STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365645	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health Center, The	35990 Westminster Ave North Ridgeville, OH 44039

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on medical record review, and resident and staff interview, the facility failed to ensure residents were treated with dignity and respect. This affected two (Resident #13 and #74) of four residents reviewed for dignity. The facility census was 74. Findings include: 1. Review of the medical record for Resident #13 revealed an admitted [DATE]. Diagnoses included psychosis, depression, anxiety, delusional disorders, altered mental status, heart failure, chronic kidney disease. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #13 was cognitively intact. Interview on [DATE] at 1:22 P.M. with Resident #13 stated Licensed Practical Nurse (LPN) #346 was always saying things that were sarcastic and rude. Resident #13 also reported being pretty sure LPN #346 cursed at her on an unknown date. 2. Review of the medical record for Resident #74 revealed an admitted [DATE]. The resident expired in the facility on [DATE]. Diagnoses included hypertensive heart and chronic kidney disease, heart failure, depression, anxiety, and insomnia. Review of the comprehensive Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #74 had intact cognition. Interview on [DATE] at 10:45 A.M. with Former Licensed Practical Nurse (LPN) #405 revealed they previously worked as a nurse at the facility. LPN #405 reported observing LPN #346 demanding Resident #74 to open their mouth to take medications, pushing the resident because they had been leaning, and shoving the medications into the resident's mouth. Interview on [DATE] at 4:28 P.M. with the Administrator verified they were unaware of any concerns regarding LPN #346 treating the residents. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 11:06 A.M. with Registered Nurse (RN) #355 stated LPN #346 cursed a lot and would yell at residents. RN #355 reported they heard LPN #346 yelling at an unknown resident stating take your medications mother-explicit. RN #355 verified they did not report the observation of LPN #346 yelling at the resident because everyone knew of how LPN #346 treated residents and the administrative staff did not do anything. Interview on [DATE] at 11:38 A.M. with LPN #315 stated the staff member observed LPN #346 yelling at residents and used to report it. LPN #315 was unable to report any specific resident name and/or date of incidents. This deficiency represents non-compliance investigated under Complaint Number OH00161986 and Complaint Number OH00161487.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36650 Based on medical record review, observation, resident and staff interviews, and policy review, the facility failed to ensure all residents' call lights were within reach. This affected three (Residents #14, #34, and #42) of 74 residents reviewed for call lights within reach. The facility census was 74. Findings include: 1) Review of the medical record for Resident #42 revealed an admitted [DATE]. Review of the plan of care dated 04/19/21 revealed Resident #42 was at a potential risk for falls related to dementia, bipolar and decreased safety awareness. Interventions included to ensure call light was within reach. Observation on 01/28/25 at 11:10 A.M. revealed Resident #42's call light laying on floor at the bottom of bed. Resident #42 was unable to reach the call light. Interview on 01/28/25 at 11:15 A.M. with Certified Nursing Assistant (CNA) #334 verified Resident #42's call light was at the bottom of bed and out of reach. CNA #334 stated staff were to ensure call lights were within reach and residents were able to use the call light. 2) Review of the medical record for Resident #14 revealed an admitted [DATE]. Review of the plan of care dated 02/06/24 revealed Resident #14 was at potential risk for falls related to dementia, incontinence and safety awareness. Intervention included to ensure call light was within reach. Observation on 01/28/25 at 10:49 A.M. of Resident #14's call light cord laying on the floor by the wall at the bottom of the bed. Resident #14 was unable to reach the call light. Interview on 01/28/25 at 11:11 A.M. with Certified Nursing Assistant (CNA) #334 verified Resident #14's call light was not within reach. CNA #334 stated staff were to ensure call lights were within reach and residents were able to use the call light. 3) Review of the medical record for Resident #34 revealed an admitted [DATE]. Review of the plan of care dated 02/05/24 revealed Resident #34 was at potential risk for falls related to brain damage and seizures. Intervention included to ensure call light was within reach. Observation on 01/28/25 at 10:47 A.M. of Resident #34's call light not within reach and Resident #34 stated she hurt and would like a pain medication. Interview on 01/28/25 at 11:13 A.M. with Certified Nursing Assistant (CNA) #334 verified Resident #34's call light was on the floor at the bottom of the bed and out of reach. CNA #334 stated staff were to ensure call lights were within reach and residents were able to use the call light. Review of the facility policy titled Call Lights: Accessibility and Timely Response, dated 04/01/22 revealed with each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of resident and secured.

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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** 35033 Based on review of the medical record, staff interview and policy review, the facility failed to ensure a resident's family was notified of a resident's decline in condition. This affected one (#178) of four residents reviewed for change in condition. The facility census was 74. Findings include: Review of the closed medical record for Resident #178 revealed an admitted [DATE], a readmitted [DATE] and a discharge date of [DATE]. Diagnoses included pneumonia, hypertension, and acute and chronic respiratory failure with hypoxia. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #178 had impaired cognition. Review of a physician order dated [DATE] revealed Resident #178's code status was Do Not Resuscitate Comfort Care (DNRCC). Review of nurse's note dated [DATE] at 11:16 A.M. revealed the nurse went to assess and provide resident medication and resident was noted with respiratory distress. The resident's pulse oximetry level was 80 percent on four liters via trach collar. The resident was suctioned with copious amount of thick clear sputum. Pulse oximetry level increased to ,d+[DATE] percent. The resident's inner cannula and tracheostomy care were completed and an as needed aerosol was administered. Pulse oximeter level increased to 85 percent. Resident resting comfortably with eyes closed. The nursing dated dated [DATE] at 1:02 P.M. revealed the resident had an absence of vital signs at 10:55 A.M. There was no documentation the family was notified of Resident #178's change in condition. Interview on [DATE] at 11:47 A.M., Licensed Practical Nurse (LPN) #353 stated Resident #178 had been declining. LPN #353 revealed she went to administer the residents medications around 8:30 A.M. to 8:45 A.M. and noticed the resident was in respiratory distress. LPN #353 stated she increased the resident's oxygen, suctioned the resident, and changed the inner cannula and administered an aerosol treatment. LPN #353 stated the resident had a DNRCC code status. LPN #353 stated she notified the Assistant Director of Nursing (ADON) #392 and the Director of Nursing (DON) who then administered suctioning again and another aerosol treatment. LPN #353 stated the DON and ADON #392 notified her the resident's oxygen level came back up. LPN #353 stated she periodically kept checking the resident while passing medications to other residents. LPN #353 verified she had not called the family to notify them of the decline in the resident's condition. LPN #353 stated she thought ADON #392 was going to notify the family. LPN #353 also verified she had not documented the progress note until after the resident had expired. Interview on [DATE] at 12:02 P.M. with ADON #392 and the DON stated the nurse requested assistance for Resident #178. ADON #392 and the DON stated they suctioned the resident, changed the inner cannula and provided an aerosol treatment and the resident's pulse oximetry increased to 93 percent. The DON stated LPN #353 was notified the resident's oxygen level was back up. The DON stated she then went to a meeting and was notified ten to 20 minutes later the resident had passed away. The DON verified the care she provided to the resident with ADON #392 had not been documented in the medical record. The DON stated, too many hands were in the pot. (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 [DATE] at 3:31 P.M. stated ADON #392 stated she did not notify the resident's family when Resident #178 had a decline in condition. Interview on [DATE] at 11:35 A.M. with the DON verified there was no documentation Resident #178's family was notified of the decline in condition. Review of the policy titled Notification of Changes, revised [DATE], revealed the facility would notify a resident's family member or legal representative when there was a significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental or psychosocial status. This deficiency represents non-compliance investigated under Complaint Number OH00161986.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on record review, staff interview, and policy review, the facility failed to ensure residents were provided a written notice of transfer/discharge when sent to the hospital. This affected four (#44, #46, #76, and #78) of four residents reviewed for transfer/discharge. The facility identified 32 residents who were discharged to the hospital since 05/2024. The facility census was 74. Findings include 1) Review of the medical record for Resident #78 revealed an admitted [DATE]. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #78 had intact cognition. Review of the medical record dated 07/17/24 through 10/09/24 revealed Resident #78 was discharged to the hospital on 07/17/24, 07/29/24, and 10/09/24. There was no documentation Resident #78 had been provided with a written notice of transfer/discharge when sent to the hospital Interview on 02/03/25 at beginning at 11:08 A.M. with Regional Administrator (RA) #408 verified the facility had not provided a written notice of transfer/discharge to Resident #78 and/or resident representatives when the resident went to the hospital on 07/17/24, 07/29/24, and 10/09/24. 2) Review of the medical record for Resident #46 revealed an admitted [DATE]. Review of the quarterly MDS assessment dated [DATE] revealed Resident #46 had intact cognition. Review of the medical record dated 10/07/24 through 01/13/25 revealed Resident #46 had discharged to the hospital on 10/07/24, 11/25/24, 12/05/24, 12/10/24, and 01/13/25. There was no documentation Resident #46 was provided with a written notice of transfer/discharge when sent to the hospital. Interview on 02/03/25 at beginning at 11:08 A.M. with Regional Administrator (RA) #408 verified the facility had not provided a written notice of transfer/discharge to Resident #46 and/or resident representatives when the resident went to the hospital on 10/07/24, 11/25/24, 12/05/24, 12/10/24, and 01/13/25. 3) Review of the medical record for Resident #76 revealed an admitted [DATE]. Review of the quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. Review of nurse progress notes dated 09/30/24 revealed Resident #76 was discharged to the hospital. There was no documentation Resident #76 was provided with a written notice of transfer/discharge when sent to the hospital. Interview on 02/03/25 at beginning at 11:08 A.M. with Regional Administrator (RA) #408 verified the facility had not provided a written notice of transfer/discharge to Resident #76 and/or resident representatives when the resident went to the hospital on 09/30/24. 4) Review of the medical record for Resident #44 revealed an admitted [DATE]. Review of the quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the nurse progress notes dated 10/06/24 through 02/02/24 revealed Resident #76 was discharged to the hospital on 10/06/24, 10/18/24, and 11/10/24. There was no documentation Resident #76 was provided with a written notice of transfer/discharge when sent to the hospital. Interview on 02/03/25 at 11:08 A.M. with Regional Administrator (RA) #408 verified the facility had not provided a written notice of transfer/discharge to Resident #76 and/or resident representative when the resident went to the hospital on 10/06/24, 10/18/24, and 11/10/24. RA #408 stated the facility identified the issue on the first day of the annual survey on 01/28/25 and stated the residents who went to the hospital since 05/2024 were not provided written notice of transfer/discharge when sent to the hospital. Review of the policy titled Transfer and Discharge revised 08/22/22, revealed for emergency transfers/discharges, the facility would provide a notice of transfer to the resident and representative.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on record review, staff interview, and policy review, the facility failed to ensure residents were provided a notice of bed hold policy when the resident was sent to the hospital. This affected four (#44, #46, #76, and #78) of four residents reviewed for transfer/discharge. The facility identified 32 residents who were discharged to the hospital since 05/2024. The facility census was 74. Findings include 1) Review of the medical record for Resident #78 revealed an admitted [DATE]. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #78 had intact cognition. Review of the medical record dated 07/17/24 through 10/09/24 revealed Resident #78 was discharged to the hospital on 07/17/24, 07/29/24, and 10/09/24. There was no documentation Resident #78 had been provided with a copy of the bed hold notice. Interview on 02/03/25 at beginning at 11:08 A.M. with Regional Administrator (RA) #408 verified the facility had not provided a copy of the bed hold policy to Resident #78 and/or resident representatives when the resident went to the hospital on 07/17/24, 07/29/24, and 10/09/24. 2) Review of the medical record for Resident #46 revealed an admitted [DATE]. Review of the quarterly MDS assessment dated [DATE] revealed Resident #46 had intact cognition. Review of the medical record dated 10/07/24 through 01/13/25 revealed Resident #46 had discharged to the hospital on 10/07/24, 11/25/24, 12/05/24, 12/10/24, and 01/13/25. There was no documentation Resident #46 was provided with a copy of the bed hold notice. Interview on 02/03/25 at beginning at 11:08 A.M. with Regional Administrator (RA) #408 verified the facility had not provided a copy of the bed hold policy to Resident #46 and/or resident representatives when the resident went to the hospital on 10/07/24, 11/25/24, 12/05/24, 12/10/24, and 01/13/25. 3) Review of the medical record for Resident #76 revealed an admitted [DATE]. Review of the quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. Review of nurse progress notes dated 09/30/24 revealed Resident #76 was discharged to the hospital. There was no documentation Resident #76 was provided with a copy of the bed hold notice. Interview on 02/03/25 at beginning at 11:08 A.M. with Regional Administrator (RA) #408 verified the facility had not provided a copy of the bed hold policy to Resident #76 and/or resident representatives when the resident went to the hospital on 09/30/24. 4) Review of the medical record for Resident #44 revealed an admitted [DATE]. Review of the quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the nurse progress notes dated 10/06/24 through 02/02/24 revealed Resident #76 was discharged to the hospital on 10/06/24, 10/18/24, and 11/10/24. There was no documentation Resident #76 was provided with a copy of the bed hold notice. Interview on 02/03/25 at beginning at 11:08 A.M. with Regional Administrator (RA) #408 verified the facility had not provided a copy of the bed hold policy to Resident #76 and/or resident representative when the resident went to the hospital on 10/06/24, 10/18/24, and 11/10/24. RA #408 stated the facility identified the issue on the first day of the annual survey on 01/28/25 and stated the residents who went to the hospital since 05/2024 were not provided a bed hold notice. Review of the policy titled Bed Hold Notice Upon Transfer revised 06/01/24, revealed at the time of transfer for hospitalization s, the facility would provide the facility's written bed hold policy to the resident and representative.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on staff interview, record review, and review of the facility policy, the facility failed to ensure a care plan was completed for Resident #61 to include depression, anxiety, and the use of psychotropic medications. This affected one (Resident #61) of 27 residents reviewed for care plans. The facility census was 74. Findings include: Review of the medical record for Resident #61 revealed an admitted [DATE]. Diagnoses included delirium, dementia without behavioral disturbance, psychotic disturbance and mood disturbance, and major depressive disorder. Review of Resident #61's care plan initiated on 11/13/24 revealed the resident's anxiety, depression, behaviors, and use of antipsychotic and psychotropic medications were not addressed in the comprehensive care plan. Review of the physician orders revealed the following psychotropic medications: on 11/04/24, an order for quetiapine 50 milligrams (mg) at bedtime for anxiety. On 11/09/24, an order for Zoloft 25 mg in the morning for dementia and anxiety and Depakote sprinkles 125 mg at bedtime for delirium, dementia and anxiety. On 11/28/24 the order for the quetiapine was updated for the diagnosis of unspecified dementia and anxiety. On 01/22/25, the Zoloft diagnosis was noted as depression. On 01/22/25, the Depakote sprinkles had a diagnosis for behaviors. Interview on 02/04/25 at 9:48 A.M. with Minimum Data Set (MDS) Nurse #354 stated she began working in the facility three weeks ago and did not have a chance to review all the previous care plans. MDS Nurse #354 verified Resident #61 had no care plan in place for depression, anxiety, behaviors, and for the use of antipsychotic and psychotropic medications. Review of the policy titled Comprehensive Care Plans, revised 06/01/24, revealed the comprehensive care plan would include the service to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42011 Based on resident and staff interview, record review, and review of the facility policy, the facility failed to have routine/scheduled care plan meetings for the residents and/or resident representative in 2024. This affected one (Resident #51) of one resident reviewed for care plan meetings. The facility identified all residents residing at the facility with the exception of 18 residents admitted after November 2024 (Residents #17, #18, #23, #24, #29, #34, #45, #51, #53, #59, #61, #66, #65, #135, #179, #181, #182, and #183) did not have care conferences in 2024. The facility census was 74. Findings include: Record review for Resident #51 revealed an admitted [DATE]. Diagnoses included displaced midcervical fracture of the left femur, atrial fibrillation, and hemiplegia and hemiparesis following cerebral infarction. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 was moderately cognitively impaired. Resident #51 had impairment on both sides of the lower extremities. Interview on 01/28/25 at 2:08 P.M. with Resident #51 stated he was not invited to a care plan meeting that he could recall. Record review for Resident #51 revealed the last care plan meeting was documented 08/18/23 at 8:03 A.M. Interview on 02/03/25 at 12:47 P.M. with Licensed Social Worker (LSW) #330 confirmed Resident #51 or his responsible party did not have a care plan meeting at all in 2024. LSW #330 stated several other residents also did not have a care plan meeting or did not have quarterly care plan meetings in 2024 prior to November 2024. LSW #330 provided a list which included residents who did not have all quarterly care plan meetings in 2024 and new admission residents. LSW #330 identified all residents, with the exception of new admissions (Resident #17, #18, #23, #24, #29, #34, #45, #51, #53, #59, #61, #66, #65, #135, #179, #181, #182, and #183) did not have the annual and quarterly care plan meetings. Interview on 02/03/25 at 1:10 P.M. with Regional Director of Clinical Services (RDCS) #615 confirmed care plan meetings were not consistently completed for residents residing in the facility in 2024. RDCS #615 revealed the meetings should have been completed at the minimum quarterly for each resident. Review of the facility policy titled titled Care Planning-Resident Participation dated 06/01/24 revealed the facility will discuss the plan of care with the resident and or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. This deficiency represents non-compliance investigated under Complaint Number OH00161487 and Complaint Number OH00161986.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on resident and staff interview, record review, and review of the facility policy the facility failed to ensure a resident who required assistance from staff with activities of daily living received the care and services with bathing/showers. This affected one (Resident #182) of three residents reviewed for bathing/showers. The facility census was 74. Findings include: Record review for Resident #182 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included presence of right artificial hip joint and encounter for orthopedic aftercare. Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #182 was cognitively intact. Resident #182 had impairment on one side of the lower extremity. Resident #182 was dependent on staff for showering/bathing. Review of the care plan dated 11/21/24 revealed Resident #182 had no care plan for activities of daily living (ADL). Review of the physician orders for Resident #182 dated 11/24/24 revealed skin checks weekly with showers on Mondays and Thursdays. Review of the shower/bath schedule for Resident #182 revealed Resident #182 was scheduled to receive a shower 11 times on 11/25/24, 11/28/24, 12/02/24, 12/05/24, 12/09/24, 12/12/24, 12/16/24, 12/19/24 12/23/24, 12/26/24 and 12/30/24. Review of the Shower/Tub Bath/Bed Bath Sheets provided by Regional Registered Nurse (RRN) #410 revealed Resident #182 was not offered a shower/bath six times on 11/25/24, 11/28/24, 12/05/24, 12/09/24, 12/12/24, 12/23/24, and 12/30/24. There were no other records indicating the resident was offered a shower or bath on other days of the week. Interview on 02/03/25 at 2:00 P.M. with Resident #182 stated he was admitted to the facility to recuperate from a shattered femur. Resident #182 stated after his admission, three days went by before he was offered a toothbrush and 15 days went by before he was even offered a shower or bath. Interview on 02/06/25 at 11:40 A.M. with RRN #410 stated each resident was scheduled showers/baths weekly. Resident #182 was scheduled two showers/baths a week. When the shower/bath was offered and or completed, the Shower/Tub Bath/Bed Bath Sheet was filled out and signed by the Certified Nursing Assistant (CNA) and the Licensed Nurse, even if the resident refused. RRN #410 confirmed only four Shower/Tub Bath/Bed Bath Sheets were completed for Resident #182 confirming Resident #182 was offered a shower/bath only four of the scheduled 11 to be offered. Interview on 02/06/25 at 12:00 P.M. with CNA #307 confirmed she cared for Resident #182 during his stay at the facility. CNA #307 stated some days there were enough staff to offer showers and other days there were not. CNA #307 stated if there was not enough staff then showers were not done because there was just not enough time to get to them. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Activities of Daily Living, reviewed/revised 01/01/25, revealed care and services will be provided for the following activities of daily living: Bathing, dressing, grooming, and oral care. This deficiency represents non-compliance investigated under Complaint Number OH00161986.

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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** 42011 Based on observation, family and staff interview, record review, and review of the facility policy, the facility failed to ensure physician ordered compression socks were implemented for Resident #55 and failed to timely provide care and treatment to treat a resident's excessive sweating causing skin issues. This affected two (Residents #54 and #55) of seven residents reviewed for care and services. The facility census was 74. Findings include: 1. Record review for Resident #55 revealed an admitted [DATE]. Diagnoses included Parkinson's disease, dementia, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 was severely cognitively impaired. Resident #55 had impairment on both sides of the upper and lower extremities. Resident #55 was dependent on staff for personal hygiene. Review of the care plan for Resident #55 dated 05/15/23 and revised 07/17/24 revealed an intervention was to apply TED (thrombo-embolic deterrent; type of compression stocking that helps prevent blood clots in the legs) hose in the morning and remove them at night. Review of the physician orders for Resident #55 dated 03/27/24 revealed an order to apply TED hose knee high on in the morning and off in the evening for deep vein thrombosis (DVT) prophylactic. Observation on 01/30/25 at 12:55 P.M. revealed Certified Nursing Assistant (CNA) #401 pushed Resident #55's Broda chair from the dining room to the lounge. Resident #55's feet were dangling and Resident #55 did not have TED hose on. Continued observation on 01/30/25 from 1:28 P.M. through 2:23 P.M. revealed Resident #55 stayed in the lounge in the Broda chair in the upright position with his feet dangling. No staff addressed Resident #55 to offer care. Record review on 01/30/25 at 2:17 P.M. of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for 01/30/25 revealed Licensed Practical Nurse (LPN) #353 signed the orders as completed for Resident #55 to apply TED hose knee high on in the morning and off in the evening for DVT prophylactic. Observation on 01/30/25 at 2:24 P.M. revealed CNA #357 and #395 assisted Resident #55 to his room. CNA #357 confirmed she was Resident #55's primary CNA and stated she assisted Resident #55 up out of bed at 6:30 A.M. that day (01/30/25). CNA #357 and #395 stated Resident #55 never wore TED hose, they had both worked with him over the past six months and he never wore TED hose. Interview on 01/30/25 at 2:37 P.M. with Licensed Practical Nurse (LPN) #353 confirmed she was Resident #55's Charge Nurse. LPN #353 verified Resident #55 was supposed to wear TED hose daily but she was not sure if they were on him because she does not look. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/04/25 at 4:52 P.M. with Registered Nurse Supervisor (RNS) #308 confirmed Resident #55 did not have his TED hose on. RNS #308 stated she told the CNA earlier in the day to apply the TED hose, the CNA informed her there was none in his room to apply so she told the CNA she would get him some out of stock but she just had not done it yet. Observation with RNS #308 confirmed Resident #55 did not have any TED hose available in his room to be applied. RNS #308 confirmed the TED hose was signed in the medical record as being applied in the A.M. 2. Record review for Resident #54 revealed an admitted d of 05/30/23. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #54 was rarely or never understood. Resident #54 was dependent on staff for activities of daily living (ADLs). Resident #54 had an indwelling catheter and was always incontinent of bowel. Resident #54 had moisture associated skin damage (MASD) and received applications of ointments/medications. Review of the care plan dated 12/18/23 revealed Resident #54 required assistance for activities of daily living. Interventions included to inspect skin condition daily during personal care and report any impaired areas to charge nurse. Resident #54 was totally dependent on staff and does not participate in any aspect of the task including toileting hygiene or personal hygiene. Resident #54 experiences bowel incontinence interventions included to provide incontinence care every two hours and as needed. Resident #54 had potential for alteration in skin integrity: required protective/preventative skin care maintenance related to bowel incontinence, decreased mobility, apply house moisture barrier as ordered, assist with cleansing the peri area and apply the house protective barrier after each episode of incontinence. There was no mention of Resident #54 having an issue with excessive sweating. Record review of the physician orders for Resident #54 revealed venelex external ointment apply to sacrum topically two times a day for prevention dated 11/15/23. Record review of the medical record for Resident #54 revealed no documentation of excoriation to the buttocks or moisture-associated skin damage (MASD). Interview on 01/28/25 at 12:44 P.M. with Resident #54's spouse stated she was concerned about the rash on Resident #54's bottom, she felt Resident #54 was not being changed enough. Interview on 01/30/25 at 12:01 P.M. with CNA #395 stated Resident #54 had an indwelling catheter and only needed changed if he had a bowel movement. Resident #54 had not had a bowel movement so there was no need to change him that day. Observation and interview on 02/05/25 at 11:07 A.M. revealed CNA #357 and #395 were completing a brief change for Resident #54. Resident #54 was wet with sweat on his shirt and in his brief. CNA #357 and #395 stated Resident #54 always sweats and that was why his bottom was wet and very red. Observation revealed Resident #54's bilateral buttocks was deep red/discoloration with open excoriated areas to bilateral buttocks. CNA #357 and #395 stated Resident #54 was unable to move without assistance. (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 02/05/25 at 12:58 P.M. with Wound Care Certified Nurse Practitioner (CNP) #611 confirmed she assessed Resident #54 on this day and observed the buttocks was discolored and diagnosed with MASD; MASD was caused by moisture, the moisture could be caused by the sweating, and the area needed to be kept clean and dry. Interview on 02/06/25 at 11:36 A.M. with Regional Registered Nurse (RRN) #410 confirmed there was no documentation of MASD in Resident #54's medical record and stated it looked like it comes and goes because the venelex external ointment, ordered in November 2023 was used for the MASD. RRN #410 stated each time Resident #54 had MASD, the nurses should have measured, monitored, and documented the areas. Interview on 02/06/25 at 11:56 A.M. with Licensed Practical Nurse (LPN) #361 stated Resident #54's excoriation (MASD) comes and goes on Resident #54's buttocks and it has been going on for at least six months. LPN #361 stated it was from his sweat. This deficiency represents non-compliance investigated under Complaint Number OH00161986.

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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** 36650 Based on medical record review, observation, and resident and staff interview, the facility failed to ensure a resident received the appropriate treatment and services to maintain/improve mobility according to physician orders. This affected one (Resident #26) of one resident reviewed for range of motion. The facility census was 74. Findings include: Review of the medical record for Resident #26 revealed an admitted [DATE]. Diagnoses included left hand contracture. Review of the physician orders for February 2025 revealed palm protective splint to left hand on in the PM and off in the AM, activated on 01/20/23. Review of the plan of care revealed Resident #26 required assistance with needed for activities of daily living (ADL) related to decreased range of motion to left hand. Interventions included palm protective splint to left hand on in the PM and off in the AM. Observation and interview on 01/28/25 at 2:51 P.M. revealed Resident #26 was propelling self in her wheelchair down the hall and her left hand was contracted and no splint was on. Interview with Resident #26 stated the staff have not put her splint, on for months. Staff were unable to find her splint, so she has not been able to wear it. Resident #26 stated if staff can find her splint she would like to wear it. Observation and interview on 02/05/25 at 5:40 A.M. revealed Resident #26 was lying in bed and not wearing her left palm splint. The resident stated the certified nursing aide (CNA) did not put her splint on when she went to bed the night before (02/04/25). Interview on 02/05/25 at 5:40 A.M. with Licensed Practical Nurse (LPN) #367 verified Resident #26 was to have a splint or rolled up towel in her left hand at night. LPN #367 verified Resident #26 was not wearing her splint and did not have a rolled-up washcloth in her hand.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, staff interview, record review and review of the facility policy, the facility failed to prevent an avoidable fall with minor injury for Resident #54, failed to ensure fall interventions were in place for Resident #54 who was at a fall risk, and did not complete a thorough fall investigation into Resident #173' fall. This affected two (Residents #54 and #173) of three residents reviewed for falls. The facility census was 74. Findings include: 1) Record review for Resident #54 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side, aphasia, muscle weakness, tracheostomy, cerebral infarction, and acute respiratory failure. Review of the care plan created 06/05/23 revealed Resident #54 was totally dependent on staff for ADLs and does not participate in any aspect of the task for bed mobility. Interventions included to use two persons assistance for repositioning, hygiene and bathing. The care plan was revised on 12/18/23 revealed Resident #54 had a potential risk for falls. Interventions included bed to be in the lowest position while occupied. Ensure call light within reach at all times. Review of the significant change Minimum Dat Set (MDS) assessment dated [DATE] revealed Resident #54 was unable to complete the cognitive interview. Resident #54 was dependent on staff for all activities of daily living (ADLs), Resident #54 had impairment on one side of the upper and lower extremities, was dependent for bed mobility and personal hygiene. Resident #54 had no falls since admission. Review of the Fall Risk Evaluation dated 12/05/24 at 2:54 P.M. completed by Licensed Practical Nurse (LPN) #613 revealed Resident #54 was a moderate risk for falls. Review of the progress note for Resident #54 dated 12/31/24 at 5:00 A.M. completed by LPN #394 included the certified nursing aide (CNA) called the nurse into the room stating the resident had rolled out of bed while being given a bed bath. This nurse went to assess the resident and witnessed the resident on the left side of the bed on the floor. The resident had a large skin tear on his left forearm. The nurse attempted to clean the area and wrap it up. Review of the Skin Grid Non-Pressure form for Resident #54 dated 12/31/24 at 9:42 A.M. completed by Registered Nurse Supervisor (RNS) #308 revealed the left forearm skin tear, was newly acquired on 12/31/24, measuring 9.7 centimeters (cm) in length by 3.3 cm in width. Moderate amount of drainage, attempted to place skin back in place, open. Observation on 01/30/25 at 11:05 A.M. revealed Resident #54 was lying in a bed, and the bed was positioned in the high position. There were no staff or visitors present in Resident #54's room. Observation on 01/30/25 at 11:07 A.M. with CNA #401 confirmed Resident #54's bed was left in the high position. CNA #401 stated the bed should be in the lowest position. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone interview on 01/30/25 at 4:00 P.M. with LPN #394 stated she did remember the incident on 12/31/24 when Resident #54 fell out of bed. LPN #394 stated the CNA was giving Resident #54 a bed bath when Resident #54 rolled out of bed. LPN #394 confirmed the CNA was working with Resident #54 by himself, and no staff were assisting with the care. Interview 02/05/25 at 10:30 A.M. with RNS #308 confirmed the left arm skin tear was obtained from the fall on 12/31/24. Interview with Regional Registered Nurse (RRN) #410 on 02/05/25 at 11:01 A.M. confirmed Resident #54 was to have two staff members to assist with bed mobility and bathing on 12/31/24 when Resident #54 fell out of bed. RRN #410 confirmed there was only one staff member providing the bathing and bed mobility when Resident #54 fell out of bed and stated she believed it was not communicated to the staff that Resident #54 required two-persons assistance with ADL care. Review of the facility policy titled Fall prevention and Management revised 01/08/25 revealed each resident will be assessed for fall risk on admission, quarterly, after any fall and as needed. If risks are identified, preventative measures will be put into place and added to the resident's care plan. Individualized interventions will be implemented based on assessment and risk factors. Interventions will be monitored for effectiveness. 36650 2) Review of the medical record for Resident #173 revealed an admitted [DATE] and discharged on [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left dominant side and muscle weakness. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #173 had intact cognition. Review of the fall investigation completed on 08/12/24 revealed Resident #173 was found on the floor in bedroom and stated he was trying to get in his dresser drawer and the drawer was stuck. Resident #173 tried to pull it open and he leaned forward and fell . Review of Registered Nurse (RN) #381 witness statement dated 08/12/24 revealed Resident #173 stated he was attempting to open dresser drawer, it was stuck, and he pulled too hard and he fell on his left shoulder. Review of the fall investigation did not have witness statement from the Certified Nurses Assistant (CNA) that found Resident #173 nor a statement from Resident #173. Interview on 01/30/25 at 11:24 A.M. with Resident #173's wife via telephone stated on 08/12/24, Resident #173 called her and stated he fell out of the Hoyer oft. When the CNA used a Hoyer pad, the one strap was broke and when she lifted him to be put in the wheelchair, the strap completely broke and he fell laying on the wheels of the Hoyer. Interview on 01/30/25 at 11:59 A.M. with Resident #173 via telephone stated he fell out of the Hoyer during a transfer. He stated he was up in the air and he fell when the Hoyer pad strap completely broke and he fell landing on the wheels of the Hoyer. His left shoulder hit the Hoyer wheels and it still hurts. The facility did an X-ray at the facility of his shoulder and it came back negative. Then they came back about a week later and said he had a dislocated shoulder, and someone pulled his arm and put his shoulder back in place. There was just one CNA using the Hoyer when he fell . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/30/24 at 4:10 P.M. with the Director of Nursing (DON) verified she did not have a statement from the CNA #381 that was working on 08/12/24 at the time of Resident #173's fall and did not have a statement from Resident #173. The DON verified all staff that were working during the fall should be interviewed regarding the fall incident to ensure a accurate and full investigation was completed. Interview on 01/30/24 at 8:15 A.M. with the Regional Administrator #407, Regional Nurse #408 stated CNA #381 stated she filled out a statement on 08/12/24 for Resident #173's fall. Regional Administrator #407 stated they were unable to find any statement for CNA #381. Interview on 01/30/24 at 10:00 A.M. with CNA #381 stated she was the CNA that found Resident #173 on the floor when he pulled too hard on his drawer and fell out of his wheelchair. CNA #381 stated she wrote a statement on the day of the fall. CNA #381 denied that she was using the Hoyer and the strap on the Hoyer pad breaking. Interview on 02/03/25 at 10:40 A.M. via telephone with Registered Nurse (RN) #380 stated she was the nurse that went in to Resident #173's room after he fell out of his wheelchair. RN #380 stated Resident #173 stated he was trying to open his drawer and fell out of his wheelchair hitting his left shoulder on the ground. RN #380 stated she could not remember anything else if it was not written on the witness statement. Review of the facility policy titled Fall Prevention and Management Policy, dated 01/08/25 revealed that in the event of a fall, the resident will be assessed by a nurse the Physician/Nurse Practitioner and the responsible party will be notified and an intervention aimed to prevent further falls will be implemented. Details of the fall will be gathered and documentation completed as indicated. This deficiency represents non-compliance investigated under Complaint Number OH00161986.

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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** 42011 Based on record review, observations, resident, family, and staff interview, and policy review, the facility failed to ensure the resident's indwelling catheter tubing was secured to the resident to prevent dislodgement of the urinary catheter. Additionally, the facility failed to ensure residents receive timely incontinence care. This affected two (Resident #5 and #47) of three residents reviewed for indwelling catheters and two (Residents #55 and #181) of three residents reviewed for incontinence care. The facility identified seven residents who have an indwelling catheters. The facility census was 74. Findings include: 1) Record review for Resident #181 revealed an admitted [DATE]. Diagnoses included atrial fibrillation, atherosclerotic heart disease of native coronary artery, and chronic kidney disease. Review of the care plan dated 01/16/25 revealed Resident #181 experienced bowel and/or bladder incontinence. Interventions included to provide incontinence care every two hours and as needed. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #181 was cognitively intact. Resident #181 required partial/moderate assistance with toileting hygiene, personal hygiene, and transfers. Resident #181 was occasionally incontinent of urine and frequently incontinent of bowel. Interview on 01/29/25 at 3:25 P.M. with Certified Nursing Assistant (CNA) #309 stated at times the facility did not have enough staff to complete resident's care timely including incontinence care and not being assisted to bed timely. CNA #309 stated yesterday (01/28/25), while she went to the dining room to assist with meals, that only left one CNA on the floor to assist the residents. Last Thursday (01/23/25), the assigned CNA #399 refused to change Resident #181 during dinner service. Starting at 4:00 P.M., CNA #309 was assigned to the dining room. LPN #364 went into Resident #181's room and turned her call light off twice. Resident #181 had diarrhea and needed changed. LPN #364 did not assist the resident and no one told her Resident #181 needed changed. At 5:20 P.M., Resident #181 was passed a meal tray by CNA #399. CNA #399 told her she could not change her while dinner was being passed. Resident #181 tried to refuse her dinner tray hoping she would then be able to be changed. CNA #399 said no she had to pass trays. CNA #309 was in the dining room, and Resident #181's husband came and got her (CNA #309) around 6:15 P.M. and CNA #309 changed her. Resident #181 had stool everywhere. Interview on 01/29/25 at 3:40 P.M. with Resident #181 stated she was sitting up in her chair in her room. Resident #181 stated she had diarrhea really bad last Thursday (01/23/25) and after she put her call light on, an unidentified CNA came into her room, turned her call light off and said she was giving a shower. Resident #181 stated she waited about a half hour sitting in diarrhea and then the CNA came back in and said she had to wait until after dinner to avoid cross contamination. Resident #181 said it took a few hours for her to receive incontinence care. Resident #181 stated it was very upsetting and embarrassing when she had to sit in diarrhea and no one would help her. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/29/25 at 4:03 P.M. with Licensed Practical Nurse (LPN) #364 confirmed she worked the previous Thursday (01/23/25) at dinner time when Resident #181 had diarrhea and needed changed. LPN #364 stated she never shut the call light off. LPN #364 stated Resident #181 said she needed changed, CNA #399 went in there, and told Resident #181 it was dinner. LPN #364 explained during dinner, generally they do not change residents, and the residents need to wait until after the meal. Interview on 02/06/25 at 11:10 A.M. with Regional Nurse (RN) #410 stated if a resident was incontinent and staff were passing trays, she would expect the staff member to get assistance so the resident could be changed at the time the resident was incontinent. The resident should not have to wait until after meal service to receive incontinence care. 2) Record review for Resident #55 revealed an admitted [DATE]. Diagnoses included Parkinson's disease, dementia and muscle weakness. Review of the care plan for Resident #55 dated 05/15/23 and revised 07/17/24 revealed Resident #55 was totally dependent on staff for activities of daily living and does not participate in locomotion in wheelchair, provide incontinence care with routine rounds and as needed. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 was severely cognitively impaired. Resident #55 had impairment on both sides of the upper and lower extremities. Resident #55 was dependent for toileting hygiene, personal hygiene, and transfers. Resident #55 required substantial/maximal assistants for bed mobility and was frequently incontinent of urine and always incontinent of bowel. Review of the physician orders for Resident #55 dated 01/14/25 revealed to check and change Resident #55 every two hours to offload coccyx - peri area. Resident #55 was to be up in the Broda chair (a chair that provides comfort, support, and mobility) for a maximum of four hours a day. An order dated 07/10/24 revealed to encourage Resident #55 to let staff put him back to bed after lunch. Interview and observation on 01/30/25 at 11:14 A.M. with Resident #55's wife revealed she visited Resident #55 frequently. Resident #55 was supposed to be changed every two hours, the staff get him up at 5:00 A.M. every morning and he would sit in the chair all day without being laid down or changed. Observation with Resident #55's wife revealed Resident #55 was sitting in the Broda chair in an upright position sleeping in the dining room. Observations revealed on 01/30/25 at 11:56 A.M., Resident #55 was still sitting in the Broda chair in an upright position sleeping in the dining room. The meal was not served. On 01/30/25 at 12:54 P.M., Resident #55 was still sitting in the Broda chair in an upright position sleeping in the dining room. The meal was completed and the tray was removed. On 01/30/25 at 12:55 P.M., Certified Nursing Assistant (CNA) #401 pushed Resident #55's Broda chair from the dining room to the lounge. CNA #401 did not offer Resident #55 to lay down after lunch, after taking him in the lounge. CNA #401 left Resident #55 in the Broda in the upright position in the lounge. Continuous observations on 01/30/25 from 1:28 P.M. through 2:23 P.M. revealed Resident #55 stayed in the lounge in the Broda chair in the upright position with his feet dangling. No staff addressed Resident #55 to offer care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on 01/30/25 at 2:17 P.M. of Resident #55's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for 01/30/25 revealed Licensed Practical Nurse (LPN) #353 signed the orders as completed for Resident #55 to check and change Resident #55 every two hours to offload coccyx - peri area, to be up in the Broda chair for a maximum of four hours a day, and to encourage Resident #55 to let staff put him back to bed after lunch. Observation and interview on 01/30/25 at 2:24 P.M. revealed CNA #357 and #395 assisted Resident #55 to his room. CNA #357 confirmed she was Resident #55's primary CNA and stated she assisted Resident #55 up out of bed at 6:30 A.M. that day (01/30/25) CNA #357 confirmed this was the first time today she laid Resident #55 down and confirmed she did not check or change him either until now. CNA #357 stated she thought hospice was in earlier and changed him. CNA #357 stated she was busy and did not have time. Observation of incontinence care provided by CNA #357 and #395 revealed Resident #55's brief was saturated with urine. Resident #55's pants were also wet and CNA #395 confirmed the seat cushion in the Broda chair was also wet with urine. Resident #55's scrotum and peri area were red. CNA #357 stated Resident #55 gets up again before dinner and will stay up until laid down by the next shift. Interview on 01/30/25 at 2:37 P.M. with Licensed Practical Nurse (LPN) #353 confirmed she was Resident #55's Charge Nurse. LPN #353 stated the hospice aid was in today and provided care for Resident #55 then left between 7:00 A.M. and 7:30 A.M. LPN #353 stated she was not sure how long Resident #55 was to be up in the chair, maybe two or three hours. LPN #353 confirmed she signed all orders on MAR and TAR as completed for 01/30/25. Observation on 02/04/25 at 4:52 P.M. with Registered Nurse (RN) Supervisor #308 confirmed Resident #55 was sitting up in his chair. Review of the facility policy titled Incontinence reviewed 07/01/24 revealed based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services. 35768 3) Review of the medical record for Resident #5 revealed an admitted [DATE]. Diagnoses included dementia, generalized anxiety, and retention of urine. Resident #5 had impaired cognition. Review of the plan of care dated 07/24/24 revealed Resident #5 had the potential for complications related to the use of indwelling catheter. Interventions included to assist with catheter care as needed, follow facility policy for enhanced barrier precautions and observe for signs and symptoms of infections. Review of the physician order dated 09/26/24 revealed staff were to provide catheter care every shift and as needed. Observation and interview on 02/03/25 at 11:45 A.M. revealed Resident #5's tubing was not secured to the resident. Licensed Practical Nurse (LPN) #369 verified the tubing for the catheter was not secured to the resident. LPN #369 stated she would secure the tubing. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4) Review of medical record for Resident #47 revealed an admitted [DATE]. Diagnoses included obstructive and reflux uropathy. Resident #47 had intact cognition. Review of the plan of care dated 11/06/24 revealed Resident #47 had the potential for complications related to the use of indwelling catheter. Interventions included to assist with catheter care as needed, follow facility policy for enhanced barrier precautions and observe for signs and symptoms of infections. Review of the physician order dated 10/05/24 revealed staff were to provide catheter care every shift and as needed. Observation on 02/03/25 at 12:01 P.M. revealed Licensed Practical Nurse (LPN) #359 verified Resident #47's tubing for the catheter was not secured to the resident. LPN #369 stated she would secure the tubing. This deficiency represents non-compliance investigated under Complaint Number OH00161986 and OH00161487.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, resident, family, and staff interview, record review, and review of the facility assessment, the facility failed to provide sufficient staffing to consistently meet the resident's needs. This affected three (Residents #55, #181, and #182) and had the potential to affect all 74 residents residing at the facility. Findings include: 1) There was inadequate staff to complete timely incontinence care and bathing/showering for the residents. 1a. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #181 was cognitively intact. Resident #181 required partial/moderate assistance with toileting hygiene. Resident #181 was occasionally incontinent of urine and frequently incontinent of bowel. Interview on 01/29/25 at 3:25 P.M. with Certified Nursing Assistant (CNA) #309 stated at times the facility did not have enough staff to complete resident's care timely including incontinence care and not being assisted to bed timely. CNA #309 stated yesterday (01/28/25), while she went to the dining room to assist with meals, that only left one CNA on the floor to assist the residents. Last Thursday (01/23/25), the assigned CNA #399 refused to change Resident #181 during dinner service. Resident #181 had diarrhea and needed changed. At 5:20 P.M., Resident #181 passed a meal tray by CNA #399. CNA #399 told her she could not change her while dinner was being passed. Resident #181 tried to refuse her dinner tray hoping she would then be able to be changed. CNA #399 said no she had to pass trays. CNA #309 was in the dining room, and Resident #181's husband came and got her (CNA #309) around 6:15 P.M. and CNA #309 changed her. Resident #181 had stool everywhere. Interview on 01/29/25 at 3:40 P.M. with Resident #181 stated she had diarrhea really bad last Thursday (01/23/25) and after she put her call light on, an unidentified CNA came into her room, turned her call light off and said she was giving a shower. Resident #181 said it took a few hours for her to receive incontinence care. Resident #181 stated it was very upsetting and embarrassing when she had to sit in diarrhea, and no one would help her. Resident #181 stated there were times staff did not assist timely when she requested care. Interview on 01/29/25 at 4:03 P.M. with Licensed Practical Nurse (LPN) #364 confirmed she worked the previous Thursday (01/23/25) at dinner time when Resident #181 had diarrhea and needed changed. LPN #364 stated Resident #181 said she needed changed, CNA #399 went in there, and told Resident #181 it was dinner. LPN #364 explained during dinner, generally they do not change residents, and the residents need to wait until after the meal. Interview on 02/06/25 at 11:10 A.M. with Regional Nurse (RN) #410 stated if a resident was incontinent and staff were passing trays, she would expect the staff member to get assistance so the resident could be changed at the time the resident was incontinent. The resident should not have to wait until after meal service to receive incontinence care. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1b. Review of the quarterly MDS assessment dated [DATE] revealed Resident #55 was severely cognitively impaired. Resident #55 had impairment on both sides of the upper and lower extremities. Resident #55 was dependent on staff for toileting hygiene and was frequently incontinent of urine and always incontinent of bowel. Review of the physician orders for Resident #55 dated 01/14/25 revealed to check and change Resident #55 every two hours to offload coccyx - peri area. Resident #55 was to be up in the Broda chair (a chair that provides comfort, support, and mobility) for a maximum of four hours a day. An order dated 07/10/24 revealed to encourage Resident #55 to let staff put him back to bed after lunch. Interview and observation on 01/30/25 at 11:14 A.M. with Resident #55's wife revealed she visited Resident #55 frequently. Resident #55 was supposed to be changed every two hours, the staff get him up at 5:00 A.M. every morning and he would sit in the chair all day without being laid down or changed. Observation with Resident #55's wife revealed Resident #55 was sitting in the Broda chair in an upright position sleeping in the dining room. Observations revealed on 01/30/25 at 11:56 A.M., Resident #55 was still sitting in the Broda chair in an upright position sleeping in the dining room. On 01/30/25 at 12:55 P.M., Certified Nursing Assistant (CNA) #401 pushed Resident #55's Broda chair from the dining room to the lounge. Continuous observations on 01/30/25 from 1:28 P.M. through 2:23 P.M. revealed Resident #55 stayed in the lounge in the Broda chair in the upright position with his feet dangling. No staff addressed Resident #55 to offer care. Observation and interview on 01/30/25 at 2:24 P.M. revealed CNA #357 and #395 assisted Resident #55 to his room. CNA #357 confirmed she was Resident #55's primary CNA and stated she assisted Resident #55 up out of bed at 6:30 A.M. that day (01/30/25) CNA #357 confirmed this was the first time today she laid Resident #55 down and confirmed she did not check or change him until now. CNA #357 stated she was busy and did not have time. 1c. Review of the physician orders for Resident #182 dated 11/24/24 revealed skin checks weekly with showers on Mondays and Thursdays. Review of the shower/bath schedule for Resident #182 revealed Resident #182 was scheduled to receive a shower 11 times on 11/25/24, 11/28/24, 12/02/24, 12/05/24, 12/09/24, 12/12/24, 12/16/24, 12/19/24 12/23/24, 12/26/24 and 12/30/24. Review of the Shower/Tub Bath/Bed Bath Sheets provided by Regional Registered Nurse (RRN) #410 revealed Resident #182 was not offered a shower/bath six times on 11/25/24, 11/28/24, 12/05/24, 12/09/24, 12/12/24, 12/23/24, and 12/30/24. There were no other records indicating the resident was offered a shower or bath on other days of the week. Interview on 02/03/25 at 2:00 P.M. with Resident #182 stated he was admitted to the facility to recuperate from a shattered femur. Resident #182 stated 15 days went by before he was even offered a shower or bath. Interview on 02/06/25 at 11:40 A.M. with RRN #410 stated each resident was scheduled showers/baths weekly. Resident #182 was scheduled two showers/baths a week. RRN #410 confirmed only four Shower/Tub Bath/Bed Bath Sheets were completed for Resident #182 confirming Resident #182 was offered a shower/bath only four of the scheduled 11 to be offered. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 02/06/25 at 12:00 P.M. with CNA #307 confirmed she cared for Resident #182 during his stay at the facility. CNA #307 stated some days there were enough staff to offer showers and other days there were not. CNA #307 stated if there was not enough staff then showers were not done because there was just not enough time to get to them. 2) Review of the Payroll Based Journal (PBJ) Staffing Data Report for the fourth quarter for 2024 revealed excessively low weekend staffing was triggered (Submitted Weekend Staffing data was excessively low). Review of the Facility Assessment (FA) dated 11/22/24 approved by Administrator and Medical Director #614 and reviewed by Quality Assurance and Assessment (QAA) Committee dated 11/26/24 revealed the purpose of the assessment is to determine what resources are necessary to care for our residents competently both day to day operations (including nights and weekends) and emergencies. The assessment addressed the following elements: The facility's resident population, including but not limited to the number of residents and the facility's resident capacity. The care required by the resident population using evidence-based data, data driven methods that consider the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within the population, consistent with and informed by individual resident assessments. The FA included staffing needs as per shift using the ratio of staff to residents: Night shift: registered nurse (RN) 1:40, LPN 1:40, and CNA 1:14 Day shift: RN 1:22, LPN 1:22, and CNA 1:8 Evening shift: RN 1:22, LPN 1:22, and CNA 1:8 Review of the staffing time sheets with Human Resource Director #325 for 01/03/25 through 01/09/25 which included department heads who picked up to work on the floor revealed the facility did not meet their staffing needs according to the FA on the following days and shifts: On 01/03/25, the RN ratio for night shift was 1:78 (FA was 1:40); CNA ratio on evening shift was 1:11 (FA was 1:8), CNA ratio for night shift was 1:15 (FA was 1:14). On 01/04/25, CNA ratio on day shift was 1:16 (FA was 1:8) and CNA ratio for evening shift was 1:16 (FA was 1:8). On 01/05/25, RN ratio on evening shift was 1:79 (FA was 1:22), CNA ratio on day shift was 1:13 (FA was 1:8) , on CNA ratio on evening shift was 1:15 (FA was 1:8). On 01/06/25, the RN ratio night shift was 1:81 (FA was 1:40) and CNA ratio on night shift was 1:20 (FA was 1:14) On 01/07/25, the RN ratio on night shift was 1:80 (FA was 1:40), CNA ratio on day shift was 1:11 (FA was 1:8), and CNA ratio on evening shift was 1:13 (FA was 1:8). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/08/25, the RN ratio on night shift was 1:78 (FA was 1:40), CNA ratio on day shift was 1:14 (FA was 1:8), and CNA ratio on evening shift was 1:16 (FA was 1:8). On 01/09/25, the RN ratio on night shift was 1:72 (FA was 1:40), CNA ratio on day shift was 1:10 (FA was 1:8) and CNA ratio on evening shift was 1:12 (FA was 1:8). Interview with the Regional Licensed Nursing Home Administrator (LNHA) on 02/05/25 at 3:30 P.M. confirmed the FA required staffing ratios for the care of residents residing at the facility was not met for each shift on any of the days reviewed 01/03/25 through 01/09/25. Regional LNHA verified the facility had low weekend staffing for the fourth quarter of 2024. This deficiency represents non-compliance investigated under Complaint Numbers OH00161986 and OH00161487.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on review of the medical record, staff interview, and policy review, the facility failed to ensure residents on psychotropic medications were monitored for adverse consequences and behaviors were routinely monitored. This affected three (Residents #13, #42, and #61) of five residents reviewed for unnecessary medications. The facility identified 48 residents receiving psychotropic medications. The facility census was 74. Findings include: 1. Review of the medical record for Resident #61 revealed an admitted [DATE]. Diagnoses included delirium, hypertension, unspecified dementia without behavioral disturbance, psychotic disturbance and mood disturbance, urinary tract infection, pneumonia, and major depressive disorder. Review of the care plan initiated 11/13/24 revealed no plan of care was in place for anxiety, depression, behaviors, use of antipsychotic and psychotropic medications. Review of the physician orders revealed the following psychotropic medications for Resident #61: on 11/04/24, an orders for quetiapine 50 milligrams (mg) at bedtime for anxiety. On 11/09/24, an order for Zoloft 25 mg in the morning for dementia and anxiety and Depakote sprinkles 125 mg at bedtime for delirium, dementia and anxiety. Review of the Medication Administration Records (MARs) and the nursing progress notes from 11/04/24 through 02/04/25 revealed no documentation Resident #61 was monitored for potential adverse effects for the antipsychotic medication quetiapine and psychoactive medication Zoloft. Interview on 02/05/25 at 11:01 A.M. with Regional Nurse (RN) #410 verified there was no documentation the facility had been monitoring Resident #61 for adverse effects of antipsychotic and psychotropic medications. RN #410 stated the nursing staff should have documented the monitoring on the medication administration record or the treatment administration record. 44454 2. Review of the medical record for Resident #13 revealed an admitted [DATE]. Diagnoses included psychosis, depression, anxiety, delusional disorders, and altered mental status. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 11/04/24, revealed Resident #13 was cognitively intact. Review of the active physician orders for January 2025 revealed the following psychotropic medications: on 09/13/24 for Duloxetine (antidepressant medication) 30 milligrams (mg) give three capsules by mouth one time per day for antidepressant, and an order dated for 09/23/24 for Quetiapine Fumarate (antipsychotic medication) 50 mg give one tablet by mouth two times per day for behaviors related to major depressive disorder, recurrent severe with psychotic symptoms. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #13's medical record revealed no evidence of behavior monitoring or the monitoring of medications for efficacy and adverse consequences. Interview on 02/05/25 at 11:01 A.M. with Regional Nurse (RN) #410 verified behavior monitoring should be documented within the administration record and verified behavior monitoring was not completed for Resident #13. 36650 3. Review of the medical record for Resident #42 revealed an admitted [DATE]. Diagnoses included dementia with agitation, bipolar, depression and anxiety. Review of the physician orders for February 2025 revealed Resident #42 had the following psychotropic medications: Olanzapine (antipsychotic) and Mirtazapine (antidepressant). Reviews of Resident #42's medical record revealed there was no documentation of side effects or behaviors for the antipsychotic and antidepressant medications. Interview on 02/05/25 at 8:40 A.M with Registered Nurse (RN) #410 verified there was no documentation of side effects or behaviors for Resident #42. RN #410 stated it should be in the orders and documented daily. Review of the facility policy titled Psychotropic Medication, dated 01/01/25 revealed the response to the medications, including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35768 Based on record review, observation, staff interview, review of Medscape guidance, and policy review, the facility failed to prime an insulin pen per manufacturer instructions prior to administration, resulting in a significant medication error. This affected one (Resident #30) of five residents reviewed for medication administration. The facility identified 14 residents who receive insulin via a pen-injector. The facility census was 74. Findings include: Review of the medical record for Resident #30 revealed an admitted [DATE]. Diagnosis included type two diabetes mellitus with hyperglycemia. Review of the plan of care dated 11/07/23 revealed Resident #30 was at risk for hyper/hypoglycemia related to diabetes mellitus. Intervention included to administer medications as ordered. Review of the physician orders revealed Resident #30 was ordered Lantus Solostar 50 units subcutaneously via a pen-injector, two times a day and Novolog 10 units via a pen-injector before meals. Observation on 01/29/25 at 6:46 A.M. revealed Licensed Practical Nurse (LPN) #353 administered 20 medications including insulin to Resident #30. LPN #353 grabbed two pen-injectors, dialed up 10 units of Novolog and 50 units of Lantus. LPN #353 failed to prime the pen-injectors removing any air before administering insulin to Resident #30. Interview on 01/29/25 at 7:05 A.M., LPN #353 verified she did not prime the Novolog and Lantus pens as she should have. Review of the facility policy titled Medication Administration, dated 2017 noted insulin pens require priming or an air-shot, prior to administration. Review of Medscape guidance titled Intermittent Insulin Injections Insulin Overview dated 11/05/20 and located at https://emedicine.medscape.com/article/2049311-overview#a1 revealed to avoid air and to ensure proper dose, you will need to prime the syringe each time; to do this, dial two units; hold the pen with the needle pointing up and tap the cartridge gently a few times to get rid of any air bubble; press the push button all the way in until the dose selector returns to zero; a drop of insulin must appear at the needle tip; if not, change the needle and repeat the procedure.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36650 Based on observation, resident and staff interviews, and record review, the facility failed to ensure all medications were stored appropriately and residents were watched when taking medications. This affected two of sevens (Resident #24 and #181) for medication storage. The facility census was 74. Findings include: 1. Review of the medical record for Resident #181 revealed an admitted [DATE]. Diagnosis included pain management. Review of the physician orders for February 2025 revealed an order for Tylenol 325 milligrams (mg) give 650 mg by mouth every four hours as needed for pain. Observation and interview on 02/03/25 at 4:35 P.M. of Resident #181 revealed there was a pill cup sitting on the bedside table with two round tablets in it. Resident #181 stated she did not know what was in the pill cup, the nurse just set them down and left the room. There were no staff in the room or insight of Resident #181. Interview on 02/03/25 at 4:40 P.M. with Registered Nurse (RN) #358 stated she though Resident #181 took them, they were Tylenol 325 milligrams (mg). RN #358 verified the medication in the medication cup was Tylenol 325 mg, two tablets and verified she should have observed Resident #181 consume the medication prior to leaving the resident unattended. 44454 2. Review of Resident #24's medical record revealed an admitted [DATE]. Diagnoses included hallucinations and altered mental status. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Review of the self-administration assessment dated [DATE] revealed all areas were marked as not applicable, and Resident #24 was not marked as being able to self-administer any medications. Observation on 02/04/25 8:18 A.M. revealed Resident #24 called out and stated they had been given medications but needed apple juice to take them. The resident was sitting up on the side of their bed. Resident #24 was holding a small, clear-plastic cup containing a mixture of approximately eight medication capsules/tablets. There were no staff members in or near Resident #24's room. Interview on 02/04/25 at 8:20 A.M. with Registered Nurse (RN) #380 verified the staff member gave Resident #24 their medications and did not observe the resident consuming them. RN #380 stated Resident #24 did not say they needed apple juice and RN #380 thought the resident was taking the medications as they left the resident's room. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/04/25 at 8:22 A.M. revealed RN #380 entered the room of Resident #24 and stated you are supposed to take your medications in front of me. RN #380 then verified Resident #24 was given eight different medications, documented the medications as administered, and did not observe the resident taking the medications as they should have.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36650 Based on record review, review of personnel job descriptions, review of personnel files, review of the facility's infection control program, resident, staff, and family interview, and interview with the local health department (LHD), the administration team lacked involvement to ensure staff and resident reports of staff mistreatment were not dismissed before investigating the allegations, did not identify an issue with the resident's medical records being accurate and factual, and did not ensure adequate staffing was maintained to meet the needs of their residents and according the facility's assessment. Administration did not ensure routine care conferences were being held routinely with the residents and resident representatives and did not ensure routine written notices of transfer and bed hold notices were completed upon the resident's transfer to the hospital. Additionally, the administration team demonstrated inaction and failed to perform their job responsibilities to ensure infection control policies and guidelines were implemented to ensure contact tracing was completed to identify close contacts of residents positive for COVID-19, failed to ensure COVID-19 testing was completed for residents and staff identified as close contacts, and furthermore failed to implement broad based testing of staff during a COVID-19 outbreak within the facility. This affected 49 residents (#2, #4, #7, #9, #11, #13, #17, #20, #21, #23, #24, #26, #27, #29, #32, #34, #35, #37, #42, #44, #45, #46, #50, #51, #52, #53, #54. #55, #57, #59, #61, #65, #66, #67, #68, #74, #76, #78, #79, #80, #81, #82, #135, #173, #177, #179, #181, #182, and #183) reviewed during the annual survey and had the potential to affect all 74 residents residing in the facility. Findings include: 1) The facility did not implement effective and recommended infection control practices beginning on [DATE] when two residents (#78 and #32) tested positive for COVID-19. The facility did not complete timely contact tracing to identify close contacts of COVID-19 positive residents and staff, timely reporting of a COVID-19 outbreak to the local health department (LHD), and a system to ensure all staff and residents were tested for COVID-19 per Centers for Disease Control and Prevention (CDC) guidelines and facility policy to prevent the potential spread of COVID-19 to vulnerable residents within the facility. This affected 26 residents who resided throughout the facility (#2, #4, #7, #9, #11, #20, #21, #26, #27, #32, #34, #37, #42, #45, #50, #52, #55, #57, #59, #67, #68, #79, #80, #81, #82, and #177) and three staff (Certified Nursing Assistant (CNA) #357, CNA #366, Licensed Practical Nurse (LPN) #369) who tested positive for COVID-19 and had the potential to affect all residents. In addition, the facility did not ensure the residents and staff were educated on the risks, benefits, and side effects of the COVID-19 vaccine. This affected five (#14, #42, #53, #57, and #64) of five residents reviewed for immunization and seven of seven employees reviewed for immunization and had the potential to affect all residents. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on [DATE] at 12:05 P.M. with Assistant Director of Nursing (ADON) #392 stated the staff were offered the COVID-19 vaccine at an all-staff meeting. ADON #392 stated she just offered the staff the vaccine and had not provided any education to the staff about the risks and benefits of the vaccine. ADON #392 verified only one staff member had requested the vaccine. ADON #392 also verified Residents #57, #14, #64, #53, and #42 were offered the COVID-19 vaccine but they were not provided information on the benefits, risks, and side effects. ADON #392 verified there was no separate consent form for the COVID-19 vaccine and she documented refusals on either their influenza or pneumococcal consent forms. Interview on [DATE] at 11:30 A.M. with Regional Nurse (RN) #410 verified no contact tracing or testing of staff caring for residents who had tested positive had been completed. RN #410 verified the facility policy indicated the facility would follow CDC guidelines to test close contacts. RN #410 verified the facility had not completed contact tracing for staff to identify close contacts and had not completed testing of staff. Subsequent interview on [DATE] at 7:35 A.M. with RN #410 stated the facility had not maintained assignment sheets to track staff assignments and was looking into why the building was not completing staff assignment sheets which would assist with contact tracing. Also, some staff could not be determined to have been close contacts as they may not have documented care. Further interview on [DATE] at 8:32 A.M., RN #410 stated the facility should have completed contact tracing and COVID-19 testing on days one, three, and five for the staff and residents identified as close contacts of the COVID-19 positive residents. RN #410 stated as the outbreak expanded throughout all four halls, the facility should have conducted broad-based testing every three to seven days until there were no new positive for two weeks. RN #410 verified the facility stopped testing residents on [DATE] and should have continued testing for one additional week. Interview on [DATE] at 1:46 P.M. with Local Health Department (LHD) Staff #500 revealed all nursing homes were sent an email on [DATE] with directions on reporting and managing a COVID-19 outbreak with a line listing to record positive cases for submission to the LHD. LHD Staff #500 stated COVID-19 was a Class B reportable infectious disease, and the facility was legally required to report COVID-19 cases by the end of the following business day. LHD #500 stated the facility had not reported a COVID-19 outbreak until [DATE]. LHD #500 stated she had reviewed her emails and the facility never submitted a line listing of positive COVID-19 cases. 2) Administration did not identify an issue with the resident's medical records being accurate and factual. 2a. Resident #177's medical record did not have documentation of a physician order for Hospice Services, no documentation of any discussion by the facility of family regarding initiation of hospice services and no documentation of Hospice services initiated. The record review also revealed no documentation of the physician being notified on [DATE] at 1:00 P.M. when Resident #177 began to have a change in condition. Resident #177 expired in the facility on [DATE]. 2b. Resident #54 had ongoing issues for approximately six months with moisture-associated skin damage (MASD) and there was no documentation in the medical records of this MASD. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the DON's job description signed [DATE] revealed the primary purpose of the position was to plan, organize, develop, control and direct the overall operation of the nursing department in accordance with current federal, state, and local standards, guidelines, and regulations that govern the facility, and as may be directed by the Administrator and the Medical Director, to ensure the highest level of quality care was maintained at all times. The DON would be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines pertaining to long-term care. Review of ADON #392's job description signed [DATE] revealed the primary purpose of the position was to assist the DON in planning, organizing, developing, and directing the day-to-day functions of the nursing department in accordance with current federal, state, and local standards, guidelines, and regulations that govern the facility, and as may be directed by the DON, Administrator and the Medical Director, to ensure the highest level of quality care was maintained at all times. Also to participate in the development, implementation, and maintenance of the infection control program for monitoring communicable and/or infectious diseases among the residents and personnel. This deficiency represents non-compliance investigated under Complaint Number OH00161487 and Complaint Number OH00161986.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36650 Based on observations, resident, family, and staff interviews, and record review, the facility failed to ensure medical records were accurate and factual. This affected eight (Residents #26, #35, #38, #53, #53, #55, #57, and #177) of 27 residents medical records reviewed during the annual survey. The facility census was 74. Findings include: 1 Review of the medical record for Resident #26 revealed an admitted [DATE]. Diagnoses included left hand contracture. Review of the physician orders for February 2025 revealed palm protective splint to left hand on in the PM and off in the AM, activated 01/20/23. Review of the plan of care revealed assistance needed for activities of daily living (ADL) related to decreased range of motion to left hand. Interventions included palm protective splint to left hand on in the PM and off in the AM. Review of the Treatment Administration Record (TAR) for February 2025 revealed treatment for palm protector splint to left hand was marked that it was put on 02/04/25 and signed off that the splint was in place and taken off. Observation and interview on 02/04/25 at 2:51 P.M. with Resident #26 stated she was to have a palm protector on her left hand at night and the staff have not been putting the splint on for months. Observation and interview on 02/05/25 at 5:40 A.M. revealed Resident #26 was still in bed, not wearing her left palm splint. The resident stated the certified nursing aide did not put her splint on when she went to bed. An interview on 02/05/25 at 5:40 A.M. with Licensed Practical Nurse (LPN) #367 stated Resident #26 was to have a splint or rolled up towel in her left hand at night. LPN #367 verified Resident #26 was not wearing her splint and did not have a rolled-up washcloth in her hand. LPN #673 stated she did not look to see if the splint was on and just signed off the order on the TAR. 42011 2) Record review for Resident #55 revealed an admitted [DATE]. Diagnoses included Parkinson's disease, dementia, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #55 was severely cognitively impaired. Resident #55 had impairment on both sides of the upper and lower extremities. Resident #55 was dependent on staff for toileting hygiene, personal hygiene, and transfers. Resident #55 required substantial/maximal assistance for bed mobility and was frequently incontinent of urine and always incontinent of bowel. Resident #55 used a wheelchair with assistants for mobility. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan for Resident #55 dated 05/15/23 and revised 07/17/24 revealed Resident #55 was totally dependent and does not participate in locomotion in wheelchair, provide incontinence care with routine rounds and as needed. Apply ted hose in the morning and remove them at night. Review of the physician orders for Resident #55 dated 01/14/25 revealed to check and change Resident #55 every two hours to offload coccyx - peri area. Resident #55 to be up in the Broda chair for a maximum of four hours a day dated 01/14/25. The physician orders also included to encourage Resident #55 to let staff put him back to bed after lunch dated 07/10/24 and to apply ted hose knee high on in the morning and off in the evening for (deep vein thrombosis) DVT prophylactic dated 03/27/24. Interview on 01/30/25 at 11:14 A.M. with Resident #55's wife revealed she visited Resident #55 frequently. Resident #55 was supposed to be changed every two hours, the staff get him up at 5:00 A.M. every morning and he would sit in the chair all day without being layed down or changed. Observation with Resident #55's wife revealed Resident #55 was sitting in the Broda chair in an upright position sleeping in the dining room. Observations on 01/30/25 revealed at 11:56 A.M., Resident #55 was still sitting in the Broda chair in an upright position sleeping in the dining room. The meal was not served. At 12:54 P.M., Resident #55 was still sitting in the Broda chair in an upright position sleeping in the dining room. The meal was completed and the tray was removed. At 12:55 P.M., Certified Nursing Assistant (CNA) #401 pushed Resident #55's Broda chair from the dining room to the lounge. CNA #401 did not offer Resident #55 to lay down after lunch, after taking him in the lounge, she left leaving Resident #55 in the Broda in the upright position. Resident #55's feet were dangling, observation revealed Resident #55 did not have ted hose on. From 1:28 P.M. through 2:23 P.M., continuous observations revealed Resident #55 stayed in the lounge in the Broda chair in the upright position with his feet dangling. No staff addressed Resident #55 to offer care. Record review on 01/30/25 at 2:17 P.M. of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for 01/30/25 revealed Licensed Practical Nurse (LPN) #353 signed the orders as completed for Resident #55 to check and change Resident #55 every two hours to offload coccyx - peri area, to be up in the Broda chair for a maximum of four hours a day, to encourage Resident #55 to let staff put him back to bed after lunch, and to apply ted hose knee high on in the morning and off in the evening for DVT prophylactic. Further review of the MAR/TAR for the entire month of January 2025 revealed all orders for the month were signed as completed. Observation and interview on 01/30/25 at 2:24 P.M. revealed CNA #357 and #395 assisted Resident #55 to his room. CNA #357 confirmed she was Resident #55's primary CNA and stated she assisted Resident #55 up out of bed at 6:30 this A.M. Both CNA #357 and #395 stated Resident #55 never wore ted hose, they had both worked with him over the past six months and he never wore ted hose. CNA #357 confirmed this was the first time today she laid Resident #55 down and confirmed she did not check or change him either until now. CNA #357 stated she thought hospice was in earlier and changed him. CNA #357 stated she was busy and did not have time. Observation of incontinence care provided by CNA #357 and #395 revealed Resident #55's brief was saturated with urine. Resident #55's pants were also wet and CNA #395 confirmed the seat cushion in the Broda chair was also wet with urine. Resident #55's scrotum and peri area were red. CNA #357 stated Resident #55 gets up again before dinner and will stay up until laid down by the next shift. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/30/25 at 2:37 P.M. with LPN #353 confirmed she was Resident #55's Charge Nurse. LPN #353 stated the hospice aide was in today and provided care for Resident #55 then left between 7:00 A.M. and 7:30 A.M. LPN #353 confirmed Resident #55 was supposed to wear ted hose daily but she was not sure if they were on him because she does not look. LPN #353 stated she was not sure how long Resident #55 was to be up in the chair, maybe two or three hours. Observation on 02/04/25 at 4:52 P.M. with Registered Nurse (RN) Supervisor #308 confirmed Resident #55 was sitting up in his chair. Resident #55 did not have his ted hose on. RN Supervisor #308 stated she told the CNA earlier in the day to apply the ted hose, the CNA informed her there was none in his room to apply so she told the CNA she would get him some out of stock but she just had not done it yet. Observation with RN Supervisor #308 revealed Resident #55 did not have any ted hose available in his room to be applied. RN Supervisor #308 confirmed the ted hose was signed in the medical record as being applied in the A.M. and this was inaccurate. Record review of the TAR revealed the orders to apply the ted hose in the A.M. was signed for Resident #55 as completed. 3) Record review for Resident #177 revealed an admitted [DATE] and a discharge date of [DATE]. Resident #177 had a hospital stay from 01/05/25 through 01/11/25. Diagnoses included diastolic congestive heart failure (CHF), hypertensive heart and chronic kidney disease with heart failure, Parkinsonism, emphysema, vascular dementia, bradycardia, muscle weakness, atrial fibrillation, and chronic obstructive pulmonary disease (COPD). Review of the quarterly MDS assessment dared 11/11/24 revealed Resident #177 was cognitively intact. Resident #177 had no chronic condition, or chronic disease that may result in a life expectancy of less than six months. Review of the physician orders for Resident #177 revealed orders dated 01/11/25 for enteral feed order every shift osmolite 1.5 at 60 cubic centimeters per hour continuous. Review of the progress note for Resident #177 dated 01/14/25 at 1:00 P.M. completed by RN #345 revealed family member at bedside. Made this nurse aware Resident #177 began to spit up TF. Resident was suctioned and repositioned. Hospice nurse entered room at this time and stated to hold TF at this time, working on admission. Review of the medical record including the census for Resident #177 revealed no documentation of a physician order for Hospice Services, no documentation of any discussion by the facility of family regarding initiation of hospice services and no documentation of Hospice services initiated. The record review also revealed no documentation of the physician being notified on 01/14/25 at 1:00 P.M. when Resident #177 began to spit up TF. Interview on 02/03/25 at 9:32 A.M. with Business Office Manager (BOM) #610 revealed Hospice came in on 01/14/24 to assess Resident #177, the family was going to sign the paperwork, but they did not because Resident #177 passed and hospice never picked her up. Interview on 02/03/25 at 9:41 A.M. with Registered Nurse (RN) Supervisor #308 and Regional RN #410 revealed the physician should have been notified on 01/14/25 at 1:00 P.M. when Resident #177 was spitting up TF. Regional RN #410 confirmed there was no further documentation of hospice services in the medical records. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/04/25 at 10:30 A.M. with RN #345 stated Resident #177 declined very quickly after returning from the hospital that was why hospice was called to assess the resident. Interview on 02/04/25 with Regional RN #410 revealed the facility spoke with Hospice Services and they picked Resident #177 up for about an hour before passing. Regional RN #410 confirmed they were unaware Hospice picked her up until they called Hospice services themselves. 4) Record review for Resident #54 revealed an admitted d of 05/30/23. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side and muscle weakness. Review of the quarterly MDS assessment dated [DATE] revealed Resident #54 was rarely or never understood. Resident #54 was dependent on staff for activities of daily living (ADL's). Resident #54 had an indwelling catheter and was always incontinent of bowel. Resident #54 had moisture associated skin damage (MASD) and received applications of ointments/medications. Interview on 01/28/25 at 12:44 P.M. with Resident #54's spouse revealed she was concerned about the rash on Resident #54's bottom, she felt Resident #54 was not being changed enough. Interview on 01/30/25 at 12:01 P.M. with CNA #395 revealed Resident #54 had an indwelling catheter and only needed changed if he had a bowel movement. Resident #54 had not had a bowel movement so there was no need to change him today. Observation and interview on 02/05/25 at 11:07 A.M. revealed Resident #54's brief was changed by CNA #357 and #395. Resident #54 was wet with sweat on his shirt and in his brief. CNA #357 and #395 stated Resident #54 always sweats and that was why his bottom was wet and very red. Resident #54's bilateral buttocks was deep red/discoloration with open excoriated areas to bilateral buttocks. CNA #357 and #395 stated Resident #54 was unable to move without assistance. Interview on 02/05/25 at 12:58 P.M. with Wound Care Certified Nurse Practitioner (CNP) #611 confirmed she assessed Resident #54 on this day and observed the buttocks was discolored and diagnosed with moisture associated skin damage (MASD); MASD was caused by moisture, the moisture could be caused by the sweating, and the area needed to be kept clean and dry. Record review of the medical record for Resident #54 revealed no documentation of excoriation to the buttocks or MASD. Interview on 02/06/25 at 11:36 A.M. with Regional RN #410 confirmed there was no documentation of MASD in Resident #54's medical record describing the wound and measurements including when it healed and when it returned and revealed it looked like it comes and goes because the venelex external ointment, ordered in November 2023 was used for the MASD. Regional RN #410 stated each time Resident #54 had MASD, the nurses should have measured, monitored, and documented the areas. Interview on 02/06/25 at 11:56 A.M. with LPN #361 revealed the excoriation (MASD) comes and goes on Resident #54's buttocks for at least six months. 35033 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5) Review of the medical record for Resident #57 revealed an admitted [DATE]. Diagnoses included anoxic brain damage, and sudden cardiac arrest. Review of the annual Minimum Data Set (MDS) assessment revealed SR #57 had impaired cognition. Review of census rosters dated 01/02/25, 01/07/25, 01/10/25, 01/14/25, and 01/17/25 revealed all the residents had a plus or minus by their name indicating if the resident had tested positive or negative for COVID-19 that day. Review of the nurse progress notes dated 01/02/25 and 01/17/24 revealed no documentation Resident #57 had been tested for COVID-19. Interview on 02/06/25 beginning at 11:00 A.M. with Regional Nurse (RN) #410 verified there was no documentation in the medical record of COVID-19 testing on 01/02/25 and 01/17/25 for Resident #57. 6) Review of the medical record for Resident #35 revealed an admitted [DATE]. Diagnoses included heart failure, hypertension, atrial fibrillation, chronic kidney disease, and type two diabetes mellitus. Review of census rosters dated 01/02/25, 01/07/25, 01/10/25, 01/14/25, and 01/17/25 revealed all the residents had a plus or minus by their name indicating if the resident had tested positive or negative for COVID-19 that day. Resident #35 was listed with minuses on all five testing dates. Review of the nurse progress notes dated 01/02/25 through 01/18/25 revealed there was no documentation Resident #35 had been tested for COVID-19 on 01/02/25. Interview on 02/06/25 beginning at 11:00 A.M. with Regional Nurse (RN) #410 verified there was no documentation in the medical record of COVID-19 testing on 01/02/25 for Resident #35. 7) Review of the medical record for Resident #38 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease and chronic pain syndrome. Review of the quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. Review of census rosters dated 01/02/25, 01/07/25, 01/10/25, 01/14/25, and 01/17/25 revealed all the residents had a plus or minus by their name indicating if the resident had tested positive or negative for COVID-19 that day. Resident #38 was listed with minuses on all five testing dates. Review of the nurse progress notes dated 01/02/25 through 01/18/25 revealed no documentation Resident #38 had been tested for COVID-19 on 01/17/25. Interview on 02/06/25 beginning at 11:00 A.M. with Regional Nurse (RN) #410 verified there was no documentation in the medical record of COVID-19 testing on 01/17/25 for Resident #38. 8) Review of the medical record for Resident #53 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, hypertension, and post-traumatic stress disorder. Review of a significant change assessment dated [DATE] revealed the resident had intact cognition. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of census rosters dated 01/02/25, 01/07/25, 01/10/25, 01/14/25, and 01/17/25 revealed all the residents had a plus or minus by their name indicating if the resident had tested positive or negative for COVID-19 that day. Resident #53 was listed with minuses on all five testing dates. Review of the nurse progress notes dated 01/02/25 through 01/18/25 revealed no documentation Resident #53 had been tested for COVID-19 on 01/10/25 and 01/17/25. Interview on 02/06/25 beginning at 11:00 A.M. with Regional Nurse (RN) #410 verified there was no documentation in the medical record of COVID-19 testing on 01/10/25 and 01/17/25 for Resident #53. Review of the facility policy titled Documentation in Medical Record, revised 11/12/24, revealed the medical record would contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Licensed staff and interdisciplinary team members would document all assessments, observations, and services provided in the resident's medical record in accordance with state law. Documentation would be completed at the time of service, but no later than 24/48 hours in which the assessment, observation, or care service occurred.

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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** 35033 Based on review of the medical record, review of a COVID-19 outbreak log, review of staffing schedules, review of staff timecards, review of the staff call-off log, staff and resident interview, observation, interview with the Local Health Department (LHD), review of the Centers for Disease Control and Prevention (CDC) infection control guidance, and policy review, the facility failed to implement an effective and recommended infection control practices, including timely contact tracing to identify close contacts of COVID-19 positive residents and staff, timely reporting of a COVID-19 outbreak to the LHD, and a system to ensure all staff and residents were tested for COVID-19 per CDC guidelines and facility policy to prevent the potential spread of COVID-19 to vulnerable residents within the facility. This affected 26 residents who resided throughout the facility (#2, #4, #7, #9, #11, #20, #21, #26, #27, #32, #34, #37, #42, #45, #50, #52, #55, #57, #59, #67, #68, #79, #80, #81, #82, and #177) and three staff (Certified Nursing Assistant (CNA) #357, CNA #366, Licensed Practical Nurse (LPN) #369) who tested positive for COVID-19 and had the potential to affect all residents. Additionally, the facility failed to ensure infection control procedures were followed during tracheostomy care. This affected one (#54) of three residents reviewed for respiratory care. The facility identified three residents with a tracheostomy. The facility census was 74. Findings include: 1) Review of the medical record for Resident #79 revealed an admitted [DATE] and a discharge date of [DATE]. Review of a nurse's note dated 12/31/24 at 9:20 A.M. revealed the resident was discharged to another facility. The other facility notified the facility the resident tested positive for COVID-19 upon arrival. Review of census documentation revealed Resident #79 had a roommate (#134) who was admitted to the hospital on 12/29/24. Review of the medical record for Resident #32 revealed an admitted [DATE]. Review of a nurses progress note dated 12/31/24 at 10:02 P.M., revealed the hospital notified the facility the resident was positive for COVID-19 and a urinary tract infection. The resident was being sent back to the facility. Resident #32's roommate (#51) was tested and was negative. Review of the medical record for Resident #51 revealed an admitted [DATE]. Review of the nurse's note dated 12/31/24 and 01/01/25 revealed no documentation the resident was tested for COVID-19 after his roommate (#32) tested positive for COVID-19 on 12/31/24. Review of a COVID-19 outbreak log revealed two residents (#79, #32) residing on the 300-hall tested positive for COVID-19 on 12/31/24. Review of the staffing schedules and employee timecards revealed 11 staff (Licensed Practical Nurse (LPN) #405, LPN #303, LPN #420, LPN #369, LPN #361, Certified Nurse Assistant (CNA) #305, CNA #324, CNA #397) had provided care for Resident #79 and Resident #32 on 12/30/24 and 12/31/24. Further review of the outbreak documentation revealed no staff contact tracing or testing for COVID-19 was completed for staff identified as close contacts of the two residents. (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 COVID-19 outbreak log revealed an additional three residents (#177, #80, #68) residing on the 100, 300, and 400 halls had tested positive for COVID-19 on 01/02/25. No contact tracing or staff testing was completed. Review of the COVID-19 outbreak log revealed an additional 21 residents (#57, #7, #81, #9, #50, #11, #26, #2, #67, #21, #27, #59, #52, #82, #37, #20, #4, #45, #55, #34, #42) residing on the 100, 200, 300, and 400 halls tested positive for COVID-19 from 01/03/25 through 01/14/25. There was no documentation staff were tested . CNA #357 and CNA #366 tested positive on 01/02/25. LPN #369 tested positive on 01/05/25. Review of the employee call-off log revealed on 12/30/24 and 12/31/24 one staff member had called off from work, on 01/01/25 five staff had called off, and on 01/02/25 four staff had called off. On 01/03/25 nine staff had called off and five staff called off on 01/04/25. Two staff called off on 01/05/25 and five staff called off on 01/06/25. On 01/07/25 eight staff called off and on 01/08/25 four staff had called off. On 01/09/25 three staff had called off and five staff called off on 01/10/25. On 01/11/25 two staff had called off and on 01/12/25 there were six staff who called off. There was one staff call off on 01/13/25. The type of call offs from 12/30/24 through 01/13/25 were listed as sick or other with two listed as no call no show. Review of census rosters dated 01/02/25, 01/07/25, 01/10/25, 01/14/25, and 01/17/25 revealed all the residents had a plus or minus by their name indicating if the resident had tested positive or negative for COVID-19 that day. Resident #2 was listed on 01/02/25 with a minus. Resident #35, Resident #38, and Resident #53 were listed with minuses on all five testing dates. Review of the medical records revealed there was no documentation Resident #57 was tested on [DATE]. Resident #57 was positive for COVID-19 on 01/03/25 after family requested testing due to respiratory symptoms. The medical record for Resident #35 revealed there was no documentation the resident was tested for COVID-19 on 01/02/25 and 01/17/25. The medical record for Resident #38 revealed there was no documentation the resident was tested for COVID-19 on 01/07/25. The medical record for Resident #53 revealed there was no documentation the resident was tested for COVID-19 on 01/10/25 and 01/17/25. Interviews with staff revealed the following: on 02/03/25 at 2:06 P.M. with CNA #357 stated she tested herself at home and was positive for COVID-19 on 01/02/25. On 02/04/25 at 1:51 P.M., CNA #340 stated she had not been tested during the COVID-19 outbreak. CNA #340 further revealed facility management had poor communication with staff. CNA #340 stated management were directing staff not to tell anyone if they tested positive for COVID-19 as they would not have enough staff. CNA #340 could not pinpoint which management staff as it worked its way down and made it to all the aides. On 02/04/25 at 3:41 P.M., CNA #362 stated the facility had not tested her for COVID-19 during the COVID-19 outbreak. On 02/04/25 at 3:46 P.M., CNA #368 stated the facility had not tested her for COVID-19 during the COVID-19 outbreak. On 02/05/25 at 7:51 A.M., LPN #318 stated the facility had not tested her for COVID-19 during the outbreak. Interview on 02/03/25 beginning at 2:20 P.M., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) #392 stated staff were tested on [DATE] but there was no documentation of the testing. The DON stated staff would only need tested if they were symptomatic per the facility policy. The DON and ADON #392 revealed the last day residents were tested was on 01/17/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 02/04/25 at 11:30 A.M. with Regional Nurse (RN) #410 verified no contact tracing or testing of staff caring for residents who had tested positive had been completed. RN #410 verified the facility policy indicated the facility would follow CDC guidelines to test close contacts. RN #410 verified the facility had not completed contact tracing for staff to identify close contacts and had not completed testing of staff. Interviews with the residents revealed the following: on 02/04/25 at 1:47 P.M., Resident #38 stated he had only been tested twice during the COVID-19 outbreak, once when it first started and then once a couple days later. On 02/04/25 at 12:56 P.M., Resident #35 stated testing for COVID-19 was completed maybe twice during the COVID-19 outbreak. On 02/04/25 at 2:13 P.M., Resident #53 stated only being tested two or three times during the COVID-19 outbreak. Interview on 02/05/25 at 7:35 A.M. with RN #410 stated the facility had not maintained assignment sheets to track staff assignments and was looking into why the building was not completing staff assignment sheets which would assist with contact tracing. Also some staff could not be determined to have been close contacts as they may not have documented care. Further interview on 02/05/25 at 8:32 A.M., RN #410 stated the facility should have completed contact tracing and COVID-19 testing on days one, three, and five for the staff and residents identified as close contacts of the COVID-19 positive residents. RN #410 stated as the outbreak expanded throughout all four halls, the facility should have conducted broad-based testing every three to seven days until there were no new positive for two weeks. RN #410 verified the facility stopped testing residents on 01/17/24 and should have continued testing for one additional week. Interview on 02/05/25 at 7:58 A.M. with LPN #369 stated she was assigned to work on all the halls in the facility. LPN #369 stated she tested positive at home on 01/05/25 then went to the facility the same day and tested positive again. Interview on 02/05/25 at 9:11 A.M. with ADON #392 stated she thought she had notified the local health department (LHD) of the COVID-19 outbreak on 01/02/25. ADON #392 stated the LHD had not asked for a line listing of COVID-19 positive residents. ADON #392 stated she thought the LHD indicated to conduct contact tracing. ADON #392 verified staff were not tested on [DATE]. ADON #392 stated she left out COVID-19 tests and encouraged the staff to test themselves. ADON #392 stated staff were not checked if they had tested as we could not force anyone to test themselves. Interview on 02/05/25 at 1:46 P.M. with Local Health Department (LHD) Staff #500 revealed all nursing homes were sent an email on 04/01/24 with directions on reporting and managing a COVID-19 outbreak with a line listing to record positive cases for submission to the LHD. LHD Staff #500 stated COVID-19 was a Class B reportable infectious disease and the facility was legally required to report COVID-19 cases by the end of the following business day. LHD #500 stated the facility had not reported a COVID-19 outbreak until 01/08/25. LHD #500 stated she had reviewed her emails and the facility never submitted a line listing of positive COVID-19 cases. Interview on 02/06/25 beginning at 11:00 A.M., RN #410 verified there was no documentation in the medical record of COVID-19 testing on 01/02/25 for Resident #57 and Resident #35, on 01/10/25 for Resident #53, and on 01/17/25 for Resident #38 and Resident #57. (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 Prevention and Control Program, revised 08/01/23, revealed the facility would implement a system of surveillance for prevention, identification, reporting, investigating, and controlling infections and communicable disease for all residents, staff, volunteers, visitors, and other individuals providing services according to accepted national standards. Residents with close contact with someone with SARS-CoV-2 (COVID-19) infection should have a series of three viral tests for SARS-CoV-2 infection. Testing recommended immediately (but not earlier than 24 hours after exposure) and if negative, again 48 hours after first negative test and if negative, again 48 hours after the second negative test. Typically, on day one, day three, and day five. If healthcare-associated transmission is suspected or identified, the facility may consider expanded testing of health care personnel (HCP) and resident as determined by the distribution and number of cases throughout the facility and ability to identify close contacts. If expanded testing approach is taken and testing identified additional infections, testing should be expanded more broadly. If possible, testing should be repeated every three to seven days until no new cases were identified for at least 14 days. Review of the facility policy COVID-19 Prevention, Response and Reporting, revised 06/01/24, revealed a close contact was being within six feet for a cumulative total of 15 minutes or more over a 24-hour period with someone with SARS-CoV-2 infection. If a COVID-19 threat was detected, the facility would respond promptly and implement emergency and/or outbreak procedures. The facility would perform viral testing for SARS-CoV-2 as per national standards such as CDC recommendations. Review of the CDC Infection Control Guidance: SARS-CoV-2 dated 06/04/24, revealed the approach to an outbreak investigation involves either contact tracing or a broad-based approach. A broad-based approach was preferred if all potential contacts could not be identified or managed with contact tracing or if contact tracing fails to halt transmission. Perform testing for all residents and HCP identified as close-contacts or on the affected units if using a broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day one, day three and day five. 42011 2) Record review for Resident #54 revealed an admitted d of 05/30/23. Diagnoses included tracheostomy, cerebral infarction, and acute respiratory failure. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #54 was rarely or never understood. Resident #54 was dependent on staff for activities of daily living (ADLs). Resident #54 received oxygen, had a tracheostomy and required suctioning. Review of the care plan dated 12/18/23 revealed Resident #54 had a tracheostomy. Resident #54 was at risk for complications including respiratory distress, increased secretions, and infection. Interventions included to follow facility protocol for enhanced barrier precautions and suction as necessary. Review of the physician orders for Resident #54 revealed a number six shiley uncuffed trach and trach care every shift and as needed initiated 05/18/24. Additional orders included tracheostomy suction as needed for excessive secretions initiated 05/30/23. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation and interview on 02/04/25 at 3:50 P.M. of trach suctioning for Resident #54 with Licensed Practical Nurse (LPN) #361 revealed on the entrance door for Resident #54's room was a sign which revealed Resident #54 was on Enhanced Barrier Precautions (EBP). The information on the sign included providers must clean their hands, including before entering and leaving the room, providers and staff must also wear gloves and a gown for the following high contact resident care activities which included tracheostomy care. Observation revealed LPN #361 did not wash her hands prior to entering Resident #54's room. LPN #361 also did not don a gown or mask. LPN #361 walked over to Resident #54's bed, opened up sterile gloves (did not wash her hands prior to opening or putting on the gloves) then completed trach suctioning for Resident #54. After completing this task, LPN #361 removed her gloves then exited the room (did not wash her hands) then walked back towards the nursing station. LPN #361 confirmed she did not wash her hands prior to or after going in Resident #54's room. LPN #361 also confirmed she did not wash her hands before or after trach care for Resident #54. LPN #361 confirmed Resident #54 was on EBP and confirmed she did not wear a gown or mask while providing trach (respiratory) care for Resident #54. Review of the facility's undated policy titled Suctioning Tracheostomy revealed tracheostomy suctioning removes thick mucous and secretions from the traches and lower airway that the resident is not able to clear by coughing. To reduce the possibility of contamination, a sterile technique is essential. The procedure included to wash hands and tell the resident what you are doing, assemble the equipment, position the resident and wash hands thoroughly. Open the suction kit, it is very important to keep everything as clean as possible to prevent infection. After suction has been completed, wash hands. This deficiency represents non-compliance investigated under Complaint Number OH00161986 and Complaint Number OH00161487.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365645	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health Center, The	35990 Westminster Ave North Ridgeville, OH 44039

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on review of resident immunizations, review of personnel records, staff interview, and policy review, the facility failed to ensure residents and staff were educated on the risks, benefits, and side effects of the COVID-19 vaccine. This affected five (#14, #42, #53, #57, and #64) of five residents reviewed for immunization and seven of seven employees reviewed for immunization and had the potential to affect all residents. The facility census was 74. Findings include 1) Review of the medical record for Resident #57 revealed an admitted [DATE]. Diagnoses included anoxic brain injury, and sudden cardiac arrest. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment Review of Resident #57's undated consent form for the pneumococcal vaccine revealed a hand written note stating the resident would like the COVID-19 vaccine. There was no information sheet for the COVID-19 vaccine and no documentation the resident/representative had been provided education on the COVID-19 vaccine. 2) Review of the medical record for Resident #14 revealed an admitted [DATE]. Diagnoses included chronic kidney disease, diabetes insipidus, and peripheral vascular disease. Review of the annual MDS assessment dated [DATE] revealed the resident had impaired cognition. Review of the influenza vaccine consent form dated 10/02/24 revealed a handwritten note per the power of attorney, no COVID-19 vaccine at this time. There was no information sheet for the COVID-19 vaccine and no documentation the resident/representative had been provided education on the COVID-19 vaccine. 3) Review of the medical record for Resident #64 revealed an admitted [DATE]. Diagnoses included acute respiratory failure, anoxic brain damage, chronic lymphocytic leukemia of B-Cell type, and tracheostomy status. Review of the quarterly MDS assessment dated [DATE] revealed the resident had impaired cognition. Review of Resident #64's influenza form dated 10/01/24 revealed a handwritten note dated 08/15/24 stating no COVID-19 vaccine wanted per the power of attorney. There was no information sheet for the COVID-19 vaccine and no documentation the resident/representative had been provided education on the COVID-19 vaccine. 4) Review of the medical record for Resident #53 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, hypertensive heart disease, and chronic pain syndrome. Review of the significant change MDS assessment dated [DATE] revealed the resident had intact cognition. (continued on next page)

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #53's pneumococcal vaccine form dated 10/01/24 revealed a handwritten note stated the resident refused the COVID-19 vaccination. There was no information sheet for the COVID-19 vaccine and no documentation the resident/representative had been provided education on the COVID-19 vaccine. 5) Review of the medical record for Resident #42 revealed an admitted [DATE]. Diagnoses included dementia, bipolar disorder and hypothyroidism. Review of the quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. Review of Resident #42's pneumococcal vaccine consent form dated 10/04/24 revealed a handwritten note stating the resident had declined the COVID-19 vaccine at this time. 6) Review of personnel files for seven staff (Certified Nursing Assistant (CNA) #331, CNA #357, Maintenance Director #400, CNA #342, CNA #341, Registered Nurse (RN) #355, Dietary Aide #344) revealed no documentation the staff had been educated regarding the COVID-19 vaccine. There was no documentation the staff had been offered or had refused the COVID-19 vaccine. Interview on 01/29/25 at 12:05 P.M. with Assistant Director of Nursing (ADON) #392 stated the staff were offered the COVID-19 vaccine at an all-staff meeting. ADON #392 stated she just offered the staff the vaccine and had not provided any education to the staff about the risks and benefits of the vaccine. ADON #392 verified only one staff member had requested the vaccine. ADON #392 also verified Residents #57, #14, #64, #53, and #42 were offered the COVID-19 vaccine but they were not provided information on the benefits, risks, and side effects. ADON #392 verified there was no separate consent form for the COVID-19 vaccine and she documented refusals on either their influenza or pneumococcal consent forms. Review of the policy titled Infection Prevention and Control Program, revised 08/01/23 revealed residents and staff would be offered the COVID-19 vaccine when vaccine supplies were available. Education about the vaccine, risks, benefits, and potential side effects would be given to residents and staff prior to offering the vaccine.