

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365628	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2025
NAME OF PROVIDER OR SUPPLIER S.E.M. Haven Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 225 Cleveland Avenue Milford, OH 45150	
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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to provide laboratory services in a timely and efficient manner to prevent the delay of treatment for residents symptomatic of urinary tract infections (UTIs) for 4 (Residents #58, #76, #84, and #22) of 5 residents reviewed for UTIs. Findings included: A facility policy titled, Diagnostic Services, revised 05/2020, revealed a section titled, Policy Interpretation and Implementation, specified, 2. Radiologic and other diagnostic services, including pathology and clinical laboratory services, are available 24 hours a day, seven days a week. The policy revealed a section titled, Urinary Culture Policy, specified, 1. Urine cultures will only be ordered when clinical indications meet McGeer's criteria for urinary tract surveillance. Routine or screening urine cultures in asymptomatic individuals are not permitted. The policy also revealed a section titled, Procedure, specified, 1. Nursing staff must document signs/symptoms and notify the provider. Nursing staff must complete the infection screening evaluation to ensure criteria are met. 2. A [brand name urine reagent strip] shall be performed and reported to the medical director and documented in the resident's chart. A [brand name urine reagent strip] is considered positive if both leukocytes and nitrites are present. 3. Staff will encourage fluids for 24 hours and then complete a second [brand name] urine reagent strip. Results and resident symptoms are reported to the provider. 4. Providers must verify that McGeer's criteria are met before ordering a urine culture. Providers will await the final urine culture and sensitivity before prescribing an antibiotic. 5. Providers can choose to prescribe a broad-spectrum antibiotic at their discretion if severe symptoms (i.e. [id est, that is], fever, leukocytosis, dysuria, flank pain, change in physical ability, etc. [et cetera, and so forth]) are present. A facility policy titled, Infection Control Plan/Program, revised 03/2025, indicated that Diagnostic testing and procedures are performed as ordered and in a timely manner. The policy further indicated, Radiologic and other diagnostic services, including pathology and clinical laboratory services, are available 24 hours a day, seven days a week. 1. An admission Record revealed the facility admitted Resident #58 on 04/30/2024. According to the admission Record, the resident had medical diagnoses that included benign prostatic hyperplasia (BPH) with lower urinary tract symptoms, urinary tract infection, and bladder disorder. A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/18/2025, revealed Resident #58 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. Resident #58's Care Plan Report, included a focus area initiated on 08/07/2024, that stated the resident had diagnoses of BPH, obstructive and reflux uropathy and a bladder disorder. Interventions directed staff to monitor for signs and symptoms of UTI and notify the medical doctor as needed. Resident #58's nursing Progress Notes, dated 10/21/2024 at 2:00 PM, written by Licensed Practical Nurse (LPN) #8, revealed Resident #58 complained of urinary pain and burning at the indwelling catheter insertion site. The Progress Notes revealed a urine sample was obtained from the resident, which was observed to be yellow, cloudy, thick with mucous present and small blood clots noted. The Progress Notes revealed a strong foul odor was noted, and the urine dipstick was positive for leukocytes (white blood cells) and nitrites (a chemical compound formed primarily when bacteria converts nitrates, common in healthy urine, into nitrites). Resident #58's nursing Progress Notes, (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 10/21/2024 at 5:38 PM, written by LPN #8, revealed that Resident #58's urine was collected and placed with the admission Record and a laboratory (lab) requisition in the unit refrigerator. Resident #58's Order Recap [Recapitulation] Report for the timeframe from 09/01/2024 through 09/30/2025, revealed an order dated 10/21/2024 to obtain urine and place the sample in the refrigerator for pick up on 10/22/2024 one time only. Resident #58's Lab Results Report, with a report date of 10/24/2024 at 10:01 AM, revealed the resident's urine sample was collected on 10/21/2024 at 4:00 PM and was received by the lab on 10/22/2024 at 9:18 AM. The Lab Results Report revealed the urine culture had over 100,000 colony-forming units (CFUs) per milliliter (mL) of mixed pathology, indicating a contamination. Resident #58's Order Recap Report for the timeframe from 09/01/2024 through 09/30/2025, revealed an order dated 10/27/2024, to obtain a urinalysis and culture and sensitivity one time only for possible UTI. Resident #58's Lab Results Report, with a report date of 10/31/2024 at 3:44 PM, revealed the resident's urine sample was collected on 10/28/2024 at 9:00 AM and was received by the lab on 10/28/2024 at 11:24 AM. The Lab Results Report revealed the urine culture had over 100,000 CFUs/ml of proteus mirabilis (a bacteria commonly associated with UTIs). The Lab Results Report revealed the culture also yielded over 100,000 CFUs /ml of pseudomonas aeruginosa (a bacteria associated with UTIs). Resident #58's Order Recap Report for the timeframe from 09/01/2024 through 09/30/2025, revealed an order dated 10/31/2024, for ciprofloxacin hydrochloride tablet 500 milligrams (mg) with instructions to give one tablet two times daily for seven days for UTI. Resident #58's nursing Progress Notes, dated 07/25/2025 at 4:06 PM, written by LPN #8, revealed Resident #58 complained of urinary pain, burning, and frequency. The Progress Notes revealed the resident's urine was a concentrated dark-yellow color with foul odor. The Progress Notes revealed a urinalysis dipstick was performed on the resident's urine and was positive for leukocytes and nitrites. The Progress Notes revealed the facility encouraged clear fluids, and the nursing supervisor was notified. Resident #58's nursing Progress Notes, dated 07/26/2025, written by Registered Nurse (RN) #7, revealed Resident #58 had a second positive urinalysis dipstick. The Progress Notes revealed a urine sample was obtained through a straight catheter and placed in the unit refrigerator for the lab to pick up on Monday morning. Resident #58's Order Recap Report for the timeframe from 09/01/2024 through 09/30/2025, revealed an order dated 07/26/2025 (a Saturday) to obtain urine sample through a straight catheter and place in the refrigerator for the laboratory on Monday morning. Resident #58's Lab Results Report, with a report date of 07/31/2025 at 1:57 PM, revealed the resident's urine sample was collected on 07/27/2025 at 7:00 PM and was received by the lab on 07/29/2025 at 8:52 AM. The Lab Results Report revealed the urine culture yielded over 100,000 CFUs /ml of proteus mirabilis. Resident #58's Order Recap Report for the timeframe from 09/01/2024 through 09/30/2025, revealed an order dated 07/31/2025 with a start date of 08/01/2025, for amoxicillin and potassium clavulanate oral tablet 500 - 125 mg with instructions to give once in the morning for seven days related to a UTI. During an interview on 09/24/2025 at 2:08 PM, LPN #8 stated that for a resident with a suspected UTI, the nurse checked their vitals, assessed the resident's urine for foul odor, documented their findings, and informed the supervisor. LPN #8 stated nursing typically conducted a urine dip test for leukocytes and nitrites if they suspected a UTI. She stated that if the first dip test was positive, they obtained a second dip test within 24 hours and did an infection screening. LPN #8 stated after a second urine sample evaluated revealed a positive result, they obtained a third specimen to send to an outside laboratory to complete culture and sensitivity testing. She stated nursing did not usually obtain a urine sample to be sent to the laboratory prior to evaluating the second urine sample via dipstick method. LPN #8 stated that if everything went smoothly, the interval between the start of symptoms and start of treatment should be three to four days maximum. She stated the laboratory company could do a urinalysis on the weekends, but the culture and sensitivity could not be done on weekends. She stated that she had a situation arise where a sample needed to be obtained, but staff did not collect one because the lab would not run it on the weekend. LPN #8 stated Resident #58 experienced a delay in treatment from (continued on next page)		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Report, included a focus area revised on 09/03/2024, that indicated the resident had an activity of daily living (ADL) self-care performance deficit related to a history of amputation of the resident's toes on the left foot and left arm below the elbow, pain, and activity intolerance. Interventions directed staff to provide assistance of one to two staff members to help with toileting, brief changes, and incontinence care. Resident #76's nursing Progress Notes, dated 08/12/2025 at 9:32 AM, revealed Resident #76 experienced hallucinations, facial flushing (redness of the skin due to increase blood flow to the area), and had foul smelling and dark colored urine which contained mucous. The Progress Note further indicated that the resident complained of burning during urination and showed facial grimacing during assessment using palpation (touch) of Resident #76's abdomen. The Progress Notes indicated that the Nurse Practitioner (NP) was made aware of Resident #76's symptoms. Resident #76's nursing Progress Notes, dated 08/12/2025 at 1:58 PM, indicated Resident #76 was seen by the NP and staff were instructed to obtain a (brand name) urinalysis dipstick. Resident #76's nursing Progress Notes, dated 08/12/2025 at 6:06 PM, indicated Resident #76's urinalysis dipstick test results indicated the resident's urine sample was positive for leukocytes (a white blood cell involved in counteracting foreign substances and diseases) and negative for nitrates. The Progress Notes revealed that the nursing supervisor (Registered Nurse [RN] #7) was notified of the results. Resident #76's nursing Progress Notes, dated 08/13/2025 at 1:30 PM, revealed Resident #76's urine was sampled for a second time with results that indicated a strong positive for leukocytes but remained negative for nitrates. The Progress Notes indicated Resident #76 continued to experience hallucinations causing the resident to believe they had a nail puncturing their (the resident's) skin. The Progress Notes revealed the resident had urine which appeared neon yellow with a green hue containing a large amount of mucous present. The Progress Notes revealed the resident stated that they felt burning during urination. Resident #76's nursing Progress Notes, dated 08/13/2025 at 3:04 PM, revealed an order to collect a urine sample via straight catheter to be sent to the laboratory for evaluation. Resident #76's nursing Progress Notes, dated 08/13/2025 at 4:15 PM, revealed a urine sample was obtained from Resident #76 via straight catheter. The Progress Notes indicated the urine sample contained large amounts of mucous, was foul smelling and appeared yellow in color with a green tinge. A Lab [Laboratory] Results Report, dated 08/15/2025, indicated a specimen was collected on 08/14/2025 at 1:00 AM and was received by the laboratory on 08/14/2025 at 6:58 AM. The Lab Results Report revealed that the lab reported the specimen was mislabeled and another specimen and laboratory requisition were needed to process the requested laboratory testing for Resident #76. The Lab Results Report indicated the facility was notified via fax with the reported time stamped as 08/15/2025 at 5:13 PM. Resident #76's Order Summary Report for the timeframe from 04/01/2025 through 09/30/2025, contained an order dated 08/17/2025 (two days after being notified by the lab of the mislabeled specimen) to obtain a urinalysis with culture and sensitivity for possible UTI. The Order Summary Report revealed an order dated 08/18/2025 to obtain a urine sample via straight catheter and place in the refrigerator for pickup by the lab. Resident #76's nursing Progress Notes, dated 08/18/2025 at 6:10 AM, revealed Resident #76 had combative behaviors throughout the shift and staff were unable to obtain the urine specimen due to the resident hitting and kicking all staff involved with the resident's care. Resident #76's nursing Progress Notes, dated 08/18/2025 at 6:18 PM, revealed a urine specimen was obtained from Resident #76 via straight catheter. The Progress Notes revealed the sample contained yellow urine with a large amount of sediment and had a foul odor. Resident #76's Lab Results Report, dated 08/22/2025, indicated a urine specimen was collected on 08/19/2025 at 1:00 AM and was received by the laboratory on 08/19/2025 at 7:28 AM. The Lab Results Report revealed the results were provided to the facility on [DATE]. The Lab Results Report revealed Resident #76's urine sample was extra turbid in clarity, positive for the presence of blood, protein, nitrates, and contained 4+ leukocytes (reference range indicated these items should be negative). The Lab Results Report revealed that the culture results indicated that Resident #76's urine sample contained greater than 100,000 colony forming units per milliliter (continued on next page)		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(CFU/ml) of <i>Citrobacter Koseri</i> (a bacteria found in the gastrointestinal tract). During an interview on 09/24/2025 at 3:45 PM, Licensed Practical Nurse (LPN) #4 stated when a resident exhibited symptoms of a UTI, a urine sample would be collected and tested by facility staff via a dipstick method. LPN #4 stated that when the resident's urine was positive for both leukocytes and nitrites, the urine would be tested a second time after 24 hours. LPN #4 stated when the resident's urine was positive for both leukocytes and nitrites, they would encourage the resident to drink more fluids and notify the resident's physician. LPN #4 stated that when the second urine test was positive for leukocytes and nitrites, a urine sample would be collected to send to the lab for a urinalysis and culture and sensitivity. LPN #4 stated it would typically take one to two days to get results from the laboratory. During an interview on 09/25/2025 at 9:32 AM, RN #5 stated when a resident was showing signs of a UTI such as burning urination, flank pain, increased frequency, new incontinence, or blood in the urine, they would let the nursing supervisor know and collect a urine sample for testing. RN #5 stated they notified RN #7 of the resident's test results and re-tested the urine in 24 hours. RN #5 stated depending on the results of the second urine test, the nursing supervisor would notify the resident's physician, and a specimen would be sent to the laboratory for testing based on what orders the physician's provided. RN #5 stated the laboratory usually picked up specimens sometime between 5:00 AM and 9:00 AM unless it is ordered STAT (statim, immediately), which they would not be able to do for a culture and sensitivity test. RN #5 stated she spoke with Medical Doctor (MD) #2 a couple of weeks ago, who had a concern related to the amount of time that passed between a resident experiencing symptoms and the time the resident was treated, but she could not remember who the resident was. RN #5 stated she did not think residents should have to wait that long for treatment of UTI symptoms because it was important to treat the infection before it got too bad. During an interview on 09/25/2025 at 10:35 AM, RN #6 stated when staff reported a resident was having symptoms of a UTI, they would conduct a nursing assessment and obtain a urine sample to evaluate via the dipstick method. RN #6 stated when the resident's urine sample was positive for leukocytes and/or nitrites, the resident's physician would be notified, and the facility would encourage the resident to drink more fluids. RN #6 stated another sample would be collected and evaluated 24 hours after the initial test, and the results would be communicated to the resident's physician, who would determine the next steps in the process. RN #6 stated it would be up to the physician to determine when lab work would need to be sent to the laboratory. RN #6 stated the facility's antibiotic stewardship program required the resident's urine to be evaluated twice and was based on McGeer's criteria. RN #6 reviewed McGeer's criteria related to UTI's and could not find any information related to a requirement to evaluate a resident's urine multiple times. RN #6 stated that when a urine specimen was sent out to the laboratory, it took two to three days to get results. RN #6 stated the facility was allowed to request a urinalysis with culture and sensitivity be performed STAT if the facility notified the laboratory it needed to be picked up. RN #6 stated there had been occasions on the weekends when facility staff would transport specimens to the laboratory for testing. RN #6 stated when a sample was mislabeled, she would expect an order for a new specimen to be obtained within 24 hours, and she would expect nursing staff to document all attempts to collect a specimen from a resident. During a telephone interview on 09/25/2025 at 2:46 PM, RN #7 stated when a resident was experiencing symptoms of having a UTI, the resident's urine would be collected and evaluated to assess for presence of leukocytes and nitrites. RN #7 stated the facility staff would encourage the resident to drink more fluids and collect another sample for repeat testing in 24 hours to determine a true positive. RN #7 stated that when the resident's urine tested positive a second time, a third urine sample would be collected and sent to the laboratory to perform a urinalysis and culture and sensitivity. RN #7 stated when the facility received the results of the urinalysis and culture and sensitivity, the results were sent to the resident's physician, and they would start the resident on an antibiotic when ordered by the provider. RN #7 stated from the time symptoms began to the time the resident was treated should only be about four days. RN #7 stated the laboratory was not (continued on next page)		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	open on weekends, so there was sometimes a delay because the specimens had to be sent to a nearby hospital for testing and the laboratory did not process them correctly. RN #7 stated that when the laboratory rejected a sample for any reason, she would transcribe another order in the resident's medical record to obtain another sample, which might be a 24-hour delay. RN #7 stated she was familiar with Resident #76 and stated the period of then the resident's urine specimen was rejected to the time it was recollected again was a really long delay. RN #7 stated she did not know why there was such a delay, but Resident #76's specimen should have been collected on 08/15/2025 which was the day the specimen was rejected. During an interview on 09/26/2025 at 8:17 AM, the Director of Nursing (DON) stated that when a resident had a suspected UTI, the nurse would assess the resident, complete a screening evaluation, and try to obtain a urine sample to evaluate. The DON stated that when the resident's urine sample was positive for leukocytes, the resident would be encouraged to drink fluids and the resident's urine would be collected and evaluated again in 24 hours. The DON stated that when the second urine sample was positive, the resident's physician would be notified, and staff would obtain an order for a urine sample to be collected and sent to the outside laboratory for evaluation. The DON stated she expected nursing staff to notify the resident's physician following the first urine test because when the resident was also having other symptoms, the provider could prescribe a broad-spectrum antibiotic when needed. The DON stated treatment for a UTI could take four or five days based on when nursing staff was able to obtain the specimen. The DON stated the facility was aware that transportation of specimens was difficult, and, in the past, the facility staff drove specimens over to the laboratory to get the testing completed faster. The DON stated the facility also had difficulty getting laboratory testing completed at the local hospital because in the past, the laboratory failed to complete the requested culture and sensitivity from the urine sample. The DON stated the facility was unable to get urine specimens to the laboratory for STAT processing. The DON stated that when a sample was rejected by the laboratory, she expected another specimen to be collected immediately. The DON stated Resident #76's urine specimen was not collected until Monday, 08/18/2025, because the laboratory did not pick up specimens on the weekend. The DON stated the facility staff chose to wait because it was the lesser of two evils. During a telephone interview on 09/24/2025 at 11:13 AM, MD #2 stated he expressed concerns to facility administration that when a resident was showing symptoms of a UTI, the facility collected multiple urine tests before a urine sample could be collected to be sent to the laboratory to perform a urinalysis with culture and sensitivity. He stated this practice delayed treatment to residents who were symptomatic of a UTI. During a telephone interview on 09/25/2025 at 2:21 PM, the facility's Medical Director stated when a resident was presenting with signs and symptoms of a UTI, she would expect facility staff to evaluate the resident's urine and assess for any symptoms. The Medical Director stated that when the resident's urine was positive, her understanding was that the facility required an additional sample to be evaluated the following day for confirmation. The Medical Director stated the facility had a protocol, but she was not sure what it was because she did not have the protocol in front of her. The Medical Director stated she would expect the facility staff to notify her when the resident refused to provide a specimen for lab or when there was any issue with collecting a specimen to send to the lab. The Medical Director stated when the lab rejected a specimen sample for any reason, she would expect the nursing staff to collect another sample pretty quickly. The Medical Director stated laboratories were notoriously bad with how they operated. During an interview on 09/25/2025 at 9:46 AM, the Executive Director (ED) stated that when a resident had a suspected UTI, she expected nursing staff to evaluate the resident's urine and encourage fluids. The ED said, depending on the results from the first testing, a second test of the resident's urine may be completed in 24 hours. The ED stated that depending on the results of the second urine testing, a third specimen would be collected and sent out to the laboratory within 24 hours. The ED stated they had some issues with the laboratory on the weekends, because the laboratory struggled to keep staff at times. The ED stated facility staff transported specimens to the lab[TRUNCAT		

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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. Based on observation, interview, record review, and facility policy review, the facility failed to provide dining services in a dignified manner for 2 (Resident #11 and Resident #38) of 6 residents sampled for dependent dining. Findings included: An undated facility policy titled, Dining/Eating Program, revealed the section titled, Goals, included, 6. Promote resident's self-esteem and dignity. The policy revealed the section titled, Policy Interpretation and Implementation, included, 6. All department heads and supervisors should rotate to the dining area to interact with the residents and assist in serving meals. The nursing assistants and nurses actually do any feeding. This helps provide social interactions for the residents, reinforces teamwork and promotes [facility name]-wide restorative program. The policy revealed, 11. When feeding residents staff attention should be directed to the resident. A facility policy titled, Resident Rights, last reviewed on 07/2025, revealed the section titled, Resident Rights, included, 1. The right to be treated with dignity and respect. An admission Record revealed the facility admitted Resident #11 on 04/28/2025. According to the admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease and dysphagia. A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/01/2025, revealed Resident #11 had severe impairment in cognitive skills for daily decision-making and had a short- and long-term memory problem per a staff assessment of mental status (SAMS). Resident #11's MDS indicated the resident was dependent on staff for eating. Resident #11's Care Plan Report, included a focus area initiated on 04/28/2025, that indicated the resident had an activity of daily living self-care performance deficit related to cognitive and functional deficits. Interventions directed staff to supervise the resident with eating (initiated 04/28/2025). An admission Record revealed the facility admitted Resident #38 on 10/06/2018. According to the admission Record, the resident had a medical history that included diagnoses of unspecified dementia with other behavioral disturbances and dysphagia. A quarterly MDS with an ARD of 07/18/2025 revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident had severe cognitive impairment. Resident #38's MDS indicated the resident was dependent on staff for eating. Resident #38's Care Plan Report, included a focus area initiated on 08/27/2024, that indicated the resident had an activity of daily living self-care performance deficits. The focus area indicated that the resident required extensive to total assistance with all activities of daily living. Interventions directed staff to assist the resident as they allowed with eating (revised 08/06/2025). During an observation on 09/22/2025 at 9:36 AM in the unit dining room, Resident #11 and Resident #38 were observed seated in their wheelchairs at a table with three other residents eating at the table. Resident #38 was observed being assisted with their meal by Registered Nurse (RN) #12, who was seated at the end of the table between Resident #11 and Resident #38. Two small bowls of food were observed in front of Resident #11, and no staff were observed assisting Resident #11 with eating. During the observation, RN #12 stopped providing feeding assistance to Resident #38, got up from her seat, and retrieved a beverage for another resident, before returning to her seat to resume providing feeding assistance to Resident #38. During the observation, RN #12 stopped providing feeding assistance to Resident #38 again, got up from her seat, and assisted another resident with cutting food, before returning to her seat to resume providing feeding assistance to Resident #38. During that time, Resident #11 was observed with two small bowls of food, and no staff were observed assisting the resident. During an observation on 09/23/2025 at 12:43 PM in the unit dining room, Resident #11 was observed seated in their wheelchair with three other residents eating at a table in the dining room. Two small bowls of pureed food were observed in front of Resident #11. No staff were observed assisting Resident #11 with the meal until 12:51 PM, when Certified Nursing Assistant (CNA) #9 sat down next to the resident and assisted them with eating. At 12:53 PM, Resident #38 was brought into the dining room and sat at the table in their wheelchair with Resident #11 and three other residents. Staff placed two small bowls of (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pureed food in front of the resident and two beverage cups with lids. Staff members were observed passing food to other residents in the dining room while Resident #38 sat at the table, unassisted by staff. At 1:12 PM, CNA #10 was observed seated next to Resident #38 and assisted the resident with their meal. During an interview on 09/23/2025 at 2:23 PM, CNA #9 stated the unit had two residents who were dependent on staff for eating, Resident #11, and Resident #38. CNA #9 stated the unit usually had two CNA staff at the table with the residents who needed assistance to assist them with the meal and one CNA staff member to serve the food to residents. CNA #9 stated residents were usually served by table, so residents would be served at the same time. CNA #9 stated staff would usually assist Resident #11 and Resident #38 with the meal at the same time as the other residents at the table, so residents were not eating alone. During an interview on 09/25/2025 at 3:43 PM, CNA #10 stated the unit had two residents who required full assistance at meals, Resident #11, and Resident #38. CNA #10 stated neither resident was able to feed themselves, but Resident #38 could, at times, hold and drink out of a cup without assistance. CNA #10 stated they would usually have one staff member sit with either Resident #11 or Resident #38 to start assisting one of them with their meal. CNA #10 stated once another staff member was available, they could assist in feeding the other dependent resident. CNA #10 stated if one of the dependent residents was still chewing their food, they could get up from the table and assist with passing out beverages to the other residents. CNA #10 stated sometimes Resident #11, and Resident #38 would be served last, but they usually served the residents at the same table at the same time, so no residents were left out. CNA #10 stated they would usually try and assist residents with eating as soon as they receive their food. During an interview on 09/25/2025 at 4:01 PM, Licensed Practical Nurse (LPN) #11 stated that the unit had two residents who required assistance with dining, Resident #11, and Resident #38. LPN #11 stated CNA staff usually provided feeding assistance to the residents at the table at the same time, so no residents were left out. LPN #11 stated that sometimes a CNA would provide feeding assistance to either Resident #11 or Resident #38 while the other CNA staff served the other residents in the dining room. LPN #11 said once the other CNA staff finished serving the meal, they would provide feeding assistance to the other resident. LPN #11 stated she would expect staff who were assisting a resident with their meal to keep assisting that resident and refrain from getting up from the service to attend to other needs. LPN #11 stated she would not expect residents to wait more than 10 minutes before being assisted with their meals. During an interview on 09/26/2025 at 7:46 AM, RN #12 stated she would occasionally provide assistance to dependent diners Resident #11 and Resident #38, usually during the breakfast meal. RN #12 stated Resident #38 was dependent on staff for eating but could lift a cup if they needed to. RN #12 stated Resident #11 could not feed themselves and required assistance from staff. RN #12 stated if more than one staff member were available to assist with eating, both residents would be assisted one-to-one. RN #12 stated there were times when she would assist both Resident #11 and Resident #38 at the same time using separate hands. RN #12 stated normally she would sit with the resident during the meal while assisting the resident with eating, but there had been times when she got up to assist other residents in the dining room. RN #12 stated that assisting residents on a one-on-one basis was more pleasant for the residents. She stated starting and stopping during the meal can be hard for the residents. During an interview on 09/26/2025 at 9:23 AM, the Director of Nursing (DON) stated all residents at the same table should be served their meal at the same time and residents should be assisted with tray set up and cutting of food as the staff member served the meal. The DON stated they would prefer staff to provide feeding assistance to residents on a one-to-one basis, but it was allowable for a staff member to provide feeding assistance to two residents at the same time if they used opposite hands. The DON stated staff who were assisting residents with their meal should only be engaged in assisting the resident with their meal, and she would expect the resident to be assisted within a few minutes of receiving their food. During an interview on 09/26/2025 at 10:28 AM, the Executive Director (ED) stated she would expect residents seated at the same table for meals to be served at the same time. The ED stated she would (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not expect residents who needed assistance with eating to have food sitting in front of them while other residents were eating. The ED stated she would not expect meal service to be interrupted unless it was an emergency.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure physicians were notified of all changes in a resident's medical condition and failed to notify the physicians when delay in initiation of medical orders occurred for 3 (Residents #76, #84, and #22) of 5 residents reviewed for urinary tract infections (UTIs). Findings included: A facility policy titled, Change in Resident's Condition or Status, revised on 05/2020, revealed, Our facility promptly notifies the resident, his or her attending physician, and responsible party of changes in the resident's condition and/or status. The policy revealed, 1. The Nurse Supervisor will notify the resident's attending physician when: b. There is a significant change in the residents' physical, mental or psychosocial status, c. There is a need to alter resident treatment or diagnosis related information; f. Deemed necessary or appropriate in the best interest of the resident. The policy revealed, 3. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change in the resident's condition or status. The policy revealed, 5. The nurse will record in the resident's medical record any changes in the resident's medical condition or status as well as the resident response to care treatment and services. A facility policy titled, Corporate Compliance Standards of Conduct-Physician Orders, dated 07/2028, revealed, All care provided to residents of [facility name] must be based on written, dated and signed orders from a licensed physician or other authorized healthcare provider such as certified nurse practitioner. The policy also revealed, Nursing staff shall obtain and transcribe orders in a timely and accurate manner, monitor for side effects and notify the physician. A facility policy titled, Medical Records Content for Practitioners, last reviewed by the facility on 01/2022, revealed, A medical record shall be maintained for every resident admitted and treated at a [corporate provider] Community. The medical record is the primary tool used by multiple disciplines for communicating resident care information. To ensure accuracy, the documentation in the medical record shall be completed as care occurs or in as timely a manner as possible. The medical record shall contain the notes, the reports and documentation set forth below. The policy revealed a section titled, Medical Record Content Requirements, that indicated, Resident medical records shall contain the following information: 6. Physician Orders; 9. Orders for diet diagnostic testing, therapeutic procedures, and medications; 15. Progress Notes; and 17. Clinical Laboratory testing reports. The policy revealed a section titled, Orders, which specified, The practitioner's orders shall be placed within the electronic medical record utilizing Computerized Physician Order Entry (CPOE). The section titled, Verbal and Telephone Orders, specified, A practitioner may issue a verbal order only during an emergent or urgent situation that requires immediate action. Telephone orders are accepted from the practitioner when he/she is not on the premises. All Community based credentialed practitioner orders (including verbal and/or telephone orders) must be signed in the electronic medical record. All orders must be signed within 14 days. 1. An admission Record revealed the facility admitted Resident #76 on 10/15/2013 and readmitted the resident on 10/10/2017. According to the admission Record, the resident had a medical history that included a diagnosis of personal history of urinary (tract) infections (infection of the kidneys, ureters, bladder, or urethra). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/18/2025, revealed Resident #76 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderately impaired cognition. The MDS indicated the resident was always incontinent with bowel and bladder. The MDS revealed the resident was dependent on staff for toileting hygiene and toilet transfers. Resident #76's Care Plan Report, included a focus area revised on 09/03/2024, that indicated the resident had an activity of daily living (ADL) self-care performance deficit related to a history of amputation of the residents' toes on the left foot and left arm below the elbow, pain, and activity intolerance. Interventions directed staff to provide assistance from one to two staff members to help with (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	toileting, brief changes, and incontinence care. Resident #76's nursing Progress Notes, dated 08/12/2025 at 6:06 PM, indicated Resident #76's urinalysis dipstick test results indicated the resident's urine sample was positive for leukocytes (a white blood cell involved in counteracting foreign substances and diseases) and negative for nitrates. The Progress Notes revealed that the nursing supervisor (Registered Nurse [RN] #7) was notified of the results. Resident #76's nursing Progress Notes, dated 08/13/2025 at 1:30 PM, revealed Resident #76's urine was sampled for a second time with results that indicated a strong positive for leukocytes but remained negative for nitrates. The Progress Notes indicated Resident #76 continued to experience hallucinations causing the resident to believe they had a nail puncturing their (the resident's) skin. The Progress Notes revealed the resident had urine which appeared neon yellow with a green hue containing a large amount of mucous present. The Progress Notes revealed the resident stated that they felt burning during urination. Resident #76's nursing Progress Notes, dated 08/13/2025 at 3:04 PM, revealed an order to collect a urine sample via straight catheter to be sent to the laboratory for evaluation. Resident #76's nursing Progress Notes, dated 08/13/2025 at 4:15 PM, revealed a urine sample was obtained from Resident #76 via straight catheter. The Progress Notes indicated the urine sample contained large amounts of mucous, was foul smelling and appeared yellow in color with a green tinge. A Lab [Laboratory] Results Report, dated 08/15/2025, indicated a specimen was collected on 08/14/2025 at 1:00 AM and was received by the laboratory on 08/14/2025 at 6:58 AM. The Lab Results Report revealed that the lab reported the specimen was mislabeled and another specimen and laboratory requisition were needed to process the requested laboratory testing for Resident #76. The Lab Results Report indicated the facility was notified via fax with the reported time stamped as 08/15/2025 at 5:13 PM. Resident #76's nursing Progress Notes, dated 08/18/2025 at 6:10 AM, revealed Resident #76 had combative behaviors throughout the shift, and staff were unable to obtain the urine specimen due to the resident hitting and kicking all staff involved with the resident's care. Resident #76's nursing Progress Notes, dated 08/18/2025 at 6:18 PM, revealed a urine specimen was obtained from Resident #76 via straight catheter, and the sample was described to contain yellow urine with a large amount of sediment and foul odor. Resident #76's Lab Results Report, dated 08/22/2025, indicated a urine specimen was collected on 08/19/2025 at 1:00 AM and was received by the laboratory on 08/19/2025 at 7:28 AM. The Lab Results Report revealed the results were provided to the facility on [DATE]. The Lab Results Report revealed Resident #76's urine sample was extra turbid in clarity, positive for the presence of blood, protein, nitrates, and contained 4+ leukocytes (reference range indicated these items should be negative). The Lab Results Report revealed that the culture results indicated that Resident #76's urine sample contained greater than 100,000 colony forming units per milliliter (CFU/ml) of Citrobacter Koseri (a bacteria found in the gastrointestinal tract). Resident #76's nursing Progress Notes, dated 08/22/2025 at 11:18 AM, revealed Resident #76 continued to have the presence of cloudy urine and was experiencing increased lethargy and needed additional assistance by staff with meals. Resident #76's Order Summary Report for the timeframe from 04/01/2025 through 09/30/2025, contained an order with a start date of 08/22/2025 and end date of 08/29/2025, for levofloxacin tablet (an antibiotic) 500 milligrams (mg) with instructions to give one tablet by mouth every night shift for UTI for seven days. The Order Summary Report revealed an order with a start date of 08/23/2025 and end date of 08/30/2025 for Augmentin oral tablet (an antibiotic) 500-125 mg with instructions to give one tablet by mouth two times a day for acute UTI for seven days. Resident #76's physician Progress Notes, dated 09/04/2025, electronically signed by Resident #76's Primary Care Provider (Medical Doctor [MD] #2) revealed Resident #76's primary reason for assessment was recurrent urinary tract infection. The Progress Notes indicated Resident #76 was recently treated with Augmentin therapy that was completed with good clinical response without ill effects reported. The Progress Notes revealed that due to the resident's recurrent urinary tract infection, MD #2 recommended Trimethoprim (an antibiotic) 100 mg by mouth at night for 90 days along with lactobacillus (an oral medication which (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contains healthy bacteria that aid the gastrointestinal system) two tablets daily while on Trimethoprim therapy. The Progress Notes revealed the Current Medications list included an order for Trimethoprim 100 mg orally once a day for 90 days. Resident #76's nursing Progress Notes, dated 09/05/2025 at 4:59 PM, indicated Resident #76 continued to experience periods of combativeness, decrease appetite with meals, and was resistive to care to include medication administration. Resident #76's physician Progress Notes, dated 09/11/2025, electronically signed by MD #2, revealed an examination of the resident completed by MD #2 indicated that Resident #76 had no current complaints of dysuria and was afebrile but was recently prescribed Trimethoprim suppressive oral therapy (on 09/04/2025) and the order had been neglected. Resident #76's nursing Progress Notes, dated 09/11/2025 at 9:09 AM, revealed Resident #76 was seen by MD #2 with recommendations to continue Trimethoprim therapy for UTI prevention. Resident #76's nursing Progress Note dated 09/11/2025 at 9:09 AM, written by RN #7, revealed Resident #76 was seen by MD #2 with recommendations to continue Trimethoprim therapy for UTI prevention. Resident #76's Order Summary Report for the timeframe from 04/01/2025 through 09/30/2025, revealed no order for Trimethoprim 100 mg. Resident #76's Progress Notes for the timeframe from 09/04/2025 through 09/24/2025, revealed no documented explanation why MD #2's order for Trimethoprim for suppressive therapy was not transcribed and followed as prescribed. During an interview on 10/09/2025 at 2:42 PM, RN #7 stated that when Resident #76 exhibited symptoms of a UTI, she notified the nurse to encourage fluids for the resident and transcribed an order for the nurse to do another urinalysis via the dipstick method the following day. RN #7 stated they did not notify the physician of ongoing symptoms or results of preliminary urinalysis performed in the facility and did not contact the physician to notify them until the facility received the test results from a urinalysis and culture and sensitivity test that was performed by an outside laboratory. During a follow-up interview on 10/09/2025 at 3:10 PM, RN #7 stated they facility could not obtain Resident #76's urine sample on 08/18/2025 as a result of the resident's combative behavior. RN #7 stated the medial provider should have been notified of the delay in obtaining the ordered lab and the resident's combative behavior, and she verified she could not locate documentation of the notification to the provider. During a follow-up interview on 10/09/2025 at 3:34 PM, RN #7 stated that on 09/04/2025, MD #2 recommended Trimethoprim and on 09/11/2025 he ordered Trimethoprim. She stated normally the facility did not allow prophylactic antibiotics, and she would have taken that to the Director of Nursing (DON) to make sure it was okay to order. She stated she did not notify MD #2 that orders could not be initiated because he was mad on 09/11/2025 about the antibiotic orders that were not initiated on 09/04/2025. She stated that she missed the 09/04/2025 order and that it was her mistake. She stated that for the prophylactic antibiotic orders, MD #2's order was reviewed with the Medical Director. She stated that the Medical Director would make the final decision to make sure it followed their antibiotic stewardship. During a follow up interview on 10/11/2025 at 12:37 PM, RN #7 stated she notified the DON verbally of the order by MD #2 for prophylaxis antibiotic therapy and she thought that it was escalated to the Medical Director for determination. She stated that she should have documented a note about the DON notification. She stated that the determination by the Medical Director was not given back to her in order to notify the physician that the order was not being followed. During an interview on 10/11/2025 at 12:50 PM, RN #7 stated she acknowledged she should have notified the physician when Resident #76's urine specimen was mislabeled, and she confirmed all notifications to the physician should be documented in the residents' medical records. During an interview on 10/09/2025 at 4:07 PM, the DON stated that the nursing staff should notify the medical provider of all lab results, behaviors, and symptoms. She stated she was unable to determine if MD #2 was notified because the medical record contained no documentation of the notification. During a follow up interview on 10/09/2025 at 4:12 PM, the DON stated she interpreted the 09/04/2025 order for the antibiotic for Resident #76 to be a recommendation and not an order and MD #2 knew that was against the facility's protocol. The DON stated Resident #76 had many medication allergies, had a (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDRO (multi drug resistant organism), and the Medical Director stated she would not approve that order. She stated that the determination should have been documented in the medical record and MD #2 should have been notified. The DON stated for the suppressive therapy recommendation for Resident #76 they felt it was not good practice for the resident. She stated that typically the nursing supervisor (RN #7) would contact the doctor if an order was not implemented due to antibiotic stewardship protocol. She stated that the Medical Director made the decision not to allow the facility to implement this order. During a follow-up interview on 10/09/2025 at 4:25 PM, the DON stated the physician should have been notified that the prophylaxis antibiotic was not initiated for Resident #76 because the order did not follow the facility's antibiotic stewardship program; however, she was unable to verify if the physician was notified because the notification was not documented in the medical record. The DON stated Resident #76 was treated for a UTI, and the UTI had resolved following treatment. The DON stated the refusal to allow Resident #76 to receive prophylaxis antibiotic therapy was the decision of the Medical Director, but she was not able to verify when the Medical Director was notified, or when the decision was made by the Medical Director. During an interview on 10/11/2025 at 2:03 PM, the DON stated and confirmed she did not document her conversation with the Medical Director when orders for prophylaxis antibiotics ordered by MD #2 on 09/04/2025 for Resident #76 were not initiated and admitted she did not provide him an explanation that his orders for prophylaxis antibiotics were not initiated because they did not follow the facility's antibiotic stewardship policy. She stated her expectation would be that the nursing supervisor (RN #7) should notify the physician if there was a delay in labs and if orders were not initiated. During a telephone interview on 10/09/2025 at 4:47 PM, the Medical Director stated she was not notified MD #2 wrote orders for prophylaxis antibiotic therapy; however, if she were notified, she stated she would have declined the recommended order for treatment. She stated she did not believe in that (suppressive therapy), and it never worked. She said she was made aware of the concern later, although she could not verify the date she was notified. She stated that if she created an order, she expected them to follow it or to notify her of why the facility would not follow the order. During a telephone interview on 10/09/2025 at 5:07 PM, the Nurse Practitioner (NP) stated she last saw Resident #76 on 08/12/2025. She stated the facility staff did not notify her about delays in their ability to obtain laboratory specimens or results for the ordered urinalysis and culture and sensitivity. She stated the facility staff did not notify her that Resident #76 had experienced abnormal behaviors and lethargy. She stated the facility did not notify her when antibiotic orders were not initiated as ordered for Resident #76. During a telephone interview on 10/10/2025 at 8:30 AM, MD #2 stated that the facility did not notify him when ordered antibiotics were not initiated for Resident #76. During a follow-up telephone interview on 10/10/2025 at 1:40 PM, MD #2 stated he saw Resident #76 on 09/04/2025, and confirmed his progress notes included a statement that specified the resident had recent treatment with antibiotic therapy with good response and he stated he recommended suppressive therapy for 90 days. He stated he was also not notified when Resident #76's urine specimen had a delay in processing due to a specimen that was mislabeled. He stated he was also not notified of the resident not starting antibiotics until 08/22/2025. He stated he was not aware the lab did not pick up on weekends. 2. An admission Record revealed the facility admitted Resident #84 on 08/26/2025. According to the admission Record, the resident had a medical history that included a diagnosis of overactive bladder (frequent urgency of urination). The admission Record revealed the resident was discharged from the facility on 09/07/2025 after a 12-day admission to the facility. A Medicare 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/30/2025, revealed Resident #84 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident had intact cognition. The MDS revealed Resident #84 required partial/moderate assistance with toileting hygiene, toileting transfers, and had occasional bladder incontinence. Resident #84's Care Plan Report, included a focus area initiated on 08/27/2025, that indicated the resident had chronic kidney disease. Interventions directed staff to administer medications as ordered by the (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician, monitor changes in mental status, and monitor for signs and symptoms of infection. The Care Plan Report also included a focus area initiated on 09/03/2025 that indicated the resident had mixed bladder incontinence related to active infections with symptoms of UTI, chronic symptomatic infections, and impaired mobility. Interventions directed staff to clean the residents' perineal area with each incontinent episode; monitor/document for signs and symptoms of UTI; and monitor/document/report as needed for any potential causes of incontinence. Resident #84's provider Progress Notes, dated 09/02/2025, electronically signed by the Nurse Practitioner (NP) revealed a section titled, History of Present Illness, that specified, Patient states, I know I have a UTI and the staff took 3 samples already, and, I was taking a maintenance Keflex (a medication used to treat infection) for frequent UTI's and somewhere along the line it was discontinued and now I have a UTI. The Progress Notes revealed Resident #84's treatment plan included orders to obtain a urinalysis with culture and sensitivity and to start ciprofloxacin hydrochloride (HCl) (an antibiotic) 250 milligrams (mg) with instructions to give one tablet by mouth every 12 hours and Lactobacillus. The Progress Notes also indicated there was a need for a follow-up every two to three days as needed due to the complexity of the resident's medical condition. Resident #84's Lab [Laboratory] Results Report, dated 09/03/2025, revealed a urine specimen was collected on 09/03/2025 at 3:00 AM, received by the laboratory on 09/03/2025 at 8:06 AM, and reported to the facility on [DATE] at 2:55 PM. The Lab Results Report revealed Resident #84's urine was turbid in clarity, positive for nitrates, contained 4+ leukocytes, clumps of white blood cells, and contained 100,000 colony forming units per milliliter (CFU/ml) of Klebsiella Pneumoniae (a bacteria normally found in the gastrointestinal system). Resident #84's provider Progress Notes, dated 09/04/2025, electronically signed by Medical Doctor (MD) #2, revealed the facility requested the provider follow-up on Resident #84's persistent dysuria. The Progress Notes indicated the resident complained of dysuria associated with urinary frequency and was not currently on the antibiotic therapy prescribed by the NP on 09/02/2025 and remained at high-risk for decline due to age and medical complexity. The Progress Notes revealed Resident #84's treatment plan included concerns for the resident's dysuria with notes that indicated Resident #84 was symptomatic with dysuria associated urinary frequency and had an abnormal urinalysis and MD #2 agreed with NP's assessment that Resident #84 should be prescribed an antibiotic and again wrote an order for Resident #84 to receive ciprofloxacin 500 mg with instructions to give one tablet by mouth two times a day for five days. Resident #84's Order Summary Report for the timeframe from 08/01/2025 through 09/30/2025, contained an order with a start date of 09/06/2025 and end date of 09/13/2025 for ciprofloxacin HCl 500 mg with instructions to give one tablet by mouth two times a day for seven days for acute UTI. The Order Summary Report revealed no orders for ciprofloxacin HCl prior to 09/06/2025. Resident #84's Progress Notes for the timeframe from 08/26/2025 through 09/07/2025, revealed no notes explaining why MD #2 and the NP's order for ciprofloxacin HCl were not followed prior to 09/06/2025 which was eight days after becoming symptomatic. During a telephone interview on 10/10/2025 at 8:30 AM, MD #2 stated the facility did not notify him when the antibiotic prescribed for Resident #84 was not initiated on 09/02/2025. During a follow-up telephone interview on 10/10/2025 at 1:40 PM, MD #2 stated he was concerned with the delay of initiation of Resident #84's ordered antibiotics because the resident went for six full days with an acute UTI without treatment. He stated the facility did not notify him until he discovered the error one week later when he realized the antibiotic had not been started. He stated he emailed the DON on 09/04/2025 and asked what occurred. During an interview on 10/11/2025 at 12:50 PM, Registered Nurse (RN) #7 stated she failed to notify the NP when antibiotics were not initiated for Resident #84 on 09/02/2025. During an interview on 10/10/2025 at 10:30 AM, the Director of Nursing (DON) stated she thought MD #2 wrote an order for antibiotics for Resident #84. The DON stated RN #7 verbally notified him that the results from the lab would be available that day (09/04/2025) and the culture and sensitivity were pending. The DON stated that RN #7 asked him if he wanted to see the culture. She stated she thought the physician was leaving the facility at the time but stated yes. The DON (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the facility did not receive results of Resident #84's urinalysis and culture and sensitivity until 09/05/2025. She stated her understanding was that the physician did not respond to the email to confirm he still wanted the order for ciprofloxacin to be initiated as previously prescribed until 09/06/2025. The DON reviewed RN #7's progress notes about Resident #84's urinalysis being complete and that the note was vague and did not address that the ordered ciprofloxacin was not initiated as ordered. She stated she was not aware of the missed orders for the ciprofloxacin written on 09/02/2025 and 09/04/2025 until MD #2 became upset. She stated she could not recall RN #7 notifying her about the order for ciprofloxacin on 09/04/2025. She stated that after reviewing the medical record, orders for Resident #84's ciprofloxacin were missed both on 09/02/2025 and 09/04/2025 and they were considered medication errors. The DON stated that if there was a medication error, she expected staff to notify the doctor, the pharmacy, and the family and document these notifications in the medical record. 3. An admission Record revealed the facility admitted Resident #22 on 05/15/2025. According to the admission Record, the resident had a medical history that included a diagnosis of obstructive and reflux uropathy. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/15/2025, revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS revealed Resident #22 required substantial/maximal assistance of staff for toileting hygiene and partial/moderate assistance for toileting transfers. The MDS revealed the resident was frequently incontinent of bowel and bladder. Resident #22's Care Plan Report, included a focus area initiated on 05/21/2025, that indicated the resident had benign prostatic hyperplasia (BPH) (condition where prostate gland enlarges over time causing urinary problems). Interventions directed staff to monitor/record/report to medical doctor for signs and symptoms of a UTI such as pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, altered mental status, change in behavior, or change in eating patterns. Resident #22's Nursing Narrative Note, dated 08/21/2025 at 6:08 PM, revealed Resident #22 experienced increased voiding that was dark yellow in color with a foul smell and complaint of urinary pain with voiding. Resident #22's Nursing Narrative Note, dated 08/22/2025 at 2:05 PM, revealed a second urine specimen was obtained from Resident #22 and evaluated via a the dipstick method. The Progress Notes indicated Resident #22's urine sample was yellow in color with cloudy sediment and showed the specimen was positive for leukocytes and nitrites. The Progress Notes revealed the resident continued to complain of urinary pain and burning when voiding. Resident #22's Lab [Laboratory] Results Report, dated 08/28/2025, revealed that a urine sample was collected on 08/22/2025 at 4:00 PM and received by the lab on 08/23/2025 at 2:15 AM. The Lab Results Report revealed the lab was reported on 08/26/2025 at 2:34 PM. The Lab Results Report revealed the results section of the document was blank. Further review revealed there was no documentation as to why there were no results documented. Resident #22's Nursing Narrative Note, dated 08/26/2025 at 12:43 PM, revealed the resident's urine was obtained via straight catheter and sent to the lab for processing. The Nursing Narrative Note revealed that the Nurse Practitioner (NP) was notified. Resident #22's Nursing Narrative Note, dated 08/26/2025 at 6:09 PM, revealed Resident #22's urine was obtained via a straight catheter. The Nursing Narrative Note revealed Resident #22's urine was cloudy, light yellow, and had sediment with a foul odor. The Nursing Narrative Note revealed the resident's urine sample was placed in the refrigerator for the lab to pick up. Resident #22's Lab Results Report, dated 08/29/2025, indicated a specimen was collected on 08/27/2025 at 3:00 AM and received by the laboratory on 08/27/2025 at 8:29 AM. The Lab Results Report revealed the lab results were provided to the facility on [DATE] at 9:56 AM. The Lab Results Report revealed Resident #22's urine sample contained 4+ leukocytes (reference range indicated these items should be negative) and had greater the 50 white blood cells (reference range is less than six). The Lab Results Report revealed Resident #22's urine sample contained greater than 100,000 colony forming units per milliliter (CFU/ml) of Escherichia coli (a bacteria found in the gastrointestinal tract). The Lab Results (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Report revealed it was reviewed on 08/30/2025 at 10:28 AM. Resident #22's Lab Results note dated 08/30/2025 at 10:27 AM, revealed Medical Doctor (MD) #2 was notified of the lab results and Resident #22 was to start nitrofurantoin macrocrystal oral capsule 100 milligrams (mg) by mouth two times a day for seven days. During an interview on 10/11/2025 at 2:06 PM, the Director of Nursing (DON) stated that when RN #7 received the lab results for Resident #22 on Monday (08/25/2025), there was no culture or sensitivity results for the urine sampled on Friday (08/22/2025). The DON stated RN #7 called the hospital lab, and she was notified they did not do a culture and sensitivity on the weekends, and a culture and sensitivity required another sample to be submitted. The DON stated that the facility collected a urine specimen on 08/27/2025 and sent it to the laboratory for processing. During a follow-up interview on 10/10/2025 at 4:51 PM, the DON stated that the NP was notified on 08/26/2025 that another specimen was obtained and sent out to the lab. The DON stated the urine test results were received by the facility on 08/29/2025 and the provider was notified but antibiotics were not ordered until 08/30/2025 and Resident #22 received a dose of antibiotics that same day. During an interview on 10/10/2025 at 5:53 PM, the Executive Director (ED) acknowledged the facility's lack of documentation of communication with the provider and the Medical Director was a problem but thought the communication was completed but not documented. During a follow-up interview on 10/11/2025 at 5:14 PM, the DON stated that she acknowledged notifications to the physicians were not documented for Residents #76, #84, and #22, and her expectation was the physician was immediately notified of all delays of lab testing, lab results and not following physician orders and stated this should have been completed by the nursing supervisor or herself. During a follow-up interview on 10/11/2025 at 5:15 PM, the ED stated her expectation was that the physician would be notified immediately and the notification was documented in the medical record for each resident. This deficiency represents non-compliance investigated under Complaint Number OH2612855.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure staff provided timely and appropriate treatment and services related to urinary tract infections (UTIs) for symptomatic residents. Specifically, the facility failed to initiate antibiotic therapy prescribed by a medical provider for 2 (Resident #76 and Resident #84) of 5 residents reviewed for urinary tract infections. Findings included: An undated facility policy titled, Corporate Compliance Standards of Conduct-Physician Orders, revealed, All care provided to residents of [facility name] must be based on written, dated and signed orders from a licensed physician or other authorized healthcare provider such as certified nurse practitioner. The policy also revealed, Orders shall be entered into the resident's medical record within a clinically appropriate period. STAT [statim, immediate] order shall be prioritized and documented accordingly. A facility policy titled, Diagnostic Services, revised 05/2020, revealed a section titled, Policy Interpretation and Implementation, specified, 2. Radiologic and other diagnostic services, including pathology and clinical laboratory services, are available 24 hours a day, seven days a week. The policy revealed a section titled, Urinary Culture Policy, that specified, 1. Urine cultures will only be ordered when clinical indications meet McGreer's criteria for urinary tract surveillance. Routine or screening of urine cultures in asymptomatic individuals are not permitted. The policy also revealed a section titled, Procedure, that specified, 1. Nursing staff must document signs/symptoms and notify the provider. Nursing staff must complete the infection screening evaluation to ensure criteria are met. 2. A [brand name urine reagent strip] shall be performed and reported to the medical director and documented in the resident's chart. A [brand name urine reagent strip] is considered positive if both leukocytes and nitrites are present. 3. Staff will encourage fluids for 24 hours and then complete a second [brand name urine reagent strip]. Results and resident symptoms are reported to the provider. 4. Providers must verify that McGreer's criteria are met before ordering a urine culture. Providers will await the final urine culture and sensitivity before prescribing an antibiotic. 5. Providers can choose to prescribe a broad-spectrum antibiotic at their discretion if severe symptoms (i.e. [id est, that is], fever, leukocytosis, dysuria, flank pain, change in physical ability, etc. [et cetera, and so forth]) are present. A facility policy titled, Antibiotic Stewardship Policy and Procedures, revised 06/13/2023, revealed a section titled, Community Actions, specified, 1. All antibiotic orders will come with the following: a. A specific prescribing order with dose and duration; b. A progress note explaining the reason for the antibiotic; c. If other treatment (example: COVID19) is to coincide with the antibiotic treatment, the Medical Director will verify the reason for the antibiotic prior to beginning the treatment; d. If a culture and sensitivity is performed and results are obtained, a re-evaluation will be undertaken to ensure proper spectrum coverage, e. For those orders that may not follow the standards of practice for prescribing antibiotics, they will be referred to the Director of Nursing for [facility name] for review and recommendations. 1. An admission Record revealed the facility admitted Resident #76 on 10/15/2013 and readmitted the resident on 10/10/2017. According to the admission Record, the resident had a medical history that included a diagnosis of personal history of urinary (tract) infections (infection of the kidneys, ureters, bladder, or urethra). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/18/2025, revealed Resident #76 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderately impaired cognition. The MDS indicated the resident was always incontinent with bowel and bladder. The MDS revealed the resident was dependent on staff for toileting hygiene and toilet transfers. Resident #76's Care Plan Report, included a focus area revised on 09/03/2024, that indicated the resident had an activity of daily living (ADL) self-care performance deficit related to a history of amputation of the residents' toes on the left foot and left arm below the elbow, pain, and activity intolerance. Interventions directed staff to provide assistance from one to (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	two staff members to help with toileting, brief changes, and incontinence care. Resident #76's nursing Progress Notes, dated 08/12/2025 at 9:32 AM, revealed Resident #76 experienced hallucinations, facial flushing (redness of the skin due to increase blood flow to the area), and had foul smelling and dark colored urine which contained mucous. The Progress Notes further indicated that the resident complained of burning during urination and showed facial grimacing during assessment using palpation (touch) of Resident #76's abdomen. The Progress Notes indicated that the Nurse Practitioner (NP) was made aware of Resident #76's symptoms. Resident #76's nursing Progress Notes, dated 08/12/2025 at 1:58 PM, indicated Resident #76 was seen by the NP and staff were instructed to obtain a (brand name) urinalysis dipstick. An Infection Screening Evaluation, dated 08/12/2025, indicated Resident #76 had acute dysuria and abdominal pain or tenderness. The Infection Screening Evaluation revealed a section titled, Infection Analysis, that indicated a Loeb's Criteria: Suspected UTI (SUTI) and McGreer's Criteria: Suspected UTI without indwelling catheter assessments were triggered. The Infection Screening Evaluation further revealed that the evaluation manually triggered a case to the IPC (Infection Prevention Consultant). Resident #76's nursing Progress Notes, dated 08/12/2025 at 6:06 PM, indicated Resident #76's urinalysis dipstick test results indicated the resident's urine sample was positive for leukocytes (a white blood cell involved in counteracting foreign substances and diseases) and negative for nitrates. The Progress Notes revealed that the nursing supervisor (Registered Nurse [RN] #7) was notified of the results. Resident #76's nursing Progress Notes, dated 08/13/2025 at 1:30 PM, revealed Resident #76's urine was sampled for a second time with results that indicated a strong positive for leukocytes but remained negative for nitrates. The Progress Notes indicated Resident #76 continued to experience hallucinations causing the resident to believe they had a nail puncturing their (the resident's) skin. The Progress Notes revealed the resident had urine which appeared neon yellow with a green hue containing a large amount of mucous present. The Progress Notes revealed the resident stated that they felt burning during urination. Resident #76's nursing Progress Notes, dated 08/13/2025 at 3:04 PM, revealed an order to collect a urine sample via straight catheter to be sent to the laboratory for evaluation. Resident #76's nursing Progress Notes, dated 08/13/2025 at 4:15 PM, revealed a urine sample was obtained from Resident #76 via straight catheter. The Progress Notes indicated the urine sample contained large amounts of mucous, was foul smelling and appeared yellow in color with a green tinge. A Lab [Laboratory] Results Report, dated 08/15/2025, indicated a specimen was collected on 08/14/2025 at 1:00 AM and was received by the laboratory on 08/14/2025 at 6:58 AM. The Lab Results Report revealed that the lab reported the specimen was mislabeled and another specimen and laboratory requisition were needed to process the requested laboratory testing for Resident #76. The Lab Results Report indicated the facility was notified via fax with the reported time stamped as 08/15/2025 at 5:13 PM. Resident #76's Order Summary Report for the timeframe from 04/01/2025 through 09/30/2025, contained an order dated 08/17/2025 (two days after being notified by the lab of the mislabeled specimen) to obtain a urinalysis with culture and sensitivity for possible UTI. The Order Summary Report revealed an order dated 08/18/2025 to obtain a urine sample via straight catheter and place in the refrigerator for pickup by the lab. Resident #76's nursing Progress Notes, dated 08/18/2025 at 6:10 AM, revealed Resident #76 had combative behaviors throughout the shift and staff were unable to obtain the urine specimen due to the resident hitting and kicking all staff involved with the resident's care. Resident #76's nursing Progress Notes, dated 08/18/2025 at 6:18 PM, revealed a urine specimen was obtained from Resident #76 via straight catheter. The Progress Notes revealed the sample contained yellow urine with a large amount of sediment and had a foul odor. Resident #76's Lab Results Report, dated 08/22/2025, indicated a urine specimen was collected on 08/19/2025 at 1:00 AM and was received by the laboratory on 08/19/2025 at 7:28 AM. The Lab Results Report revealed the results were provided to the facility on [DATE]. The Lab Results Report revealed Resident #76's urine sample was extra turbid in clarity, positive for the presence of blood, protein, nitrates, and contained 4+ leukocytes (reference range indicated these (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	items should be negative). The Lab Results Report revealed that the culture results indicated that Resident #76's urine sample contained greater than 100,000 colony forming units per milliliter (CFU/ml) of Citrobacter Koseri (a bacteria found in the gastrointestinal tract). Resident #76's nursing Progress Notes, dated 08/22/2025 at 11:18 AM, revealed Resident #76 continued to have the presence of cloudy urine and was experiencing increased lethargy and needed additional assistance by staff with meals. Resident #76's Order Summary Report for the timeframe from 04/01/2025 through 09/30/2025, contained an order with a start date of 08/22/2025 and end date of 08/29/2025, for levofloxacin tablet (an antibiotic) 500 milligrams (mg) with instructions to give one tablet by mouth every night shift for UTI for seven days. The Order Summary Report revealed an order with a start date of 08/23/2025 and end date of 08/30/2025 for Augmentin oral tablet (an antibiotic) 500-125 mg with instructions to give one tablet by mouth two times a day for acute UTI for seven days. Resident #76's nursing Progress Notes, dated 08/26/2026 at 3:09 PM, revealed Resident #76 continued to experience cloudy urine with a presence of a strong odor after starting antibiotic therapy. Resident #76's nursing Progress Notes, dated 08/31/2025 at 11:45 AM, revealed Resident #76 continued to have dark colored urine with a foul smell present. Resident #76's physician Progress Notes, dated 09/04/2025, electronically signed by Resident #76's Primary Care Provider (Medical Doctor [MD] #2) revealed Resident #76's primary reason for assessment was recurrent urinary tract infection. The Progress Notes indicated Resident #76 was recently treated with Augmentin therapy that was completed with good clinical response without ill effects reported. The Progress Notes revealed that due to the resident's recurrent urinary tract infection, MD #2 recommended Trimethoprim (an antibiotic) 100 mg by mouth at night for 90 days along with lactobacillus (an oral medication which contains healthy bacteria that aid the gastrointestinal system) two tablets daily while on Trimethoprim therapy. The Progress Notes revealed the Current Medications list included an order for Trimethoprim 100 mg orally once a day for 90 days. Resident #76's nursing Progress Notes, dated 09/05/2025 at 4:59 PM, indicated Resident #76 continued to experience periods of combativeness, decrease appetite with meals, and was resistive to care to include medication administration. Resident #76's nursing Progress Notes, dated 09/09/2025 at 2:32 PM, revealed Resident #76 continued to experience poor oral intake. Resident #76's physician Progress Notes, dated 09/11/2025, electronically signed by MD #2, revealed an examination of the resident completed by MD #2 indicated that Resident #76 had no current complaints of dysuria and was afebrile but was recently prescribed Trimethoprim suppressive oral therapy (on 09/04/2025) and the order had been neglected. Resident #76's nursing Progress Notes, dated 09/11/2025 at 9:09 AM, revealed Resident #76 was seen by MD #2 with recommendations to continue Trimethoprim therapy for UTI prevention. Resident #76's Order Summary Report for the timeframe from 04/01/2025 through 09/30/2025, revealed no order for Trimethoprim 100 mg. Resident #76's Progress Notes for the timeframe from 09/04/2025 through 09/24/2025, revealed no documented explanation why MD #2's order for Trimethoprim for suppressive therapy was not transcribed and followed as prescribed. During an interview on 09/25/2025 at 9:32 AM, RN #5 stated she spoke with MD #2 a couple of weeks prior, and said MD #2 had a concern related to the amount of time that passed between a resident's initial symptoms and the time the resident was treated, but she could not remember who the resident was. RN #5 stated she did not think residents should have to wait that long for treatment of UTI symptoms because it was important to treat the infection before it worsened. During an interview on 09/25/2025 at 10:35 AM, RN #6 stated floor nurses were not allowed to transcribe physician orders into the medical record, and all order transcriptions were delegated to the nurse supervisor. RN #6 was unaware of why MD #2's order for antibiotic therapy for Resident #76 was neglected to be transcribed into the resident's medical record and started. RN #6 stated she expected to see documentation in the resident's medical record to reflect why the order was not followed. During a telephone interview on 09/25/2025 at 2:46 PM, RN #7 stated some providers wrote orders for antibiotic therapy prior to the results of the culture and sensitivity being received, but the facility preferred to wait for the culture (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER S.E.M. Haven Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 225 Cleveland Avenue Milford, OH 45150	
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She stated she was not notified about the delay in obtaining Resident #76's lab nor the resident's behavioral symptoms and lethargy. The NP stated she attempts to order a urine specimen and start a resident on antibiotics quickly and then once we get a culture and sensitivity, we will change the antibiotic if necessary. She stated that the facility's unwillingness to follow provider orders for antibiotics has been a frequent problem at this facility. She stated when she saw Resident #76 on 09/04/2025 the antibiotic orders never got put in and then on 09/11/2025 MD #2's order for the antibiotic was never put in. She stated she saw Resident #76 this past Tuesday (10/07/2025) and the staff told her the resident's urine looked awful, and she ordered a urinalysis and culture and sensitivity laboratory test and then the resident was admitted to hospice services. She stated the facilities program that required two urine specimens to be evaluated by dipstick method in-house prior to sending a specimen to the laboratory to perform a urinalysis with culture and sensitivity was the providers struggle in properly caring for the resident's needs. During a telephone interview on 09/24/2025 at 11:13 AM, MD #2 stated he discovered the facility was not following his orders because of the facility protocol which caused residents of the facility to wait at least 72 hours after being symptomatic before being treated for the resident's UTI signs and symptoms. MD #2 stated that when a resident experienced symptoms of a UTI, he learned the facility's normal practice was to collect a urine sample and assess the urine using a dipstick method. MD #2 stated if the testing indicated the sample was positive, the urine was evaluated two to three more times 24 hours apart before a urine specimen was obtained and sent to a laboratory to determine the results for an ordered urinalysis and culture and sensitivity. MD #2 stated he had written orders for urinalysis with culture and sensitivity labs to be obtained when a resident was displaying signs and symptoms of a UTI, but dipstick urines were obtained instead because that was the facility's protocol. MD #2 stated he was told by RN #7 they could not start a resident on an antibiotic until the culture and sensitivity came back due to the facility's protocol. MD #2 stated following his visit to the facility, he expressed his concerns to the facility's DON and Executive Director (ED) via an email but received no response. MD #2 stated he reached out to the facility's Medical Director, but nothing was changed. MD #2 stated the facility's nursing staff needed to contact him and discuss concerns with medication if they were not going to transcribe and follow the physician's orders he provided. MD #2 stated he attempted to start Resident #76 on suppressive antibiotic therapy due to recurrent UTI infections, but RN #7 never transcribed the orders, and the resident was not started on the medication. MD #2 stated he discovered the resident was never started on the therapy because the DON felt that the facility could not allow a prophylactic antibiotic to be prescribed. MD #2 stated he was very familiar with Resident #76 and had been seeing the resident for years. MD #2 stated he no longer practiced medicine at the facility because the facility refused to follow his orders. During a follow up telephone interview on 10/10/2025 at 1:40 PM, MD #2 stated he assessed Resident #76 on 09/04/2025 and dictated in his notes that the resident had recently completed treatment with antibiotics for recurrent UTI with good response and stated he recommended suppressive therapy for 90 days. He stated he was not notified when the facility was not able to obtain the requested urine specimens nor when Resident #76's urine sample was mislabeled and required recollection. He stated, That is horrible! MD #2 stated had he been notified, he could have ordered the resident needed antibiotics; however, the resident would not (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have received them due to the facility saying, they needed the results first. He stated he was not notified that the facility did not have laboratory pick up on the weekends. He stated his opinion was that the facility put Resident #76 at risk of harm because they do not follow his physician's orders. MD #2 stated this practice placed Resident #76 at risk for septic shock from UTI. During a telephone interview on 09/25/2025 at 2:21 PM, the facility's Medical Director stated that when a resident presented with signs and symptoms of a UTI, she expected the facility staff to assess the resident's urine and assess for any further symptoms. The Medical Director stated if the resident's urine sample contained abnormalities, I think they dip it again. The Medical Director stated the facility had a protocol, but she was not sure what it was because she did not have the protocol in front of her. The Medical Director stated it was not normal practice to prescribe antibiotics before the results of the culture and sensitivity were received because she did not feel there was a need for it. The Medical Director stated she had no concerns with the facility not following her orders and stated she heard things about staff not following orders from other prescriber's but stated, I'm not privy to what all of the other doctors do. The Medical Director could not state why MD #2's orders were not followed by the facility and stated she did not know what other providers had ordered. During an interview on 09/25/2025 at 9:46 AM, the ED stated that if the prescriber ordered an antibiotic, the order was given to the nursing supervisor for transcription into medical record. The ED stated she was aware of a concern related to prophylactic antibiotic orders which were prescribed by providers not being transcribed into the medical record, but she thought they did not follow the facility's protocol. The ED stated that any issues with orders were to be discussed with the provider and documented. The ED stated it was not appropriate for the nursing supervisor to hold a prescriber's order or choose not to transcribe the order. An Order Summary Report, dated 10/10/2024, revealed an order for Nitrofurantoin Macrocrystal oral capsule 50 mg to be given by mouth at bedtime for recurring UTI for 90 Days, ordered on 07/04/2024 with an end date of 10/02/2024 and that it was completed. During an interview on 10/10/2025 at 4:00 PM, the DON reviewed the medical record and stated the suppressive therapy for Resident #76, Nitrofurantoin 50 mg along with Acidophilus therapy for 90 days in July of 2024 was administered as ordered. During an interview on 10/10/2025 at 5:18 PM, the ED confirmed that the antibiotic stewardship program for the facility had not changed since 2024. She stated she did not know why Resident #76 had suppressive therapy before and not now. She stated it was still the physician's determination of what he orders to be administered to the resident. During a follow up interview on 10/11/2025 at 5:18 PM, the ED stated her expectations aligned with the DON's expectation. 2. An admission Record revealed the facility admitted Resident #84 on 08/26/2025. According to the admission Record, the resident had a medical history that included a diagnosis of overactive bladder (frequent urgency of urination). The admission Record revealed the resident was discharged from the facility on 09/07/2025 after a 12-day admission to the facility. A Medicare 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/30/2025, revealed Resident #84 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident had intact cognition. The MDS revealed Resident #84 required partial/moderate assistance with toileting hygiene, toileting transfers, and had occasional bladder incontinence. Resident #84's Care Plan Report, included a focus area initiated on 08/27/2025, that indicated the resident had chronic kidney disease. Interventions directed staff to administer medications as ordered by the physician, monitor changes in mental status, and monitor for signs and symptoms of infection. The Care Plan Report also included a focus area initiated on 09/03/2025 that indicated the resident had mixed bladder incontinence related to active infections with symptoms of UTI, chronic symptomatic infections, and impaired mobility. Interventions directed staff to clean the residents' perineal area with each incontinent episode; monitor/document for signs and symptoms of UTI; and monitor/document/report as needed for any potential causes of incontinence. Resident #84's nursing Progress Notes, dated 08/28/2025 at 12:21 PM, revealed Resident #84 had foul smelling urine. Resident #84's nursing Progress Notes, dated 08/28/2025 at 5:10 PM, revealed Resident #84's urine (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was cloudy and had a foul odor and RN #7 was notified. Resident #84's nursing Progress Notes, dated 08/29/2025 at 12:21 AM, revealed a urine dipstick specimen was obtained which showed Resident #84's sample appeared cloudy and contained leukocytes and protein and was negative for nitrates. Resident #84 nursing Progress Notes, dated 08/30/2025 at 12:30 AM, revealed Resident #84 had complaints of burning during urination and experienced polyuria (excessive urination) and a second urine sample was obtained from Resident #84's for a dipstick analysis. The Progress Notes indicated Resident #84's urine was cloudy with a strong odor and contained leukocytes and protein. Resident #84's Order Summary Report for the timeframe from 08/01/2025 through 09/30/2025, contained an order dated 08/28/2025 to obtain a (brand name) urine dipstick once. The Order Summary Report revealed an order dated 08/29/2025 to obtain a second (brand name) urine dipstick for possible UTI. The Order Summary Report revealed an order dated 09/02/2025 to obtain a urine specimen via straight catheter and send to the laboratory (lab) for processing of a urinalysis with culture and sensitivity. Resident #84's provider Progress Notes, dated 09/02/2025, electronically signed by the Nurse Practitioner (NP) revealed a section titled, History of Present Illness, that specified, Patient states, I know I have a UTI and the staff took 3 samples already, and, I was taking a maintenance Keflex (a medication used to treat infection) for frequent UTI's and somewhere along the line it was discontinued and now I have a UTI. The Progress Notes revealed Resident #84's treatment plan included orders to obtain a urinalysis with culture and sensitivity and to start ciprofloxacin hydrochloride (HCl) (an antibiotic) 250 milligrams (mg) with instructions to give one tablet by mouth every 12 hours and Lactobacillus. The Progress Notes also indicated there was a need for a follow-up every two to three days as needed due to the complexity of the resident's medical condition. Resident #84's nursing Progress Notes, dated 09/03/2025 at 3:40 PM, revealed a urine specimen was obtained from Resident #84 and placed in the refrigerator to be picked up by the lab. Resident #84's nursing Progress Notes, dated 09/04/2025 at 12:47 AM, revealed Resident #84 complained of burning during urination. The Progress Notes also indicated that the urinalysis was positive, and the culture and sensitivity were pending. Resident #84's Lab Results Report, dated 09/03/2025, revealed a urine specimen was collected on 09/03/2025 at 3:00 AM, received by the laboratory on 09/03/2025 at 8:06 AM, and reported to the facility on [DATE] at 2:55 PM. The Lab Results Report revealed Resident #84's urine was turbid in clarity, positive for nitrates, contained 4+ leukocytes, clumps of white blood cells, and contained 100,000 colony forming units per milliliter (CFU/ml) of Klebsiella Pneumoniae (a bacteria normally found in the gastrointestinal system). Resident #84's provider Progress Notes, dated 09/04/2025, electronically signed by MD #2, revealed the facility requested the provider follow-up on Resident #84's persistent dysuria. The Progress Notes indicated the resident complained of dysuria associated with urinary frequency and was not currently on the antibiotic therapy prescribed by the NP on 09/02/2025 and remained at high-risk for decline due to age and medical complexity. The Progress Notes revealed Resident #84's treatment plan included concerns for the resident's dysuria with notes that indicated Resident #84 was symptomatic with dysuria associated urinary frequency and had an abnormal urinalysis and MD #2 agreed with NP's assessment that Resident #84 should be prescribed an antibiotic and again wrote an order for Resident #84 to receive ciprofloxacin 500 mg with instructions to give one tablet by mouth two times a day for five days. Resident #84's nursing Progress Notes, dated 09/06/2025 at 2:45 [TRUNCATED]		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to ensure food items stored in the refrigerator were covered in 1 (Ripple Ridge) of 4 satellite kitchens. Findings included:Reference: The United States FDA (Food and Drug Administration) 2022 Food Code contained Chapter 3 Food, 3-305 Preventing Contamination from the Premises, which revealed, 3-305.11 Food Storage, (A) Except as specified in [paragraphs] (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (2) Where it is not exposed to splash, dust, or other contamination. Paragraph (B) was regarding food in packages and working containers being stored above the floor on case lot handling equipment and paragraph (C) was regarding the floor storage of pressurized beverage containers, cased food in waterproof containers, and milk containers in plastic crates, which did not apply here. 3.305.14 Food Preparation revealed the statement, During preparation, unPACKAGED FOOD shall be protected from environmental sources of contamination. Food Code 2022 FDAA facility policy titled Food Storage, with a copyright date of 2023, revealed a section titled, 13. Refrigerated food storage that specified, f. All foods should be covered, labeled and dated and routinely monitored to assure that foods (including leftovers) will be consumed by their use by dates, or frozen (where applicable) or discarded.A concurrent observation and interview on 09/23/2025 at 12:24 PM with the Dietary Director revealed a refrigerator located in the Ripple Ridge satellite kitchen had a metal container containing approximately 12 tomatoes slices, 12 cucumber slices, and 12 sliced eggs, as well as a dinner plate inside the refrigerator with several slices of light brown meat that were uncovered. The Dietary Director stated that, as long as the items were used within a reasonable timeframe, it was acceptable for them not to be covered, noting a reasonable timeframe was about one hour. During an interview on 09/25/2025 at 10:03 AM, Homemaker #3 stated she was responsible for covering all food items stored in the satellite kitchen's refrigerator. She stated the tomatoes, cucumbers, eggs, and the dinner plate containing meat were left uncovered because they were going to be used for the lunch meal on 09/23/2025. She stated she received training to cover all food items in the refrigerator during her orientation, with the exception of food for immediate use, which Homemaker #3 stated the Kitchen Manager told her did not have to be covered. She stated her understanding was that immediate use meant that same day. During an interview on 09/26/2025 at 9:00 AM, the Kitchen Manager stated everything stored in a refrigerator, including prepped items, should be covered, which she noted applied to all refrigerators, including satellite kitchen refrigerators. She stated the homemaker assigned to a unit was responsible for covering all food items. During a follow-up interview on 09/25/2025 at 11:10 AM, the Dietary Director stated she expected all food to be covered while being stored in a refrigerator, with the exception of premade foods items placed in the refrigerator as a preparation for meals. She stated the homemakers were responsible for the refrigerator in their units to ensure all items were stored per facility policy. She stated she and the Kitchen Manager were responsible for the daily monitoring of satellite kitchen refrigerators to ensure food storage items were correctly covered. During an interview on 09/25/2025 at 11:26 AM, Dietary Aide (DA) #4 stated she did not monitor the kitchen. Regarding expectations for refrigerator food storage, she stated she expected all food items to be covered. During an interview on 09/25/2025 at 11:37 AM, the facility's Registered Dietitian (RD) stated the storage of food in the refrigerator required, in part, covering the food, with the exception of food in the refrigerator that was prepped for meals that day, because the refrigerator was like a preparation station. The RD noted that preparation storage usually only meant that food could be stored for 15 to 20 minutes prior to a meal without covering the food. The RD also noted it was acceptable to have food items uncovered for 45 minutes, describing that immediate use food did not need to be covered. The RD stated that standard and best practice was to use the refrigerator as a staging area for items prepped for a meal, identifying that staging areas did not require the covering of food. During an interview on 09/25/2025 (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 1:00 PM, the Director of Nursing deferred her expectation of food storage and procedures to the Dietary Director, but noted she expected facility policies to be followed. During an interview on 09/25/2025 at 1:13 PM, the Executive Director (ED) stated she expected staff to follow the facility's food storage policies, but thought it was an acceptable practice to store uncovered, prepped food in the satellite refrigerators. After reviewing the facility's policy, the ED stated that, ultimately, staff would follow the policy, which revealed all food should be covered. The ED also stated the policy was grey because it was a storage policy and, in the main kitchen, the refrigerators were only for storage but, in the satellite kitchens, the policy might need to be expanded because the refrigerators in the satellite kitchens were used as both preparation and storage areas.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to implement an effective infection control and prevention program by failing to ensure staff conducted hand hygiene during 1 of 3 meal services observed, affecting 2 (Residents #38 and #76). Findings included: A facility policy titled, Infection Control Plan/Program, last revised in 03/2025, revealed It is the policy of the community to establish guidelines to follow to facilitate maintaining a safe, sanitary and comfortable environment; to proactively prevent and manage transmission of diseases and infections; to identify, reduce, control or prevent the risks of acquiring and transmitting infections among elders, employees, volunteers, visitors, and others; to investigate through surveillance to prevent infections in the facility; and to provide on-going elder and care partner education on infection control policies and procedures. The policy also revealed, Hand hygiene policies will be followed by all employees and volunteer workers. An undated facility policy titled, Hand Washing/Hand Hygiene revealed, Handwashing and use of hand sanitizer shall be regarded by this organization as the most important means of preventing the spread of infection. The policy also revealed a section titled, Policy Interpretation and Implementation that specified, 1. All personnel shall follow our established hand washing and use of hand sanitizer procedures to prevent the spread of infection and disease to other personnel, patients, and visitors. Handwashing facilities will be readily available in laundry, dietary, resident rooms, utility rooms, and medication rooms and 2. Appropriate thirty15-20 [sic] second handwashing must be performed under the following conditions: h. After handling items potentially contaminated with blood, body fluids, excretions, or secretions. An admission Record revealed the facility admitted Resident #38 to the facility on [DATE]. According to the admission Record, the resident had a medical history that included diagnoses of moderate unspecified dementia with other behavioral disturbance and oral phase dysphagia (difficulty in the oral phase of swallowing). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/18/2025, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on staff assistance for eating. An admission Record revealed the facility admitted Resident #76 to the facility on [DATE] with a recent readmission on [DATE]. According to the admission Record, the resident had a medical history that included a diagnosis of type 2 diabetes mellitus with diabetic neuropathy (complication of diabetes that damaged the nerves). A quarterly MDS, with an ARD of 09/18/2025, revealed Resident #76 had a BIMS score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident required setup or clean-up assistance for eating. An observation of a dining room on 09/22/2025 at 9:36 AM revealed Resident #38 and Resident #76 were seated in their wheelchairs at a table. Registered Nurse (RN) #12 began to assist Resident #38 with their meal. RN #12 stopped assisting Resident #38 to cut up food for Resident #76 using Resident #76's cutlery, then returned to the table to resume assisting Resident #38 to eat. During the observation, RN #12 was not observed performing hand hygiene after feeding Resident #38 and before touching Resident #76's cutlery. During a telephone interview on 09/26/2025 at 12:53 PM, RN #12 stated she was taught to perform hand hygiene in between resident contact, before feeding a resident, and before touching resident food items. RN #12 stated she did not complete hand hygiene during the observation in the dining room on 09/22/2025 at 9:36 AM because she did not know she touched anything that required her to perform hand hygiene. During an interview on 09/26/2025 at 12:55 PM, the Director of Nursing (DON) stated she expected staff to perform hand hygiene after touching anything dirty and before serving food to a resident. The DON stated she would have expected RN #12 to perform hand hygiene between assisting multiple residents in the dining room. During an interview on 09/26/2025 at 12:55 PM, the Administrator (ADM) stated she expected staff to perform hand hygiene between tasks in the dining room and between assisting more than one resident with dining.		