STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365674	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Minerva	400 Carolyn Court Minerva, OH 44657

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 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** 42015 Based on observation, interview, medical record review, and policy review the facility to maintain privacy during Resident 7's wound care and failed provide a covering to prevent Resident #51's urine from being visible related to his catheter. This affected two residents (#7 and #51) of two residents reviewed for dignity. The facility census was 69. Findings include: 1. Review of the medical record for Resident #7 revealed an admitted [DATE]. Diagnoses included spina bifida, paraplegia, and stage three pressure ulcers to the resident's right and left ischial tuberosity. Review of Resident #7's Quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively intact and had two stage three pressure areas. Observation on 08/21/24 at 1:06 P.M. through 1:20 P.M. revealed Licensed Practical Nurse (LPN) #216 and State tested Nursing Assistant (STNA) #502 entered Resident #7's room to complete wound care. LPN #216 left the resident's door open and pulled the treatment cart up to the resident's door. She opened the resident's curtain and began to complete wound care while STNA #502 assisted with positioning. The resident was positioned on her left side, exposing the resident's buttocks, abdomen, perineal area, and pressure wounds, during the treatment. The resident could be seen, from the hallway by other residents visitors and staff. Interview on 08/21/24 at 1:35 P.M. with LPN #216 verified she did not provide privacy by shutting Resident #7's door or closing her curtain during wound care. She also confirmed the resident could be visualized from the hallway while she was providing Resident #7's wound care. Review of the facility policy, Clean Dressing Change dated 12/28/23 revealed the first step for compliance was to explain the procedure to the resident and screen for privacy. 26706 2. Review of Resident #51's medical record revealed an admitted [DATE] with diagnoses including type II diabetes, generalized anxiety, cognitive communication disorder, need for assistance with personal care, muscle weakness, obstructive and reflux uropathy. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS assessment dated [DATE] revealed the resident was moderately impaired for daily decision making, no upper or lower extremity impairment, used a walker and wheelchair for mobility, substantiation/maximal assistance for personal hygiene, toileting, rolling, and sitting to standing and was always incontinent of bowel and has an indwelling catheter. Observation on 08/19/24 at 10:28 A.M. revealed the resident was seated in his wheelchair, waiting to go out to smoke. A urinary catheter drainage bag was observed, uncovered, hanging under the resident's wheelchair, exposing yellow urine in the drainage bag and tubing. On 08/19/24 at 12:22 P.M. the resident was observed in the dining room, eating lunch, with the exposed catheter bag under his wheelchair. He had yellow urine in the bag. On 08/19/24 at 1:35 P.M. the resident was observed outside smoking with other residents. The urine drainage bag was hanging from underneath his wheelchair, and yellow urine was observed in the drainage bag. Interview on 08/19/24 at 4:51 P.M. with the Director of Nursing and Administrator verified the resident's catheter bag was not covered and was exposing his urine. Review of the facility's Catheter Care Procedure Urinary policy revised 12/28/23 included provide catheter care in accordance with current clinical standards. Privacy bags are used to cover catheter drainage bags while in use.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28701 Based on observation, medical record review, policy review and staff interview the facility failed to ensure the use of a geri chair was appropriate and not considered a restraint. This affected one (Resident #58) of one residents reviewed for restraints. The facility census was 69. Findings include: Observation of Resident #58 throughout the annual survey from 08/19/24 to 08/22/24 revealed the resident seated in a reclined geri chair (comfortable and supportive wheeled seating solution beyond typical wheelchairs and recliners). Review of Resident #58's medical record revealed an admitted [DATE] with diagnosis that included cerebrovascular accident with hemiplegia, prostate cancer and vascular dementia. Review of Resident #58's Minimum Data Set (MDS) 3.0 quarterly assessment with a reference date of 07/24/24 indicated the resident had a severely impaired cognition level and indicated no restraint use in place for the resident. Review of the resident assessments found no evidence of any type of assessment for the use of the geri chair to determine if the resident was able to release the chair from the reclining position independently. Additional review of the medical record revealed physician's orders from 02/21/24 to 05/06/24 for the use of a broda chair (wheeled, reclined and padded wheelchair). A safety device assessment for the use of the broda chair was completed on 05/02/24 which indicated the device was utilized for end of life care and comfort care. Review of Resident #58's care plans revealed no evidence of any use of a geri chair. On 08/21/24 at 10:30 A.M. interview with the Director of Nursing verified there was no order or assessment prior to the use of the geri chair for Resident #58. Review of the facility policy titled Use of Assistive Devices with a revision date of 10/26/23 indicated use of assistance devices will be based on the resident's comprehensive assessment. The policy did not indicate a physician's order was required for use.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on observation, record review, and interview, the facility failed to provide comprehensive, resident centered activities for dependent residents. This affected two (Resident's #35 and #42) of three residents reviewed for activities. The census was 69. Findings include: 1. Review of Resident #35's medical record revealed an admitted [DATE] with diagnoses including palliative care, Parkinson's disease, vascular dementia, psychotic disturbance, mood disturbance and anxiety, depression, and weakness. Review of an Activities Evaluation dated 06/24/24 revealed he finds strength in faith/religion, gardening/outdoors, movies/television, music/talk radio, pet visits, religious activities, and beauty and barber. Prefers activities in his room in the afternoon and evenings and 1:1 activities. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was moderately impaired for daily decision making, no behaviors, has little interest or pleasure in doing things, feeling down, depressed or hopeless, and sometimes social isolation. It was very important to him to have snacks available between meals, chose a bedtime, have family involved, listen to music, somewhat important to be around pets, do favorite activities, participate in religious services, and go outside when the weather was good. His family provided the answers to the assessment. He had no upper or lower extremity impairment, partial moderate assist for eating, oral hygiene, substantial/maximum assistance for toileting, dressing, personal hygiene, and from rolling from left to right, sit to lying Review of an Activity plan of care dated 07/03/24 and revised 07/08/24 revealed Resident #35 was at risk for altered activity patterns/pursuits related to decline in health status. The resident will express satisfaction with the type of activities and level of activity involvement when asked, 1:1 visits from staff and volunteers as resident will allow, allow resident to make choices/decisions about their preferred activity pursuits, encourage to participate in leisure interests throughout the day, provide, when possible, based on interest (internet access, preferred radio programs, audio books, library books, word puzzles, magazines, etc.) for in-room use, provide resident with activity calendar, enjoys religious activities, and respect wishes to decline invitations into structured activity programs. Review of the State tested Nursing Assistant (STNA) task list in the electronic documentation system included one 1:1 activity for music on 07/22/24, and an activity refusal on 07/27/24 for planned activities. The music 1:1 was the only activity documented in the electronic record in the last 30 days. Observation 08/19/24 at 10:00 A.M. revealed the resident was on an alternating air mattress while he was in bed. Additional observations at 10:15 A.M., 12:56 P.M. and 4:30 P.M. revealed the resident remained in bed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview 08/19/24 at 1:59 P.M. with the resident's wife revealed her husband does not get out of bed. He doesn't watch television and isn't interested in a whole lot. Activities does not come in and interact with him. Observation 08/20/24 at 9:37 A.M., 12;03 P.M., 1:57 P.M., 2:09 P.M., and 5:57 P.M. the resident was in bed. His television was not on and a radio was not playing in the room. Interview on 08/21/24 at 9:54 A.M. with Resident #35 revealed no one has brought a pet in for him to see and he doesn't think anyone has read scripture to him. The resident stated it hurts to move. Observation 08/21/24 at 9:54 A.M. and 12:36 P.M. and 08/22/24 at 9:06 A.M. the resident was more awake and did not get out of bed. His television was not on. There was not a radio playing in the room. There were no observations of activities interacting with the resident. Review of the activity 1:1 binder revealed there was not a 1:1 sheet for Resident #35. Review of the monthly calendar for August 2024 revealed the resident had on the television/movie in room, radio, reminisce, conversation, sermon on in room on television on Sundays. There were up to five refusals a day marked on the activity sheet, 50 refusals in the first 19 days of the month. Interview 08/20/24 at 2:43 P.M. with Activities Aide #267 verified she does not ask Resident #35 if he wants to attend activities because he stays in bed. She stated she was new to her position in the last few months and said she was taught if a resident did not come to an activity, to mark them as refused even if she did not ask them if they wanted to attend. She said she did not have a 1:1 activity sheet for the resident but had cleaned his fingernails a few times when his wife asked her to. Interview on 08/20/24 at 2:47 P.M. with Activities Director #200 revealed she missed putting a 1:1 sheet in the binder for Resident #35. She verified the 1:1's were not completed per the plan of care for a hospice resident who was bed bound. Activity Director #200 further verified refused should not be marked on activity sheets if the resident was not asked or did not refuse to attend an activity. 2. Review of Resident #42's medical record revealed an initial admitted [DATE] and re-admitted [DATE] with diagnoses including traumatic subarachnoid hemorrhage contracture of muscle right forearm, left forearm, tracheostomy, seizures, dysphagia, cognitive communication disorder, and persistent vegetative state. Review of the activity plan of care dated 08/03/23 revealed the resident was at risk for altered activity patterns/pursuits related to being dependent on staff for meeting social needs. Resident is at risk for altered activity patterns/pursuits related to resident will accept and participate in 1:1 visits as evidenced by turning head, making eye contact one to two times a week from staff and volunteers. The resident's preferred activities are: offer aromatherapy, being read to, and music. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Annual MDS dated [DATE] revealed the resident was severely impaired for daily decision making,, behaviors not present, little interest or pleasure in doing anything, feeling tired or having little energy, being short tempered and easily annoyed, rejection of care one to three days, it was somewhat important to take care of personal belongings, have animals around, keep up with the news, and to get fresh air when the weather is good. It was very important to chose between a tub bath, shower, bed bath or sponge bath, choose bedtime, have family involved, to listen to music, and do favorite activities. The resident had upper and lower extremity impairment on both sides, totally dependent for all care, always incontinent of bowel and bladder, received scheduled pain medication, tube feed (enteral nutrition), oxygen and tracheostomy. Review of the residents 1:1 activity sheet revealed 1:1 activities were not offered one to two times a week per the resident's plan of care. There was not a 1:1 activity between 06/03/24 and 06/16/23 (13 days) and between 07/25/24 and 08/09/24 (15 days). There was no aroma therapy, a preferred activity, since May 2024. Review of the monthly activity log for August 2024 revealed two to four refusals a day for activities, 54 refusals marked in the first 20 days of the month. The resident had movie/TV in his room, radio on and visitors as the only activities marked for the month. Observation of the resident on 08/19/24 at 10:00 A.M. revealed a sign on his wall that stated please have resident up in chair and taken to all in-house activities every day, No exceptions. Resident is to be up, dressed, and taken to the day room during the day to allow interaction with staff and residents. The resident was laying in bed, dressed in a t-shirt, sweatpants and socks. He was receiving oxygen per a tracheostomy mask, receiving enteral nutrition via a pump. The resident's eyes were open but made no eye contact when spoken to. The radio in his room was playing music. On 08/19/24 at 4:33 P.M., 08/20/24 at 9:30 A.M., 12:25 P.M., 1:59 P.M., 5:58 P.M. and 08/22/24 at 9:01 A.M the resident was observed either in his bed or in a wheelchair in his room. The radio was on during observations. There were no observations of the resident out of his room, with the television on or engaged with activity staff. Interview 08/20/24 at 2:43 P.M. with Activities Aide #267 revealed she does not ask Resident #42 if he wants to come to activities. She said she only asks the residents who usually come to activities. She stated she was new in the last few months and indicated she was taught if a resident did not come to an activity, to mark them as refused even if she did not ask them if they wanted to attend. She verified did not know he had a sign on his wall to attend all activities. Interview 08/20/24 at 02:49 P.M. with Activities Director #200 revealed she was short of staff so 1:1's were not completed one to two a week. Activity Director #200 further verified refused should not be marked on activity sheets if the resident was not asked or did not refuse to attend an activity. Interview 08/21/24 at 4:10 P.M. with the Director of Nursing DON revealed she called the resident's mother, who said the note on the wall to take to activities was an old note from when he first arrived at the facility and his mother does not expect him to be out at all activities. The DON verified the note should not be on the wall if it was outdated and it was not to be followed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Activities policy revised 10/30/23 revealed activities will be designed with the intent to enhance the resident's sense of well-being , belonging, and usefulness, promote physical activity, cognition, emotional health, self esteem, dignity, pleasure, comfort, education, creativity, success and independence, reflect age and interest, cultural and religious interests.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on observation, record review, policy and interview, the facility failed to ensure preventative skin care was provided to residents with pressure ulcers. This affected one (Resident #35) of three residents reviewed for pressure ulcers. The census was 69. Findings include: Review of Resident #35's medical record revealed an admitted [DATE] with diagnoses including palliative care, Parkinson's disease, vascular dementia, psychotic disturbance, mood disturbance and anxiety, depression, weakness, chronic obstructive pulmonary disease, transient cerebral ischemic attack, and hypertension. Review of a Braden Scale for Predicting Pressure Sore Risk dated 06/23/24 revealed the resident had no sensory impairment, skin was occasionally moist, walks occasionally, very limited mobility, probably inadequate nutrition, potential problem with shear and friction, and was identified at risk for pressure ulcer development. Review of a resident plan of care for at Risk for Impaired Skin Integrity related to decline in mobility, and end of life/hospice care was initiated 06/24/24. The goal was the resident will have intact skin to the extent allowed by the resident's age, mobility status, continence status, nutritional status, medication and/or treatment compliance, medical condition and/or comorbidities, and compliance with wound prevention recommendations. Interventions included to apply protective barrier cream after each incontinence episode. Review of a wound evaluation dated 06/27/24 revealed the resident had a Kennedy terminal ulcer (dark sores that develop rapidly in the final stages of life), Stage 1 (the mildest and affects the upper layer of your skin. In this stage, the wound has not yet opened) measuring 5.39 centimeters (cm) length x 5.02 cm width. Review of the Admission Minimum Data Set assessment dated [DATE] revealed the resident was moderately impaired (cognition) for daily decision making, He had no upper or lower upper extremity impairment, partial moderate assist for eating, oral hygiene, substantial/maximum assistance for toileting, dressing, personal hygiene, rolling from left to right, sit to lying, and was frequently incontinent of urine and always incontinent of bowel. Review of physician orders dated 08/01/24 revealed to cleanse the sacrum with generic wound cleanser, pat dry, apply medihoney and calcium alginate, cover with silicone foam dressing (four by four) daily and as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of a dressing change on 08/21/24 at 12:42 P.M. with Licensed Practical Nurses #246 and #237 revealed the sacrum had several open areas. The resident was turned onto his right side. He had a small bowel movement contained between his gluteal folds. LPN #237 performed the dressing change. The open areas left spots of blood on the resident's brief and the periwound area was deep red. After cleansing the wound, calcium alginate, medihoney and a foam dressing was applied. LPN #237 then cleansed the bowel movement. The resident had deep red skin between his gluteal folds. The LPN's cleaned the bowel movement, and placed a clean brief on the resident. The staff did not apply barrier cream to the red periwound or red gluteal folds areas. Barrier cream was observed on the resident's chest of drawers in his room. Interview 08/21/24 at 1:00 P.M. with LPN's #246 and #237 verified between the resident's gluteal folds his skin was deep red and the periwound exposed outside of the resident's newly placed sacral dressing was red. Both nurses verified the resident had barrier cream available that should have been applied per his plan of care. Review of the facility's Pressure Injury Prevention Guidelines policy revised 03/20/24 included to prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of the facility to implement evidence based interventions for residents who are assessed at risk or have a pressure injury present.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on medical record review, staff interview, and review of the facility policy, the facility failed to adequately monitor enteral nutrition administration for Resident #42 which resulted in a significant weight loss. In addition, the facility did not notify the physician or Registered Dietitian of the significant weight loss in a timely manner. This affected one resident (#42) of one identified by the facility as receiving enteral nutrition. The facility census was 69. Findings include: Review of the medical record for Resident #42 revealed an admitted [DATE] with diagnoses including traumatic brain injury, severe protein-calorie malnutrition, gastrostomy status, dysphagia, persistent vegetative state, aphasia, and tracheostomy status. Review of the physician's orders for June 2024 identified orders for Nutren 2.0 at 50 milliliters (ml) per hour for 24 hours and may substitute Jevity 1.5 if Nutren is unavailable (ordered 05/23/24). The order did not specify an administration rate for the substitution of Jevity 1.5. Review of the Medication Administration Record (MAR) for June 2024 revealed there was no documentation of Resident #42's enteral nutrition being held at any point from 06/01/24 to 06/30/24 and it was documented that Resident #42 received 400 ml of Nutren 2.0 on each of three shifts every day, which indicated Resident #42 received the full ordered amount of 1200 ml per day, every day. There were no variances in the amount of formula infused and every shift was documented as exactly 400 ml infused. Enteral feeding residuals were documented ranging from 0 ml to 60 ml and there was no documentation on the MAR of any residual greater than 60 ml. On 06/09/2024 Resident #42 weighed 161.2 pounds (lbs) and on 07/03/2024 Resident #42 weighed 150.7 lbs, which is a significant weight loss of 10.5 pounds (6.51%) in one month. On 07/04/24 Resident #42 weighed 150.7 pounds. There was no documentation in the medical record of the physician or Registered Dietitian (RD) #278 being notified of the weight loss. Review of the progress note dated 06/17/24 at 5:27 A.M. revealed Resident #42 had emesis, the physician was notified and stated to check residuals and report any further episodes of emesis, Resident #42 had further emesis and residuals greater than 100 ml during morning medication pass, and the tube feeding was turned off. Review of the progress note dated 06/17/24 at 4:29 P.M. revealed Resident #42 had no further emesis. Further review of the progress notes dated 06/17/24 through 07/09/24 revealed there were no additional nurses notes indicating the tube feeding was turned off or held, there was no note indicating how long the tube feeding was turned off on 06/17/24 or when it was turned back on, and there were no notes indicating Jevity 1.5 had to be used due to unavailability of Nutren 2.0. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nutrition progress note dated 07/09/24 at 10:50 A.M. revealed Resident #42 had a 6.5% weight loss from 06/09/24 to 07/04/24. The note indicated Resident #42 had a period of intolerance as evidenced by emesis and Jevity 1.5 had to be used for a period of time as Nutren 2.0 was unavailable. The note did not specify a timeframe for the intolerance or use of Jevity 1.5, and the note did not specify an administration rate for Jevity 1.5. RD #278 recommended continuing the tube feeding as ordered and starting weekly weights. On 08/21/24 at 5:37 P.M., an interview with the Director of Nursing (DON) confirmed the MAR for June 2024 indicated Resident #42 received the same amount of formula on every shift, there was no indication on the MAR for when Jevity 1.5 had to be used, there was no specification in the order for an administration rate if Jevity 1.5 had to be substituted for Nutren 2.0, and the nurses note on 06/17/24 indicated Resident #42's tube feeding had to be turned off. She further stated that when the weight loss occurred, she told RD #278 that weight loss for a resident with tube feeding is the facility's fault. On 08/22/24 at 8:41 A.M., an interview with the DON stated RD #278 should have specified an administration rate for the use of Jevity 1.5. She also confirmed that although there was a nurses note indicating the tube feeding was held, the documentation on the MAR indicated the full amount of formula was provided and there was no indication on the MAR that the tube feeding was held at any point. The DON further stated that the nurse on duty that day verified to the DON that she did not document when the tube feeding was held or how long it was held. On 08/22/24 at 10:49 A.M., an interview with RD #278 stated Resident #42 was not tolerating his tube feed for a period of time and the tube feed had to be stopped for a period of time. He further stated the facility was short on Nutren 2.0 and Jevity 1.5 had to be used for a short period of time which could have contributed to the weight loss. RD #278 stated he did not know at what rate Jevity 1.5 was administered and he did not know how long Jevity 1.5 had to be used in place of Nutren 2.0. RD #278 said ideally, nursing should have contacted him when Jevity 1.5 had to be substituted so a rate adjustment could be made. He further stated when he reviewed the weight loss, he did not review the tube feed formula intake documentation on the MAR and he only used the information told to him by the nurses. RD #278 said he thought the main cause of the weight loss was inadequate nutrition provided via tube feed due to the tube feed being held and Jevity 1.5 being substituted for Nutren 2.0. On 08/22/24 at 12:22 P.M., an interview with the DON verified there was no documentation of the physician or RD #278 being notified of the weight loss on 07/03/24 (which was a Wednesday). The DON further stated that the interdisciplinary team (IDT) meets on Mondays and Tuesdays and the notification would not have occurred until the following Monday at the IDT meeting. Review of the facility's policy titled Feeding Tubes, revised 06/30/22, revealed feeding tubes would be used when medically necessary to maintain acceptable parameters of nutrition and hydration, the RD would estimate a resident's daily nutritional and hydration needs, staff would be directed on the types of enteral nutrition formulas available for use, the facility would collaborate with the RD to determine whether the tube feedings meet the resident's needs and when to adjust them accordingly, staff would ensure the administration of enteral nutrition was consistent with and followed the practitioner's orders, and the facility would notify and involve the physician or designated practitioner of any complications. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Minerva	400 Carolyn Court Minerva, OH 44657

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Weight Monitoring, revised 10/26/23, revealed the facility would ensure all residents maintained acceptable parameters of nutritional status, interventions would be identified and implemented with ongoing monitoring to maintain acceptable parameters of nutrition with intervention modifications made as appropriate, a significant change was defined as a 5% change in one month or a 7. 5% change in three months or a 10% change in six months, the physician should be informed of a significant weight loss, meal consumption information should be recorded and may be referenced by the IDT as needed, the RD should be consulted to assist with interventions and actions should be recorded in the nutrition progress notes, and care instructions should be communicated to facility staff by the IDT.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on observation, record review and interview, the facility failed to label the contents in a tube feeding/enteral nutrition bag. This affected one (Resident #42) of one residents reviewed for tube feeding. The census was 69. Findings include: Review of Resident #42's medical record revealed an admitted [DATE] and readmitted [DATE] with diagnoses including traumatic subarachnoid hemorrhage, severe protein calorie malnutrition, gastrostomy, tracheostomy, seizures, dysphagia, cognitive communication disorder, and persistent vegetative state. Physician orders included a 05/23/24 order for Nutren 2.0 calorie at 50 millimeters (ml) an hour. Review of the 07/16/24 Annual Minimum Data Set (MDS) Assessment revealed the resident was severely impaired for daily decision making and the resident received tube feeding. Observation of Resident #42 on 08/19/24 at 10:00 A.M. revealed the resident had tube feeding infusing at 50 milliliters an hour through a gastrostomy tube. The bag of tube feeding was labeled with the resident's last name and dated 08/19/24. The label did not identify what was poured into the bag or at what time. Interview and observation on 08/19/24 at 4:33 P.M. with the Director of Nursing and Administrator verified the tube feeding was placed into a bag and the contents were not identified. It was undetermined what type of tube feeding was in the bag infusing. Review of the facility's Tube Feeding policy last updated 06/30/22 included ensuring the administration of enteral nutrition is consistent with and follows the practitioners orders.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on observation, record review, policy and interview, the facility failed to ensure oxygen tubing was dated when changed. This affected two (Resident's #32 and #35) of two residents reviewed for oxygen therapy. The census was 69. Findings include: 1. Review of Resident #35's medical record revealed admitted [DATE] with diagnoses including dysphagia, palliative care, Parkinson's disease, vascular dementia, psychotic disturbance, mood disturbance and anxiety, depression, chronic obstructive pulmonary disease, transient cerebral ischemic attack, and hypertension. Physician orders included an order dated 06/22/24 for oxygen tubing/filter to be changed every week. An order dated 07/29/24 to run the oxygen at 4.0 liters per minute continuous. Review of the Admission Minimum Data Set assessment dated [DATE] included the resident was moderately impaired for daily decision making and he received oxygen. Observation on 08/19/24 at 10:00 A.M. revealed the resident was in bed, His nasal cannula was on the floor, The oxygen condenser was set at 3.5 Liters Per Minute (LPM). The nasal cannula equipment was not dated but bag hanging on the oxygen condenser said 08/01/24, A nebulizer mask was on the bedside table not in the bag. The nebulizer mask had white spots inside the mask and the mask was dated 08/01/24. Review of the August treatment sheet revealed the oxygen tubing was signed off as being changed on 08/08/24, and 08/14/24 but the tubing was dated 08/01/24. Observation and interview on 08/19/24 at 4:32 P.M. with the Director of Nursing (DON) and the Administrator verified the nasal cannula attached to the oxygen condenser was not dated but the bag said 08/01/24. Further interview verified the nebulizer mask was soiled and not replaced as per policy. Interview 08/20/24 at 11:49 A.M. with the DON verified the treatment to change oxygen tubing weekly was signed off as completed weekly when it had not been changed. 2. Review of Resident #32's medical record revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, cognitive communication deficit, muscle weakness, difficulty walking, anxiety disorder, need for assistance with personal care, and hypertension. A plan of care for pulmonary/respiratory status related to Chronic Obstructive Pulmonary Disease (COPD) initiated 01/31/24 included to administer oxygen as ordered. Physician orders included on 01/31/24 an order for oxygen tubing/filter change every week on Wednesday night shift. On 02/05/24 oxygen saturation every shift and as needed, and oxygen two to four liters per minute continuous via nasal cannula to keep oxygen saturation greater than 92 percent. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 08/06/24 Quarterly Minimum Data Set Assessment (MDS) revealed the resident was moderately impaired for daily decision making, and received oxygen. Observation 08/19/24 at 11:13 A.M. the resident was in physical therapy. He had oxygen being delivered via canister at three liters per minute (LPM). The nasal cannula tubing was dated 07/07/24. Review of the treatment sheets revealed the treatment to change the oxygen tubing weekly was signed off as completed 08/07/24 and 08/14/24. The tubing was signed of as being changed weekly when it was dated 07/07/24. Observation and interview 08/19/24 at 4:37 P.M. with the Director of Nursing (DON) and the Administrator verified the nasal cannula attached to the oxygen canister on his wheelchair was dated 07/07/24 and was not changed per orders Interview 08/20/24 at 11:49 A.M. with the DON verified the treatment to change oxygen tubing weekly was signed off as completed weekly when it had not been changed.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 42015 Based on employee file review, staff interview and review of facility policy, the facility failed to ensure State tested Nursing Assistants (STNAs) had evaluations completed as required. This had the potential to affect all 69 residents residing in the facility. Findings Include: Review of the employee file for State tested Nursing Assistant (STNA) #274 revealed a hire date of 06/14/23. No annual performance evaluation was found. Review of the employee file for STNA #219 revealed a hire date of 08/17/22. No annual performance evaluation was found. Review of the employee file for STNA #501 revealed a hire date of 02/2024. A 90-day performance evaluation was not found. Interview on 08/22/24 at 12:30 P.M. the facility Administrator verified the evaluations for STNAs #274, STNA #219, and STNA #501 were not completed. Review of the facility policy Performance Appraisals dated 01/01/22 revealed it is the facility policy to evaluate performance of employees at least annually.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on medical record review, review of pharmacy recommendations, and staff interview, the facility did not ensure pharmacy recommendations were reviewed and addressed by a physician in a timely manner. This affected three residents (#10, #51, and #58) of five reviewed for unnecessary medications. The facility census was 69. Findings include: 1. Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses including major depressive disorder, hypertension, type two diabetes mellitus, morbid obesity, congestive heart failure, vitamin D deficiency, personal history of transient ischemic attack and cerebral infarction, and chronic obstructive pulmonary disorder. Review of the physician's orders for August 2024 identified orders for Mirtazapine tablet 15 milligrams (mg) one tablet once daily at bedtime (ordered 11/30/21), Rivaroxaban 20 mg one tablet once daily in the evening (ordered 11/01/22), Diltiazem HCl extended release 12 hour 120 mg one capsule once daily in the morning (ordered 12/08/23), and Vitamin D 1.25 mg (50,000 UT) one capsule once weekly on Thursday (ordered 08/02/22). Review of the pharmacy recommendation dated 03/06/24 revealed a recommendation was made to discontinue Mirtazapine. The physician/prescriber response section on the recommendation form was blank. Review of the pharmacy recommendation dated 03/06/24 revealed a recommendation was made to re-evaluate use of Rivaroxaban due to updated criteria which recommended to avoid using for long-term treatment of nonvalvular atrial fibrillation and venous thrombosis. The physician/prescriber response section on the recommendation form was blank. Review of the pharmacy recommendation dated 04/03/24 revealed a recommendation was made to change Diltiazem extended release 12 hour capsule from once daily to twice daily. The physician/prescriber response section on the recommendation form was blank. Review of the psychiatric provider note dated 05/31/24 revealed use of Mirtazapine was addressed, which was 86 days after the pharmacy recommendation was made. Review of the pharmacy recommendation dated 06/13/24 revealed a recommendation was made to change the order for Vitamin D from weekly to monthly. The physician/prescriber response section on the recommendation form was blank. On 08/20/24 at 4:29 P.M., an interview with the Director of Nursing (DON) verified the pharmacy recommendations forms did not have a provider response on the forms and she was unable to locate any evidence in the medical records that the recommendations were addressed by a physician. 28701 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #58's medical record revealed an admitted [DATE] with diagnoses that included cerebrovascular accident with hemiplegia, prostate cancer and vascular dementia. Further review of the medical record including pharmacist recommendations revealed on 07/11/24 the pharmacist made a recommendation to evaluate continued use of Lipitor (cholesterol lowering medication) due to resident receiving end of life hospice services at this time. No evidence was found indicating the physician was notified and reviewed the pharmacist recommendation as of 08/21/24. On 08/21/24 at 1:30 P.M. interview with the Director of Nursing verified the pharmacy recommendation dated 07/11/24 had not been reviewed and addressed by Resident #58's physician. 26706 3. Review of Resident #51's medical record revealed an admitted [DATE] with diagnoses including type 2 diabetes, generalized anxiety, cognitive communication disorder, depression, need for assistance with personal care, metabolic encephalopathy, gastroesophageal reflux disease without esophagitis, bipolar disorder, peripheral vascular disease, nicotine dependence, difficulty walking, muscle weakness, fractured femur, obstructive and reflux uropathy, anemia, hypertension, acquired absence of left great toe, acute respiratory failure, anemia, acute embolism and thrombosis of unspecified vein, Parkinson's disease, chronic obstructive pulmonary disease, severe sepsis with septic shock and ventilator associated pneumonia. Review of the 08/30/23 pharmacy review recommendation included to make order read Miralax or polyethylene 17 Grams (gm) in six to eight ounces of liquid and give by mouth or gastrostomy tube. Review revealed the order was not updated until 01/09/24 to please update the Miralax order to include dissolve in 4-8 ounces of liquid and drink. Review of a 03/06/24 pharmacy recommendation included please update the Miralax order to include: dissolve in six to eight ounces of liquid and drink. The order was not updated until 06/24/24. Review of a 04/03/24 Note to Attending Physician from the Pharmacist included the resident has an order for Depakote Delayed Release (DR) 500 milligrams (mg) every morning. The DR formulation is twice daily, Extended release (ER) is once daily. Should this be Depakote ER 500 mg every morning? The order was not changed until 06/24/24 when the DR was discontinued and Depakote ER 500 mg was ordered every morning. The 07/11/24 pharmacy recommendation included the resident has been taking the antidepressant Zoloft 25 mg every bedtime and Depakote ER 500 mg every morning. Please evaluate the current dose and consider a reduction. The recommendation had not yet been addressed on 08/21/24. Interview 08/21/24 at 3:00 P.M. with the Director of Nursing verified the physician had not addressed pharmacy recommendations timely. Further verified several recommendations were for the same medication where the order was not clarified on readmission. Review of the facility's Addressing Medication Regimen Review Irregularities last revised 12/28/23 included facility nursing staff will notify attending physician of any recommendations and forward a copy to the medical director and Director of Nursing. If orders are received via telephone the nurse shall indicate in the nursing response portion of the form.

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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** 42015 Based on observations, medical record review, staff interview, and review of the facility policy the facility failed to maintain a medication error rate of less than five percent (%). The medication error rate was calculated to be 7.69% which included two medication errors of 26 medication administration opportunities. This affected one resident (Resident #22) of six residents observed for medication administration. The facility census was 69. Findings include: Review of the medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease with acute exacerbation (COPD), myocardial infarction, Coronary artery disease (CAD), and cute respiratory failure with hypoxia. Review of Resident #22 physician orders dated August 2024 revealed an order for Amlodipine Besylate Oral Tablet 5 mg by mouth in the morning for CAD and Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 MCG inhale one puff orally in the morning for COPD. Observation of medication administration on 08/20/24 08:42 A.M. revealed Registered Nurse (RN) #208 preparing medications to administer to Resident#22. The following medications were administered: Amlodipine Besylate 10 milligrams (mg) oral tablet, Plavix 75 mg, Gabapentin 600 mg, Hydroxyzine 75 mg, Omeprazole 20 mg, Carvedilol 6.25 mg, Isosorbide Mononitrate ER Tablet Extended Release 24 Hour 30 MG, Cozaar Tablet 25 MG, Iron 325 mg, and B 12 1000 micrograms (mcg), and Folic Acid 1 mg. Additionally RN #208 assisted with administering the residents Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 mcg inhaler by holding it to her mouth and activating the inhalant. RN #208 left the resident room without advising or assisting the resident with rinsing out her mouth after receiving her inhaler. Observation of the Trelegy Ellipta Inhalation storage box revealed to rinse mouth after use. Interview on 08/20/24 at 9:40 A.M. RN #208 confirmed she administered Amlodipine Besylate 10 mg when the order stated to administer 5 mgs. She revealed the order changed on 08/08/24 but the facility nurses had not replaced the 10 mg medication card with the 5 mg medication card. RN #208 was able to fine the correct card and dose in her medication cart unused. She also confirmed she did not advise or assist Resident #22 with rinsing her mouth after using her Trelegy inhaler. Review of the Trelegy Ellipta Inhalation Aerosol Powder Breath Activated insert revealed Candida albicans infection of the mouth and pharynx may occur. Monitor patients periodically. Advise the patient to rinse his/her mouth with water without swallowing after inhalation to help reduce the risk. Review of the facility policy, Medication Administration, dated 01/17/23 revealed facility nurses should compare medication source with the medication administration record to verify resident name, medication name, form, dose, route, and time.

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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** 26706 Based on observation, record review, and interview, the facility failed to maintain accurate medical records. This affected five (Resident's #4, #35, #37, #42, and #49) of 19 records reviewed. The census was 69. Findings include: 1. Review of Resident #35's medical record revealed an admitted [DATE] with diagnoses including dysphagia, palliative care, Parkinson's disease, vascular dementia, psychotic disturbance, mood disturbance and anxiety, depression, gastroesophageal reflux disease, weakness, chronic obstructive pulmonary disease, transient cerebral ischemic attack, and hypertension. Interview 08/19/24 at 01:59 P.M. with the resident's wife included her husband does not get out of bed. He doesn't watch television and isn't interested in a whole lot. Activities does not come in and interact with him. Review of the monthly calendar for August 2024 revealed the resident had on the television/movie in room, radio, reminisce, conversation, sermon on in room on television on Sundays. There were up to five refusals a day marked on the activity sheet, 50 refusals in the first 19 days of the month. Interview 08/20/24 at 2:43 P.M. with Activities Aide #267 revealed she does not ask Resident #35 if he wants to come to activities because he stays in bed. She stated she was new in the last few months. She indicated she was taught if a resident did not come to an activity to mark them as refused even if she did not ask them if they wanted to attend. Interview 08/20/24 02:47 P.M. with Activity Director #200 verified refused should not be marked on activity sheets if the resident was not asked or did not refuse to to attend an activity. Activity #200 verified it would be misleading to say a resident had refused to attend an activity when they had not been asked if they want to attend. 2. Review of Resident #42's medical record revealed an admitted [DATE] and re-admitted [DATE] with diagnoses including traumatic subarachnoid hemorrhage with loss of consciousness greater than 24 hours, severe protein calorie malnutrition, hyperosmolality and hypernatremia, contracture of muscle right forearm, left forearm, chronic respiratory failure with hypoxemia, gastrostomy, tracheostomy, seizures, dysphagia, cognitive communication disorder, wedge compression fracture of fourth lumbar vertebra, hypertension, esophageal reflux disease, post traumatic hydrocephalus, persistent vegetative state, and metabolic encephalopathy. The resident had a sign on his wall to please have the resident up in the chair and taken to all in-house activities every day, No exceptions. Resident is to be up, dressed, and taken to the day room during the day to allow interaction with staff and residents. Observation 08/19/24 at 10:00 A.M. of Resident #42 was lying in bed. His eyes were open but made no eye contact. He was dressed in a t shirt, sweat pants and socks. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/19/24 at 04:33 P.M., 08/20/24 at 9:30 A.M., 12:25 P.M., 1:59 P.M., 5:58 P.M. and 08/27/24 at 9:50 A.M. 08/22/24 at 9:01 A.M the resident was either in bed or in a wheelchair his room. The radio was on during observations. There were no observations of the resident out of his room, with the television on or engaged with activity staff. Review of the monthly activity log revealed in August two to four refusals a day for activities, 54 refusals marked in the first 20 days of the month. The resident had movie/TV in room, radio on and visitors as the only activities marked for the month. Interview 08/20/24 at 2:43 P.M. with Activities Aide #267 revealed she does not ask Resident #42 if he wants to come to activities. She said she only ask the residents who usually come to activities. She stated she was new in the last few months. She indicated she was taught if a patient did not come to an activity to mark them as refused even if she did not ask them if they wanted to attend. Interview 08/20/24 at 02:49 P.M. with Activities Director #200 revealed refused should not be marked on activity sheets if the resident was not asked or did not refuse to attend an activity. 3. Review of Resident #37 revealed a 09/23/23 admission with diagnoses including acute and chronic respiratory failure with hypoxia, COPD, congestive heart failure, osteoarthritis, type 2 diabetes, muscle weakness, morbid severe obesity, depression, asthma, hypertension, hypolipidemia, hypothyroidism, edema, insomnia, obstructive sleep apnea, and transient ischemic attack. Review of cut letters revealed the resident received Medicare Part A skilled services from 02/06/24 till 04/05/24. A facility initiated cut when days were not exhausted was signed 04/03/24 by the resident. A 10055 and 10123 were provided. The 10055 was marked the resident wanted to appeal. There was no evidence of the appeal being made. Interview 08/21/24 at 11:10 A.M. with Business Office Manager (BOM) #229 revealed she was with the resident when she signed the cut letter and she did not ask for an appeal. BOM #229 said she did not realize the resident filled in the square Option 1 indicating she wanted an appeal. Option 1: I want the care listed above. I want Medicare to be billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN). I understand if Medicare doesn't pay I'm responsible for paying, but I can appeal to Medicare by following the directions on MSN. BOM #229 did not file an appeal because the resident did not say she wanted one and must of marked that she did by mistake and she did not notice what was marked. Interview 08/21/24 at 11:19 A.M. with Resident #37 revealed she did not remember if she asked for an appeal or not. She was not upset about how services ended. 42015 4. Review of the medical record for Resident #49 revealed an admitted for 10/18/22. Diagnoses included unspecified dementia, mood disturbance, and chronic atrial fibrillation. Review of Resident #49's Quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had a severe cognitive impairment. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Minerva	400 Carolyn Court Minerva, OH 44657

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #49's Physician orders dated physician order dated 08/08/24, revealed Resident to be up in wheelchair for meals. Resident to be in dining room for meals. Observations of Resident #49 on 08/19/24 at 12:34 P.M., 08/20/24 at 9:56 A.M., 08/20/24 at 12:35 PM , and 08/21/24 at 11:01 A.M. revealed the resident was eating his in breakfast and lunch meals while in his bed. Review of Resident #49's medication administration record from 08/19.24 through 08/21/24 reveled the facility nurses were initialing that the resident was up in his chair at mealtimes. Interview on 08/21/24 at 9:31 A.M. with STNA #502 revealed the resident frequently refused to get out of bed but is offered to get up at each meal. Interview on 08/21/24 at 11:49 A.M. Interview with Registered Nurse (RN) #503 reported she has been documenting that Resident #49 is getting up for meals when he is actually refusing. She stated she thought that she was supposed to documented he was up for meals as long as the staff offered to get him up even if he refused. Interview on 08/21/24 at 12:38 P.M. the facility's Director of Nursing verified the facility's nurses are incorrectly documenting that Resident #49 is getting up out of bed for meals when he is refusing to do so. 44808 5. Review of the medical record for Resident #42 revealed an admitted [DATE] with diagnoses including traumatic brain injury, severe protein-calorie malnutrition, gastrostomy status, dysphagia, persistent vegetative state, aphasia, and tracheostomy status. Review of the physician's orders for June 2024 identified orders for Nutren 2.0 at 50 milliliters (ml) per hour for 24 hours and may substitute Jevity 1.5 if Nutren unavailable (ordered 05/23/24). The order did not specify an administration rate for the substitution of Jevity 1.5. Review of the Medication Administration Record (MAR) for June 2024 revealed there was documentation of Resident #42's enteral nutrition being held at any point from 06/01/24 to 06/30/24 and it was documented that Resident #42 received 400 ml of Nutren 2.0 on each of three shifts every day, which indicated Resident #42 received the full ordered amount of 1200 ml per day every day. There were no variances in the amount of formula infused and every shift was documented as exactly 400 ml infused. Enteral feeding residuals were documented ranging from 0 ml to 60 ml and there was no documentation on the MAR of any residual greater than 60 ml. Review of the progress note dated 06/17/24 at 5:27 A.M. revealed Resident #42 had emesis, the physician was notified and stated to check residuals and report any further episodes of emesis, Resident #42 had further emesis and residuals greater than 100 ml during morning medication pass, and the tube feed was turned off. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the progress notes dated 06/17/24 through 07/09/24 revealed there were no additional nurses notes indicating the tube feed was turned off or held, there was no note indicating how long the tube feed was turned off on 06/17/24 or when it was turned back on, and there were no notes indicating Jevity 1.5 had to be used due to unavailability of Nutren 2.0. Review of the nutrition progress note dated 07/09/24 at 10:50 A.M. revealed Resident #42 had a 6.5% weight loss from 06/09/24 to 07/04/24. The note indicated Resident #42 had a period of intolerance as evidenced by emesis and Jevity 1.5 had to be used for a period of time as Nutren 2.0 was unavailable. The note did not specify a timeframe for the intolerance or use of Jevity 1.5, and the note did not specify an administration rate for Jevity 1.5. RD #278 recommended continuing the tube feeding as ordered and starting weekly weights. On 08/21/24 at 5:37 P.M., an interview with the Director of Nursing (DON) confirmed the MAR for June 2024 indicated Resident #42 received the same amount of formula on every shift, there was no indication on the MAR for when Jevity 1.5 had to be used, there was no specification in the order for an administration rate if Jevity 1.5 had to be substituted for Nutren 2.0, and the nurses note on 06/17/24 indicated Resident #42's tube feed had to be turned off. On 08/22/24 at 8:41 A.M., an interview with the DON stated RD #278 should have specified an administration rate for the use of Jevity 1.5. She also confirmed that although there was a nurses note indicating the tube feed was held, the documentation on the MAR indicated the full amount of formula was provided and there was no indication on the MAR that the tube feeding was held at any point. The DON further stated that the nurse on duty that day verified to the DON that she did not document when the tube feed was held or how long it was held. 28701 6. Review of Resident #4's medical record revealed an admitted [DATE] with diagnoses that included end staff renal disease with hemodialysis, atrial fibrillation and diabetes mellitus. Further review of the medical record revealed Resident #4 currently received hemodialysis three times weekly. Review of a quarterly nutritional assessment completed on 07/19/24 indicated the facility dietician (RD #278) communicated with Resident #4's hemodialysis dietician who recommended to continue a regular diet, oral nutritional supplements and to add protein. Further review of the nutritional assessment indicated a recommendation to add 30 milliliters (ml) of liquid protein daily to provide an additional 100 kilocalories and 15 grams of protein. Further review of the medical record for Resident #4 found no evidence of any type of liquid protein supplement ordered or provided. A dietary progress note from 08/20/24 completed by RD #278 indicated a regular diet and four ounces of oral nutritional supplement three times daily. No evidence of any type of liquid protein supplement was noted. On 08/21/24 at 10:30 A.M. interview with the Director of Nursing indicated a she had communicated with RD #278 who indicated the recommendation of adding a liquid protein supplement was a documentation error as he and the dialysis RD had discussed the resident's current diet, oral nutritional supplement and weights and determined a liquid protein supplement was not indicated at this time.

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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** 26706 Based on record review, policy and interview, the facility failed to ensure Enhanced Barrier Precautions were in place, indwelling catheters were not dragging on the floor, handwashing met professional standards and tuberculin testing of staff was conducted on hire and annually. This affected Resident's #35 and #51 and had the potential to affect all the residents in the facility. The census was 69. Findings include: 1. Review of Resident #51's medical record revealed an admitted [DATE] with diagnoses including type 2 diabetes, generalized anxiety, cognitive communication disorder, depression, need for assistance with personal care, metabolic encephalopathy, gastroesophageal reflux disease without esophagitis, bipolar disorder, peripheral vascular disease, nicotine dependence, difficulty walking, muscle weakness, fractured femur, obstructive and reflux uropathy, anemia, hypertension, acquired absence of left great toe, acute respiratory failure, anemia, acute embolism and thrombosis of unspecified vein, Parkinson's disease, chronic obstructive pulmonary disease, severe sepsis with septic shock and ventilator associated pneumonia. Review of the 06/17/24 quarterly Minimum Data Set Assessment (MDS) included the resident was moderately impaired for daily decision making, behaviors not present, no upper or lower extremity impairment, uses a walker and wheelchair, substantiation/maximal assistance for personal hygiene, toileting, rolling, and sitting to standing, always incontinent of bowel and has an indwelling catheter. Observation 08/19/24 at 10:28 A.M. revealed the resident had a urinary drainage bag hanging under his wheelchair. He was in a wheelchair in the hall waiting to smoke. The urine drainage bag was not covered and exposed yellow urine in the bag and tubing. [NAME] urine was visible in the bag and tubing. Observation on 08/20/24 at 11:57 A.M. revealed the resident was in the dining room. His indwelling urinary catheter bag was now a privacy bag colored blue. The catheter bag was hanging under the seat of the wheelchair. The bag was resting on the floor. Observation on 08/20/24 at 12:21 P.M. the resident went to his room with the catheter bag dragging on the floor hooked under the wheelchair. Observation on 08/20/24 at 2:02 P.M. the resident was sitting in the dining room at an activity. The indwelling catheter bag was resting on the floor. Interview 08/20/24 at 2:04 P.M. with the Administrator verified the indwelling catheter bag was not positioned to remain off the floor and was resting on the floor. 2. Review of Resident #35's medical record revealed an admitted [DATE] with diagnoses including dysphagia, palliative care, Parkinson's disease, vascular dementia, psychotic disturbance, mood disturbance and anxiety, depression, gastroesophageal reflux disease, weakness, chronic obstructive pulmonary disease, transient cerebral ischemic attack, and hypertension. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A resident plan of care for at Risk for Impaired Skin Integrity related to decline in mobility, and end of life/hospice care was initiated 06/24/24. The goal was resident will have intact skin to the extent allowed by the resident's age, mobility status, continence status, nutritional status, medication and/or treatment compliance, medical condition and/or comorbidities, and compliance with wound prevention recommendations. Interventions included a 06/24/24 intervention to apply protective barrier cream after incontinence episode. A 06/27/24, wound evaluation documented a Kennedy terminal ulcer (dark sores that develop rapidly in the final stages of life), Stage 1 (the mildest and affects the upper layer of your skin. In this stage, the wound has not yet opened) measuring 5.39 centimeters (cm) length x 5.02 cm width. There was not an order for Enhanced Barrier Precautions. A 08/01/24 physician order included Sacrum- cleanse with generic wound cleanse, pat dry, apply medihoney and calcium alginate, cover with silicone foam dressing (4x 4) daily and as needed. Observation of dressing change 08/21/24 at 12:42 P.M. with Licensed Practical Nurses #246 and #237 revealed the sacrum had several open areas. The LPN's wore gloves. There was no other personal protective equipment (PPE) used. Review of the facility's Enhanced Barrier Precautions revised 03/26/24 included even if the resident is not known to be infected or colonized with Multi Drug Resistant Organism (MDRO), an order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds (chronic wounds such as pressure injuries, diabetic foot ulcers, unhealed surgical wounds and chronic venous stasis ulcers. Note:wounds generally include chronic wounds, not shorter-lasting wounds such as skin breaks or skin tears coverers with an adhesive bandage (e.g. Band-Aid) or similar dressing. Interview 08/21/24 at 01:00 P.M. with LPN's #246 and #237 verified the resident was in hospice care, bedridden, with an open wound terminal ulcer , on a pureed diet with weight loss. Neither nurse knew why the resident was not in enhanced barrier precautions. Interview 08/21/24 at 01:16 P.M. with the Director of Nursing verified the resident should of been on EBP with an open wound. 3. Review of Resident #35's medical record revealed an admitted [DATE] with diagnoses including dysphagia, palliative care, Parkinson's disease, vascular dementia, psychotic disturbance, mood disturbance and anxiety, depression, gastroesophageal reflux disease, weakness, chronic obstructive pulmonary disease, transient cerebral ischemic attack, and hypertension. A 08/15/24, wound evaluation documented a Kennedy terminal ulcer (dark sores that develop rapidly in the final stages of life), Unstageable (slough and/or eschar) measuring 1.38 centimeters (cm) length x 0.84 cm width and 0.3 cm depth. The 08/15/24 Wound Evaluation photo revealed the wound was open. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of the sacrum dressing change 08/21/24 at 12:42 P.M. with Licensed Practical Nurses #246 and #237 revealed the sacrum had several open areas. Both washed their hands and gloved. The resident was turned onto his right side for the dressing change. He had a small bowel movement contained between his gluteal folds. LPN #237 performed the dressing change. After cleansing the wound calcium alginate, medihoney and a foam dressing was applied all with technique meeting professional standards,. LPN #237 then cleansed the bowel movement. She wore the gloves she had changed into prior to applying the clean foam dressing. Perifresh was applied to a cloth and she wiped from back to front to remove the bowel movement, taking care not to touch the new dressing. There was deep red skin between the gluteal folds. She wiped with different parts of the cloth six times to remove the bowel movement until the cloth came out clean when wiped. With the same gloves on both LPN's turned the resident to his left side, pulled the soiled brief through and placed a new brief. LPN #246 threw the brief in the trash. Without removing their gloves they had on while cleaning the bowel movement LPN #237 who cleansed the bowel movement grabbed the pillow on each side of his face and pulled it down further to his shoulders. Her left hand was on the pillow near his mouth. She put a brown printed pillow between his knees and a pillow under his heels. She placed a pillow under his right arm. He stayed positioned to his left. She used the remote control on the bed to adjust the height of the bed. Then touched his overbed table moving it with her gloved hand, handed the resident his call light with his right hand, pulled a blue banket up to his chin along with LPN #246's help. Neither nurse had removed their gloves used for cleaning the bowel movement until after they made him comfortable in bed. Interview 08/21/24 at 01:00 P.M. with LPN's #246 and #237 verified between they did not remove their gloves after cleaning a bowel movement and touched the resident's pillows, bedding, call light, bed control and overbed table. 42015 4. Review of the facility's Annual tuberculosis (TB) Risk Assessment for 2024 revealed health care workers (HCW) will receive a baseline skin testing performed with two-step Tuberculin Skin Test. The assessment stated HCW are tested for TB at hire and annually. Review of the facility's policy, Employee Health Records dated 12/13/23 revealed, a health record for each employee should be maintain (with) a document (of a) TB screening record including the evidence of the most recent TB test as well as sign and symptom risk assessment screening. Review of the employee files revealed State tested Nursing Assistant (STNA) #219 was hired on 08/17/22 but did not receive annual TB test or screening. Review of the employee files revealed STNA #501 was hired on 07/16/24 but did not receive an initial TB two step test. Review of the employee files revealed STNA #504 was hired on 07/16/24 but did not receive an initial TB two step test. Review of the employee files revealed Licensed Practical Nurse (LPN) #265 was hired on 10/01/22 but did not receive annual TB test or screening. (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 employee files revealed STNA #274 was hired on 06/14/23 but did not receive an annual TB test or screening. Review of the employee files revealed Director if Nursing was hired on 06/25/24 but did not receive an initial TB two step test. Review of the employee files revealed Registered Nurse #207 was hired 06/21/23 but did not receive an annual TB test or screening. Interview on 08/22/24 at 1:10 P.M. the facility Administer confirmed she was unable to find the above employees initial and annual TB test and screenings.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 28701 Based on observation and interview the facility failed to maintain a clean environment. This affected residents but had the potential to affect all residents residing in the facility. The census was 69. Findings include: On 08/22/24 fro 9:00 A.M. through 9:20 A.M. the following observations were made: 1. Torn wallpaper border was noted between resident rooms, above the medical and storage room on the 100 hall; 300 hall resident rooms as well as above the 300 hall shower room and nurses' station; and 400 hall resident rooms. 2. Black marks from adhesive tape where noted on the ceiling near Resident #20's room and the ceiling above the medical and storage rooms on 100/200 halls. 3. Repaired drywall with unfinished/untextured drywall compound was observed outside the women's bathroom in the front lobby, inside and outside the private dining room, at the 300/400 nurses' station and fire doors, 100/200 hall nurses' station and fire doors. 4. Scraped and damaged drywall from resident beds was noted in the following resident rooms: Resident #7, Resident #20, Resident #33, Resident #42, Resident #62 and Resident #20. On 08/22/24 at 9:20 A.M. interview with the Administrator and Maintenance Director verified the observations.