STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365672	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Hills Care Center	2565 Niles Vienna Rd Niles, OH 44446

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 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** 44461 Based on observation, interview and record review the facility failed to ensure Resident #61 and Resident #70 had call lights in reach at all times for reasonable accomodation of needs. This affected two residents (Resident #61, and #70) of five residents reviewed for resident right to reasonable accomodation of needs. The facility census was 108. Finding includes: 1. Review of the medical record for Resident #61 revealed an admitted [DATE]. Diagnoses included unspecified fracture of first lumbar vertebra, hepatic encephalopathy, multiple rib fractures right and left side, esophageal varices without bleeding, type two diabetes mellitus, cognitive communication deficit, mild protein-calories malnutrition, difficulty in walking, muscle weakness, need for assistance with personal care, and muscle wasting with atrophy. Review of Resident #61's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had impaired cognition. She required setup or cleanup assistance with eating. She required partial to moderate assistance with oral hygiene, and she required substantial to maximum assistance with toileting hygiene, dressing, personal hygiene, bed mobility and showers. Review of Resident #61's care plan dated 06/08/24 revealed she required assistance with activity of daily living (ADL) secondary to decreased mobility, difficulty in walking, weakness, recent fall at home, shortness of breath with activity, shortness of breath when lying flat, decompensated liver cirrhosis with ascites requiring paracentesis, syncope, chronic peripheral edema, poor endurance, easily fatigues, end stage liver disease, portal hypertension, and hepatic encephalopathy. Interventions included staff to adjust care as needed to meet resident's needs, staff to encourage resident to participate in ADLs during care, and staff will assist as needed with daily hygiene and will assist with showering residents as per facility policy weekly. Interview on 07/31/24 at 3:36 P.M. with Resident #61's family revealed when the family was visiting they noticed the call light was not always in reach of the resident so she would not be able to activate it if she needed something. 2. Review of the medical record for Resident #70 revealed an admitted [DATE]. Diagnoses included hydrocephalus, chronic obstructive pulmonary disease, lack of coordination, hypertension, anxiety, type two diabetes mellitus, muscle wasting and atrophy, peripheral vascular disease, and a hospital acquired stage four sacral pressure ulcer. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #70's annual MDS dated [DATE] revealed the resident had intact cognition. She required setup or cleanup assistance for eating, and Resident #70 was dependent on staff for oral hygiene, toileting hygiene, dressing, personal hygiene, bed mobility, and showers. Review of Resident #70's care plan dated 07/26/24 revealed she was at risk for decline in ADL function related to alteration in ADL performance participation due to weakness, impaired mobility, lack of coordination, and right above the knee amputation. Interventions included the staff will assist as needed with daily hygiene and will assist with showering resident as per facility policy weekly. Interview on 08/12/24 at 5:05 P.M. with Resident #70 revealed she had been up in her wheelchair since she had her shower at 10:30 A.M When asked where her call light was she stated it was behind her tied around the side rail on her bed and she could not reach it to use it. She stated she had not had her call light since she was put in her chair. Observation made on 08/12/24 from 5:09 P.M. to 5:28 P.M. of Resident #70 in her room revealed the call light remained out of her reach throughout the observation. Interview on 08/12/24 at 5:28 P.M. with the Administrator who entered Resident #70's room verified the call light was not within the residents reach. Review of the facility policy titled Call Light Answering, last revised March 2019, revealed staff were to respond to resident's call light in a timely manner, knock before entering and evaluate the resident's needs, turn off the call light in the room so that others know it has been answered, complete the task the resident has requested, if able, if unable to complete the requested task, inform the resident or family and notify the appropriate discipline. When leaving the room, be sure the call light is placed within the resident reach. If the call light system is not functioning properly, the assigned staff should make ongoing rounds, where each resident is visually observed, and need for assistance assess on an ongoing basis, until the call light system is working properly. This deficiency represents non-compliance investigated under Complaint Number OH00156576.

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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 - Some	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** 44461 Based on observation, record review, shower schedule review, interview and policy review, the facility failed to ensure residents, who were dependent and/or required staff assistance for activities of daily living care, received timely and adequate assistance with showers and/or incontinence care, per the residents' plan of care and/or resident preference. This affected eight residents (#2, #24, #54, #61, #62, #70, #72, and #111) of 16 residents reviewed for showers. The facility census was 108. Finding includes: 1. Review of the medical record for Resident #2 revealed an admitted [DATE]. Diagnosis included epilepsy, schizoaffective disorder, bipolar type, chronic obstructive pulmonary disorder, asthma, morbid obesity, generalized anxiety disorder, hypertension, and muscle wasting and atrophy. Review of Resident #2's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had intact cognition, she was independent with eating, oral hygiene, dressing, personal hygiene, and bed mobility. Resident #2 required supervision or touching assistance with showers. Review of Resident #2's care plan revealed the resident required assistance with Activities of Daily Living (ADLs) related to generalized muscle weakness, difficulty in walking, ataxia, major depressive disorder, anxiety disorder, hypertension, arthritis, seizure disorders, and neuropathy. Interventions related to ADLs and showers included the resident required supervision or oversight, including verbal cues or encouragement with bathing/showering care and needs. Resident #2 preferred to shower three times a week and showers were scheduled every Tuesday, Thursday, and Saturday. Resident #2 preferred as well to have a wash up/clean up at the sink in between her shower days. Review of Resident #2's shower sheets from May 2024, June 2024, and July 2024 revealed she was scheduled every Tuesday, Thursday, and Saturday and out of 39 scheduled showers during those three months, she only received 16 showers and had refused only one shower on 05/04/24. Interview on 08/01/24 at 11:35 A.M. with Resident #2 revealed showers are a problem, she does not receive her showers three times a week as scheduled or per her preference. She stated the shower aides get pulled to the floor to cover call offs and when this happens, showers are not completed, and they are not made up throughout the week. 2. Review of the medical record for Resident #24 revealed an initial admitted [DATE] and a current admitted [DATE]. Diagnosis included megaloblastic anemia, asthma, morbid obesity, congestive heart failure, type II diabetes mellitus, hypertension, anxiety disorder, muscle wasting and atrophy, and the need for assistance with personal care. Review of Resident #24's quarterly MDS dated [DATE] revealed the resident had intact cognition. she was independent with eating, she required setup or clean up assistance with oral hygiene, she required substantial to maximal assistance for bed mobility and was dependent on staff for toileting hygiene, dressing, personal hygiene, and showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #24's care plan revealed the resident was dependent on staff for ADLs related to generalized muscle weakness, difficulty in walking, ataxia, muscle wasting and atrophy, morbid obesity, and anxiety disorder. Interventions related to ADLs and showers included the resident was dependent on staff to perform bathing and showering care and needs. Resident #24 preferred showers three times a week and showers were scheduled every Monday, Wednesday, and Friday. Review of Resident #24's shower sheets form April 2024, May 2024, June 2024, and July 2024 revealed she was scheduled every Monday, Wednesday, and Friday and out of 48 scheduled showers, during the four months, the resident received only 14 showers. There was no documentation supporting Resident #24 received the other 34 showers. Resident #24 was not in the hospital at any time during the review period. Interview on 08/01/24 at 11:55 A.M. with Resident #24 revealed she confirmed she does not get her showers as scheduled or how she preferred. She stated she usually does not get her shower when the shower aides are pulled to the floor or when they are off. The aides on the floor do not have the time to do any showers and she stated there should be more staff. 3. Review of the medical record for Resident #54 revealed an admitted [DATE]. Diagnosis included multiple sclerosis, chronic obstructive disorder, alcoholic cirrhosis of liver with ascites, peripheral vascular disease, osteoarthritis, history of deep vein thrombosis of left lower extremity, major depressive disorder, and muscle weakness. Review of Resident #54's annual MDS dated [DATE] revealed the resident had intact cognition. Resident #54 required setup or clean up assistance for eating, oral hygiene, and personal hygiene. Resident #54 was dependent on staff for toileting hygiene, and required partial to moderate assistance with dressing and the resident required substantial to maximal assistance for bed mobility and showering. Review of Resident #54's care plan, dated 07/12/24, revealed the resident required assistance with ADLs related to impaired physical ability secondary to multiple sclerosis, generalized muscle weakness, and difficulty in walking. Interventions included staff to encourage the resident to participate in ADLs during care, staff will assist with daily hygiene and will assist with showering as per facility policy weekly. Review of Resident #54's shower sheets from April 2024, May 2024, June 2024, and July 2024 revealed the resident was scheduled to have a shower every Monday, Wednesday, and Friday and out of 44 scheduled showers, the resident only received 18 showers during the four months reviewed. There was documentation to support the resident refused showers on 06/02/24, 07/08/24, and 07/31/24. Resident #54 was not hospitalized at any point during the review period. Interview on 08/01/24 at 12:10 P.M. with Resident #54 revealed she did not receive her showers three times a week as she was scheduled to and stated her needs are not met (due to the lack of showers provided). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of the medical record for Resident #61 revealed an admitted [DATE]. Diagnosis included unspecified fracture of first lumbar vertebra, hepatic encephalopathy, multiple rib fractures right and left side, esophageal varices without bleeding, type II diabetes mellitus, cognitive communication deficit, mild protein-calorie malnutrition, difficulty in walking, muscle weakness, need for assistance with personal care, and muscle wasting with atrophy. Review of Resident #61's five-day MDS dated [DATE] revealed the resident had impaired cognition. She required setup or cleanup assistance with eating. She required partial to moderate assistance with oral hygiene, and she required substantial to maximum assistance with toileting hygiene, dressing, personal hygiene, bed mobility and showers. Review of Resident #61's care plan, dated 06/08/24, revealed she required assistance with ADLs secondary to decreased mobility, difficulty in walking, weakness, recent fall at home, shortness of breath with activity, shortness of breath when lying flat, syncope, chronic peripheral edema, poor endurance, easily fatigues, end stage liver disease, and hepatic encephalopathy. Interventions included staff to adjust care as needed to meet resident's needs, staff to encourage resident to participate in ADLs during care, and staff will assist as needed with daily hygiene and will assist with showering residents as per facility policy weekly. Review of Resident #61's shower sheets from June 2024, July 2024, and August 2024 revealed the resident was scheduled to have a shower on every Tuesday, Thursday, and Saturday and out of 39 scheduled showers [NAME] provided during the identified months, Resident #61 only received eight showers. There was no documentation to support the resident had refused any showers and they were not hospitalized during the review period. Interview on 07/31/24 at 3:36 P.M. with Resident #61's family revealed the resident did not receive her showers three times a week per facility policy and her preference. 5. Review of the medical record for Resident #62 revealed an admitted [DATE]. Diagnosis included hemiplegia and hemiparesis following cerebral infarction affecting her left non dominant side, generalized anxiety, peripheral vascular disease, muscle wasting and atrophy, and muscle weakness. Review of Resident #62's quarterly MDS dated [DATE] revealed the resident had impaired cognition. She required setup or clean up assistance with eating, she required substantial to maximal assistance with oral hygiene and dressing. Resident #62 was dependent on staff for assistance with toileting hygiene, personal hygiene, bed mobility and showers. Review of Resident #62's care plan, dated 07/26/24, revealed she required assistance with ADLs related to impaired mobility, weakness, muscle wasting and atrophy, cognitive impairment, personal history or cerebral vascular accident, anxiety, depression, atrial fibrillation, and hypertension. Interventions included the resident will continue to participate in ADLs as able and have no decline in ADLs through review date. Staff are to assist in all ADLs due to the resident being totally dependent and does not participate in any aspect of the task for toileting hygiene, showering or bathing, dressing, and bed mobility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #62's shower sheets dated from April 2024, May 2024, June 2024, and July 2024 revealed the resident was scheduled to have showers on Monday, Wednesday, and Friday, and out of 45 showers scheduled, she only received 14 showers during the reviewed months. Resident #62 did refuse six showers, and three were not given due to the shower aide being pulled to the floor to cover call offs. 6. Review of the medical record for Resident #70 revealed an admitted [DATE]. Diagnosis included hydrocephalus, chronic obstructive pulmonary disease, lack of coordination, hypertension, anxiety, type II diabetes mellitus, muscle wasting, and atrophy, peripheral vascular disease, and a hospital acquired sacral pressure ulcer. Review of Resident #70's annual MDS dated [DATE] revealed the resident had intact cognition. She required setup or cleanup assistance for eating, and Resident #70 was dependent on staff for oral hygiene, toileting hygiene, dressing, personal hygiene, bed mobility, and showers. Review of Resident #70's care plan, dated 07/26/24, revealed she was at risk for decline in ADL function related to alteration in ADL performance participation due to weakness, impaired mobility, lack of coordination, and right above the knee amputation. Interventions included the staff will assist as needed with daily hygiene and will assist with showering resident as per facility policy weekly. Interventions also included the resident would continue to participate in ADLs as able and have no decline in ADLs through review date, she would remain well groomed and free of odors as all times, staff to adjust care as needed to meet the resident's needs, staff were to encourage resident to participate in ADLs during care, and staff were to assist as needed with daily hygiene. a. Review of Resident #70's shower sheets dated May 2024, June 2024, and July 2024 revealed the resident was scheduled to have showers on Monday, Wednesday, and Friday, and out of 40 scheduled showers the resident received 14 showers during the months indicated. Documentation revealed she refused two showers, two were not provided due to the shower aide being pulled to the floor to cover call offs, and one bed bath was given, however this was not her preference. Interview on 08/12/24 at 5:05 P.M. with Resident #70 revealed she does not get her showers per facility schedule or per her preference. She stated she never gets her showers when the shower aides are pulled to the floor to cover call offs and feels there should be more staff in the facility so this does not happen. b. Interviews conducted throughout the survey from 07/31/24 to 08/12/24 with LPN #799, LPN #801, LPN #802, LPN #803, LPN #804, LPN #805, STNA #806, STNA #807, STNA #808, LPN #809, STNA #810, LPN #811 and LPN #819 revealed, at times, they were unable to provide timely incontinence care due to staffing issues. Interview on 08/12/24 at 5:05 P.M. with Resident #70 revealed she had been up in her wheelchair since she had her shower at 10:30 A.M. When asked where her call light was, she stated it was behind her, tied around her side rail on her bed. She stated she had not had her call light since she was put in her chair that morning. This surveyor asked if she could activate her light to see how long it took the staff to come in and answer the call light and the resident agreed. While waiting for staff to come in her room, she stated they never come right away. The resident stated she was incontinent of urine and had a colostomy bag and had not been changed since she was put in her chair, after her shower that morning, at 10:30 A.M. (continued on next page)

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Autumn Hills Care Center	2565 Niles Vienna Rd Niles, OH 44446

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation made on 08/12/24 from 5:09 P.M. to 5:28 P.M. revealed Resident #70's call light, which was activated by this surveyor with the resident's permission, had been on with no staff coming in to see what the resident needed until the Administrator entered the room at 5:28 P.M. There were multiple staff members observed to walk past the resident's room, including nurses and STNAs. Interview on 08/12/24 at 5:28 P.M. with the Administrator verified Resident #70 stated she had been up since 10:30 A.M. with no staff member coming in to check on her, provide incontinence care or give the resident her call light. She confirmed multiple staff members had walked past the resident's activated call light and were observed in the hallway. She confirmed the resident's call light was wrapped around the side rail on the resident's bed which was located behind the resident and not within the resident's reach. 7. Review of the medical record for Resident #72 revealed an admitted [DATE]. Diagnosis included atherosclerotic heart disease, hypertension, congestive heart failure, anxiety disorder, convulsions, dementia, muscle weakness, lack of coordination, repeated falls, and muscle wasting with atrophy. Review of Resident #72's annual MDS dated [DATE] revealed the resident had severely impaired cognition. She required substantial to maximum assistance for eating and bed mobility. Resident #72 was dependent for oral hygiene, dressing, personal hygiene, and showers. Review of Resident #72's care plan, dated 07/22/24, revealed she required assistance with ADLs related to weakness, impaired mobility, muscle wasting and atrophy, lack of coordination, other symbolic dysfunction, congestive heart failure, and repeated falls. As of 09/14/23, Resident #72 was placed on hospice with declines expected and anticipated. Interventions included staff to adjust care as needed to meet the resident's needs, staff to encourage resident to participate in ADLs during care. Resident #72 was totally dependent and did not participate in any aspect of ADL tasks including daily hygiene and showering per facility policy weekly. Review of Resident #72's shower sheets dated for April 2024, May 2024, June 2024, and July 2024 revealed the resident was scheduled to have showers every Tuesday, Thursday, and Saturday, and out of 52 scheduled showers, the resident received 27 showers during the months reviewed. The facility provided nine showers and hospice provided 18. There were no refusals documented and the resident was not hospitalized during the review period. Interview on 08/07/24 at 3:43 P.M. with the DON confirmed facility staff are to give residents showers or baths three times a week per the facility schedule and if the resident is under hospice care, the showers or baths hospice give are in addition to what the facility staff provides. 8. Review of the closed medical record for Resident #111 revealed an initial admitted [DATE], with a hospital stay from 06/01/24 to 06/05/24 and most recent admitted [DATE] and a discharge date of [DATE]. Diagnosis included fracture of the first lumbar vertebra, fracture of right index finger with laceration, left sided rib fractures, syncope and collapse, type II diabetes mellitus, chronic obstructive pulmonary disease, muscle wasting with atrophy, abdominal aortic aneurysm, cervical disc degeneration, difficulty in walking, repeated falls, and benign prostatic hyperplasia with lower urinary tract symptoms. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #111's discharge MDS dated [DATE] revealed the resident had cognitive impairment. He required setup or clean up help with eating, and oral hygiene. He required partial to moderate assistance with dressing, supervision or touching assistance with personal hygiene and bed mobility and required substantial to maximum assistance for showers. Review of Resident #111's care plan, dated 06/05/24, revealed the resident required assistant with ADLs secondary to decreased mobility, difficulty in walking, generalized muscle weakness, and chronic pain. Interventions included staff to adjust care as needed to meet the resident's needs, staff to encourage the resident to participate in ADLs during care, and the resident required weight bearing assistance including holding, lifting, or supporting trunk or limbs, with toileting hygiene, showering or bathing, upper and lower body dressing, shower transfers, and wheelchair mobility. Review of Resident #111's shower sheets dated May 2024, June 2024, and July 2024 revealed the resident was scheduled to have showers every Monday, Wednesday, and Friday, and out of 40 scheduled showers, seven were provided with three refusals noted during the months reviewed. Interview on 08/05/24 at 11:00 A.M. with Resident #111's wife revealed the resident did not receive showers per the facility schedule or preference. She stated there was one instance when she requested for the resident to have a shower due to going to the doctor's office for an appointment related to his catheter, the DON ensured her she asked her best aide to give him a shower and when he showed up to the appointment, the Physician and his nurse noted dried feces on his buttocks and yeast under his abdominal folds. The physician's appointment was on 06/18/24 and there was no coordinating shower sheet indicating a shower was completed that date. The Physician included in his progress notes that were sent back to the facility about the yeast in his abdominal folds and groin and the areas should be treated Interviews completed on 08/05/24 from 5:16 A.M. to 12:45 P.M. with LPN #799, LPN #801, LPN #802, LPN #803, LPN #804, LPN #805, STNA #806, STNA #807, and STNA #808 revealed showers are not completed as scheduled or per the residents' preference. Staff stated if the shower aides are pulled to the floor to cover call offs, showers are the responsibility of the aide assigned to care for the resident that shift when the resident is due for a shower and they do not have the time to complete the showers and their other duties. Interview on 08/07/24 at 3:43 P.M. with the Director of Nursing (DON) confirmed facility staff were to provide residents with showers or baths three times a week per the facility policy. Review of the undated facility policy titled Personal Care/Bathing revealed under the category Purpose the Residents of the health care facility of the corporation will receive personal care in the facility according to the Resident's plan of care to promote dignity, cleanliness, and general well-being. Under the category Procedure number one stated Shower, Bath, or Tub- offered to the the resident twice a week, as needed, and as often as the resident would like per their request. This deficiency represents non-compliance investigated under Master Complaint Number OH00156576 and OH00156524, OH00156388, and OH00156011.

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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** 44461 Based on closed record review and interview, the facility failed to ensure Resident #111, who had an indwelling urinary (Foley) catheter was provided care (including the administration of an antibiotic) as directed by the resident's urologist for a diagnosis of benign prostatic hyperplasia with lower urinary tract infection. This affected one resident (#111) of 16 sampled residents. Findings include: Review of Resident #111's closed medical record revealed an initial admitted [DATE] with a hospital stay from 06/01/24 to 06/05/24 and then a final discharge to the hospital on 07/20/24. Resident #111 had diagnoses including fracture of first lumbar vertebrae, non-displaced fracture or right index finger, left sided rib fracture, syncope and collapse, type II diabetes mellitus, laceration to right hand, muscle wasting and atrophy, repeated falls, benign prostatic hyperplasia with lower urinary tract infection, hypertension, pulmonary nodule, and thyroid nodule. Record review revealed the resident was admitted to the facility on [DATE] with an order for the antibiotic, Cipro 500 mg to be administered with each Foley catheter change. The resident was followed by a urologist and this order was in place due to the resident's diagnosis of benign prostatic hyperplasia with lower urinary tract infection. Review of Resident #111's medication administration record (MAR) and treatment administration record (TAR) from June 2024 revealed on 06/05/24 the resident received a dose of Cipro 500 mg with no correlating documentation on the TAR of a catheter change. However, on 06/07/24 and 06/08/24 there was documentation on the TAR of a catheter change due to the resident's catheter being clogged but no Cipro was documented as being administered. Review of Resident #111's discharge Minimum Data Set (MDS) dated [DATE] revealed the resident had cognitive impairment. The MDS assessment revealed the resident required setup or clean up assistance for eating, and oral hygiene. He required supervision or touching assistance for personal hygiene, and bed mobility. Finally, he required partial to moderate assistance for dressing and substantial to maximal assistance for toileting hygiene and showers. On 08/07/24 at 2:45 P.M. interview with LPN #811 revealed she had given Resident #111 a dose of Cipro on 06/08/24 with the catheter change but forgot to document the administration on the MAR. LPN #811 stated the resident's son had brought in a bag of medications from an outside pharmacy and this was where she took the Cipro from instead of obtaining the medication delivered from the facility pharmacy. On 08/07/24 at 3:43 P.M. interview with the DON confirmed on 06/05/24 Resident #111 received a dose of Cipro 500 mg but no catheter change was done. During the interview, the DON confirmed on 06/07/24 and on 06/08/24 Resident #111 had catheter changes completed with no Cipro documented as being given, however she stated in an interview with LPN #811, the LPN indicated she had given Resident #111 a dose of Cipro but did not document it on the MAR. Additionally the DON confirmed there was an order in place on the MAR and TAR to give Resident #111 Cipro 500 mg with each catheter change. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00156388.

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	365672	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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** 44461 Based on medical record review, resident representative interview, resident interview, staff interview, observation, review of the facility assessment, and review of the facility policy, the facility failed to maintain sufficient levels of nursing staff services to provide activities of daily living (ADL) assistance to residents according to their plan of care. This affected six (Residents #2, #24, #54, #61, #62, and #70) and had the potential to affect all 108 residents residing in the facility. Findings include: 1. Review of the medical record for Resident #2 revealed an admitted [DATE] with diagnoses including epilepsy, schizoaffective disorder, chronic obstructive pulmonary disorder, asthma, morbid obesity, generalized anxiety disorder, and hypertension. Review of the Minimum Data Set (MDS) assessment for Resident #2 dated 06/08/24 revealed the resident had intact cognition and required supervision or touching assistance with showers. Review of the care plan for Resident #2 revealed the resident required assistance with activities of daily living (ADLs) related to generalized muscle weakness, difficulty in walking, ataxia, major depressive disorder, anxiety disorder, hypertension, arthritis, seizure disorders, and neuropathy. Interventions included the following: staff to provide verbal cues or encouragement with bathing/showering care and needs, shower three times a week on Tuesday, Thursday, and Saturday, offer a wash up/clean up at the sink in between shower days. Review of the shower sheets for Resident #2 dated May 2024, June 2024, and July 2024 revealed the resident was scheduled for a shower on Tuesday, Thursday, and Saturday. Resident #2 received 16 of 39 scheduled showers with one documented refusal on 05/04/24. 2. Review of the medical record for Resident #24 revealed an admitted [DATE] with diagnoses including megaloblastic anemias, asthma, morbid obesity, congestive heart failure, type two diabetes mellitus, hypertension, and anxiety disorder. Review of the MDS assessment for Resident #24 dated 06/26/24 revealed the resident had intact cognition and required maximal assistance for bed mobility and was dependent on staff for toileting hygiene, dressing, personal hygiene, and showers. Review of the care plan for Resident #24 revealed the resident was dependent on staff for ADLs related to generalized muscle weakness, difficulty in walking, ataxia, muscle wasting and atrophy, morbid obesity, and anxiety disorder. Interventions included the following: staff to provide for showering care and needs, showers three times a week on Monday, Wednesday, and Friday. Review of the shower sheets for Resident #24 dated April 2024, May 2024, June 2024, and July 2024 revealed the resident was scheduled for showers on Monday, Wednesday, and Friday. Resident #24 received 14 of 48 scheduled showers with no documented refusals. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Review of the medical record for Resident #54 revealed an admitted [DATE] with diagnoses including multiple sclerosis, alcoholic cirrhosis of liver with ascites, peripheral vascular disease, osteoarthritis, and major depressive disorder. Review of the MDS assessment for Resident #54 dated 07/13/24 revealed the resident had intact cognition and required setup or clean up assistance for eating, oral hygiene, and personal hygiene. Resident #54 was dependent on staff for toileting hygiene and required partial to moderate assistance with dressing and required substantial to maximal assistance for bed mobility and showering. Review of the care plan for Resident #54 revealed the resident required assistance with ADLs related to impaired physical ability secondary to multiple sclerosis, generalized muscle weakness, and difficulty in walking. Interventions included the following: staff to encourage the resident to participate in ADLs during care, staff to assist with daily hygiene, staff to assist with showering as per facility policy. Review of the shower sheets for Resident #54 dated April 2024, May 2024, June 2024, and July 2024 revealed the resident was scheduled to have a shower on Monday, Wednesday, and Friday. Resident #54 received 18 of 44 scheduled showers with no documented refusals. 4. Review of the medical record for Resident #61 revealed an admitted [DATE] with diagnosis including unspecified fracture of first lumbar vertebra, hepatic encephalopathy, multiple rib fractures right and left side, esophageal varices without bleeding, and type two diabetes mellitus. Review of the MDS assessment for Resident #61 dated 06/26/24 revealed the resident had impaired cognition and required setup or cleanup assistance with eating, partial to moderate assistance with oral hygiene, and substantial to maximum assistance with toileting hygiene, dressing, personal hygiene, bed mobility and showers. Review of the care plan for Resident #61 revealed the resident required assistance with ADLs secondary to decreased mobility, difficulty in walking, weakness, recent fall at home, shortness of breath with activity, shortness of breath when lying flat, decompensated liver cirrhosis with ascites requiring paracentesis, syncope, chronic peripheral edema, end stage liver disease, portal hypertension, and hepatic encephalopathy. Interventions included the following: staff to adjust care as needed to meet resident's needs, staff to encourage resident to participate in ADLs during care, staff to assist as needed with daily hygiene, staff to assist with showering residents as per facility policy. Review of the shower sheets for Resident #61 dated June 2024, July 2024, and August 2024 revealed the resident was scheduled to have a shower on Tuesday, Thursday, and Saturday. Resident #61 received eight of 39 showers scheduled with no documented refusals. 5. Review of the medical record for Resident #62 revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side, generalized anxiety, and peripheral vascular disease. Review of the MDS assessment for Resident #62 dated 07/30/24 revealed the resident had impaired cognition, required setup or clean up assistance with eating, required substantial to maximal assistance with oral hygiene and dressing, and was dependent on staff for assistance with toileting hygiene, personal hygiene, bed mobility and showers. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the care plan for Resident #62 revealed the resident required assistance with ADLs related to impaired mobility, weakness, muscle wasting and atrophy, cognitive impairment, personal history or cerebral vascular accident, anxiety, depression, atrial fibrillation, and hypertension. Interventions included staff were to assist with all ADLs due to the resident being totally dependent and not able to participate in any aspect of the task for toileting hygiene, showering or bathing, dressing, and bed mobility. Review of the shower sheets for Resident #62 dated April 2024, May 2024, June 2024, and July 2024 revealed the resident was scheduled to have showers on Monday, Wednesday, and Friday. Resident #62 received 14 of 45 showers with six documented refusals and three showers not given due to the shower aide being pulled to the floor to cover call offs. 6. Review of the medical record for Resident #70 revealed an admitted [DATE] with diagnoses including hydrocephalus, chronic obstructive pulmonary disease, hypertension, type two diabetes mellitus, and peripheral vascular disease. Review of the MDS assessment for Resident #70 dated 07/27/24 revealed the resident had intact cognition, required setup or cleanup assistance for eating, and was dependent on staff for oral hygiene, toileting hygiene, dressing, personal hygiene, bed mobility, and showers. Review of the care plan for Resident #70 revealed the resident was at risk for decline in ADL function due to weakness, impaired mobility, lack of coordination, and right above the knee amputation. Interventions included the staff would assist as needed with daily hygiene and would assist with showering resident as per facility policy. Review of the shower sheets for Resident #70 dated May 2024, June 2024, and July 2024 revealed the resident was scheduled to have showers on Monday, Wednesday, and Friday. Resident #70 received 14 of 40 scheduled showers with two documented refusals and two showers not given due to the shower aide being pulled to the floor to cover call offs. Interview on 07/31/24 at 3:36 P.M. with Resident #61's family confirmed the resident did not receive her showers three times a week, and the facility staff did not answer the resident's call light timely. Interview on 08/01/24 at 11:35 A.M. with Resident #2 confirmed she did not receive her showers three times a week as scheduled and per her preference. Resident #2 confirmed the shower aides got pulled to the floor to cover call offs and when this happened showers were not completed, and they were not made up throughout the week. Interview on 08/01/24 at 11:55 A.M. with Resident #24 confirmed she did receive her showers as scheduled or how she preferred. Resident #24 confirmed she didn't get her showers when the shower aides were pulled to the floor or when they were off. Resident #24 further confirmed the aides on the floor did not have the time to do showers and there should be more staff. Interview on 08/01/24 at 12:10 P.M. with Resident #54 confirmed she did not receive her showers three times a week as scheduled. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interviews on 08/05/24 from 5:16 A.M. to 12:45 P.M. with Licensed Practical Nurse (LPN) #799, LPN #801, LPN #802, LPN #803, LPN #804, LPN #805, and State tested Nurse Aide (STNA) #806, STNA #807, and STNA #808 confirmed showers were not completed as scheduled or per the residents' preferences. Staff stated if the shower aides were pulled to the floor to cover call offs, showers were the responsibility of the aide assigned to resident. Staff confirmed they aides did not have time to complete the showers along with their other duties. Interview on 08/07/24 at 3:43 P.M. with the Director of Nursing (DON) confirmed facility staff were to provide residents with showers or baths three times a week per the facility policy. Interview on 08/12/24 at 5:05 P.M. with Resident #70 confirmed she had been up in her wheelchair since she had her shower at 10:30 A.M. Resident #70 confirmed she rarely received her showers as scheduled because the shower aides were pulled to the floor to cover call offs. Resident #70 confirmed her call light was behind her and tied to the side rail of the bed and she had not had her call light since staff put her in her wheelchair. Resident #70 confirmed the Surveyor could activate the call light to see how long it would take the staff to answer, and while waiting for staff to respond to the light, the resident stated they never come right away. Observation on 08/12/24 from 5:05 P.M. to 5:28 P.M. revealed Resident #70's call light was activated by the Surveyor with the resident's permission and no staff responded until the Administrator entered the room at 5:28 P.M. Multiple staff members walked past Resident #70's room, including nurses and aides, but did not respond to the activated call light. Interview on 08/12/24 at 5:28 P.M. with the Administrator confirmed Resident #70 stated she had been up since 10:30 A.M. with no staff member coming in to check on her, provide incontinence care or give the resident her call light. The Administrator confirmed multiple staff members had walked past Resident #70's activated light and were in the hallway. The Administrator further confirmed the Resident #70's call light was wrapped around the side rail on the resident's bed behind her and was not within reach of the resident. Review of the Facility assessment dated [DATE] revealed the average daily census at the facility was 104. There was no staffing plan outlined indicating staff needed to meet the acuity needs of the residents. Review of the facility policy titled Personal Care/Bathing undated revealed residents would receive personal care in the facility according to the resident's plan of care to promote dignity, cleanliness, and general well-being. Showers or baths should be offered to the resident twice a week, as needed, and as often as the resident would like per their request. Review of the facility policy titled Call Light Answering revised March 2019 revealed staff were to respond to a resident's call lights in a timely manner, evaluate the resident needs, turn off the call light in the room so that others know it has been answered, and complete the task the resident has requested, if able. If staff were unable to complete the requested task, they should inform the resident or family and notify the appropriate discipline. This deficiency represents noncompliance investigated under Master Complaint Number OH00156576 and Complaint Number OH00156545, OH00156524, OH00156388, OH00156011 and OH00155578.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 44461 Based on observation, record review and interview the facility failed to ensure posted staffing information was updated daily as required. This had the potential to affect all 108 residents residing in the facility. Findings include: On 08/05/24 at 4:45 A.M. the facility posted staffing information was observed. Review of the posted form revealed it was dated 08/01/24 and did not appear to have been updated daily with the facility staffing information on 08/02/24, 08/03/24, 08/04/24 or 08/05/24. On 08/05/24 at 5:00 A.M. interview with the Director of Nursing (DON) confirmed the current posted facility staffing information was dated from 08/01/24 and had not been updated since that date. The DON revealed it was the scheduler's responsibility to ensure staffing was posted/updated daily as required. On 08/12/24 at 4:35 P.M. interview with Scheduler #813 verified she was the staff person responsible for updating the facility daily posted information. Scheduler #813 revealed if she was off work, it was the DON's responsibility to post the information daily. Scheduler #813 revealed she had been on vacation during this time period and was unaware the information had not been posted after 08/01/24 as required. This deficiency is an incidental finding to Master Complaint Number OH00156576.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44461 Based on observation, record review, staff interview, and facility policy review the facility failed to maintain a medication administration error rate of less than five percent (%). The facility medication error rate was calculated to be 6.06% and included two errors of 33 opportunities. This affected one resident (#107) of three residents observed during the medication administration. The facility census was 108. Findings include: Review of the medical record for Resident #107 revealed an admitted [DATE] with diagnosis including type II diabetes mellitus (DM), heart failure, hypertension, and long term use of insulin. Review of Resident #107's physician orders dated August 2024 revealed the resident was to receive Carvedilol (Coreg) 12.5 milligrams (mg) by mouth twice a day for heart failure with an order to hold the medication if the resident's systolic blood pressure (SBP) was less than 110 millimeters of Mercury (mmHg). The resident also had an order to receive insulin, Toujeo SoloStar subcutaneous (sub-q) solution pen-injector 15 units in the morning related to type II DM. Review of Resident #107's Medication Administration Record (MAR) dated July 2024 and August 2024 revealed the resident had not received the Toujeo insulin since 07/30/24. In addition, the resident's blood pressure was not checked or documented prior to administration of Coreg in July 2024 or between 08/01/24 and 08/05/24 (the date of this record review). Review of Resident #107's progress notes from July 2024 to 08/05/24 revealed there was no documentation stating why the resident had not received her Toujeo. There was no evidence the physician and/or resident's family were notified. On 08/05/24 between 8:20 A.M. and 8:46 A.M. Licensed Practical Nurse (LPN) #803 was observed administering medications to Resident #107. At the time of the administration, LPN #803 did not check the resident's blood pressure (prior to administering the Coreg 12.5 mg. Observation of the physician order printed on medication card noted to hold the medication if the resident's SBP was less than 110 mmHg. Resident #107 was also scheduled to receive Toujeo 300 U/mL, however this medication was not available to give. On 08/05/24 at 8:57 A.M. interview with LPN #803 verified she had not taken Resident #107's blood pressure prior to administering the resident her Coreg 12.5 mg. LPN #803 confirmed the order in the electronic medical record and the printed order on the medication card both indicated to hold the medication if the resident's SBP was less than 110 mmHg. LPN #803 indicated she did not take the resident's blood pressure because the electronic medical record did not prompt her to take it. During the interview, LPN #803 also confirmed Resident #107's Toujeo was not given and not available to administer. The LPN verified the resident had not received the Toujeo since 07/30/24. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/05/24 at 10:10 A.M. interview with the Pharmacy Director revealed Resident #107's Toujeo insulin mediation was last filled and sent to the facility on [DATE] and arrived in the evening. The director reviewed the manifest and verified Resident #107's Toujeo was on it and the manifest was signed by a facility nurse confirming the medication was delivered/received by the facility. The Pharmacy Director indicated he did see the medication was then reordered (by the facility) on 07/28/24 and an electronic message was sent to the facility stating it was too soon to refill the medication. The facility reordered the medication again on 07/31/24 at which time the pharmacy again sent an message to the facility stating it was too soon to refill. The Pharmacy Director indicated the Toujeo pen the resident received should last approximately three weeks. Review of the undated facility policy titled Medication Administration-General Guidelines, revealed medications were to be administered according to written orders of the attending physician. This deficiency represents non-compliance investigated under Complaint Number OH00155752.