STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365619	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Bucyrus	1170 W Mansfield Street Bucyrus, OH 44820

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on interviews, record review, policy review, the facility failed to ensure care conferences were completed timely. This affected six residents (#05, #07, #08, #12, #19, #29, and #45) of the 19 residents reviewed for care conferences. The facility census was 74. Findings include: 1) Review of medical record for Resident #07 revealed an admitted [DATE] with diagnoses including but not limited to hemiplegia/hemiparesis following cerebral vascular accident (CVA/stroke) affecting non-dominant right side, post-traumatic stress disorder (PTSD), bipolar disorder, schizophrenia, anxiety, and altered mental status. Review of Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #07 had moderate cognitive impairment. Review of progress notes including social service notes for Resident #07, revealed no documented evidence care conferences were held in May 2024 or August of 2024. 2) Review of medical record for Resident #08 revealed an admitted [DATE] with diagnoses including but not limited to atrial fibrillation, bipolar, dementia, and hypertension. Review of MDS assessment dated [DATE], revealed Resident #08 was cognitively intact. Review of progress notes including social service notes for Resident #08, revealed no documented evidence a care conference was held in July 2024. 3) Review of medical record for Resident #12 revealed an admitted [DATE] with diagnoses including but not limited to chronic obstructive pulmonary disease (COPD), type two diabetes, congestive heart failure (CHF), anxiety, post-traumatic stress disorder, depression, bipolar disorder, and schizophrenia. Review of MDS assessment dated [DATE], revealed Resident #12 was cognitively intact. Review of progress notes including social service notes for Resident #12, revealed no documented evidence a care conference was held in September 2024. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) Review of medical record for Resident #19 revealed an admitted [DATE] with diagnoses including but not limited to brief dementia with severe agitation, type two diabetes, hypertension, anxiety, depression, and abnormal posture. Review of MDS assessment dated [DATE], revealed Resident #19 had severe cognitive impairment. Review of progress notes including social service notes for Resident #19, revealed no documented evidence care conferences were held in April 2024 and July 2024. 5) Review of medical record for Resident #29 revealed an admitted [DATE] with diagnoses including but not limited to disorder of muscle, COPD, type two diabetes, panic disorder, major depressive disorder, chronic pain, arthritis, depression, anxiety, and claustrophobia. Review of MDS assessment dated [DATE], revealed Resident #29 was cognitively intact. Review of progress notes including social service notes for Resident #29, revealed no documented evidence a care conference was held in August 2024. 6) Review of medical record for Resident #45 revealed an admitted [DATE] with diagnoses including but not limited to fracture of right femur, major depressive disorder, cognitive communication deficit, anxiety, and chronic pain. Review of MDS assessment dated [DATE], revealed Resident #45 had moderate cognitive impairment. Review of progress notes including social service notes for Resident #45, revealed no documented evidence care conferences were held in April 2024 and July 2024. Interview on 12/16/24 at 2:54 P.M. with Social Worker/Administrative Assistant (SW/AA) #869 verified that care conferences are to be completed upon admission and quarterly. SW/AA #869 verified that Residents (#07, #08, #12, #19, #29, and #45) care conferences were not held quarterly. 44454 7) Review of the medical record revealed Resident #05 was admitted to the facility on [DATE]. Diagnoses included paranoid schizophrenia, anxiety, depression, type II diabetes mellitus, asthma, rheumatoid arthritis, hypertension, and cognitive communication deficit. Review of MDS assessment dated [DATE], revealed Resident #05 was cognitively intact. Review of progress notes including social service notes for Resident #05, revealed no documented evidence a care conference was held or attempted in July 2024. An interview on 12/18/24 at 3:32 P.M. with the Director of Nursing (DON), verified Resident #05 did not have a quarterly care conference in July 2024. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Care Planning - Interdisciplinary Team, not dated, revealed the interdisciplinary team was responsible for the development of resident care plans and residents, families, and/or legal representatives were encouraged to participate in the development of and revisions to the care plan. Care plan meetings would be scheduled at the best time of day for the resident and family if possible. If it was determined the participation of the resident or representative was not practicable, an explanation would be documented in the medical record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on record review, staff interview, and policy review, the facility failed to ensure the code status matched the medical record and the physician's order. This affected one (#12) of the 19 residents reviewed for code status. The facility census was 74. Findings include: Review of medical record for Resident #12 revealed an admitted [DATE] with diagnoses including but not limited to chronic obstructive pulmonary disease (COPD), type two diabetes, congestive heart failure, narcolepsy, anxiety, post-traumatic stress disorder, convulsions, depression, bipolar disorder, and paranoid schizophrenia. Review of Advanced Directives in the hard/paper chart for signed and dated 10/23/24 for Resident #12, revealed a code status document of Do Not Resituate Comfort Care Arrest (DNRCCA). Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 was cognitively intact. Review of the physician orders in the electronic medical record (EMR) dated 12/16/24 for Resident #12, revealed the resident was ordered to be a full code. Interview on 12/16/24 at 2:09 P.M. with Registered Nurse (RN) #230, verified Resident #12 had a physician order in the EMR for a Full Code and the hard/paper chart contained a DNRCCA documentation. RN #230 stated the resident was a DNRCCA since it was dated 10/23/24 and the order did not get updated in the EMR. Review of policy titled Advance Directive, not dated, revealed the interdisciplinary team will review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded in the medical record. The interdisciplinary team will be informed of changes and/or revocations so that appropriate changes can be made in the resident medical record and care plan.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on observation, resident and staff interviews, record review, and review of the facility policy, the facility failed to ensure residents had a safe, clean, comfortable and homelike environment. This affected one (#37) of two residents reviewed for physical environment. The facility census was 74. Findings include: Review of the medical record revealed Resident #37 was admitted to the facility on [DATE]. Diagnoses included anxiety, heart failure, and weakness. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], identified Resident #37 was cognitively intact. The resident was always continent of bladder and bowel. An interview on 12/16/24 at 2:53 P.M. with Resident #37, revealed the bathroom was not thoroughly cleaned on a regular basis. Observation at the same time with Resident #37, revealed there was dried feces on the lower left side of the toilet. There was also a towel on the floor on the left side of the toilet, and a brown paper towel behind the toilet. A follow-up observation on 12/19/24 at 7:29 A.M. of Resident #37's bathroom with Certified Nursing Assistant (CNA) #438, revealed the dried feces, towel, and paper towel were still in the same location in the bathroom. There was also a small puddle in front of the toilet. An interview with CNA #438 at the same time verified the conditions of the resident's bathroom. CNA #438 stated the residents' bathrooms were supposed to be cleaned daily, so the towel, paper towel, and feces should not have been there.

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F 0606 Level of Harm - Potential for minimal harm Residents Affected - Some	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 45751 Based on employee personnel records, background check log, and staff interviews, the facility failed to ensure reference checks were completed for four new employees. This affected four (Registered Nurse [RN] #229, Social Worker/Administrative Assistant [SW/AA] #869, Medication Technician [MT] #388, and Certified Nursing Assistant [CNA] #443) of the four personnel files reviewed but had the potential to affect all 74 residents residing in the facility. Findings include: Review of employee file for RN #229, revealed no documented evidence of reference checks being completed. Review of employee file for SW/AA #869, revealed no documented evidence of reference checks being completed. Review of employee file for MT #388, revealed no documented evidence of reference checks being completed. Review of employee file for CNA #443, revealed no documented evidence of reference checks being completed. Interview with Human Resource Director (HRD) #900 on 12/19/24 at 2:17 P.M. verified there were no reference checks for RN #229, SW/AA #869, MT #388, and CNA #443.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on observation, record review, staff interview, review of the activity calendar, and policy review the facility failed to ensure activities on memory care unit met the needs and preferences of the residents. This affected all 13 residents (#02, #04, #11, #13, #19, #24, #35, #40, #41, #46, #58, #174, and #175) on the memory care unit. The facility census was 74. Findings include: Review of medical record for Resident #04, revealed an admitted [DATE] with diagnoses including but not limited to Alzheimer's disease with late onset, dementia with other behavioral disturbance, and cognitive communication deficit. Review of care plan dated 10/16/24, revealed Resident #04 had the potential for decreased activity participation, involvement and or social isolation related to illness/disease process, immobility, and impaired decision making. Interventions included assist with arranging community activities and arrange transportation, encourage attendance and participation in activities, if the resident is physically unable to participate or facility cannot provide activities of interest provide alternate methods to keep the resident involved in the activity for example television programs, reading material, conversations, and field trips, offer a variety of activity types and locations to maintain interests, and provide a calendar of scheduled activities, and notify of any changes to the calendar. Review of Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #04 had severe cognitive impairment. Review of medical record for Resident #175, revealed an admitted [DATE] with diagnoses including but not limited to dementia, traumatic subdural hemorrhage without loss of consciousness, seizures, depression, and cannabis use. Review of care plan dated 12/13/24 for Resident #175, revealed impaired cognitive function/impaired thought processes related to resident meets criteria for secure dementia unit. Interventions included engaging the resident in simple, structured activities that avoid overly demanding tasks. Interview on 12/16/24 at 9:29 A.M. with Resident #175, revealed the resident did not think the facility had any activities. Resident #175 stated it gets boring at times in his room. Observation of the memory care unit on 12/16/24 at 10:08 A.M., revealed no activity calendar posted. Observation of the memory care unit on 12/16/24 at 11:40 A.M., revealed six residents in the common area and dining area on the memory care unit. Christmas music was playing on the television. Observation of the memory care unit on 12/16/24 at 2:47 P.M., revealed no activities going on in the memory care unit. Four residents were observed in the television room where a movie was playing; however, no residents were observed watching the movie. No activities calendar posted in the memory care unit and unable to determine if the movie was an activity. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/17/24 at 8:25 A.M. with Certified Nursing Assistant (CNA) #493 stated they try to do activities in the memory care unit. CNA #493 stated they barely see the Activity staff. CNA #493 stated they usually have two aides on the memory care unit, and it can get overwhelming when there are behaviors, and attempting to do activities. Observation of memory care unit on 12/17/24 at 3:39 P.M., revealed snacks were supposed to be handled out. Observation revealed no snacks being served while five residents were observed seating in the dining/television room. A movie was started with none of the residents watching the television. Interview on 12/17/24 at 3:41 P.M. with CNA #441, verified there was no activity calendar posted in the memory care unit. CNA #441 stated normally the aides will do activities with the residents on the unit. CNA #441 stated that on second shift they do not do many activities. CNA #441 stated it is rare to see the activities department in the unit. CNA #441 verified it is hard to do activities with only two CNAs on the unit when they have behaviors. Observation of the memory care unit's bulletin board on 12/17/24 at 3:49 A.M. with CNA #441, revealed December 2024 activity calendar. CNA #441 verified the calendar was just posted. Observation of the memory care unit on 12/18/24 at 10:30 A.M., revealed CNA #441 playing connect four with two residents. Three other residents were observed in the television room. One resident was sleeping, one was sitting on the couch drinking water, and the other resident was sitting in a wheelchair holding a baby doll. The television was on with a movie playing. None of the residents were watching the television. Interview on 12/18/24 at 11:26 A.M. with Activity Director (AD) #868, revealed she has been working as AD for two months. AD #868 stated they go to the memory care unit once a day when she and the activity assistant were both working. AD #868 stated they do not work every day. AD #868 stated they take the daily chronicle to the memory care unit. AD #868 stated they post an activity calendar on the bulletin board of the memory care unit to let staff know what activities were scheduled. AD #868 verified she did not receive any special training for memory care unit activities. Review of December 2024 activity calendar in the memory care unit, revealed the following activities for the week of survey were: 12/16/24 at 9:45 A.M. daily chronicle, 11:00 A.M. hot chocolate, 12:30 P.M. lunch, 3:30 P.M. snack, 4:30 P.M. downtime, 5:30 P.M. dinner, and 7:00 P.M. wind down time. 12/17/24 at 9:45 A.M. daily chronicle, 11:00 A.M. refreshments, 12:30 P.M. lunch, 2:30 P.M. coffee hour, 3:30 P.M. snack, 4:30 P. M. down time, 5:30 P.M. dinner, and 7:00 P.M. wind down time. 12/18/24 at 9:45 A.M. daily chronicle, 11:00 A.M. lemonade and chats, 12:30 P.M. lunch, 2:30 P.M. craft, 3:30 P.M. snack, 4:30 P.M. down time, 5:30 P. M. dinner, and 7:00 P.M. wind down time. 12/19/24 at 9:45 A.M. daily chronicle, 11:00 A.M. refreshment, 12:30 P.M. lunch, 2:30 P.M. movie, 3:30 P.M. snack, 4:30 P.M. down time, 5:30 P.M. dinner, and 7:00 P.M. wind down time. Observation of the memory care unit on 12/19/24 at 9:47 A.M., revealed six residents in the dining room getting ready to do a craft. Residents were painting angels made out of clothes pins. Resident #175 was not attending the activity. Interview with Resident #175 stated he did not know there was an activity. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of policy titled Activity Programs, not dated, revealed the activities program is provided to support the well-being of residents and to encourage both independence and community interaction. The activities program is ongoing and includes facility-organized group activities, independent individual activities and assisted individual activities. Activities are considered any endeavor, other than routine activities of daily living, in which the resident participates, that is intended to enhance his or her sense of well-being and to promote or enhance physical, cognitive or emotional health. Scheduled activities are posted on the resident bulletin board. Activity schedules are also provided individually to residents who cannot access the bulletin board for example bed bound or visually impaired residents.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on medical record review, observation, and resident and staff interview, the facility failed to administer tube feedings in accordance with physician orders. This affected one (#130) of the one resident reviewed for administration of tube feedings. The facility census was 74. Findings include: Review of the medical record revealed Resident #130 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, shock, severe protein-calorie malnutrition, pleural effusion, diverticulitis of intestine, thrombocytopenia, other disorders of electrolyte and fluid imbalance, acute embolism and thrombosis of left femoral vein, cutaneous abscess, altered mental status, obstructive and reflux uropathy. Review of Resident #130's physician orders identified an order dated 12/08/24 for Osmolite 1.2 Cal (nutritional supplement) oral liquid give 80 milliliters (mL) per hour via nasogastric tube (NG) one time per day, turn on at 6:00 P.M. and turn off at 6:00 A.M. The resident also had an order dated 12/09/24 for a regular diet, ground meat and mechanical soft with soft and bite-sized consistency. Review of the plan of care dated 12/08/24, revealed Resident #130 required a tube to assist the resident in maintaining/improving nutritional status related to dysphagia and abnormal laboratory (lab) values. Interventions included tube feeding per dietitian recommendations and physician orders. An observation on 12/16/24 at 10:25 A.M., revealed Resident #130 was resting in bed with the head of the bed elevated. The Osmolite 1.2 Cal was being administered via NG tube at 80 mL per hour. An interview with Resident #130 on 12/16/24 at 10:28 A.M., revealed the resident did not eat breakfast on 12/16/24 because he was not hungry. An interview on 12/17/24 at 12:48 P.M. with Licensed Practical Nurse (LPN) #340, who was assigned to care for Resident #130 during the day shift on 12/16/24, reported connecting Resident #130's tube feed at the beginning of her shift, at approximately 6:00 A.M. on 12/16/24. LPN #340 confirmed Resident #130's tube feed should not have been running on 12/16/24 at 10:25 A.M., as it was scheduled to be disconnected daily at 6:00 A.M. so the resident would have an appetite during mealtimes. An interview on 12/17/24 at 1:00 P.M. with the Director of Nursing (DON), revealed no knowledge of Resident #130's tube feeding being administered during the daytime hours. The DON verified the tube feed was not supposed to be running during the daytime hours. A follow-up interview on 12/18/24 at 11:10 A.M. with the DON, revealed Staffing Coordinator #247, who was also a nurse, had been doing rounds on the morning of 12/16/24 and thought Resident #130's tube feed was supposed to be administered during the day. Staffing Coordinator #247 connected the tube feed at an unknown time on the morning of 12/16/24. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of December 2024 medication administration record (MAR) for Resident #130, revealed the resident did not receive their tube feeding per physician order on 12/11/24, 12/12/24, and 12/13/24. An interview on 12/18/24 at 2:10 P.M. with the DON verified the MAR did not reflect Resident #130 received their tube feeding per physician order on 12/11/24, 12/12/24 and 12/13/24.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on medical record review, review of physician and nurse practitioner (NP) progress notes, and staff interview, the facility failed to ensure physician visits were completed as required. This affected five (#60, #04, #12, #29, and #45) of the nine residents reviewed for physician visits. The facility census was 74. Findings include: 1) Review of the medical record revealed Resident #60 was admitted to the facility on [DATE]. Diagnoses included fibromyalgia, hypokalemia, hyperlipidemia, spinal stenosis, anxiety, upper abdominal pain, nausea with vomiting, gastro-esophageal reflux disease, diverticulitis of intestine, osteoporosis, osteoarthritis, chronic pain syndrome, unsteadiness on feet, muscle weakness, pain in right leg, pain in left leg, difficulty walking, and depression. Resident #60 was cognitively intact. Further review of the medical record, revealed Resident #60 was seen by the NP monthly from 02/29/24 through 12/16/24. There was no evidence of a physician visit with Resident #60 from 02/26/24 through 12/16/24. An interview with the Administrator on 12/19/24 at 1:42 P.M., verified the facility had no documented evidence, including progress notes or other documentation, to confirm Resident #60 was seen by a physician from 02/29/24 through 12/16/24. 45751 2) Review of medical record for Resident #04 revealed an admitted [DATE] with diagnoses including but not limited to Alzheimer's with late onset, unspecified fracture of right femur, dizziness and giddiness, orthostatic hypotension, dementia with other behavioral disturbance, and cognitive communication deficit. Resident #04 had severe cognitive impairment. Review of physician visit notes from March 2024 through December 2024, revealed Resident #04 was seen on 03/20/24, 04/26/24, and 10/19/24. Review of NP notes for September 2024 through December 2024, revealed Resident #04 was seen by the NP on 11/10/24, 10/21/24, 10/15/24, 10/10/24, 10/02/24, 09/26/24, 09/17/24, and 09/05/24. 3) Review of medical record for Resident #12 revealed an admitted [DATE] with diagnoses including but not limited to chronic obstructive pulmonary disease, type two diabetes, congestive heart disease, narcolepsy, anxiety, post-traumatic stress disorder, convulsions, depression, bipolar disorder, and paranoid schizophrenia. Resident #12 was cognitively intact. Review of NP notes from April 2024 through December 2024, revealed Resident #12 was seen on 09/04/24, 07/03/24, 07/01/24, 06/27/24, 05/30/24, 05/29/24, 05/23/24, 05/16/24, 05/14/24, and 04/10/24. Review of physician visit notes from March 2024 through December 2024, revealed Resident #12 was seen by the physician on 09/07/24 and 12/01/24. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) Review of medical record for Resident #29 revealed an admitted [DATE] with diagnoses including but not limited to disorder of muscle, chronic obstructive pulmonary disease, type two diabetes, panic disorder, major depressive disorder, chronic pain, depression, anxiety, claustrophobia, low back pain, and muscle wasting. Resident #29 was cognitively intact. Review of physician visit notes from March 2024 through December 2024, revealed Resident #29 was seen by the physician on 04/06/24 and 11/16/24. 5) Review of medical record for Resident #45 revealed an admitted [DATE] with diagnoses including but not limited to fracture of right femur, major depressive disorder, cognitive communication deficit, anxiety, and chronic pain. Resident #45 had moderate cognitive impairment. Review of NP notes from March 2024 through December 2024, revealed Resident #45 was seen on 04/02/24. Review of physician visit notes from March 2024 through December 2024, revealed Resident #45 was seen on 06/07/24. Interview with Assistant Director of Nursing (ADON) #891 on 12/19/24 at 3:10 P.M. verified Resident #12 was only seen on 04/06/24, 09/07/24, and 12/01/24 by the physician. ADON #891 verified that Resident #45 was only seen by the physician on 06/07/24. ADON #891 verified Resident #04 was only seen by the physician on 03/20/24 and Resident #29 was seen by the physician on 11/16/24 and 04/06/24. Review of policy titled Physician Visits, not dated, revealed the attending physician must visit his/her patients at least once every 30 days for the first 90 days following the resident's admission, and then every 60 days thereafter. After the first 90 days, if the attending physician determines that a resident need not be seen by him/her every 30 days, an alternate schedule of visits may be established, but not to exceed every 60 days. A physician assistant or nurse practitioner may make alternating visits after the initial 90 days following the admission, unless restricted by law or regulation.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on record review, and staff interview, the facility failed to provide medications as ordered by the physician which resulted in significant medication errors. This affected one (#29) of one resident reviewed for insulin. The facility census was 74. Findings include: Review of medical record for Resident #29 revealed an admitted [DATE] with diagnoses including but not limited to disorders of muscle, chronic obstructive pulmonary disease, type two diabetes, panic disorder, major depressive disorder, chronic pain, arthritis, depression, anxiety, and claustrophobia. Review of Minimum Date Set (MDS) assessment dated [DATE], revealed Resident #29 was cognitively intact. Review of the active physician orders for Resident #29, revealed an order for Humulin 70/30 (insulin) KwikPen subcutaneous (SQ) pen injector give 88 units SQ on time a day at 8:00 A.M. If blood sugar (BS) is greater than 150 milligrams per deciliter (mg/dL) then increase the supper dose by two units. If less than 100 mg/dL then decrease the supper dose by two units. Continue to adjust the dose by two units for FSBS less than 150 mg/dL and Inject 58 units SQ once daily at 5:00 P.M. If BS is greater than 150 mg/dL then increase the morning dose by two units. If less than 100 mg/dL then decrease the A.M. dose by two units. Continue to adjust the dose by two units for BS greater than 150 mg/dL. Review of medication administration record (MAR) for December 2024, revealed the nurses signed off each day that they gave Humulin 70/30 88 units in the morning and 58 units in the evening. No indication that the dose was adjusted according to physician's order and the BS obtained. The morning dose should have been adjusted on 12/02/24, 12/03/24, 12/04/24, 12/06/24, 12/11/24, 12/16/24, 12/17/24, and 12/18/24. The evening dose should have been adjusted on 12/03/24, 12/04/24, 12/07/24, 12/09/24, 12/10/24, 12/11/24, 12/15/24, 12/16/24, and 12/17/24. Interview with the DON on 12/19/24 at 8:42 A.M., verified the Humulin 70/30 insulin order was not changed in December after the physician changed the insulin order. The DON stated the order was confusing. The DON verified Resident #29's current order for the Humulin 70/30 insulin was not followed and stated there should be a new order created each time an adjustment was created by the physician. The DON verified the Humulin 70/30 insulin should have been adjusted for the morning dose at 8:00 A.M. on 12/02/24, 12/03/24, 12/04/24, 12/06/24, 12/11/24, 12/16/24, 12/17/24, and 12/18/24. The DON verified the Humulin 70/30 insulin should have been adjusted for the evening dose at 5:00 P.M. on 12/03/24, 12/04/24, 12/07/24, 12/09/24, 12/10/24, 12/11/24, 12/15/24, 12/16/24, and 12/17/24. The DON verified the facility could not prove that the dose was adjusted on those days. Interview with Physician #902 on 12/19/24 at 9:29 A.M., revealed the Humulin 70/30 insulin should have been changed according to the active orders.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48568 Based on observation, resident interviews, staff interviews, and policy review, the facility failed to ensure residents received food that was palatable and appetizing to them and which met their nutritional recommendations. This affected four (#57, #05, #62 and #61) residents out of the four residents reviewed for lunch. This had the potential to affect all but one resident (#174) who was identified by the facility as not receiving meals from the kitchen. The census was 74. Findings include: Review of medical record for Resident #57, revealed an admitted [DATE]. The resident was diagnosed with type 2 diabetes mellitus, peripheral vascular disease, and unspecified convulsions. Resident #57 was cognitively intact. Review of medical record for Resident #05, revealed an admitted [DATE]. The resident was admitted with diagnoses including paranoid schizophrenia, type 2 diabetes mellitus, and morbid obesity. Review of medical record for Resident #62, revealed an admitted [DATE]. The resident was admitted with diagnoses including type 2 diabetes mellitus, chronic obstructive pulmonary disease, and dementia. Review of medical record for Resident #61, revealed an admitted [DATE]. The resident was admitted with diagnoses including type 2 diabetes mellitus, essential hypertension, and major depressive disorder. Interview on 12/16/24 at 01:17 P.M. with Resident #57, revealed the hot food was cold. Observation on 12/18/24 at 11:31 A.M. of the lunch tray line with Dietary Manager (DM) #333, revealed the chicken breasts were holding at 176 degrees Fahrenheit (F) on the tray line. DM #333 confirmed the temperature. Interview on 12/18/24 at 12:06 P.M. with Resident #05, revealed she could not chew the chicken. Resident #05 stated the chicken was too dry and she wasn't able to eat it with her dentures. Resident #05 also revealed the Brussel sprouts were not good and today was a bad day for food. Interview on 12/18/24 at 12:18 P.M. with Resident #57, revealed the lunch tasted bad but it was warm. Interview with Resident #62 on 12/18/24 at 12:57 P.M., revealed the chicken was dry and the Brussel sprouts were mushy. Observation of a test tray on 12/18/24 at 12:37 P.M. with DM #333, revealed the chicken measured 135 degrees F, the vegetable rice measured 135 degrees F, and Brussel sprouts measured 142 degrees F. The test tray left the kitchen on 12/18/24 at 12:39 P.M. DM #333 stated the food leaving the kitchen should be at 135 degrees F or higher. DM #333 stated she wanted the residents to receive the food at 120 degrees F. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the test tray on 12/18/24 at 12:44 P.M. with DM #333, revealed the chicken measured 120 degrees F, vegetable rice measured 135 degrees F, and the Brussel sprouts measured 135 F. Observation of the chicken with DM #333 revealed the chicken had a dry taste and texture. Interview with DM #333 and District Manager #666 verified the chicken was dry. Interview with Resident #61 on 12/18/24 at 1:00 P.M., revealed the chicken was dry. Resident #61 also revealed the Brussel sprouts had no taste. Observation at the same time revealed Resident #61 still had the chicken breast and Brussel sprouts on his lunch plate. Review of the Food Quality and Palatability policy dated 02/23 stated the food will be prepared by methods that conserve nutritive value, flavor, and appearance. Food will be palatable, attractive, and served at a safe and appetizing temperature.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48568 Based on observation, interviews, and policy review, the facility failed to maintain the kitchen in a clean and sanitary condition. This affected all but one resident (#174) who was identified by the facility as not receiving meals from the kitchen. The census was 74. Findings Include: Observation of the kitchen on 12/16/24 at 10:59 A.M. with Dietary Manager (DM) #333, revealed the wall across from dishwasher had splattered food debris all over it and parts of the wall were chipping. Interview with DM #333 at the same time, verified the findings. Observation of the kitchen on 12/16/24 at 11:20 A.M. with DM #333, revealed the ventilation hood above the clean pan rack and stove top has paint strips hanging down from it. DM #333 verified the findings and stated someone cleaned too hard and now paint is hanging down. Follow up observation of the kitchen on 12/18/24 at 11:14 A.M. with District Manager #666, revealed the white paint strips were chipping from the ventilation hood above the stove top and clean dish rack. Interview with District Manager #666 at the same time verified the findings. Review of the Environment policy dated 09/2017 stated all food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. The policy also stated, the Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation. Review of the Food: Preparation policy dated 02/2023 stated dining services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on medical record reviews, staff interviews, review of the facility's infection control logs, review of facility in-services, and review of the facility's policy, the facility failed to prevent and respond to an increased pattern of urinary tract infections (UTIs). This affected two (#16 and #60) of two residents reviewed for UTIs. The facility census was 74. Findings include: Review of the medical record revealed Resident #16 was admitted to the facility on [DATE]. Diagnoses included type II diabetes mellitus, chronic obstructive pulmonary disease, shortness of breath, asthma, dysphagia, need for assistance with personal care, insomnia, hyperlipidemia, adult failure to thrive, osteoarthritis, infestation, low back pain, hypertension, anxiety, and bipolar disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], identified Resident #16 was cognitively intact. The resident was frequently incontinent of urine and occasionally incontinent of bowel. Review of the infection control logs dated 07/01/24 through 12/15/24, revealed Resident #16 was identified to have a UTI on 08/01/24, 09/05/24, 09/26/24, and 11/05/24. The urine cultures for the UTIs on 07/30/24, 09/02/24, 09/26/24 identified Escherichia coli (E. coli) in the resident's urine. All UTIs were monitored and treated. Review of the medical record revealed Resident #60 was admitted to the facility on [DATE]. Diagnoses included fibromyalgia, hypokalemia, hyperlipidemia, spinal stenosis, anxiety, upper abdominal pain, nausea with vomiting, gastro-esophageal reflux disease, diverticulitis of intestine, osteoporosis, osteoarthritis, chronic pain syndrome, unsteadiness on feet, muscle weakness, pain in right leg, pain in left leg, difficulty walking, and depression. Review of the quarterly MDS assessment dated [DATE], identified Resident #60 was cognitively intact. The resident was always continent of bladder and bowel. Review of the infection control logs dated 07/01/24 through 12/15/24, revealed Resident #60 was identified to have a UTI on 11/05/24 and 11/27/24. The urine cultures for the UTIs on 11/05/24 and 11/27/24 identified E. coli in the resident's urine. Review of the infection control logs from 07/01/24 through 12/15/24, revealed there were at least 58 residents diagnosed with UTIs which were not present upon admission. Review of the staff in-services dated 07/01/24 through 12/15/24, revealed no in-services pertaining to prevention of UTIs. One in-service regarding handwashing was completed on 10/09/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 12/19/24 at 8:33 A.M. with Registered Nurse #229, who was identified as being the facility's infection preventionist, revealed when there was an increase in any type of infection, the facility should implement education by in servicing all applicable staff. RN #229 verified the facility had not recognized an increase in UTIs or E. coli. RN #229 stated the facility conducted the handwashing in-service on 10/09/24 related to another infection control concern and had not provided any other in-services related to an increase in UTIs or E. coli. Review of the facility policy titled Surveillance for Infections, not dated, revealed the Infection Preventionist (IP) would conduct ongoing surveillance for healthcare-associated infections and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 48568 Based on observation, staff interviews, record review, and policy review the facility failed to ensure the kitchens walk-in cooler and reach-in cooler were working in a safe operable condition. This had the potential to affect all but one resident (#174) who was identified by the facility as not receiving meals from the kitchen. The census was 74. Findings include: Observation of the kitchen on 12/16/24 at 10:04 A.M. with the Dietary Manager (DM) #333, revealed the reach-in cooler had an ambient internal temperature of 44 degrees Fahrenheit (F). Interview with DM #333 at the same time, verified the reach-in cooler was 44 degrees F. Observation of the kitchen on 12/16/24 at 10:09 A.M. with DM #333, revealed the walk-in cooler had an ambient internal temperature of 47 degrees F. Interview with DM #333 at the same time verified the walk-in cooler was 47 degrees F. Observation of the walk-in cooler on 12/16/24 at 10:17 A.M. with DM #333, revealed the following temperatures: a) The cottage cheese was 44 degrees F. b) The cream cheese was 47 degrees F. c) The whole milk was 45 degrees F. d) The pre-sliced cheese in a plastic container was 49 degrees F. e) The packaged pre-sliced cheese was 43 degrees F. f) The sliced ham in a plastic container was 47 degrees F. g) The homemade coleslaw was 47 degrees F. h) The buffet ham log was 48 degrees F. Observation of the kitchen on 12/16/24 at 10:50 A.M. with DM #333, revealed the reach-in cooler had an ambient internal temperature of 44 degrees F . Interview with DM #333 at the same time verified the reach-in cooler was 44 degrees F. Observation of the kitchen on 12/16/24 at 11:33 A.M. with District Manager #666, revealed the reach-in cooler had an ambient internal temperature of 45 degrees F and the walk-in cooler had an ambient internal temperature of 46 degrees F. Interview with District Manager #666 at the same time verified the temperatures. District Manager #666 opened a pint of milk from the walk -in cooler and recorded a temperature of 45 degrees F. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 12/17/24 at 8:47 A.M. with DM #333, revealed the walk-in cooler had an ambient internal temperature of 45 degrees F. Interview with DM #333 at the same time verified the walk-in cooler was 45 degrees F. DM #333 stated the reach-in and walk-in coolers should hold food at 41 degrees F or below. DM #333 stated they would have to dispose of the food. Review of the walk-in cooler temperature logs revealed the temperature of the walk-cooler is checked twice a day in the AM and PM. The log read on 12/01/24 was 44 degrees F in the AM, 12/02/24 was 45 degrees F in the AM, 12/03/24 was 46 degrees F in the AM, 12/04/24 was 45 degrees F in the AM and 42 degrees F in the PM, 12/05/24 was 45 degrees F in the AM, 12/05/24 was 42 degrees F in the PM, 12/06/24 was 46 degrees F in the AM, 12/07/24 was 46 degrees F in the AM, 12/08/24 was 46 degrees F in the AM, 12/09/24 was 46 degrees F in the AM, 12/10/24 was 45 degrees F in the AM, 12/11/24 was 46 degrees F in the AM, 12/12/24 was 46 degrees F in the AM and 42 degrees F in the PM, 12/13/24 was 46 degrees F in the AM and 42 degrees F in the PM, 12/14/24 was 47 degrees F the AM and 42 degrees F in the PM, 12/15/24 was 46 degrees F in the AM and 42 degrees F in the PM, and 12/16/24 was 46 degrees F in the AM. Review of the Equipment policy dated 09/2017 revealed all food service equipment will be clean, sanitary, and in proper working order. The policy also stated, all equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials. Review of the Food Storage - Cold Foods policy dated 02/2023 revealed all perishable foods will be maintained at a temperature of 41 degrees F or below, except during necessary periods of preparation and service.