ROOM NUMBER]-4 times and turned his call light out and never provided incontinence care. The CNA reported she explained to the resident she was going to get help, and she would be right back. The resident was upset and was afraid she was going to leave him like the other aide did. The CNA reported she provided him with reassurance and left the room to get the lift and CNA #184 to help. When she removed the resident depends (incontinence product) it was almost disengaged. CNA #102 reported she had confronted Agency CNA #303, and she confirmed she had turned out Resident #73's call light several times and reported she forgot because she was pulled to another room. The CNA (#102) reported she tried to explain to the CNA (#303) about prioritizing. CNA #102 confirmed the Agency CNA never asked her for help. The Agency CNA continued to answer other residents call lights and did not address their needs or she would walk past call lights and not answer them. The CNA's reported they didn't realize the significant of the concerns until they started to assist residents with nighttime care and the residents were mad. CNA #102 confirmed she used the word Neglect in her written statement because she felt the Agency CNA had neglected Resident #73. Resident #73's depends/incontinence product was like jelly. It was upsetting to her as well as the resident. The CNA felt the Agency CNA #303 had neglected other residents as well by not providing care to them timely. CNA #184 reported she felt the Agency CNA (#303) had neglected to provide care to several residents that evening. Resident #35 was crying as well. Resident #35 has a history of crying, but when she went to check on the resident she found her crying. Resident #35 reported the Agency CNA #303 had dropped her when she was assisting her on the toilet and she hit her back on the toilet seat. The resident had a pink mark on her back, but no bruising was noted. The CNA reported she had checked on the resident several times during her shift. She had reported the incident to the nurse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Abuse, Mistreatment, Neglect, Misappropriation of Resident Property, and Exploitation (dated 2016) revealed it was the facility's policy to investigate all allegations, suspicions and incidents of Abuse, Neglect, Misappropriation of Resident Property and Exploitation, as well as injuries sustained by its residents. Neglect was defined as the failure of the facility, its employees or facility service providers to provide good and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress. Prevention and identification included the deployment of staff on each shift in sufficient numbers to meet the needs of the residents and ensure that the staff assigned have knowledge of the individual residents' care needs. The supervision of staff to identify inappropriate behaviors, such as ignoring residents while giving care, derogatory language, rough handling, and directing resident who need toileting assistance to urinate or defecate in their beds. The assessment, care planning, and monitoring of resident with needs and behaviors which might lead to conflict or neglect. The social service department should be notified of the incident so that it may take appropriate interventions to care for eh psychosocial needs of any involved resident. All incidents and allegation of abuse must be reported immediately to the Administrator or designee. The incident or allegation should be reported to state department of health as soon as possible but not later than 24 hours form the time of the incident/allegation was made known to the staff member. Investigation protocol included the person investigating the incident should generally take the following action: Interview the resident, the accused, and all witnesses. Witnesses generally include anyone who: witnessed or heard of the incident; came in close contact with the resident the day of the incident; and employees who worked closely with the accused employee and/or alleged victim the day of the incident. Obtain written statement form the resident, if possible, the accused, and each witness. Obtain all medical reports and statement from the physician and or hospital Review the resident medical records. Document of the investigation.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52003 Based on interview and medical record review the facility failed to ensure Resident #78 had an accurate Minimum Data Set (MDS) 3.0 assessment. This affected one resident (#78) of 22 residents reviewed for MDS assessments. The facility census was 84. Findings include: Review of Resident #78's medical record revealed an admitted [DATE] with diagnoses including acute and chronic respiratory failure with hypoxia, type 2 diabetes, bipolar disorder, depression, post-traumatic stress disorder (PTSD), adjustment disorder with depressed mood, and attention-deficit hyperactivity disorder. Interview on 05/19/25 at 3:26 P.M. with Resident #78 stated her PTSD continues. She has triggers to loud noises and has flashbacks due to a car accident at the age of 16. She continued to wake up with nightmares and is paranoid. She reports staff have not questioned her regarding the PTSD. Review of Resident #78's comprehensive MDS 3.0 assessment dated [DATE] revealed the diagnoses of PTSD and bipolar disorder were not identified. Interview on 05/20/25 at 8:14 A.M. with MDS nurse #108 stated those diagnoses were not checked because she was not on any medications. They only code it if they are on medications and if it is listed as an active diagnosis. Review of Resident #78's physician's orders revealed Resident #78 did receive psychotropic medications Cymbalta 60 milligrams (mg) twice a day and Zoloft 100 mg daily. She was also prescribed Melatonin 5 mg at bedtime as a sleep aid. Interview on 05/20/25 at 8:41 A.M. with MDS nurse #108 confirmed Resident #78 was on psychotropic medications and the resident's MDS assessment was not accurate.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52003 Based on interview and medical record review the facility failed to ensure Preadmission Screening and Resident Review (PASARR) was completed accurately on admission. This affected one resident (#78) of one resident reviewed for PASARR. The facility census was 84. Findings include: Review of Resident #78's medical record revealed an admitted [DATE] with diagnoses including acute and chronic respiratory failure with hypoxia, type 2 diabetes, bipolar disorder, depression, post-traumatic stress disorder, adjustment disorder with depressed mood, and attention-deficit hyperactivity disorder. Review of Resident #78's PASARR, dated 02/28/25, did not include the diagnosis of Post traumatic stress disorder (PTSD) or identify psychotropic medications prescribed. Interview on 05/20/25 at 3:20 P.M. with Social Worker #158 including PASARR review verified the PASARR did not include the PTSD diagnosis. Review of the DSM-5 PTSD is classified as a trauma and stressor related disorders. Interview on 05/21/25 at 9:17 A.M. with regional director of SS and activities #306 verified inaccuracy of the PASARR as it did not include residents' diagnosis of PTSD or psychotropic medications.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 28923 Based on record review, observation, interview, and policy review, the facility failed to ensure dental services were provided to Resident #32 and pressure ulcer prevention interventions were implemented for Resident #64 as per the plan of care. They also failed to ensure a comprehensive care plan was developed to address Resident #78's diagnosis of Post traumatic Stress Disorder (PTSD). This affected three residents (Resident #32, #64, and #78) of 27 residents reviewed for care plans. Findings include: 1. Review of Resident #32's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included moderate protein-calorie malnutrition, stroke without residual deficits, adult failure to thrive, and legal blindness. Review of Resident #32's payer status in the electronic medical record revealed the resident was admitted to the facility on [DATE] under Ohio Medicaid (MCD). His payer status did not change until 04/18/25, when he was changed to Hospice MCD. Review of Resident #32's clinical admission documentation dated 01/10/25 revealed the resident had the use of an upper denture that was in fair condition and was missing one tooth. He was indicated to have lower dentures, but did not wear them and they weren't brought to facility with him. Review of Resident #32's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. He required set up or clean up assistance with his oral hygiene. He was assessed on the MDS as being edentulous and there was no indication that he had any broken dentures. Review of Resident #32's care plans revealed he had a care plan in place for an alteration in dental/ oral status related to not having any natural teeth and wearing upper dentures as he chooses. The goal was for the resident to be free of dental/ oral discomfort and to have proper fitting dentures in good repair. The interventions included the need for a dentist to evaluate and treat as needed (prn). If the resident wore dentures, they were to observe the condition and proper fit. They were to report any chips, cracks, or rough edges and to notify the dentist prn. Review of Resident #32's ancillary services consent form dated 05/09/25 revealed the resident was not known to have declined any of the ancillary services. He was to receive dental services per his request. Resident #32's electronic medical record (EMR) was absent for any evidence of the resident having been seen by a dentist since his admission to the facility on [DATE]. Progress notes were absent for any attempts to arrange dental services for the resident to replace his current dentures. Review of a dental list showing when the facility's contracted dentist had last visited the facility revealed the contracted dentist had last visited the facility on 03/19/25. Resident #32 was not one of the 22 residents who had been seen on that date. (continued on next page)

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	365612	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Acres Nursing Home	44565 Sunset Road Caldwell, OH 43724

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 05/19/25 at 8:45 A.M., an interview with Resident #32 revealed he did not have his lower denture plate at the facility due to them being broken. He had the same set of dentures for the past [AGE] years. He was interested in being seen by a dentist to get a new set of dentures. On 05/20/25 at 9:52 A.M., an interview with Certified Nursing Assistant (CNA) #212 revealed he was not aware of Resident #32 wearing dentures and was not sure if he even had them. He was not aware the resident had the use of full upper dentures, or that he did not have his lower dentures with him due to them being broken and left at home. On 05/20/25 at 10:20 A.M., an interview with the Director of Nursing (DON) confirmed Resident #32 had not received any dental services while in the facility. She further confirmed the resident had consented to receive ancillary services when he was most recently asked on 05/09/25. She alleged the resident did not go under MCD until 03/19/25, and it was retroactive to 01/10/25. She was not able to provide any documentation to support that or to dispute the EMR showing he had been covered under MCD since 01/10/25, as was indicated under the census tab of the EMR. 2. Review of Resident #64's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included a history of a stroke, muscle weakness, need for assistance of personal care, difficulty walking, and age related physical debility. Review of Resident #64's annual MDS assessment dated [DATE] revealed the resident's cognition was moderately impaired. He was not known to reject any care. He was dependent on staff for bed mobility and transfers. The MDS identified him as being at risk for pressure ulcers, but did not have any unhealed pressure ulcers at the time the assessment was completed. Review of Resident #64's active care plans revealed the resident was at risk for skin breakdown related to impaired mobility, impaired cognition, and poor sensory perception. The goal was for the resident not to develop skin breakdown. The interventions included the need to encourage/assist the resident to float heels as tolerated. That intervention was added on 05/20/24. Review of Resident #64's nurses' progress notes for the past 30 days revealed no evidence of the resident not allowing the facility staff to offload his heels when in bed. He was also not indicated to remove any pillows or other devices that were being used to offload his heels. On 05/18/25 at 3:40 P.M., an observation of Resident #64 noted him to be lying in bed on an air mattress. His feet were not offloaded as his heels were noted to be in direct contact with the mattress. On 05/19/25 at 1:30 P.M. and again on 05/20/25 at 8:30 A.M., further observations of Resident #64 noted him to be lying in bed without his heels being offloaded. His heels remained in direct contact with the mattress and there was no evidence of any pillows or other offloading devices being used to elevate his heels off the mattress. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 05/20/25 at 11:19 A.M., an interview with CNA #212 revealed Resident #64 has had a recent decline in his condition and did not want out of bed. The resident was not one who wanted up even before his decline in condition that occurred over the past several weeks. He denied the resident had any current pressure ulcers, but was at risk due to his limited mobility. He was questioned about the resident's skin prevention interventions that were in place to prevent the development of his pressure ulcers. He stated the facility staff would use heels up (device to offload heels) or would use pillows to offload a resident's heels, if it was ordered by the physician. They did not offload any residents' heels, unless the physician said to. They had access to the resident's care plans in the computer kiosk. He verified Resident #64's care plans did include the need to encourage/ assist the resident to offload his heels. He was asked to accompany the surveyor back to the resident's room. He verified the resident was in bed without his heels offloaded on a pillow or other offloading device on 05/20/25 at 11:26 A.M. He was aware the resident was to have pillows to his sides, but he denied they were using pillows under the heels in an effort to offload the resident's heels. He stated he worked that unit five days a week during the day shift and had never tried putting pillows under the resident's heels. On 05/23/25 at 11:32 A.M., an interview with LPN #132 revealed Resident #64 did not have any pressure ulcers at present. She would consider him to be at risk for pressure ulcers. She denied she was aware of the resident removing any pillows that they used for positioning. She verified the resident's active care plans for being at risk for an alteration in skin integrity included the need to encourage the resident to off-load heels, as part of his skin prevention interventions. She informed CNA #212, who accompanied the survey to the nurses' station, that Resident #64 should have his heels up on a pillow from what she was able to determine. 52003 3. Review of Resident #78's medical record revealed an admitted [DATE] with diagnoses including acute and chronic respiratory failure with hypoxia, type 2 diabetes, bipolar disorder, depression, post-traumatic stress disorder (PTSD), adjustment disorder with depressed mood, and attention-deficit hyperactivity disorder. Review of Resident #78's comprehensive care plan revealed no care plan or interventions regarding PTSD. Interview on 05/19/25 at 2:16 P.M. with Social Worker #158 revealed that on resident admission a trauma informed care observation is completed by the social worker and a care plan is based off of resident answers. There is a specific template in matrix titled: Trauma or PTSD related. Even if they have a history of PTSD it is still addressed. Social Worker #158 confirmed when Resident #78 was readmitted to facility on 02/28/25 a trauma informed care observation was not completed and she was not aware of the resident diagnosis and there is no care plan in place for PTSD.

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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** 28923 Based on observation, record review, interview, and policy review, the facility failed to ensure care conferences were completed timely following a resident's significant change Minimum Data Set (MDS) assessment and care plans were revised in the areas of dental status and to reflect a resident's reported non-compliance with non-pressure skin impairment interventions. This affected one resident (#32) of two residents reviewed for care conferences and two residents (#7 and #16) of 22 residents reviewed for care plans. Findings include: 1. Review of Resident #7's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included reduced mobility, difficulty walking, and the need for assistance with personal care. Review of Resident #7's dental consults revealed the resident was seen on 03/23/22 and was indicated to have partial dentition. The resident informed the dentist that she had a dentist in a local community that was going to extract all her remaining teeth. Further review of Resident #7's dental consults revealed the resident was seen again by the dentist on on 09/25/24. The dentist referenced dentures the resident had that was about one year old. The dentist adjusted the lower left denture around the #18 tooth. The dentures were indicated to fit well and the resident was satisfied with them. Review of Resident #7's quarterly MDS assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. She was not identified on the MDS assessment as having any dental issues. Review of Resident #7's active care plans revealed the resident had a care plan in place for being edentulous (without any natural teeth) and did not wear dentures. The care plan was initiated on 09/14/22 and was not revised to reflect the resident had since received dentures. On 05/20/25 at 3:33 P.M., an interview with Aide in Training #177 revealed she thought Resident #7 had her own teeth. She denied the resident had the use of any dentures. On 05/20/25 at 3:35 P.M., an interview with Resident #7 confirmed she had full upper and lower dentures. She stated the staff assisted her with brushing and soaking her dentures at night. On 05/20/25 at 3:37 P.M., an interview with Licensed Practical Nurse (LPN) #132 revealed she was not sure if Resident #7 had dentures or her own teeth. She did not want to say without checking the resident's electronic medical record (EMR) first. She reported the resident's dental care plan indicated she was edentulous. She was informed the resident had full upper and lower dentures and there was a dental consult note that indicated the resident has had dentures since 2023. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #32's medical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included unspecified glaucoma, bilateral blindness, anxiety, depression, congestive heart failure, adult failure to thrive, chronic obstructive pulmonary disease, and cognitive communication deficit. Review of Resident #32's face sheet revealed his contacts included his father as his resident representative. Review of Resident #32's completed MDS assessments revealed the resident's latest MDS assessment was a significant change MDS assessment that was completed on 04/24/25. His prior MDS assessment was an admission MDS completed on 01/17/25. The significant change MDS assessment completed on 04/24/25 identified the resident as not having any communication issues and being cognitively intact. Review of Resident #32's care conferences revealed the resident had his initial care conference completed on 01/14/25. There was no evidence of any other care conferences being held on the resident's behalf since the initial care conference was completed. Review of Resident #32's nurses' progress notes from 04/21/25 to 05/20/25 revealed no evidence of the facility attempting to set up a care conference for the resident around the time of the completion of Resident #32's significant change MDS assessment on 04/24/25. There was not a progress note until 05/12/25 that indicated a phone call was placed to the resident's representative on that date to schedule a care conference meeting. The note indicated that a care conference was scheduled and agreed upon for 05/20/25 at 2:30 P. M. On 05/19/25 at 8:43 A.M., an interview with Resident #32 revealed he did not recall being part of any care conference since he had been in the facility. He did not recall the initial care conference that was held on 01/14/25 and denied being aware of any care conferences being held since. On 05/20/25 at 8:13 A.M., an interview with Social Service Director #158 revealed she had been the facility's social worker since 04/29/25. She reported she was the employee in charge of scheduling care conferences. She stated care conferences were to be completed upon admission and then quarterly thereafter. If an initial care conference had been done on 01/14/25, a quarterly care conference should have been completed during the month of April 2025. She stated she tried to keep them on an every three month schedule. She was not sure why a care conference had not been completed for Resident #32 in April 2025, when he had a significant change MDS assessment completed. She confirmed they had one scheduled for the resident that was to be completed that day (05/20/25) at 2:30 P.M. She reported she was trying to get everything together and was still trying to get the initial care conferences completed for those residents that had been admitted since she took over. She had not been able to get to anything that was outstanding prior to her taking over as the social service director. She was asked what prompted her to schedule a care conference for the resident on that day. She stated it was just in her May 2025 folder for her to do. (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 facility's policy on Comprehensive Care Planning updated 05/01/25 revealed the facility's interdisciplinary team (IDT) was responsible for the development of an individualized comprehensive care plan for each resident. The comprehensive care plan would be updated by a member of the IDT team as changes in the resident's condition occurred. The comprehensive care plan would be reviewed by the IDT at least quarterly or when a significant change in condition occurred, in which a MDS assessment was completed. The resident and the resident's representative would be invited to care conferences in which the resident's comprehensive care plans would be reviewed. 52003 3. Review of Resident #16's medical record revealed an admitted [DATE] with diagnosis including chronic kidney disease, stage 4 (severe), weakness, dysphagia, pharyngeal phase, acute respiratory failure with hypoxia, and unspecified diastolic (congestive) heart failure. Review of Resident #16's medical record revealed a history of skin tears on 01/26/25, 02/14/25, 02/27/25, 04/15/25, 05/10/25, 05/15/25 and 05/17/25. Review of Resident #16's care plan revised 05/12/25 revealed intervention for geri-sleeves to both arms. The non-adherence care plan revised 04/28/25 revealed no non-compliance interventions for geri-sleeves. Observations of Resident #16 on 05/27/25 2:51 P.M. revealed no geri-sleeves in place. Interview on 05/28/25 at 12:08 P.M. certified nurse aide (CNA) #219,stated Resident #16 was previously getting geri-sleeves but refused, so they removed the task from the charting. Interview on 05/28/25 at 1:00 P.M. with Regional Nurse #301 confirmed the care plan was not revised to address the non-compliance, the MDS nurse revises the care plans annually and quarterly.

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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** 50538 Based on observation, interview and record review the facility failed to provide timely incontinence care for a resident and failed to provide timely nail care for a resident. This affected two residents (#2 and #14) of seven residents reviewed for activities of daily living. Findings include: 1. Review of Resident #2's medical record revealed an admitted [DATE] and diagnoses including dementia, dysphagia, diabetes, chronic obstructive pulmonary disease, epilepsy, and schizoaffective disorder. Review of Resident #2's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of four indicating severe cognitive impairment. Further review of the MDS revealed Resident #2 required setup assist with toilet hygiene and supervision with toilet transfer and was frequently incontinent of urine. An observation on 05/19/25 at 2:14 P.M. revealed Resident #2 seated at a dining room table on the secure unit. Resident #2 was observed to urinate while seated in the chair and a large puddle of urine formed under the chair. Certified Nursing Assistant (CNA) #162 assisted Resident #2 to the bathroom for incontinence care. In an interview on 05/19/25 at 2:22 P.M. CNA #162 stated it was normal for Resident #2 to sit and sleep in a chair. CNA #162 stated Resident #2 uses a pullup style incontinence product and will frequently urinate enough to overflow the incontinence product. CNA #162 stated Resident #2 was to be changed after meals and when needed. An observation on 05/20/25 from 2:30 P.M. to 4:00 P.M. revealed the resident in bed during the observation with no staff interaction. An observation on 05/21/25 at 2:31 P.M. revealed Resident #2 to be resting in bed on her left side, dressed in brown pants and a pink and white shirt, with her back and buttocks toward the door. A dark, wet-appearing stain was observed on the resident's pants covering her buttocks area. An observation on 05/21/25 at 3:24 P.M. revealed the dark, wet-appearing stain, remained on the resident's pants. In an interview on 05/27/25 at 11:10 A.M. CNA #221 revealed CNAs were to check incontinent residents at least every two hours or more often if needed. CNA #221 stated Resident #2 prefers to use a pullup style incontinence product because the resident will sometimes take herself to the bathroom and this style is easier for her to manage. CNA #221 stated that Resident #2 seems to be incontinent more frequently now than in the past and stated Resident #2 can be difficult to get to go to the bathroom at times. An observation on 05/27/25 at 12:41 P.M. revealed Resident #2 seated at a dining room table on the secure unit. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 05/27/25 at 2:42 P.M. revealed Resident #2 remained seated at a dining room table on the secure unit. An observation on 05/27/25 at 3:11 P.M. revealed Resident#2 was assisted with toileting tasks at this time. An interview at the same time with Speret Hall Program Director Licensed Practical Nurse (LPN) #178 revealed Resident #2 was previously assisted with toileting tasks at around 12:30 P.M. Review of the policy titled Routine Resident Checks updated 10/20/22 revealed a resident check would be completed at least every two hours by nursing personnel and involved entering the resident's room to determine if the resident had needs, such as assist with toileting or incontinence care, that needed to be met. 32801 2. Record review revealed Resident #14 was admitted to the facility on [DATE] with diagnoses including Parkinson disease, weakness, fibromyalgia, and need for assistance with personal care. Review of Resident #14's quarterly minimal data set (MDS) dated [DATE] revealed the resident required partial/moderate assistance with personal hygiene. Review of Resident #14's profile dated 05/16/25 revealed Resident #14 was dependent on staff for nailcare. Observation on 05/18/25 at 10:20 A.M., of Resident #14 revealed the resident had one nail broken half the way off and a brown substance was under all her nails. The resident reported her nails looked awful and needed cleaned and the broken nail had been like that for a few days. Interview on 05/18/25 at 10:20 A.M., with hospitality aide (HA) #164 confirmed the resident had one nail half broken off and she had brown substance under her nails. Certified Nurse's Aide (CNA) #196 approached the resident during the interview and reported she saw Resident #14's broken nail this morning but didn't feel comfortable cutting it due to it was broke back into the quick of the nail. CNA #196 reported she would tell the nurse and help the resident clean her nails. The CNA went to the resident room and obtained a bush and warm soapy water and started soaking the resident nails. Review of the facility's policy and procedure titled Nail Care Finger/Toe undated 05/01/25 revealed it was the facility's policy to clean, trim, and maintain nail care to enhance the resident state of well-being. This deficiency represents non-compliance investigated under Complaint Number OH00165414.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on observations, medical record review, staff interview, and policy review, the facility failed to comprehensively assess and provide treatment to skin integrity concerns. This affected one resident (#73) of two reviewed for non-pressure skin impairments. The facility census was 84. Findings include: Record review revealed Resident #73 was admitted to the facility on [DATE] with diagnoses including cardiac arrhythmia, heart failure, muscle weakness, abnormality of gait and mobility, weakness, retention of urine, right knee pain, benign prostatic hyperplasia without lower urinary tract symptoms, obstructive and reflux uropathy, and reduced mobility. Review of Resident #73's quarterly Minimum Data Set, dated dated dated [DATE] revealed the residents Brief Interview for Mental Status (BIMS) was 11. The resident had no behaviors or rejection of care. The resident required set up for meals, dependent on staff for toileting, bathing, lower body dressing, and putting on and taking off footwear, and partial to moderate assist with personal and oral hygiene. The resident was dependent of staff for mobility. He had no skin alteration but was at risk for pressure ulcers. a. Review of Resident #73's progress note dated 05/08/25 revealed the Certified Nursing Aide (CNA) reported that when she was transferring the resident from recliner to wheelchair, the resident bumped his left arm on causing a skin tear. The skin tear was cleansed with normal saline, patted dry, applied xeroform and covered with a dry dressing. Review of Resident #73's alteration of skin integrity plan of care dated 05/09/25 revealed the resident had a skin tear to left arm. The plan of care was updated on 05/19/25 to include callus to left and right heel and right arm. Intervention included observe alteration in skin integrity for redness, swelling, drainage, increased or onset of pain and notify physician or Nurse Practitioner (NP), observe and change dressing(s) if soiled, saturated, or not adhering complications, and observe resident for any complaints of pain related to the alteration in skin integrity. Inform physician, NP and medicate after non pharmalogical approaches were / are not successful. Perform treatment(s) as per physician order see TAR. Review of Resident #73's progress note dated 05/17/25 at 2:20 A.M., and edited on 05/18/25 at 2:23 A.M., revealed weekly skin check completed no new areas noted. Continue treatment to right arm as ordered. (There was no evidence the facility had initiated an order to the right arm until 05/19/25). Review of Resident #73's progress note dated 05/19/25 revealed skin tear noted to right elbow; dressing applied. Wound nurse notified and confirmed with measurements during rounds. Resident representative notified. Observation on 05/18/25 at 10:49 A.M., of Resident #73 revealed the resident had two foam dressings on bilateral arms dated 05/17/25. The resident was not able to answer what happened to his arms at that time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Observation on 05/19/25 at 9:18 A.M., of Resident #73 with the Assistant Director of Nursing (ADON) #171 and Corporate Registered Nurse (CRN) #302 revealed the dressing on the left arm was dated 05/17/25, however the dressing on the right arm was undated. CRN #302 reported he would assume both dressing were changed on 05/17/25 due to the date on the left arm dressing. Review of Resident #73's orders dated 05/01/25 to 05/19/25 revealed no evidence of an order for a dressing to the right arm until 05/19/25 when a new order was entered on 05/19/25 to cleanse skin tear to right arm with normal saline, pat dry, apply Xeroform. Cover with dry clean dressing every third day and as needed. Review of Resident #73's events and observation documentation dated 05/01/25 to 05/19/25 revealed no evidence of skin assessment to the right arm, however there was a skin tear assessment for the left arm dated 05/08/25. Interview on 05/20/25 at 1:58 P.M., with Resident #73 and his daughter revealed her dad frequently had skin tears. She didn't know if it was related to the sit to stand lift and it was a tight squeeze to get through the bathroom door or how he was acquiring so many skin tears. The daughter confirmed the resident was dependent on staff for care. Interview on at 05/20/25 at 4:52 P.M. with the Director of Nursing (DON) revealed the facility was not aware of the skin tear to the right arm until 05/19/25 (even though a progress note dated 05/17/25 indicated continue treatment to right arm and surveyor observed a dressing on the right arm on 05/18/25). The DON had the nurse complete a statement form indicating she had interviewed the resident on 05/19/25 and he reported the skin tear to the right elbow was a result of catching his arm on the wheelchair rest. b. Review of Resident #73's medical record revealed no evidence of skin alteration to the left or right heels. Observation on 05/19/25 at 9:18 A.M., of Resident #73 with the Assistant Director of Nursing (ADON) #171 and Corporate Registered Nurse (CRN) #302 revealed the resident had two skin alteration on the left and right outer heel. The areas were pea size and slightly raised. The ADON reported the areas appeared to calluses. The resident reported they were painful to touch. The ADON reported he was not sure how the resident acquired the areas, and he was no longer being seen by the visiting wound Nurse Practitioner. The ADON confirmed the wounds were not comprehensively assessed or documented in the medical record due to calluses were not required to be monitored. An additional observation on 05/20/25 at 2:16 P.M. of Resident #73's feet with the ADON #171 and CRN #303 revealed the skin on the left outer heel was starting to flake off. The area on the right outer heel was still intact. The ADON reported he was not aware of the callus areas until yesterday and he had the visiting wound nurse look at them. The ADON reported staff would not normally document or complete a skin grid for a callus, nor did he document his assessment or the visiting wound NP assessment that was completed yesterday (05/19/25). The resident voiced complaints of pain during the exam when touching the heels and up the back of the heel. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Acres Nursing Home	44565 Sunset Road Caldwell, OH 43724

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 05/20/25 at 1:58 P.M., with Resident #73 and his daughter revealed the areas on the left and right-outer heels developed about the first of February (2025). The resident has never had skin alteration on the outer side of the heels in the past. The daughter reported she had just left a care conference with the facility and had concerns regarding her father's heel pain and treatment. The daughter reported she doesn't feel the facility was being aggressive enough. The family had requested he see the podiatrist. Review of Resident #73's visiting wound NP note dated 05/19/25 revealed she was asked by the wound nurse to assess areas to bilateral feet. The resident had one callused area to the left outer heel that was dry and flaky and an order was given for skin prep to the area twice daily. The resident had a small flat callused area to the right heel that was dry. Skin prep twice daily was ordered. Both areas were closed, and wound nurse will follow areas. Will see on wound rounds as necessary. Review of Resident #73's orders dated 05/2025 revealed skin prep to bilateral heels twice a day for prevention since 05/30/24. The order was updated on 05/19/25 to include special instructions callus. Review of the facility's policy titled Skin abrasion, Skin tears dated 05/01/25 revealed the facility's policy of care for alteration in skin integrity was using professional standards of practice. The guidelines included verifying that there was a physician order for the procedure. Review the residents' care plan, for any special needs,. The policy didn't include document assessment of the wound.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, observation, staff interview, and policy review, the facility failed to ensure skin prevention interventions were implemented for residents at risk for or having had pressure ulcers and also failed to ensure a resident's pressure ulcer was comprehensively assessed weekly to monitor for wound healing. This affected three residents (#16, #64, and #73) of four residents reviewed for pressure ulcers. Findings include: 1. Review of Resident #16's medical record revealed the resident was admitted to the facility on [DATE]. She was readmitted to the facility on [DATE] following a multiple day hospitalization stay. Her diagnoses included hemiplegia (paralysis) and hemiparesis (weakness) following a stroke affecting her left dominant side, peripheral vascular disease, adult onset diabetes mellitus, reduced mobility, muscle weakness, and dependence on a wheelchair. Review of Resident #16's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had adequate hearing and clear speech. She was usually able to make herself understood and was usually able to understand others. Her cognition was severely impaired and the resident was dependent on staff for bed mobility and transfers. She was identified as being at risk for pressure ulcers and was also identified as having an unhealed pressure ulcer that was a Stage III Pressure ulcer (full thickness skin loss, where subcutaneous fat was visible, but bone, tendon, or muscle was not) that was present upon admission. Review of Resident #16's active care plans revealed the resident had a care plan in place for having a pressure ulcer/ injury to the right heel. The goal was for the resident's pressure ulcer to show progressive signs of healing. The interventions included the need to observe the wound for any redness, warmth, drainage, odor, and report to physician as needed. They were also to perform the current treatment as ordered and to observe the treatment for effectiveness. Review of Resident #16's physician's orders revealed the resident had an order in place to cleanse the resident's right heel with normal saline, pat dry, apply skin prep, cover and protect with foam dressing changing every other day. That treatment order had been in place since 04/28/25. The special instructions included with that order indicated the treatment was for a Stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red/ pink wound bed, without slough) to the right heel. Review of Resident #16's weekly wound grid observations that the facility used to assess and document the wound evaluation revealed the pressure ulcer to the right heel was identified on 04/23/25 and was initially classified as a suspected deep tissue injury (purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/ or shear). The pressure ulcer was indicated to have been present upon the resident's re-admission to the facility and measured 2 centimeters (cm) x 1.5 cm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #16's subsequent weekly wound grid observations revealed on 04/28/25 the pressure ulcer was classified as a Stage III pressure ulcer to the right heel. Measurements obtained as part of the weekly wound evaluation revealed the length was 2 cm and the width was 1.5 cm. There was no depth recorded despite it being an open wound and classified as a Stage III pressure ulcer. There was no indication of any slough being present or any other reason to explain why the depth of the wound bed was not measured. Review of the resident's weekly wound grid observations for 05/05/25 and 05/12/25 revealed the resident's pressure ulcer to the right heel remained a Stage III pressure ulcer. Measurements were obtained that included a length and width, but again there were no depths recorded. The assessment on 05/05/25 included comments that indicated half of the open area was a closed blister and the wound healing progress was declining. The assessment on 05/12/25 did not mention anything in the comments about the open area being covered or partially covered with a closed blister. It indicated that the wound was noted to have a light growth of serosanguineous exudate (drainage) when assessed and documented as improving. Review of the last two weekly wound grid observations for 05/19/25 and 05/26/25 revealed the weekly assessment did not include a staging of the pressure ulcer. Measurements of a length and width was obtained and the wound was not indicated to have any exudate. Tissue type indicated the wound bed was closed/ resurfaced, but the wound healing status indicating it was improving, not healed or resolved. On 05/28/25 at 9:55 A.M., an interview with Registered Nurse (RN) #171 revealed he was the facility's wound nurse that assessed pressure ulcers weekly. He indicated he was not wound certified at the time, but it was his intention to become wound certified, after he finished the infection preventionist training/ testing. Due to him not being wound certified, the facility had a visiting nurse practitioner that was assessing their wounds weekly. He completed rounds with her and used her information, as part of his weekly wound evaluations, until he became wound certified. He confirmed Resident #16 returned to the facility from the hospital on 04/23/25, with a SDTI to her right heel. It then became a Stage III pressure ulcer. He acknowledged the weekly wound assessments were identifying the pressure ulcer as a Stage III pressure ulcer, but his measurements did not include a depth of the wound. He acknowledged if a wound was a Stage III pressure ulcer, a depth should be able to be recorded as part of their wound assessment/ evaluation. He further acknowledged the last two weekly wound assessments completed did not include a stage of the pressure ulcer. He acknowledged part of a comprehensive weekly wound assessment should include a staging of the pressure ulcer. He reported the nurse practitioner that was following the resident's pressure ulcer initially classified it as a Stage II, after it had opened from originally being a SDTI. He knew it could not be a Stage II pressure ulcer since it had previously been identified as a SDTI, which included the involvement of deep tissue being affected. 2. Review of Resident #64's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included a history of a stroke, muscle weakness, need for assistance of personal care, difficulty walking, and age related physical debility. Review of Resident #64's annual MDS assessment dated [DATE] revealed the resident's cognition was moderately impaired. He was not known to reject any care. He was dependent on staff for bed mobility and transfers. The MDS identified him as being at risk for pressure ulcers, but did not have any unhealed pressure ulcers at the time the assessment was completed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #64's active care plans revealed the resident was at risk for skin breakdown related to impaired mobility, impaired cognition, and poor sensory perception. The goal was for the resident not to develop skin breakdown. The interventions included the need to encourage/assist the resident to float heels as tolerated. That intervention was added on 05/20/24. Review of Resident #64's nurses' progress notes for the past 30 days revealed no evidence of the resident not allowing the facility staff to offload his heels when in bed. He was also not indicated to remove any pillows or other devices that were being used to offload his heels. On 05/18/25 at 3:40 P.M., an observation of Resident #64 noted him to be lying in bed on an air mattress. His feet were not offloaded as his heels were noted to be in direct contact with the mattress. On 05/19/25 at 1:30 P.M. and again on 05/20/25 at 8:30 A.M., further observations of Resident #64 noted him to be lying in bed without his heels being offloaded. His heels remained in direct contact with the mattress and there was no evidence of any pillows or other offloading devices being used to elevate his heels off the mattress. On 05/20/25 at 11:19 A.M., an interview with Certified Nurse Aide (CNA) #212 revealed Resident #64 has had a recent decline in his condition and did not want out of bed. The resident was not one who wanted up even before his decline in condition that occurred over the past several weeks. He denied the resident had any current pressure ulcers, but was at risk due to his limited mobility. He was questioned about the resident's skin prevention interventions that were in place to prevent the development of his pressure ulcers. He stated the facility staff would use heels up (device to offload heels) or would use pillows to offload a resident's heels, if it was ordered by the physician. They did not offload any residents' heels, unless the physician said to. They had access to the resident's care plans in the computer kiosk. He verified Resident #64's care plans did include the need to encourage/ assist the resident to offload his heels. He was asked to accompany the surveyor back to the resident's room. He verified the resident was in bed without his heels offloaded on a pillow or other offloading device on 05/20/25 at 11:26 A.M. He was aware the resident was to have pillows to his sides, but he denied they were using pillows under the heels in an effort to offload the resident's heels. He stated he worked that unit five days a week during the day shift and had never tried putting pillows under the resident's heels. On 05/23/25 at 11:32 A.M., an interview with LPN #132 revealed Resident #64 did not have any pressure ulcers at present. She would consider him to be at risk for pressure ulcers. She denied she was aware of the resident removing any pillows that they used for positioning. She verified the resident's active care plans for being at risk for an alteration in skin integrity included the need to encourage the resident to off-load heels, as part of his skin prevention interventions. She informed CNA #212, who accompanied the survey to the nurses' station, that Resident #64 should have his heels up on a pillow from what she was able to determine. Review of the facility's policy on Pressure Ulcers: Assessment, Prevention, and Treatment updated 05/01/25 revealed it was the facility's policy to identify residents at risk for developing pressure injuries, implement interventions to prevent the development of pressure injuries, and provide care for existing pressure injuries. Interventions and preventative measures as indicated based on resident risk factors included floating heels and keeping heels off of the bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	32801 3. Record review revealed Resident #73 was admitted to the facility on [DATE] with diagnoses including cardiac arrhythmia, heart failure, muscle weakness, abnormality of gait and mobility, weakness, retention of urine, right knee pain, benign prostatic hyperplasia without lower urinary tract symptoms, obstructive and reflux uropathy, and reduced mobility. Review of Resident #73's observation report dated 03/11/25 and 05/19/25 revealed the resident was at high risk for pressure ulcer/skin breakdown and his treatment plan included pressure reducing device for bed and chair. Review of Resident #73's pressure ulcer plan of care related to incontinence, impaired mobility, cancer, poor nutritional intake, low protein, anemia, friction concerns, shearing concerns, and behaviors of crossing legs and feet dated 05/20/24 revealed the resident's intervention included pressure re-distribution cushion to chair and heelzup cushion when in bed. Review of Resident #73's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had pressure relieving devices to bed and chair. Review of Resident #73's care conference note dated 05/20/25 at 1:31 P.M., revealed the family had requested staff to prompt the resident to put socks on at night and continue to put cream on his feet. The family had also requested that a soft type of barrier/mat be placed by his feet at night as well. Consent for Podiatry signed as well per request. Interview on 05/20/25 at 1:58 P.M., with Resident #73 and his daughter revealed the daughter just had a care conference with the facility and she was not too confident the facility was being aggressive enough in treating her father's sore heels. The family had offered to buy sheep skin to lay at the bottom of the bed because they felt the sheets were rough. The resident and daughter reported the facility was currently using pillows to prop up the heels off the bed, however the staff were not consistently putting the pillows under his feet. The only other intervention the facility was utilizing for the resident feet was cream and the daughter didn't feel that was sufficient due to the resident having a history of pressure ulcer on his heels shortly after he was admitted to the facility. The daughter reported she didn't want that to happen again. The resident reported he spends most of his time in his recliner. Observation during the interview revealed no evidence of heelzup cushion in the room or a pressure relieving device in the recliner/chair. Interview and observation on 05/20/25 at 3:12 P.M., with the Assistant Director of Nursing (ADON) #171 and Corporate Registered Nurse (CRN) #302 confirmed the resident didn't have heelzup cushion in the room nor a pressure relieving cushion in his recliner. CRN #302 reported that the plan of care doesn't specify which chair required the pressure relieving cushion, however the specialized wheelchair seat was a pressure-relieving cushion and would not require an additional pressure relieving cushion to be placed on it. The CRN also reported maybe the heelzup cushion was in the laundry room. The resident had reported pain in the heel region upon touch and up the back of the foot when the ADON and CRN had touched his heels and questioned the resident about the location of the pain. The ADON and surveyor went to the laundry room and there was a shelf where several pressure relieving devices were stored on the shelf. There was no indication/identification to confirm if any of the devices were from Resident #73's room. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/21/25 at 7:13 A.M., with Certified Nursing Aide (CNA) confirmed Resident #73 sits in his recliner most of the time. The resident only uses the specialized wheelchair only at lunch time when he goes to his wife's room for lunch. Review and the facility's pressure ulcer policy and procedure dated 05/01/25 revealed it was the facility's policy to identify residents at risk for developing pressure injuries, implement interventions to prevent development of pressure injuries and provide care for existing pressure injuries. A pressure ulcer injury risk assessment would be completed upon admission, quarterly, annually and with significant change. Interventions and prevention measure as indicated based on risk factors. Float heels-keep heels off of the bed. Use pillows, wedges, and/or other devices for positioning. This deficiency represents non-compliance investigated under Complaint Number OH00165414.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52003 Based on observation, record review and staff interviews, the facility failed to provide timely contracture management. This affected one resident (#56) of one resident reviewed for contractures. Facility census was 84. Findings include: Review of the medical record for Resident #56 revealed an admitted [DATE] with diagnosis including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, weakness, dysphagia following cerebral infarction, difficulty in walking, pain, and adult failure to thrive. Review of a quarterly Minimum Data Set (MDS) assessment completed 04/23/25 revealed range of motion limitation to one side. The resident was dependent upon staff for transfers. Review of occupational therapy discharge summary revealed Resident #56 received occupational therapy from 04/15/25 to 04/23/25. It stated the patient will be further assessed for splinting and palm pad during treatment. Upon discharge from occupational therapy, the resident was tolerating the trial of palm guard, and he demonstrated good rehab potential. No recommendations were made for a restorative nursing program for range of motion at discharge from therapy. Interview on 05/21/25 at 12:45 P.M. with Occupational Therapy (OT) #305 revealed the resident was trialed with palm pad which he did tolerate it. He does refuse most care. Therapy discharged due to not having a palm guard which was to be ordered. Interview on 05/21/25 at 1:21 P.M. with Environmental Services Coordinator #204 stated the palm guard was ordered and verified via shipping invoice dated 04/23/25. Interview on 05/21/25 at 3:00 P.M. with Therapy Director #304 confirmed therapy discharged Resident #56 and no restorative program was ordered, palm guard was ordered and therapy did not reevaluate the resident.

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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** 28923 Based on record review, staff interview, and policy review, the facility failed to ensure there was consistent communication between the facility and the dialysis center on the days a resident went out for hemodialysis treatments. This affected one resident (#62) of one resident reviewed for dialysis. Findings include: Review of Resident #62's medical record revealed he was admitted to the facility on [DATE] with the diagnoses of end stage renal disease, chronic kidney disease- Stage V, status post nephrectomy (removal of a kidney) in 2022, and dependence on hemodialysis. Review of Resident #62's physician's orders revealed the resident had an order in place to receive dialysis every Monday, Wednesday, and Friday. His chair times varied depending on the day of the week. His chair time was 10:30 A.M. every Monday and Friday. His chair time for Wednesday was 8:00 A.M. Review of Resident #62's active care plans revealed the resident had a care plan in place for an alteration in renal function as the resident received renal dialysis related to end stage renal disease. The goal was for the resident to receive renal dialysis without complications in coordination with the dialysis center and the facility. The interventions included the resident going to dialysis center three days per week on Monday, Wednesday, and Friday. They were to encourage the dialysis center to forward the dialysis treatment notes to the facility. Review of Resident #62's dialysis schedule for the past 30 days (04/27/25- 05/27/25) revealed the resident received dialysis treatments 13 times in that 30 day period. Review of the dialysis treatment sheets revealed there were only dialysis treatment sheets for six of those 13 visits. Seven of the 13 dialysis visits did not have a dialysis treatment sheet for. No dialysis treatment sheets were found for dialysis visits on 05/02/25, 05/05, 05/07, 05/09, 05/12, 05/16, or 05/21/25. Of the six that were found, only two (05/19/25 and 05/26/25) indicated what medications were given during his dialysis treatment. Four were left blank and did not indicate whether the resident had been given any medications during that visit. Of the six that were found, four (04/28/25, 04/30/25, 05/14/25, and 05/23/25) did not indicate if any new orders had been given and five (04/28/25, 04/30/25, 05/14/25, 05/19/25, and 05/23/25) of the six did not indicate if any problems occurred during the dialysis treatments. The dialysis treatment sheet was left blanks in those areas. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/27/25 at 3:47 P.M., an interview with Registered Nurse (RN) #112 revealed Resident #62 did go to dialysis every Monday, Wednesday, and Friday. She reported the dialysis center was not good about sending any paperwork (dialysis treatment sheets) with the resident anymore. The dialysis center's staff were to complete the dialysis treatment sheet and send it back with the resident. She stated if they received anything back, it was usually just the resident's pre and post-dialysis weights and vital signs. They usually did not bother to fill out the sections on the dialysis treatment sheet to show if the resident received any medications or how he tolerated the treatment. They would find the dialysis treatment sheets in the resident's bag or in his pocket, if they were even sent back at all. They would have to search through his bag to find it, and if one was not sent back, then they were expected to call the dialysis center to get it faxed over. She assumed the dialysis center would communicate with them, if there were any new orders, or if there had been any changes in his condition that they should be made aware of. She felt the communication with the dialysis center could be better and denied the dialysis center ever called the facility with any kind of report. Review of the facility's policy on dialysis updated 05/01/25 revealed it was the policy of the facility that all residents utilizing renal dialysis receive comprehensive interdisciplinary monitoring to ensure resident safety and support of dialysis services. The facility should initiate and maintain a professional relationship with the dialysis center for any resident admitted requiring renal dialysis. The dialysis center was to send reports from the resident's dialysis treatments to the facility after each visit.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52003 Based on record review and staff interview, the facility failed to provide services to prevent Resident #78 from experiencing triggers related to post traumatic stress disorder (PTSD). This affected one resident (#78) of one resident reviewed for PTSD. The facility census was 84. Findings include: Record review revealed Resident #78 was admitted on [DATE] with diagnoses including acute and chronic respiratory failure with hypoxia, type 2 diabetes, bipolar disorder, depression, post-traumatic stress disorder (PTSD), adjustment disorder with depressed mood, and attention-deficit hyperactivity disorder. Review of Resident #78's comprehensive care plan revealed no care plan or interventions regarding PTSD. Interview on 05/19/25 at 3:26 P.M. with Resident #78 reports she continues to have triggers to loud noises and has flashbacks due to a car accident at age of 16. Interview on 05/19/25 at 2:16 P.M. with Social Services #158 and Regional Director of Social Services and Activities #306, on admission a trauma informed care observation is completed by the social worker. During the observation the resident is asked about triggers. The care plan will reflect what answers the resident provides. Social Services #306 confirmed no trauma informed care observation was completed on admission due to the Resident #78 was discharged home in December of 2024 and readmitted in February of 2025. The previous social worker entered a progress note. Social Services #158 was not aware of Resident #78's diagnosis due to no trauma informed care observation being completed for the most recent admission.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, staff interview, review of a drug reference resource, and policy review, the facility failed to ensure a resident received a short acting anti-anxiety medication in accordance with their physician's orders to adequately manage anxiety. This affected one resident (#48) of five residents reviewed for behavioral-emotional care. Findings include: Review of Resident #48's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included anxiety disorder and major depressive disorder. Review of Resident #48's physician's orders revealed the resident had an order to receive Xanax (a benzodiazepine used in the treatment of anxiety disorders) 0.5 milligrams (mg) by mouth (po) four times a day (QID). The order originated on 04/23/25 and included specific times for administration that included 8:00 A.M., 1:00 P.M., 5:00 P.M., and 9:00 P.M. Review of Resident #48's medication administration history from 05/01/25 through 05/21/25 revealed the Xanax 0.5 mg po QID was for anxiety as evidenced by excessive worry. The medication administration history showed the Xanax was scheduled for administration at 8:00 A.M., 1:00 P.M., 5:00 P.M., and 9:00 P. M. as was indicated in the physician's orders. The nurses initialed the box to indicate the medication had been administered. 20 of the 82 doses administered during that time had an asterisk added in the box with the nurse's initials. The legend on the medication administration history indicated an asterisk meant a comment in reasons/ comments was added. Review of the comments included under the reasons/ comments revealed those 20 doses had been administered late. Dates where the nurses added an asterisk in the boxes with their initials was for the 8:00 A.M. doses on 05/01/25, 05/03, 05/06, 05/07, 05/08, 05/09, 05/14, 05/15, 05/16, 05/19, and 05/21/25; 1:00 P.M. doses on 05/12/25, 05/16, and 05/20/25; 5:00 P.M. doses on 05/20/25; and 9:00 P.M. doses on 05/08/25, 05/12, 05/17, and 05/18/25. The reasons/ comments added for those dates indicated the medication was administered late. The reasons/ comments added for those dates included columns for the scheduled date and time the Xanax was to be administered, the charted date and time, the reasons/ comments pertaining to that particular medication administration, and the name of the nurse creating the reasons/ comments for each scheduled administration. The Xanax was indicated to have been administered outside the hour window the nurses had to administer the medication for that scheduled time. The Xanax was noted to have been administered as late as 11:36 A.M. for the 8:00 A.M. dose, 2:28 P.M. for the 1:00 P.M. dose, 7:26 P.M. for the 5:00 P.M. dose, and as late as 10:35 P.M. for the 9:00 P.M. dose. On 05/18/25 at 4:13 P.M., an interview with Resident #48 revealed he did not feel he was receiving his Xanax as he should be. He reported his doses of Xanax were scheduled, but he received them at inconsistent times and often late. He reported he became anxious, as a result of his medication not being given on time, and felt like he could go off on someone when it was given to him a couple hours late. He did not know what the nurses were not giving him his Xanax when they were due. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/20/25 at 2:20 P.M., an interview with Licensed Practical Nurse (LPN) #147 confirmed she did not administer Resident #48's Xanax that was scheduled to be given at 8:00 A.M. that morning until around 10:30 A.M. She reported it should have been given sooner, but it was late. She indicated the time documented on the medication administration history was the time the medication was given and not just when it had been charted. She was not sure how long they had to administer a scheduled medication to a resident. She was not aware of the hour window they had before or after the scheduled time. She reported she was not over on the resident's unit to pass medications that much and was still trying to get her routine down. She was also responsible for passing medications on the residents on the assisted living unit. She passed them first and then passed her medications to the residents on Unit 2, where Resident #48 resided. She did not start the morning medication pass until after she was done with report. That was generally anywhere between 7:20 A.M. and 7:30 A.M. She did not feel she would have trouble passing the medications more timely once she got her routine down. Review of medication information on Xanax from Drugs.com revealed Xanax was used to treat anxiety disorders and anxiety caused by depression. Xanax was to be taken exactly as prescribed by the physician. The times of administration should be distributed as evenly as possible throughout the waking hours. Review of the facility's policy on Medication Administration - General Guidelines dated May 2020 revealed medications were to be administered within 60 minutes of the scheduled time. Unless otherwise specified by the prescriber, routine medications were administered according to the established medication administration schedule for the facility. Review of the facility's policy on Med Pass updated 05/01/25 revealed medications that were not every day (qd), twice a day (BID), or three times a day (TID) would require a specific time order by the physician.

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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** 32801 Based on medical record review, review of pharmacy recommendation, and interviews the facility failed to implement pharmacy recommendation and physician orders. This affected one resident (#14) of five residents reviewed for unnecessary medication review. Findings include: Medical record review revealed Resident #14 was admitted to the facility on [DATE] with diagnoses including iron deficiency anemia, weakness, fibromyalgia, and Parkinson's disease. Review of Resident #14's pharmacy recommendation undated revealed the resident had received ferrous sulfate 325 milligrams (mg) daily since 2023. Her complete blood count (CBC) was within normal limits on 04/28/25. Recommendation to discontinue ferrous sulfate. On 05/16/25 the physician checked the agree box and wrote an additional comment under the other box to discontinue the monthly CBC. Further review revealed there was a handwritten not authored by the Director of Nursing (DON) dated 05/18/25 that indicated the resident doesn't have monthly CBC and would readdress. Review of Resident #14's orders and medication administration records dated 05/2025 revealed the ferrous sulfate was not discontinued and the resident was still receiving and ordered ferrous sulfate 325 mg daily for anemia. Further review of Resident #14's orders revealed since 09/15/23 the resident CBC's have been ordered the first Wednesday in June and December. Review of Resident #14 Physician note dated 05/16/25 revealed to monitor CBC periodically to monitor the resident's iron deficiency anemia. Interview on 05/21/25 at 1:02 P.M., with the Physician revealed he had spoken to the DON regarding several pharmacy reviews on Friday and he could not remember the exact order but his initial gut feeling was he discontinued the ferrous sulfate and wanted to monitor the CBC periodically. Interview on 05/21/25 at 4:14 P.M., with the DON revealed the Physician did not relay to her to discontinue the ferrous sulfate and she had interpreted the pharmacy recommendation as the physician agreed to discontinue monthly CBC, however the DON confirmed the resident was not ordered monthly CBC, nor was discontinuing monthly CBC a recommendation the pharmacist had made.

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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. 52003 Based on observation, interview and facility policy review, the facility failed to ensure insulin pens were dated when opened. This affected three residents (#26, #49 and #192) of three residents reviewed for insulin use. Findings include: Observation on 05/19/25 at 8:15 A.M. of the unit short B medication cart revealed opened insulin containers with no open dates for the following medications: Resident #49 one Lantus long-acting insulin pen with the dispensed date of 05/06/25, Resident #192 one Lantus long-acting insulin pen with the dispensed date of 05/04/25. Interview on 05/19/25 at 8:15 A.M. with Licensed Practical Nurse (LPN) #186 verified insulin pens were not dated when opened in the unit short B medication cart. Observation on 05/19/25 at 8:32 A.M. of the unit 2 medication cart revealed opened insulin pens with no opened dates for the following medications: Resident #26 one Lantus long-acting insulin pen with the dispensed date of 03/27/25 and Resident #26 one Insulin Lispro pen with the dispensed date of 11/27/24. Interview on 05/19/25 at 8:32 A.M. with Registered Nurse (RN) #188 verified insulin pens were not dated when opened in the unit 2 medication cart. Review of the facility policy titled Medication Storage in the facility last revised May 2020 revealed the nurse shall place a date opened sticker on the medication and enter the date opened.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, review of the facility's contracted dental company's visit list, resident interview, and staff interview, the facility failed to ensure a resident, who consented to receive dental services while in the facility, received those services to replace a broken lower denture plate. This affected one resident (#32) of three residents reviewed for dental services. Findings include: Review of Resident #32's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included moderate protein-calorie malnutrition, stroke without residual deficits, adult failure to thrive, and legal blindness. Review of Resident #32's payer status in the electronic medical record revealed the resident was admitted to the facility on [DATE] under Ohio Medicaid (MCD). His payer status did not change until 04/18/25, when he was changed to Hospice MCD. Review of Resident #32's clinical admission documentation dated 01/10/25 revealed the resident had the use of an upper denture that was in fair condition and was missing one tooth. He was indicated to have lower dentures, but did not wear them and they weren't brought to facility with him. Review of Resident #32's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. He required set up or clean up assistance with his oral hygiene. He was assessed on the MDS as being edentulous and there was no indication that he had any broken dentures. Review of Resident #32's care plans revealed he had a care plan in place for an alteration in dental/ oral status related to not having any natural teeth and wearing upper dentures as he chooses. The goal was for the resident to be free of dental/ oral discomfort and to have proper fitting dentures in good repair. The interventions included the need for a dentist to evaluate and treat as needed (prn). If the resident wore dentures, they were to observe the condition and proper fit. They were to report any chips, cracks, or rough edges and to notify the dentist prn. Review of Resident #32's ancillary services consent form dated 05/09/25 revealed the resident was not known to have declined any of the ancillary services. He was to receive dental services per his request. Resident #32's electronic medical record (EMR) was absent for any evidence of the resident having been seen by a dentist since his admission to the facility on [DATE]. Progress notes were absent for any attempts to arrange dental services for the resident to replace his current dentures. Review of a dental list showing when the facility's contracted dentist had last visited the facility revealed the contracted dentist had last visited the facility on 03/19/25. Resident #32 was not one of the 22 residents who had been seen on that date. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 05/19/25 at 8:45 A.M., an interview with Resident #32 revealed he did not have his lower denture plate at the facility due to them being broken. He had the same set of dentures for the past [AGE] years. He was interested in being seen by a dentist to get a new set of dentures. On 05/20/25 at 9:52 A.M., an interview with Certified Nursing Assistant (CNA) #212 revealed he was not aware of Resident #32 wearing dentures and was not sure if he even had them. He was not aware the resident had the use of full upper dentures, or that he did not have his lower dentures with him due to them being broken and left at home. On 05/20/25 at 10:20 A.M., an interview with the Director of Nursing (DON) confirmed Resident #32 had not received any dental services while in the facility. She further confirmed the resident had consented to receive ancillary services when he was most recently asked on 05/09/25. She alleged the resident did not go under MCD until 03/19/25, and it was retroactive to 01/10/25. She was not able to provide any documentation to support that or to dispute the EMR showing he had been covered under MCD since 01/10/25, as was indicated under the census tab of the EMR.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, review of the facility's infection control tracking logs, observation, interview, and policy review, the facility failed to ensure all infections that occurred in the facility was included on their monthly infection control tracking log, trends/ patterns were identified by the infection preventionist when they occurred, and a resident with wounds was placed on enhanced barrier precautions as required. This affected one resident (#14) of five residents reviewed for unnecessary medications, one resident (#22) of four residents reviewed for pressure ulcers, and had the potential to affect all other residents residing in the facility. The facility's census was 84. Findings include: 1. Review of the facility's infection control tracking log for Unit 2 in March 2025 revealed there were five separate residents that were identified as having had infections on that unit during that month. Three of the five infections involved the organism of Methicillin-Resistant Staphylococcus Aureus (MRSA). The three MRSA infections identified included the following: 1 a.) Resident #24 was indicated to have been treated with an antibiotic for conjunctivitis (pink eye) between 03/03/25 and 03/13/25. A culture of the eye drainage was obtained and was positive for MRSA. The infection was identified as being healthcare associated (infections acquired in a healthcare facility such as a nursing home) as opposed to being community acquired (contracted outside of healthcare settings). 1 b.) Resident #79 was indicated to have been treated with an antibiotic for an abscess between 03/18/25 and 03/27/25. A culture was obtained of the drainage from the abscess and was positive for MRSA. His infection was identified as being a healthcare associated infection and not community acquired. 1 c.) Resident #64 was indicated to have been treated with an antibiotic for a wound infection between 03/26/25 and 04/04/25. A culture was obtained of the wound drainage and was found to be positive for MRSA. His infection was also indicated to be a healthcare associated infection and not community acquired. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/28/25 at 1:50 P.M., an interview with the facility's Director of Nursing (DON), who was also their Infection Preventionist revealed she did not identify any trends or patterns when tracking infections on Unit 2 for the month of March 2025. She was asked, if three of the five infections occurring involved MRSA, would that not indicate a trend/ pattern had occurred. The first documented MRSA infection was with a resident who had conjunctivitis with eye drainage that tested positive for MRSA. The other two residents that tested positive for MRSA on that unit had MRSA that were in wounds. All three residents were identified as having healthcare associated infections and none of the three were community acquired. The three residents were also indicated to have been placed in contact isolation precautions when their infections were noted to have involved MRSA. She denied she identified that as a trend/ pattern and did not provide any education to the staff working that unit on hand hygiene, wound care, or following appropriate contact isolation precautions. She acknowledged, with half of the infections recorded that month on that unit involving the same multi-drug resistant organism (MDRO) a trend/ pattern should have been identified and education provided to the staff to try to limit the spread to the other residents residing on that unit. Review of the facility's policy on Infection Surveillance and Monitoring Program updated November 2019 revealed it was the facility's policy for the infection surveillance program to determine baseline information about the frequency and type of healthcare associated infections (HAI) and ensure the standards in accordance with State regulations were followed. The procedure included reviewing the tracking and trending of infections. 32801 2. Medical record review revealed Resident #14 was admitted to the facility on [DATE] with diagnoses including urinary tract infection (UTI), fibromyalgia, and need for assistance with personal care. Review of Resident #14 nursing note dated 03/17/25 revealed Resident #14's urine was noted to be foul smelling and dark amber in color. The Nurse Practitioner (NP) was notified and new orders received for urinalysis (UA) and culture and sensitivity (C&S). On 03/18/25 the resident was straight cathed for UA and C&S. On 03/20/25 the UA and C&S results received. The NP ordered Ceftriaxone (antibiotic) one gram intramuscular (IM) daily for three days. Review of Resident #14's event report dated 03/20/25 revealed the resident had a urine culture that grew proteus mirabilis and the resident was placed on antibiotics. Review of Resident #14's observation report for McGeer's criteria dated 03/20/25 revealed the resident had a UTI and was treated with Ceftriaxone as evidenced by new or marked increase of urgency and frequency and at least 100 colony-forming unit (cfu)/milliliter (ml) of any number of organism in a specimen collected by in-and-out catheter. Review of Resident #14's C&S results dated 03/20/25 revealed the resident grew greater than 100 cfu/ml of proteus mirabilis and Ceftriaxone was sensitive to the organism. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the infection control log dated 03/2025 revealed no documented evidence Resident #14 was listed on the infection control log. Interview on 05/21/25 at 10:10 A.M., with the Director of Nursing (DON) confirmed Resident #14 had a UTI and was treated with antibiotic (Ceftriaxone), however she did not document the infection on the control log. 52003 3. Review of the medical record for Resident #22 revealed admitted [DATE] with diagnoses including acute diastolic (congestive) heart failure, need for assistance with personal care, depression, weakness, lack of physical exercise, other reduced mobility, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, hyperlipidemia, non-ST elevation (NSTEMI) myocardial infarction, type 2 diabetes mellitus without complications. Review of physician's orders dated 05/19/25 included wound care instructions for the left and right buttocks cleanse with soap and water, pat dry, apply triad paste and leave open to air. Review of the wound nurse practitioner note dated 05/19/25, wound measurements 1 centimeter (cm) length by 1cm width x 0.1cm depth with bloody exudate. The adhesive border dressing was discontinued on 05/19/25. Review of Resident #22's care plan revealed no care plan for enhanced barrier precautions. Observation on 05/20/25 at 9:24 A.M. revealed wound care being performed on Resident #22 by Registered Nurse (RN) #112. During the procedure, RN #112 confirmed that the wounds on the resident's buttocks were open and that the skin was not intact. RN #112 acknowledged that Enhanced Barrier Precautions were not followed, as required by CDC guidance. Review of facility policy titled Enhanced Barrier Precautions dated 05/01/25, states for procedures staff will wear gloves and a gown when performing high contact resident care activities. Review of CDC guidance dated 04/02/24 titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) states Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Wound care: any skin opening requiring a dressing.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 28923 Based on review of the facility's infection control log, staff interview, and policy review, the facility failed to ensure residents were not treated with antibiotics for urinary tract infections, unless the residents met criteria for treatment. This affected two residents (#63 and #91), who were noted on the monthly infection control logs for the past three months to receive antibiotics without meeting criteria for treatment. Findings include: 1. Review of the facility's infection control log for March 2025 revealed Resident #63 received treatment for a urinary tract infection (UTI) between 03/07/25 and 03/13/25. She was ordered to receive Levofloxacin (an antibiotic used to treat various bacterial infections to include UTI's. The infection control log included columns to indicate if a McGeer's criteria (a set of standardized definitions used for surveillance of healthcare associated infections in long term care facilities and could be used retrospectively to assess the appropriateness of antibiotic prescribing) was completed and if the resident met criteria for treatment. The infection control log revealed a McGeer's had been completed, but the resident did not meet criteria for treatment. No urinalysis with a culture and sensitivity was indicated to have been completed to determine if the resident had a UTI. There was no indication of the antibiotic having been discontinued, after it was determined she did not meet criteria for treatment. On 05/28/25 at 1:50 P.M., an interview with the facility's Director of Nursing (DON), who also served as their Infection Preventionist, confirmed Resident #63 had been treated for a UTI, when she did not meet criteria for treatment. She reviewed the infection control log and noted resident's antibiotic was ordered by her urologist. She reported the resident had issues with chronic UTI's and no urinalysis with a culture and sensitivity was collected. The urologist typically just did urine dips that would not show what type of organism was the cause of her infection, if she did in fact have one. She denied anyone questioning the need for the antibiotic, since it was indicated she did not meet criteria for treatment. She stated the facility's nurse practitioner did not usually question another physician's order for an antibiotic. She denied the resident's attending physician addressed it either. She provided her rationale for continuing the antibiotic by giving a copy of a nurse's progress note she wrote from a conversation she had with the nurse practitioner dated 03/07/25. The progress note from the DON indicated the nurse practitioner was aware of the resident's antibiotic order for a UTI from her urologist and the resident not meeting criteria. The DON indicated the nurse practitioner stated to continue the antibiotic as ordered, even though the resident did not meet criteria for treatment. (continued on next page)

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the infection control log for March 2025 for the facility's memory care unit revealed Resident #91 was documented as having received treatment for a UTI between 03/03/25 and 03/09/25. The resident was ordered and had received Macrobid (an antibiotic used in the treatment of UTI's). The infection control log indicated a McGeer's had been completed, but the resident did not meet criteria for treatment. A urinalysis with a culture and sensitivity was not completed, therefore it was not able to be confirmed if the resident had a UTI. It was also not able to be confirmed if the antibiotic ordered would have even been effective in treating the UTI, since the organism that may have caused a UTI was not determined. There was no evidence on the log of the antibiotic being discontinued when it was determined the resident did not meet criteria for treatment. The resident received a full seven day course of the antibiotic treatment, after it was initiated. On 05/28/25 at 1:50 P.M., an interview with the facility's Director of Nursing (DON), who also served as their Infection Preventionist, confirmed Resident #91 did receive treatment for a suspected UTI, when he did not meet criteria for treatment. She reported the resident was having urinary retention and had an indwelling urinary catheter placed, in addition to the start of the antibiotic. She acknowledged symptoms such as urinary retention could be caused by other medical problems and did not necessarily mean that a UTI was present. She denied the resident had any other symptoms and the symptoms were resolved with the placement of an indwelling urinary catheter. She was asked to provide a rationale as to why the resident was treated with an antibiotic when he did not meet criteria for treatment and no urinalysis had been performed to even indicate he had one. She was not able to provide any supporting documentation to show why the antibiotic was necessary. She again stated the facility's nurse practitioner did not like to discontinue antibiotics that were ordered by another advanced level provider. She provided a copy of a nurse's progress note she wrote that indicated the nurse practitioner was aware of an antibiotic that had been ordered for the resident that did not meet McGeer's criteria. The note further indicated the nurse practitioner stated to continue the antibiotic. Review of the facility's policy on the Antibiotic Stewardship Program updated November 2019 revealed the facility would establish a multi-disciplinary antimicrobial stewardship program that defined and provided guidance for optimal antimicrobial use. The facility's medical director was to set standards for antimicrobial prescribing. The procedure indicated when a facility staff member suspected that a resident had an infection, the nurse was to perform and document an assessment of the resident using established and accepted Loeb assessment (criteria designed to guide the initiation of antibiotics in long-term care facilities, focusing on clinical signs and symptoms suggestive of infection) protocols to determine if the resident's status met minimum criteria for initiating antimicrobials prior to calling the physician. When prescribing antimicrobials, the physician/ prescriber should determine if an antimicrobial was needed based on documented Loeb assessment information provided by facility staff. If possible, cultures should be obtained before starting antimicrobial therapy. Of note, prior antimicrobial therapy may interfere with bacterial growth.