STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365629	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Healthcare Center	135 Reichart Avenue Wintersville, OH 43953

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on observation, interview, and policy review the facility failed to maintain water temperatures in a manner to ensure residents were provided sufficient and comfortable hot water for use with bathing/personal hygiene. This affected four residents (#32, #42, #56, and #63) of fifteen residents interviewed. Findings included: Interview on 12/18/24 at 2:53 P.M., with Resident #32 and Resident #42 revealed the hot water in their sink was hit and miss especially the last two weeks. The residents reported the water had been so cold staff has had to go to the shower room to obtain hot water to ensure they received warm water to take their bed baths. Interview on 12/18/24 at 3:53 P.M., with Maintenance Director (MD) revealed he had started two weeks ago, and hot water temperatures had been an issue since he started. The MD reported one of the three hot water tanks was not working because it needed a new thermostat control unit. The MD reported he didn't know which hot water tank serviced which part of the building. The MD reported he randomly checked water temperatures in the resident rooms; however, he doesn't document the results. The water temperatures in residents' rooms had been running between 98-117 degrees. The hot water tanks were located at the end of 200 hall near the center of the building near the nurse's station. The MD reported the hot water tanks do not have temperatures on the dial, so he has to guess and adjust the dials to find a temperature between 105-120 degrees Fahrenheit (F) The MD confirmed the facility did not have an action plan for the low hot water temperatures at this time. Random observation of resident water temperatures on 12/18/24 beginning at 3:53 P.M., with Maintenance Director (MD) revealed Resident #32 and Resident #42's water temperature, after running for an extended period of time, finally reached 107.7 F. In addition, the water temperature in room [ROOM NUMBER] (at the end room of Unit 2) reached 105.9 F but not until the water ran for six minutes (3:58 PM to 4:04 PM). The hot water faucet was leaking, and water was streaming down into the sink in room [ROOM NUMBER]. An interview with Resident #56 revealed his room hadn't had hot water and staff went to the shower room to get hot water last night for his bed bath. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Unit 3 room [ROOM NUMBER] (close to the end of the hall) revealed the hot water had very little water pressure. The water ran six minutes (4:07 PM to 4:13 PM) and the water temperature only reached 76.8 F. During the observations on Unit 3, Resident #63 reported she had not had hot water for a long time now and the water never gets hot. In room [ROOM NUMBER] (close to the nurse's station) the water ran from 4:15 P.M. to 4:19 P.M. and the water temperature only reached 100.0 F. Observation of Unit 4 room [ROOM NUMBER] (located at the end of hall) revealed the hot water temperature reached 93.2 F after the water ran from 4:21 P.M. to 4:26 P.M. In room [ROOM NUMBER] (close to the nurse's station) the water ran from 4:22 P.M. to 4:33 P.M. but only reached 92.8 F. The MD obtained all the above temperatures using the facility's digital thermometer in the presence of the surveyor and confirmed the water temperatures at the time of the observations. Interview on 12/18/24 at 5:05 P.M., with the Administrator revealed the facility did not have an action plan to correct the identified low hot water temperatures. The facility had already replaced one hot water tank and a mixing valve. Review of the undated facility policy and procedure for water temperatures revealed hot water temperature regulatory requirements in Ohio were 105-120 (F). The policy and procedure did not include a procedure if the water temperatures didn't meet regulatory requirements.

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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** 32801 Based on medical record review, interview, and policy review the facility failed to notify the physician of resident weight loss. This affected two (Resident #45 and #73) of four residents reviewed for nutrition. Findings included: 1. Closed record review revealed Resident #73 was admitted to the facility on [DATE] and was discharged on [DATE]. The resident's diagnoses included osteomyelitis of vertebra, opioid use, acute subacute infective endocarditis, endocarditis (valve), infected surgical site, type two diabetes, edema, chronic obstructive pulmonary disease, heart failure, hypothyroidism, neuropathy, bipolar, anemia, pressure ulcer to sacral region, alcohol dependence, low back pain, localized swelling, mass and lump to left lower limb, and arthritis due to other bacteria left hand. Review of the admission assessment dated [DATE] revealed the resident had congestive heart failure (CHF) and had plus one pitting edema to bilateral lower extremities, the resident was set up or clean up assistance for eating. The resident was edentulous (no natural teeth) and wore upper and lower dentures. Review of the resident orders revealed on 09/20/24 she was ordered regular diet, regular texture, thin liquid consistency, weekly weight times four weeks upon admission. Review of Resident #73's weights revealed on 09/20/24 the resident weighed 133.9, 09/25/24 136.2, 10/03/24 136.4, 10/20/24 120.4, 10/21/24 120.4, and 11/01/24 100.0. There was no evidence the resident was weighed the week of 10/06/24 to 10/12/24 or the week 10/13/24 to 10/19/24. The resident lost 36.4 pounds in 29 days. Review of Resident #73's progress notes dated 10/20/24 to 11/04/24 revealed no evidence Resident #74 physician was notified of Resident significant weight loss of 16 pounds on 10/20/24 or the additional 20.4 pounds on 11/01/24. The last time the resident was seen by the physician was 09/30/24 and the nurse practitioner was 10/18/24. Interview on 12/17/24 at 12:33 P.M., with Resident #73's family member revealed she took her sister straight to the emergency room (ER) as soon as she was discharged on [DATE] from the facility. When they arrived at the hospital her sister only weighed 96 pounds, and she was 5'9 tall. Her sister had lost 37 pounds during her stay at the nursing home and she felt the facility wasn't providing her adequate nutrition/supplements as ordered. Interview on 12/18/24 at 3:14 P.M. with the Director of Nursing (DON) confirmed there was no documented evidence the physician was notified of significant weight loss 10/20/24 and 11/01/24. The resident had not been seen by the physician or nurse practitioner since 10/28/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/19/24 at 11:53 A.M. with Nurse Practitioner (NP) #301 confirmed she was not notified of Resident #73's significant weight loss. 35765 2. Review of the medical record revealed Resident #45 was admitted to the facility on [DATE]. Diagnoses included hypokalemia, bulbous ureteral stricture hematuria, benign prostatic hyperplasia, retention of urine, diabetes, hyperlipidemias, respiratory failure, atrial fibrillation, osteoarthritis, major depressive disorder, and dementia. Review of weights in Point Click Care for Resident #45 revealed on 07/07/24 he weighed 172.4 and on 10/09/24 he weighed 154.6 for a 10.3 percent weight loss. Review of the nutritional assessment dated [DATE] revealed Resident #45 was down seven pounds in one month and 15.4 in three months for a significant weight loss. The weight loss was discussed with the Interdisciplinary Team and the resident was much more active moving around in the hallways in his wheelchair. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #45 had intact cognition and had lost weight. He was not on a prescribed weight loss regimen. On 12/18/24 at 11:10 A.M. an interview with the Director of Nursing confirmed there was no evidence in the medical record of Resident #45 indicating the physician or nurse practitioner was notified of his significant weight loss from 10/09/24. Review of the undated facility policy titled, Resident Height and Weight, revealed any weight loss concerns were reported to the practitioner and discussed at the weekly clinical meeting.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28701 Based on resident interview, medical record review, policy review and staff interview the facility failed to ensure resident care conferences were completed quarterly. This affected two (Residents #34 and #56) of two residents reviewed for care conferences. The facility census was 74. Findings include: 1. Review of Resident #56's medical record revealed an admitted [DATE] with diagnoses that included pressure ulcer to the sacrum, diabetes mellitus and chronic kidney disease. Review of Resident #56's Minimum Data Set (MDS) 3.0 quarterly assessment revealed an intact and independent cognition level. Further review of the medical record including progress notes revealed care conferences documented as completed on 07/25/24 and 01/23/24. No other notes related to care conferences were noted. Interview with Resident #56 on 12/16/24 at 10:40 A.M. revealed he had not been to any care conferences with the facility. Interview with Social Services Designee (SSD) #119 on 12/17/24 at 11:50 A.M. revealed care conferences are to be completed with residents and representatives quarterly. Further interview with SSD #119 on 12/17/24 at 2:20 P.M. verified Resident #56 did not have care conferences completed quarterly as required. Review of the undated facility policy Process for Care Plan Meetings revealed no evidence of time frames of when care conference are required to be completed. 32801 2. Record review revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including chronic kidney disease, anxiety, asthma, depression, encephalopathy, diabetes, bipolar, gastro-esophageal reflux disease, epilepsy, morbid obesity, hypertension, acute kidney failure, sleep disorder, cirrhosis of liver. Review of Resident #34's medical record revealed there had only been one care conference for Resident #34 since 08/08/23 and it was held on 08/08/24. The note indicated the resident was invited to attend; however, the resident was not on the list that attended the care conference. The staff in attendance was the social service designee, dietary manager, therapy staff, and a representative from Via [NAME]. The resident's plan was reviewed, and no changes occurred. Interview on 12/16/24 at 10:14 A.M., with Resident #34 revealed she had only been invited to one care conference in the last two years. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/17/24 at 10:46 A.M. with the Social Services Designee (SSD) #119 confirmed there was only one care conference documented in the resident's medical record since the last annual and she would need to look into why she only documented one on 08/08/24 due to the resident was to have a care conference every quarter. Interview on 12/17/24 at 1:58 P.M., with SSD #119 revealed the resident didn't have a care conference on 09/07/23 or 12/08/23 and she forgot to document the care conference that occurred on 02/27/24, 05/07/24, and 11/07/24. The SSD confirmed the resident didn't attend any of the care conferences, but she was invited, however there was no documented evidence the resident was invited or notified of the care conferences. The SSD reported she invites the resident a week prior to the care conference in person and she doesn't ask or remind the resident prior to the start of the care conference unless she runs into them in the hall. The SSD confirmed she doesn't have staff or anyone in attendance sign that they participated in the care conference. Review of the facility's policy and procedure titled Care Plan Meetings undated revealed: 1. Social Services and/or person designated by social services contacts the resident and responsible party to set up a care plan meeting based on the resident and responsible party's availability. This meeting can be done in person or via a phone conference. 2. Social Services will be responsible to assure the care plan meeting invitation is completed and sent to the resident and responsible party. (The company has a standardized form to be used) A copy of the letter is to be placed in the chart. Social Services may delegate this task (such as to the receptionist) but is responsible to assure it has been completed. 3. The Director of Nursing (DON) identifies who from the clinical team will be available to attend the care plan meeting. 4. The following team members will be present during the care plan meeting: A clinical representative, Dietary, Social Services, Activities and Therapy. 5. A care plan note must be created at the time of the meeting to include the brief discussion of the meeting, concerns, follow up, etc. This note should include a list of all who attended the meeting, both from the resident/representatives and facility staff. The note can be found in Point Care Click (PCC) under progress notes.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on closed record review and interview the facility failed to ensure a discharge summary (recapitulation of stay, final summary of the resident stay, reconciliation of medications, and post-discharge plan of care) was completed upon resident discharge/transfer from the facility. This affected one (Resident #124) of two residents reviewed for discharge. Findings included: Closed record review revealed Resident #124 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses including displaced fracture of upper end of right humerus, hypertension, hyperlipemia, atrial fibrillation, gastro-esophageal reflux disease, bradycardia, hypothyroidism, benign prostatic hyperplasia with lower urinary tract symptoms, diabetes, kidney failure, difficulty walking, and muscle wasting, falls, lack of coordination, and presence of cardiac pacemaker. Review of Resident #124 medical record revealed no evidence of a discharge summary (recapitulation of stay, final summary of the resident stay, reconciliation of medications, and post-discharge plan of care), discharge instructions, or a progress note indicating the resident was discharged /transferred. Interview on 12/19/24 at 10:46 A.M. with the Administrator confirmed there was no documentation including a progress note or discharge summary completed when the resident was discharged /transferred to another facility on 12/12/24. The Administrator reported the family had initiated the discharge/transfer.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on interview, medical record review, and policy review, the facility failed to ensure Resident #73 received timely and appropriate surgical wound care. This affected one (Resident #73) of one resident reviewed for non-pressure skin alterations. The facility census was 74. Findings include: Review of the closed medical record for Resident #73 revealed an admitted [DATE] and a discharge date of [DATE]. Medical diagnoses included osteomyelitis of vertebra, infected surgical site, type two diabetes mellitus, peripheral neuropathy, low back pain, localized swelling, and arthritis due to other bacteria of the left hand. Review of Resident #73's admission assessment dated [DATE] revealed the resident had a surgical dehiscence (the bursting or splitting open of a wound) wound on the lumbar back measuring 24.0 centimeters (cm) by 7.5 cm by 2.0 cm. Review of Resident #73's admission orders (from the hospital) dated 09/19/24 revealed no evidence of wound care order for the surgical incision on the spine, except to apply the resident was to have a wound vac applied to a surgical wound on her spine. The order called for the wound vac to be changed on Mondays, Wednesdays, and Fridays. The order did not include what type of foam was to be applied to the spinal surgical wound, nor the setting for which the wound vac's continuous suctioning was supposed to be set at. Review of Resident #73's physician orders dated 09/22/24 revealed an order for a wound to the lumbar spine to be cleansed with Dakin's (a diluted bleach solution used to kill bacteria in skin and/or wounds). A wound vac was then to be applied. The order specified for white foam to be applied to the suture line in the center of the wound, with black foam covering the entire wound. The order called for the wound vac to be set at 80 millimeters of mercury (mmHg) of suction continuously and for the wound to be changed every Tuesday, Thursday and Saturday. The order was discontinued the same day, on 09/22/24. Additional review of Resident #73's orders revealed no order for surgical site care or treatment to the spinal surgical wound from 09/22/24 to 09/26/24. Review of the Visiting Wound Nurse Practitioner (NP) #303 progress note dated 09/24/24 revealed the lumbar surgical wound measured 25.0 cm by 8.0 cm by 2.0 cm. Two pieces of foam were removed, and black and white foam was inserted. New orders for the wound vac to lumbar spine surgical wound were provided. The wound was to be cleansed with Dakin's solution and white foam applied to the suture line in the center of the wound, with black foam covering the entire wound. The order called for the wound vac to be set at 100 mmHg of suction continuously and for the wound to be changed every Tuesday, Thursday and Saturday. Review of Resident #73's Treatment Administrator Record (TAR) dated 09/2024 revealed the treatment was not administered on 09/29/24, with a note which indicated it had been completed the day before (on 09/28/24). Further review revealed no evidence the treatment to the lumbar was completed on 09/28/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #73's physician's orders revealed an order dated 10/03/24 for the lumbar spine surgical wound to be cleansed with Dakin's solution. [NAME] foam was to be applied to the suture line in the center of the wound, with black foam covering. The order called for the wound vac to be set at 125 mmHg of suction continuously and for the wound vac dressing to be changed every Tuesday, Thursday and Sunday. The order was discontinued on 10/25/24. Review of Resident #73's Visiting Wound NP #303 note of the lumbar wound note dated 10/01/24 revealed the area measured 21.0 cm by 8.0 cm by 2.0 cm. The wound bed was 90% granulation and 10% slough. One piece of foam was removed, and one black piece of foam was applied. There was no evidence white foam was removed or applied per the orders. The note indicated the wound vac pump was set at 125 mmHg with continuous suction. Review of Resident #73's Visiting Wound NP #303 note of the lumbar wound note dated 10/08/24 revealed the area measured 21.0 cm by 8.0 cm by 2.0 cm. The wound bed was 90% granulation and 10% slough. One piece of foam was removed, and one black piece of foam was applied. There was no evidence white foam was removed or applied per the orders. The note indicated the wound vac pump was set at 125 mmHg with continuous suction. Review of Resident #73's Visiting Wound NP #303 note of the lumbar wound note dated 10/15/24 revealed the area measured 19.5 cm by 6.5 cm by 1.0 cm. The wound bed was 90% granulation and 10% slough. One piece of foam was removed, and one black piece of foam was applied. There was no evidence white foam was removed or applied per the orders. The note indicated the wound vac pump was set at 125 mmHg with continuous suction. Review of Resident #73's Visiting Wound NP #303 note of the lumbar wound note dated 10/22/24 revealed the area measured 20.5 cm by 7.0 cm by 2.0 cm. The wound bed was 90% granulation and 10% slough. One piece of foam was removed, and one black piece of foam was applied. There was no evidence white foam was removed or applied per the orders. The note indicated the wound vac pump was set at 125 mmHg with continuous suction. Review of Resident #73's physician's orders revealed an order dated 10/24/24 for the lumbar spine surgical wound to be cleansed with Normal Saline (instead of Dakin's). The wound was then to be covered with black foam. The order called for the wound vac to be set at 125 mmHg of suction continuously and for the wound vac dressing to be changed every Tuesday, Thursday and Sunday. The order was discontinued upon the resident's discharge on 11/04/24. Review of Resident #73's telehealth visit note dated 10/31/24 revealed the resident's lumbar spine surgical wound appeared as 100% granulation (healing) tissue and the wound measured 18.0 cm by 6.5 cm x 0.5 cm. Review of Resident #73's assessment revealed no evidence the facility completed a comprehensive assessment of the lumbar spine wound on 10/31/24 when the would nurse was not physically present to measure and assess the wound. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/17/24 at 8:50 A.M. with Licensed Practical Nurse (LPN) #155 revealed she was the facility's wound nurse, and she only does wound assessment on admission, for a change in condition, and if the facility's Visiting Wound NP (NP #303) was unavailable. LPN #155 stated the facility does not complete their own weekly wound assessments separate from the wound provider's. LPN #155 confirmed there were no wound vac orders for Resident #73 upon admission, and none were obtained until 09/22/24 and then discontinued the same day. LPN #155 confirmed there were no treatment orders in place from 09/23/24 to 09/26/24, however Visiting Wound NP #303 had seen Resident #73 on 09/24/24 and changed the wound vac dressing. LPN #155 confirmed the nurse practitioners were supposed to enter their own orders directly in the residents' electronic medical record, however there had been some glitches in the system preventing them from doing so. LPN #155 stated she had been entering the wound nurse practitioners' orders. LPN #155 confirmed the discrepancies in which phone was used and confirmed she was not aware of the discrepancy until questioned by the surveyor. LPN #155 stated she completed Resident #73's wound assessment on 10/31/24, when Visiting Wound NP #303 was not present in the facility, however she confirmed she did not document her assessment in the resident's medical record. Interview on 12/17/24 at 11:11 A.M. with Visiting Wound NP #303 revealed she was unaware Resident #73 did not receive her treatment as ordered because she did not have access to the resident's medical record. Visiting Wound NP #303 confirmed she could not enter her own orders or review everything in the resident's electronic medical record. She confirmed she was able to input her assessment into the electronic medical record. An interview on 12/18/24 at 10:48 A.M. with the Administrator and Corporate Nurse #300 confirmed wounds were followed weekly by a visiting wound nurse practitioner who had access to the residents' electronic medical records to enter her assessments. Visiting wound nurse practitioners were supposed to be entering their own orders. They had reached out to Visiting Wound NP #303 and she had typed up an unsigned statement indicating her documentation was inaccurate and contained discrepancies with the type of foam to be used. The unsigned statement stated to follow orders as written in the electronic medical record. An interview on 12/119/24 at 11:53 A.M. with Former NP #301 revealed she did not actively follow Resident #73's wounds, as the facility had a separate wound nurse practitioner who followed and monitored the residents with wounds. Review of the undated policy Skin Care & Wound Management revealed to conduct daily rounds to verify appropriate wound treatments are completed and documented.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on closed record review, interview, and policy review the facility failed to ensure pressure ulcer treatments were completed per orders. This affected one (Resident #73) of four residents reviewed for pressure ulcers. Findings included: Closed record review revealed Resident #73 was admitted to the facility on [DATE] with diagnoses including osteomyelitis of vertebra, opioid use, infected surgical site, type two diabetes, anemia, pressure ulcer to sacral region, mass and lump to left lower limb, and arthritis due to other bacteria left hand. Review of Resident #73's hospital orders dated 09/19/24 revealed to cleanse sacrum wound with mild soap and water, apply Triad hydrophilic paste dime thick to sacrococcygeal area twice daily and as needed. The Triad paste doesn't need to remove completely with cleaning. There was no evidence this order was written on admission to the facility or administered according to the treatment administration record (TAR). Review of admission skin assessment dated [DATE] revealed the resident had a suspected deep tissue injury on the sacrum measuring 1.0 centimeter (cm) by 1.5 cm by 0.0 cm. Review of Resident #73's pressure ulcer assessment dated [DATE] revealed the resident had a suspected deep tissue injury (Purple or maroon area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) on the sacrum measuring 1.0 cm by 1.5 cm by 0.0 cm. The skin was intact, dark purple, and non-blanchable. No treatment orders were noted. Review of Resident #73's orders dated 09/21/24 revealed to cleanse the sacrum with normal saline and cover with a foam dressing every day. Review of Resident #73's Wound Nurse Practitioner note dated 09/24/24 revealed the sacrum wound measured 1.5 cm by 2.2 cm by 0.3 cm, unstageable. The wound bed was covered with 100% slough (non-viable yellow, tan, gray, green or brown tissue; usually soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed), surrounding skin had a fungal rash, and the wound had serosanguineous drainage. The area was debrided (the removal of devitalized/necrotic tissue and foreign matter from a wound to improve or facilitate the healing process). New orders to cleanse the wound with normal saline, apply Santyl (debridement agent), and house antifungal cream to peri wound and apply a border foam daily. Review of the September 2024 TAR revealed no evidence the treatment was completed. Review of Resident #73 Treatment Administration Record (TAR) dated 09/21/24 to 09/30/24 revealed the only wound orders were written on 09/21/24 to cleanse with normal saline and cover with a foam dressing. Further review revealed on 09/29/24 the treatment was not done due to staff reported it was done yesterday (09/28/24) even though the order was daily, and it was not completed on 09/30/24 due to it will be done tomorrow (10/01/24 but the order was for daily). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #73's Wound NP note dated 10/01/24 revealed the sacrum wound measured 1.5 cm by 2.0 cm by 0.3 cm, unstageable due to the wound bed was covered with 100% slough. The wound required a mechanical debridement. The orders were to cleanse the wound with normal saline, apply Santyl, and house antifungal cream to peri wound and apply a boarder foam daily. Review of Resident #73's Wound NP note dated 10/08/24 revealed the sacrum wound measured 1.5 cm by 2.0 cm by 0.3 cm, unstageable due to the wound bed was covered with 100% slough. The wound required a mechanical debridement. The orders were to cleanse the wound with normal saline, apply Santyl, and house antifungal cream to peri wound and apply a boarder foam daily. Review of Resident #73's Wound NP note dated 10/15/24 revealed the sacrum wound measured 1.3 cm by 1.8 cm by 0.3 cm, unstageable due to the wound bed was covered with 100% slough. The orders were to cleanse the wound with normal saline, apply Santyl, and house antifungal cream to peri wound and apply a boarder foam daily. Review of Resident #73's TAR dated 10/01/24 to 10/20/24 revealed no evidence to cleanse the sacrum wound with normal saline, apply Santyl, and house antifungal cream to peri wound and apply a boarder foam daily. Review of Resident #73's orders dated 10/20/24 revealed to cleanse the sacrum wound with normal saline, apply Santyl, cover with a foam dressing daily. There was no order to apply antifungal cream. Review of Resident #73's Wound NP note dated 10/22/24 revealed the sacrum wound measured 1.0 cm by 1.5 cm by 0.3 cm, unstageable due to the wound bed was covered with 90% slough and 10% granulation tissue. The orders were to cleanse the wound with normal saline, apply Santyl, and house antifungal cream to peri wound and apply a boarder foam daily. Review of Resident #73's Wound NP telehealth note dated 10/31/24 revealed the sacrum wound measured 1.0 cm by 0.8 cm by 0.1 cm, unstageable due to the wound bed was covered with 90% slough and 10% granulation tissue. The orders were to cleanse the wound with normal saline, apply Santyl, and house antifungal cream to peri wound and apply a boarder foam daily. Review of Resident #73's assessment revealed no evidence LPN#155 had completed the weekly skin assessment on 10/31/24 due the Wound NP did not complete on onsite visit. Review of Resident #73's TAR dated 10/20/24 to 11/04/24 revealed no order to apply antifungal cream to the peri wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/17/24 from 8:50 A.M. to 9:32 A.M. with Licensed Practical Nurse (LPN)/Wound Nurse (WN) #155 confirmed the hospital order for Triad was not administered per hospital admission orders. The LPN reported she never heard of Triad before. The LPN confirmed the Wound NP recommendation/order on 09/24/24 for Santyl were not implemented as well. LPN #155 reported the facility doesn't do their own weekly wound assessment, the Wound NP enters all assessments in the electronic medical record. The LPN also reported she had been entering the Wound NP orders into the electronic medical record due to the Wound NP currently didn't have access to enter her own orders due to a glitch. Licensed Practical Nurse (LPN)/Wound Nurse (WN) #155 confirmed the NP recommendation for Santyl and antifungal cream was not administered per the Wound NP recommendation/orders as indicated. LPN #155 also confirmed she had completed the hands on wound assessment on 10/31/24 however she did not document her findings in the electronic medical record. Interview on 12/17/24 at 11:11 A.M. with the Wound NP #300 revealed she was not aware the resident wasn't receiving the Santyl and antifungal treatment as ordered, The Wound NP also reported he measures the depth from the slough to the skin even though the true depth was unknown due to the slough. Interview on 12/19/24 at 10:48 A.M., with the Administrator and Corporate Registered Nurse #300 confirmed the Wound NP should be entering her own orders for treatments. The facility LPN has been entering the orders and the Medical Director had been signing off the Wound NP orders. The Medical Director had only seen the resident once on 09/30/24. Interview on 12/19/24 at 11:53 A.M. with the previous NP who resigned on 11/01/24 revealed she did not actively follow Resident #73's wound due to the facility had a wound NP that followed the resident wounds. Review of the facility's policy and procedure titled Skin Care & Wound Management Overview undated revealed: a. Pressure Ulcer Documentation. Complete for all pressure ulcers b. Skin Impairment Documentation. Complete for all skin impairment issues that require measurement to indicate if healing is occurring 2. Review and select the appropriate treatment for the identified skin impairment. 3. Obtain a physician's order 4. Communicate interventions to the caregiving team 5. Document treatment on the Treatment Administration Record (TAR) 6. Monitor and document progress 7. Evaluate effectiveness of interventions during the clinical meeting 8. Modify goals and interventions as indicated (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9. Communicate changes to the caregiving team

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on observation, staff and resident interview, record review, and policy review, the facility failed to ensure restorative nursing programs were monitored and assessed quarterly. This affected one (Resident #58) of three residents reviewed for mobility. The facility census was 74. Findings include: Review of Resident #58's medical record revealed an admitted [DATE] with diagnoses including cellulitis to the left lower leg, legal blindness, arthritis, hypertension, and depression. Review of Resident #58's restorative care plan dated 03/25/24 revealed the resident received a passive range of motion (PROM) exercise program to his lower extremities five to seven days per week, for 15 minutes per session. Review of Resident #58's Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed the resident was assessed to have intact cognition with a Brief Interview for Mental Status (BIMS) score of a 15 out of 15. Resident #58 required assistance from staff to complete activities of daily living (ADL) tasks. The assessment noted the resident received five days of a restorative exercise program, lasting 15 minutes per session. Review of Resident #58's Point of Care (POC) documentation from 11/17/24 to 12/17/24 revealed Resident #58 participated in PROM exercise programs to his lower extremities five days per week, for 10 to 15 minutes per session. Review of Resident #58's assessments revealed no initial assessment for the restorative nursing program. Further review revealed the resident's medical record contained no evidence of quarterly monitoring assessments completed since Resident #58 began the PROM restorative exercise program on 03/25/24. Review of Resident #58's progress notes from 03/25/24 to 12/17/24 revealed no restorative nursing progress notes to review regarding Resident #58's progress while participating in the restorative exercise program for his lower extremities. Observation on 12/19/24 at 1:29 P.M. revealed Certified Nursing Assistant (CNA) #179 completing an active range of motion (ROM) restorative exercise program for Resident #58 instead of a passive ROM restorative exercise program which was the program to be performed per Resident #58's care plan and POC tasks. Interview on 12/18/24 at 1:30 P.M. with Resident #58 revealed the facility staff does not assist with a daily lower extremity exercise program. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 12/19/24 at 1:40 P.M. with the Director of Nursing (DON) confirmed Resident #58 did not have any type of initial assessments, quarterly assessments, or progress notes to reflect Resident #58's progress or decline since the initiation of restorative exercise program for both lower extremities. The DON stated there should be quarterly assessments and monitoring of the resident's progress, improvement, or decline of ROM and mobility. A review of the facility's undated policy titled, Restorative Program revealed the policy defined active ROM involved exercise and movement of a joint without any assistance or effort from another person to the muscles surrounding the joint. Passive ROM was defined as the movement of a joint through the range of motion with no effort from the patient. The purpose of the restorative program was to provide direction and guidance to the clinical team to assess and implement a plan of action for resident-specific care to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 32801 Based on observation, policy review, and interview the facility failed to maintain hot water temperatures in a safe manner to prevent potential accident/resident burns. This affected two (Residents #14 and #51) of 13 residents whose water temperatures were obtained. Findings include: On 12/18/24 from 4:34 P.M. to 4:36 P.M. observation of the water temperature in Residents' #14 and #51 room revealed the water temperature was 123.6 degrees Fahrenheit (F). The residents in the rooms were not available for an interview. The Maintenance Director (MD) obtained the water temperature using the facility's digital thermometer in the presence of the surveyor and confirmed the water temperature during observation. Review of the facility undated policy and procedure for water temperatures revealed hot water temperatures meet regulatory requirements in Ohio of 105-120 (F). The policy and procedure did not include a procedure if water temperatures didn't meet regulatory requirements. Interview on 12/18/24 at 5:05 P.M., with the Administrator revealed the facility did not have an action plan for when water temperatures feel outside of acceptable parameters. The Centers for Medicare and Medicaid (CMS) guidance related to water temperatures as an accident hazard includes: Water may reach hazardous temperatures in hand sinks, showers, tubs, and any other source or location where hot water is accessible to a resident. Burns related to hot water/liquids may also be due to spills and/or immersion. Many residents in long-term care facilities have conditions that may put them at increased risk for burns caused by scalding. These conditions include: decreased skin thickness, decreased skin sensitivity, peripheral neuropathy, decreased agility (reduced reaction time), decreased cognition or dementia, decreased mobility, and decreased ability to communicate. The degree of injury depends on factors including the water temperature, the amount of skin exposed, and the duration of exposure. Some States have regulations regarding allowable maximum water temperature. Table 1 illustrates damage to skin in relation to the temperature of the water and the length of time of exposure. Time and Temperature Relationship to Serious Burns reveals at 120 degrees F the time required for a third degree burn in occur is five minutes. At 124 degrees F the time required for a third degree burn to occur is three minutes.

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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** 32801 Based on medical record review, observation, and interview the facility failed to ensure residents were adequately assessed and treated for urinary incontinence and failed to ensure residents had adequate indication for use of an indwelling urinary catheter. This affected two (Resident #73 and #57) of three residents reviewed for bladder/bowel and catheters. Findings included: 1. Closed record review revealed Resident #73 was admitted to the facility on [DATE] with diagnoses including osteomyelitis of vertebra, opioid use, acute subacute infective endocarditis, endocarditis (valve), infected surgical site, type two diabetes, bipolar, anemia, pressure ulcer to sacral region, alcohol dependence, low back pain, localized swelling, mass, and lung to left lower limb, and arthritis due to other bacteria left hand. The resident was discharged on [DATE]. Review of Resident #73's admission assessment dated [DATE] revealed the resident was incontinent of bladder and bowel. There was no evidence of a comprehensive bladder assessment to identify the type of bladder incontinence affecting Resident #73. Review of Resident #73's plan of care revealed no evidence of a bladder incontinence plan of care. Review of Resident #73's task for bladder dated 09/20/24 to 11/04/24 revealed the resident had 10 episodes of continence and 93 episodes of incontinence. Three of the 10 episodes of continence was within the first five days of admission. Review of Resident #73's admission Minimum Data Set (MDS) dated [DATE] indicated the resident was occasionally incontinent of bladder and the discharge MDS dated [DATE] indicated the resident was always incontinent of bladder. Interview on 12/18/24 12:24 P.M. with the Director of Nursing (DON) confirmed the Resident #73 was incontinent of bladder and bowel and there was no plan of care. Interview on 12/19/24 at 10:48 A.M., with the Administrator and Corporate Registered Nurse (RN) #300 confirmed Resident #73 was not comprehensively assessed to determine the type of incontinence nor was a plan of care developed. The Corporate RN #300 revealed she didn't consider the resident had a decline due to the admission MDS dated [DATE] indicated the resident was occasionally incontinent and upon discharge she was frequently. 28701 2. Review of Resident #57's medical record revealed an admitted [DATE] with diagnoses that included end stage renal disease with hemodialysis, cerebrovascular accident and diabetes mellitus. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #57's physician's orders revealed upon readmission to the facility on [DATE] the resident had orders for the use of an indwelling urinary catheter, no indication for use was provided. Further review of the medical record including physician's and nurse practitioner assessments and other consultations including hospital records revealed no evidence of any type of indication for the use of an indwelling urinary catheter. Observation of Resident #57 throughout the annual survey from 12/16/24 to 12/19/24 revealed the use of an indwelling urinary catheter. Interview with Resident #57's representative on 12/16/24 at 11:30 A.M. revealed an unknown indication for use of an indwelling urinary catheter. On 12/17/24 at 2:30 P.M. interview with the Director of Nursing verified there was no evidence of a proper indication for use of an indwelling urinary catheter.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on closed medical record review, and interview the facility failed to ensure residents were provided a comprehensive and individualized plan to monitor and address significant weight loss. This affected one (Resident #73) of four residents reviewed for nutrition. Findings included: Closed record review revealed Resident #73 was admitted to the facility on [DATE] and was discharged on [DATE]. The resident's diagnoses included osteomyelitis of vertebra, opioid use, acute subacute infective endocarditis, endocarditis (valve), infected surgical site, type two diabetes, edema, chronic obstructive pulmonary disease, heart failure, hypothyroidism, neuropathy, bipolar, anemia, pressure ulcer to sacral region, alcohol dependence, low back pain, localized swelling, mass and lump to left lower limb, and arthritis due to other bacteria left hand. Review of the admission assessment dated [DATE] revealed the resident had congestive heart failure (CHF) and had plus one pitting edema to bilateral lower extremities, the resident was set up or clean up assistance for eating. The resident was edentulous (no natural teeth) and wore upper and lower dentures. Review of the resident orders revealed on 09/20/24 she was ordered regular diet, regular texture, thin liquid consistency, weekly weight times four weeks upon admission. Review of Resident #73's weights revealed on 09/20/24 the resident weighed 133.9, 09/25/24 136.2, 10/03/24 136.4, 10/20/24 120.4, 10/21/24 120.4, and 11/01/24 100.0. There was no evidence the resident was weighed the week of 10/06/24 to 10/12/24 or the week 10/13/24 to 10/19/24. The resident lost 36.4 pounds in 29 days. Review of Resident #73's admission dietary assessment dated [DATE] revealed the resident was a regular diet, regular texture, thin liquids, consistency. The resident consumes 50-100% of most meals. The resident consumes 2254 calories and 88 grams of protein. The resident height was 66 inches (5'6) and weight on 09/25/24 at 136.2; usually body weight unknown. The resident's body mass index (BMI) was 22 and in acceptable range for age. Estimated calorie needs were 1860- 2170 and estimated 68-87 grams protein, fluid estimated needs were 1860. Tolerating diet well. Appetite was good most days. By mouth intake was adequate. Estimated nutritional needs were being met. Food/beverage preferences in place. Does not endorse chewing or swallowing difficulties. Review of Resident #73's diet history/food preference dated 10/01/24 revealed the resident was on regular thin liquids, no nutritional supplements, appetite fair and eats 51-75% of meals, no likes or dislikes noted. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #73's re-admission dietary assessment dated [DATE] revealed the resident was ordered a regular diet, average meal intake was 50%, on Vitamin C, omeprazole, trelegy, zinc, iron, levothyroxine, Diflucan, and Cefazolin intravenous. The resident had moderate muscle (temporal and shoulder) and fate (buccal) loss. No edema noted. The resident had a surgical wound with wound vac and unstageable area on sacrum per wound report. The resident had no swallowing disorders, oral/mouth problems, or adaptive eating equipment. The resident's height was 66 (5 foot six inches) inches (family reported she was 5'9), weight was 136.2 on 09/25/24, and BMI was 22 which was within normal limits. Her estimated calorie needs were 1860-2170, 93 grams of protein, and 1860 ml of fluid needed. Resident reported that she is in a lot of pain and was affecting her meal intake. This Registered Dietician observed zero of lunch consumed today. Regular diet appears therapeutically appropriate. The resident nutrient diagnoses included to increase nutrient needs related to wounds and evidence by increase Kilo calories and protein needs. Recommendation was to continue with regular diet recommend four ounces hi cal med pass bid (480 kcals, 20 g protein) - resident agreeable - Recommend Juven twice daily - recommended 30 milliliter (ml) liquid protein daily (100 kcals, 15 g protein) - recommend continuing with zinc and vitamin C - monitor weight trends - monitor hydration status - monitor wound healing Review of Resident #73 orders revealed on 10/05/24 Juven twice daily, 10/07/24 regular diet, dysphagia advance texture, thin liquids. 10/01/24 and 10/23/24 Med Pass (two calorie) four ounces hi calorie twice daily, and 10/01/24 Modular protein 30 ml daily. Review of Resident #73 Medication/Treatment Administration Record dated 10/2024 revealed no evidence the Juven intake percentage was monitored 10/05/24 to 10/31/24 and med pass percentage was not monitored 10/02/24 to 10/23/24. Interview on 12/28/24 at 8:00 A.M., with the DON confirmed there was a discrepancy in the resident's height. The resident's height was 5'9, however she felt staff obtained the inaccurate height due to the resident was contracted and bent over making it difficult to obtain an accurate height. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/12/24 at 12:08 P.M. with the Registered Dietician #304 revealed he was not sure where the height 66 inches came from except in the header under vital signs under the resident's name it indicated 66 inches, even though it was not documented under the height section of the vital signs. The RD reported he was not aware the resident was 69 inches. The RD confirmed weights were not obtained the week of 10/06 to 10/12 or 10/13 to 10/19 and he had the resident on the weekly weight list that he provided to the facility. The RD confirmed the resident lost 36.4 pound without any explanation. The RD reported he had to go by what staff reported and what was documented. The RD reported he had spoke with the resident on 10/23/24 and she reported she was eating better and feeling better. Prior she was not eating because of pain. She did have an infection which could increase the resident's calorie needs however if staff were administering the supplement per orders and if her meal were accurate, she should have received adequate calorie intakes. He originally thought the 11/01/24 weight was inaccurate. He had no definitive answer why the resident continued to lose weight when her intakes had not changed. He did notice staff were not including percent of intakes of all the supplements in September and most of October and he had them change the order to include the percentage of intakes. This deficiency represents non-compliance investigated under Complaint Number OH00160253.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28701 Based on Ombudsman interview, resident interview, medical record review and staff interview, the facility failed to provide timely assistance to Resident #56 to obtain state photo identification. This affected one (Resident #56) of one residents reviewed for social services assistance. The facility census was 74. Findings include: Review of Resident #56's medical record revealed an admitted [DATE] with diagnoses that included pressure ulcer to the sacrum, diabetes mellitus and chronic kidney disease. Review of Resident #56's Minimum Data Set (MDS) 3.0 quarterly assessment revealed an intact and independent cognition level. Interview with the facility Ombudsman on 12/11/24 at 11:37 A.M. revealed concerns related to the facility not assisting Resident #56 in obtaining a state photo identification in a timely manner in order to gain access to his personal bank account. Interview with Resident #56 on 12/16/24 at 10:46 A.M. revealed he had not obtained a state photo identification in order to gain access to his personal bank account. Interview on 12/18/24 at 11:45 A.M. with Business Office Manager (BOM) #105 revealed on 07/22/24 she was notified by a case worker at the local Job and Family Services (JFS) office that Resident #56 was due for Medicaid reapplication and review. Resident #56 had a bank account with over $13,000 and needed to spend the account balance down or risk losing Medicaid eligibility. The facility had been working on getting the resident access to the back account, which included getting the resident a new state photo identification. BOM #105 stated the process had taken too long and the resident was very close to having Medicaid eligibility denied on 12/31/24, according to a letter from the JFS caseworker. On 12/18/24 at 12:30 P.M. interview with Social Services Designee (SSD) #119 verified the facility had not provided timely assistance in obtaining Resident #56 a new state photo identification in order for the resident to obtain access to his private bank account to spend down his account balance before losing Medicaid eligibility.

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Dixon Healthcare Center	135 Reichart Avenue Wintersville, OH 43953

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review and staff interview, the facility failed to Resident #73 was free from significant medication errors. This affected one (Resident #73) of seven residents reviewed for medication administration. Findings include: Review of the closed medical record revealed Resident #73 was admitted to the facility on [DATE] and was discharged on [DATE]. Medical diagnoses included osteomyelitis (bone infection) of the vertebra, opioid use, subacute infective endocarditis (infection of the hearts inner lining and/or heart valves), an infected surgical site, type two diabetes mellitus, low back pain, and arthritis due to other bacteria of the left hand. Review of Resident #73's record revealed the resident was hospitalized for a blood transfusion on 09/27/24 and returned on 09/28/24. Resident #73 also had a hospital stay of less than 24 hours on 10/13/24. Review of Resident #73's admission assessment dated [DATE] revealed the resident had a surgical dehiscence (the bursting or splitting open of a wound) wound on the lumbar back measuring 24.0 centimeters (cm) by 7.5 cm by 2.0 cm. Review of Resident #73's hospital admission orders dated 09/19/24 revealed the resident was to receive an eight-week course of intravenous (IV) cefazolin (antibiotic) through 11/06/24, (initiated after the surgical Incision and Drainage (I&D) of the lumbar wound on 09/11/24). Review of Resident #73's admission orders dated 09/19/24 revealed orders for cefazolin two gram per 100 milliliters (ml) intravenously every eight hours (6:00 A.M., 2:00 P.M., and 10:00 P.M.) for septic arthritis until 11/06/24. Review of Resident #73's nursing note dated 09/19/24 revealed the resident arrived at the facility on 09/19/24 at 10:40 P.M. on a gurney with two attendants. Review of Resident #73's Medication Administration Records (MAR) and corresponding MAR notes dated 09/2024 revealed on 09/20/24 the cefazolin was not administered at 6:00 A.M., 2:00 P.M., or 10:00 P.M. as ordered. On 09/20/24 at 10:00 P.M., there was a note indicating the medication had not arrived yet. On 09/22/24 the 6:00 A.M. dose of cefazolin was not signed off as administered nor was there a note indicating why the cefazolin was not administered. On 09/27/24, Resident #73's 10:00 P.M. dose was recorded as not administered as the resident was hospitalized . The resident went to the hospital on 09/27/24 in the afternoon and returned on the afternoon of 09/28/24. When the resident returned from the hospital on 09/28/24 the cefazolin order was discontinued, however on the admission orders there was a handwritten note to re-start the cefazolin until 11/06/24. The cefazolin was not administered 09/29/24 or 09/30/24. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #73's MAR dated 10/2024 revealed on 10/01/24 at 2:00 P.M. the cefazolin was re-started. There was no documented evidence the cefazolin was administered on 10/03/24 at 6:00 A.M, 10/05/24 at 10:00 P.M., 10/06/24 at 6:00 A.M. and 10:00 P.M., 10/07/24 at 6:00 A.M., 10/12/24 at 6:00 A.M., 10/17/24 at 6:00 A.M., 10/21/24 at 6:00 A.M., 10/24/24 at 6:00 A.M. and 10:00 P.M., 10/25/24 at 6:00 A.M., and 10/31/24 at 6:00 A.M. There were no corresponding notes to indicate why the medication doses were not administered as ordered. Review of Resident #73's MAR dated 11/2024 revealed on 11/02/24 the 6:00 A.M. and the 11/04/24 at 6:00 A.M. doses of cefazolin were not signed off as administered as ordered. There were no corresponding notes to indicate why the medication doses were not administered as ordered. Interview on 12/17/24 at 2:32 P.M. with the Director of Nursing (DON) confirmed the above missed doses of Resident #73's cefazolin. The DON reported the facility uses medication techs who can't administer IV medication, and she had communicated with staff to come in and administer the IV medication. The DON confirmed she had no documentation to support Resident #73's IV cefazolin doses were administered as ordered on the above dates. Review of the undated policy Medication Administration revealed the MAR is the legal documentation for medication administration. The policy stated medications are to be administered as prescribed by the provider. Medications will be charted when given. Medications that are refused or withheld or not given will be documented. Documentation of medications will follow accepted standards of nursing practice.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on observation, staff interview, medical record review, and facility policy review, the facility failed to ensure isolation laundry was handled and sanitized properly, failed to ensure infection control was maintained and enhanced barrier precautions (EBP) were implemented during tracheostomy care for Resident #53 and during medications administration for Resident #37. This had the potential to affect all residents residing in the facility who used the facility laundry, affected one resident (Resident #53) of two reviewed for tracheostomy care and affected one resident (Resident #37) of one observed for tube feeding medication administration. The facility census was 74. Findings include: 1. Review of the infection control surveillance logs revealed the last resident on isolation was on 08/20/24 for methicillin-resistant staphylococcus aureus and the last clostridium difficile was on 06/14/24. On 12/19/24 at 9:57 A.M. an interview with Laundry Staff #302 revealed she would go out to the units, get the linen barrels from the soiled linen rooms, she brought them back to the laundry room and started to sort them out into the large linen cart. She stated she wears gloves but no gown or face protection while separating. She stated she does not know anything about isolation laundry and has not had any isolation laundry in the two years she has been employed at the facility. Laundry Staff #302 stated she had never seen a red or yellow biohazard bag. She stated the washing machines were low temperature washers. On 12/19/24 at 10:00 A.M. an interview with Certified Nursing Assistant (CNA) # 179 revealed if a resident was on transmission-based (isolation) precautions, they would bag the linen up in the isolation rooms in a regular bag, bring it out to the soiled linen room, and place it in the soiled linen barrels. She stated the facility had red bags at the nurses station but they do not use them . She stated the way they handle isolation laundry just changed and they no longer have isolation barrels in the rooms. On 12/19/24 at 10:04 A.M. an interview with CNA #157 revealed the facility did not use isolation barrels in the isolation rooms anymore. CNA #157 stated they bag the isolation laundry up, bring it out to the soiled linen room, and put it in or on top the soiled linen barrel. She stated they do have red and yellow biohazard bags at the nurse station on but normally they just used the regular clear bags. On 12/19/24 at 11:54 A.M. an interview with Housekeeping Supervisor #301 revealed it was their company policy to treat all linen as isolation. She stated the isolation personals were to be in yellow or red biohazard bags. She stated the laundry personal would go out to the units and retrieve the barrels, she stated they were to be separating them with gloves, an apron and if it was isolation they were to wear goggles. She stated they only had the one cycle that had bleach administered in it and all linens were to be washed on that cycle. The isolation personal clothes were to be washed on a separate cycle with an extra additive. She verified if the facility staff were not placing the personals in the proper red or yellow biohazard bags, then the laundry staff would not be able to distinguish which was isolation and they would not be washed those linens properly. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled, Infection Control for Laundry/Linens, dated 02/24/22 revealed the purpose of the policy was to provide clarity for employees of the laundry duties and responsibilities regarding those duties as they relate to infection control and infection prevention practices at the facility. All soiled linen was considered contaminated and treated and handled as such. When sorting soiled linens, laundry staff would use Personal Protective Equipment (PPE) including gloves and an apron. 2. Review of the medical record revealed Resident #53 was admitted to the facility on [DATE]. Diagnoses included respiratory failure, hypertension, gastrostomy, tracheostomy, stage three sacral ulcer, osteomyelitis, diabetes, cerebral infarction, anoxic brain damage, conversion disorder with seizures, dysphagia, anxiety disorder, and major depressive disorder. Review of the December 2024 physician's orders revealed Resident#53 had an order dated 02/05/24 for full PPE donning, including an N-95 mask, when providing tracheostomy care and or nebulizer treatments. Observation of tracheostomy care on 12/17/24 at 12:20 P.M. revealed Registered Nurse (RN) #102 placed her supplies on Resident #53's bedside table with the suction machine, washed her hands, donned nonsterile gloves, checked Resident #53's oxygen saturation, and removed her gloves. RN #102 washed her hands and proceeded to set up her sterile field directly on the resident's bed because there was not a table present in the room. She removed Resident #53's inner tracheostomy cannula and discarded it. RN #102 then suctioned the residents with her sterile gloves on, removed her sterile gloves, washed her hands, and donned nonsterile gloves. RN #102 obtained a sterile four by four gauze, dipped the gauze into a nonsterile Styrofoam cup filled with normal saline (which she brought into the room), and cleaned Resident #53's neck, his tracheostomy faceplate, around his tracheostomy collar, and tracheostomy stoma. RN #102 removed her nonsterile gloves, washed her hands, donned nonsterile gloves and placed the tracheostomy dressing around his tracheostomy and changed his tracheostomy collar. She took off he nonsterile gloves, washed her hands, opened the new inner cannula, donned sterile gloves, placed the new inner cannula in the tracheostomy, and reapplied the resident's oxygen. RN #102 then washed her hands. On 12/17/24 at 12:30 P.M. an interview with RN #102 revealed the facility did not have complete tracheostomy cleaning kits and supplies and equipment for the procedure had to be set up separately. She verified Resident #53 was on EBP and she had not worn a gown. RN #102 additionally confirmed she had not put sterile normal saline in a sterile container, she did not wear sterile gloves while cleansing Resident #53's tracheostomy, and she set up her sterile field directly on the resident's bed. Review of the undated facility policy titled Tracheostomy Care revealed the purpose of the policy was to provide guidance for tracheostomy care. Process steps may be performed using a different sequence and does not imply incorrect procedure. Maintaining key areas of aseptic technique and working efficiently to resume oxygenation are the critical components of the process. The policy stated to maintain an aseptic (sterile) environment, to the extent possible, to reduce pathogen transmission. Open the sterile tracheostomy kit, set up sterile field, and apply sterile gloves. The policy called for the resident's faceplate to be cleansed with a sterile swab. A second swab to clean around the stoma and outer cannula, working from stoma site, outward was needed 51074 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Review of the medical record for Resident #37 revealed an admitted [DATE]. Diagnoses include acute respiratory failure with hypoxia, quadriplegia, epilepsy, dysphasia, cognitive communication deficit, and history of traumatic brain damage. Review of the Resident #37's physician's order dated 4/17/24 revealed the resident was ordered to have EBP related to the presence of percutaneous endoscopic gastrostomy (PEG) tube (a surgically placed tube into the stomach through which nutrition and medications can be administered). Review of Resident #37's care plan dated 08/02/24 revealed the resident required EBP related to the tracheostomy and PEG tube. Listed interventions included appropriate PPE will be utilized during high-contact care by caregivers which included dressing, bathing/showering, transferring, providing hygiene, changing linens, briefs, or assisting with toileting. Additional care plan focuses dated 12/17/24 noted Resident #37 was NPO (indicating nothing by mouth), required tube feedings, and was completely dependent on staff for all care. Listed interventions included to administer flushes and tube feeding per medical provider's order, administer medications via (PEG) tube per order, and maintain EBP during high-contact activities. Observation on 12/17/24 at 2:35 P.M. revealed Resident #37 had a sign on the outside of the door indicating EBP were required. Registered Nurse (RN) #102 prepared Resident #37's medications to administer via his PEG tube. Prior to administering the medications, RN #102 only applied gloves prior to entering the resident's room to administer Resident #37's medications through his PEG tube. Interview on 12/17/24 at 2:38 PM with RN #102 verified she did not wear a gown. She specified the appropriate PPE required by EBP for medication administration by PEG tube included gown and gloves. Review of the undated policy titled Medication Administration by Enteral Tube revealed section 3-d. Perform hand hygiene, apply gloves and any other PPE. Review of the undated policy titled Enhanced Barrier Precautions revealed Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employs hand hygiene, targeted gown and glove use during high contact resident care activities that include; dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any skin opening requiring a dressing.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on review of the medical record and interview with staff, the facility failed to ensure a pneumonia vaccine was given to Resident #45 after consent. This affected one resident (Resident #45) of five residents reviewed for vaccinations. The facility census was 74. Findings include: Review of the medical record revealed Resident #45 was admitted to the facility on [DATE]. Diagnoses included hypokalemia, bulbous ureteral stricture hematuria, benign prostatic hyperplasia, retention of urine, diabetes, hyperlipidemia, respiratory failure, atrial fibrillation, osteoarthritis, major depressive disorder, and dementia. Further review of the medical record revealed no evidence Resident #45 was administered the pneumonia vaccine. Review of the Consent for Immunizations of Pneumonia dated 06/28/24 revealed Resident #45 consented to receiving the pneumonia vaccine on 06/28/24. Review of the June 2024 Medication Administration Record (MAR) revealed Resident #45 had not received the pneumonia vaccine. Review of the July 2024 MAR revealed Resident #45 had not received the pneumonia vaccine. An interview on 12/18/24 at 10:13 A.M. with Infection Preventionist #115 confirmed they had not administered the pneumonia vaccine to Resident #45 on admission after he consented to receiving it.