STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365681	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Lane Healthcare Center	355 Windsor Lane Gibsonburg, OH 43431

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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 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 35033 Based on review of personnel records, staff interview, and policy review, the facility failed to ensure employee reference checks were completed and failed to complete employee verification in the Ohio Abuse Registry. This had the potential to affect all 61 residents residing in the facility. Findings include: Review of the personnel record for Activity Aide (AA) #211 revealed a hire date of 10/27/23. Further review of the personnel record revealed no verification the employee was checked in the Ohio Abuse Registry. Review of the personnel record for State tested Nursing Assistant (STNA) #272 revealed a hire date of 10/10/23. Further review of the personnel record revealed no reference checks were completed. Review of the personnel record for STNA #214 revealed a hire date of 09/01/23. Further review of the personnel record revealed no reference checks were completed. Review of the personnel record for Housekeeper (HSK) #225 revealed a hire date of 03/21/24. Further review of the personnel record revealed no verification the employee was checked in the Ohio Abuse Registry. Review of the personnel record for Dietary Staff (DS) #264 revealed a hire date of 10/26/22. Further review of the personnel record revealed no verification the employee was checked in the Ohio Abuse Registry. Review of the personnel record for HSK #206 revealed a hire date of 08/14/23. Further review of the personnel record revealed no verification the employee was checked in the Ohio Abuse Registry and no reference checks were completed. Review of the personnel record for Maintenance Staff (MS) #201 revealed a hire date of 04/17/23. Further review of the personnel record revealed no verification the employee was checked in the Ohio Abuse Registry and no reference checks were completed. Review of the personnel record for Admissions Staff (AS) #248 revealed a hire date of 05/06/24. Further review of the personnel record revealed no verification the employee was checked in the Ohio Abuse Registry. (continued on next page)

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

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

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F 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Review of the personnel record for Registered Nurse (RN) #202 revealed a hire date of 01/04/24. Further review of the personnel record revealed no verification the employee was checked in the Ohio Abuse Registry. Interview on 07/25/24 at 7:17 A.M., Human Resource Staff (HRS) #212 verified AA #211, HSK #225, DS #264, HSK #206, DS #264, MS #201, AS #248, and RN #202 were not checked in the Ohio Abuse Registry. HRS #212 verified reference checks were not completed for STNA #272, STNA #214, and MS #201. Review of the policy titled Abuse, Neglect, Exploitation & Misappropriation of Resident Property, dated 2016, revealed no guidelines for completing employee reference checks. The facility would check with all applicable licensing and certification authorities to ensure that employees hold the requisite license and/or certification status to perform their job functions and do not have a disciplinary action in effect against his or her professional license by a state licensure agency as a result of a finding of abuse, neglect, exploitation or misappropriation of resident property.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638 Based on record review and staff interview, the facility failed to ensure the resident's comprehensive care plan was completed and updated. This affected three (Resident #2 #12, and #25) of 17 residents reviewed for care plans. The facility census was 61. Findings include: 1. Review of Resident #12's medical record revealed an admitted [DATE]. Diagnoses included schizophrenia, psychosis, and congestive heart failure. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 was cognitively intact. He required a wheelchair in which he was independent on moving throughout the facility. Review of the Ohio Sex Offender Search revealed Resident #12 was a registered sex offender due to gross sexual imposition and sexual motivation. Review of Resident #12's most recent care plan revealed it was free from documentation regarding care and intervention of the sex offender. Interview on 07/25/24 at 8:05 A.M. with the Director of Nursing (DON) confirmed Resident #12's comprehensive care plan was incomplete and verified there was no care plan in place for the resident being a sex offender. 2. Review of Resident #25's medical record revealed an admitted [DATE]. Diagnoses included congestive heart failure, coronary artery disease, morbid obesity, and respiratory failure. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 was cognitively intact. The resident required the use of a wheelchair and was independent with care and mobility. Review of the Ohio Sex Offender Search revealed Resident #25 was a sex offender related to lewd and lascivious acts with a child 14 to [AGE] years old. Review of Resident #25's most recent care plan revealed it was free from documentation regarding care and interventions for a sexual offender. Interview on 07/25/24 at 8:05 A.M. with the Director of Nursing (DON) confirmed Resident #25's comprehensive care plan was incomplete and verified there was no care plan in place for the resident being a sex offender. 44815 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical record for Resident #2 revealed an admitted [DATE] with a diagnosis of dementia. Review of the five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had impaired cognition and was dependent on staff for personal hygiene. Review of the current care plan revealed no care area for activities of daily life. Interview on 07/25/24 at 8:05 A.M. with the Director of Nursing (DON) confirmed Resident #2's comprehensive care plan was incomplete and verified there was no care plan in place for activities of life . The DON stated she had been having difficulty with the electronic medical record system, and care plans were not staying updated in resident records

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638 Based on record review and staff interview, the facility failed to ensure the resident care plans were timely updated. This affected three (Residents #5, #10, and #46) of 17 residents reviewed for care plan. The facility census was 61. Findings include: 1. Review of Resident #46's medical record revealed an admitted [DATE]. Diagnoses included morbid obesity and bariatric surgery on 05/23/24. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #46 had a high cognitive function. Review of the physician order dated 04/25/24 revealed Resident #46 had a order for high protein Slim Fast shakes or Ensure high protein nutrition shakes five times a day and a clear liquid diet. Review of Resident #46's care plan revealed he was at risk for non-compliance with his diet due to morbid obesity, diabetes mellitus, and hypertension. The care plan was absent of bariatric surgery nor requirement of a high protein diet. Interview with the Dietary Manager #237 on 07/23/24 at 4:32 P.M. revealed Resident #46 began to receive the high protein shakes post bariatric surgery in April 2024. Interview with the Assistant Director of Nursing (ADON) #208 on 07/24/24 at 2:03 P.M. verified the facility failed to update Resident #46's care plan regarding the physician's orders for high protein shakes nor the bariatric surgery. 44815 2. Review of the medical record for Resident #5 revealed an admitted [DATE] with a diagnosis of chronic respiratory failure. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had intact cognition. Review of the Smoking assessment dated [DATE] revealed Resident #5 no longer smoked. The assessment did not clarify whether Resident #5 could smoke independently. Review of the current care plan for Resident #5 revealed no care area for smoking. Review of the list of residents who smoked provided by the facility on 07/22/24 revealed Resident #5 smoked. Interview on 07/22/24 at 2:44 P.M. with Resident #5 revealed she was going outside to smoke. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/24/24 at 8:16 A.M. with the Director of Nursing (DON) confirmed Resident #5 had quit smoking, but started again in the last few months. Follow-up interview with the DON on 07/24/24 at 8:40 A. M. confirmed Resident #5's smoking assessment dated [DATE] did not reflect her current smoking status, and Resident #5's care plan did not include smoking. 3. Review of the medical record for Resident #10 revealed an admitted [DATE] with a diagnosis of kidney failure (05/27/24). Review of the Brief Interview for Mental Status (BIMS) dated 05/31/24 revealed Resident #10 had moderately impaired cognition. Review of the current care plan revealed no indication Resident #10 received hemodialysis (HD). Interview on 07/22/24 at 11:30 A.M. with the Director of Nursing (DON) revealed Resident #10 was the only resident in the facility who received HD. Subsequent interview on 07/23/24 at 3:31 P.M. and 3:43 P.M. with the DON revealed Resident #10 began HD on 06/12/24. The DON confirmed Resident #10's care plan did not reflect he received HD.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638 Based on observation, record review, resident and staff interview, and policy review, the facility failed to assess and monitor the resident's skin conditions. This affected two (Residents #15 and #50) of two residents reviewed for skin conditions. The facility census was 61. Findings include: 1. Review of Resident #15's medical record revealed an admitted [DATE]. Diagnoses included muscular dystrophies, congestive heart failure, morbid obesity, and cerebral vascular accident. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15's cognition was intact. The resident required substantial assistance to move from lying to sitting on the side of the bed. Review of Resident #15's most recent care plan revealed he was at risk for uncontrolled bleeding due to anticoagulant therapy and the potential for skin breakdown related to morbid obesity. Interventions included a weekly skin assessment and observation during care. Review of Resident #15's Weekly Skin Observation sheets dated 06/21/24, 06/28/24, 07/05/24, 07/13/24, and 07/19/24 revealed the resident's skin was clean, dry and intact. Observation of Resident #15's skin on 07/24/24 at 10:50 A.M. revealed the resident had a large red and scabbed area to the left lower shin. The affected area was approximately 12 inches long and four inches wide. It was dark red and had several rounded scabbed areas to the skin. Interview with Assistant Director of Nursing (ADON) #208 on 07/24/24 at 10:55 A.M. revealed Resident #15's medical record was absent of documentation regarding redness to the left lower extremity which included the Weekly Skin Observations. Interview with Resident #15 on 07/24/24 at 10:57 A.M. revealed the left lower extremity had been red and scabbed for a long time. 44815 2. Review of the medical record for Resident #50 revealed an admitted [DATE]. Diagnoses included chronic respiratory failure, anxiety, and calculus of ureter. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #50 had intact cognition. Review of the consultant wound care note dated 06/19/24 revealed Resident #50 had a new wound to her right buttock identified as moisture-associated skin damage (MASD). Review of a nursing progress note dated 06/26/24 revealed the wound care nurse determined the left buttock was healed and identified a new area to the right buttocks. The wound care nurse began a treatment to the right buttock. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Weekly Skin Observation assessments dated 07/05/24, 07/12/24, and 07/20/24 revealed Resident #50's skin had no wounds and her skin was clean, dry, and intact. Interview on 07/22/24 at 3:07 P.M. with Resident #50 revealed she had wounds on her bottom. Interview on 07/23/24 at 12:33 P.M. with the Director of Nursing (DON) confirmed weekly skin assessments should be completed for all skin concerns. Observation and interview on 07/24/24 at 7:45 A.M. with Wound Care Nurse Practitioner #291, while she performed wound care on Resident #50, confirmed Resident #50 had ongoing MASD on her right buttock. Interview on 07/24/24 at 12:16 P.M. with the DON confirmed no skin assessments were completed for Resident #50 since 06/26/24 to monitor the progress of the right buttock MASD. The DON further confirmed the Weekly Skin Observations indicating Resident #50's skin was clean, dry and intact did not reflect an accurate assessment of her skin. Review of the facility's undated Weekly Skin Assessment Policy revealed licensed nurses would complete skin assessments every seven days from start of admission to discharge. Nurses will observe any open areas, signs of infection, and any abnormalities. Nurses will ensure treatment is in place for any existing areas.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on resident and staff interview, observation, review of the medical record, and review of the facility policy, the facility failed to ensure residents wore smoking aprons as ordered by the physician. This affected one (#5) of two residents reviewed for smoking. The facility census was 61. Findings include: Review of the medical record for Resident #5 revealed an admitted [DATE] with a diagnosis of chronic respiratory failure. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had intact cognition. Review of a current physician order for 07/2024 revealed Resident #5 was required to wear a smoking apron while smoking, initiated on 03/23/23. Review of the most recent Smoking Assessment completed on 01/11/24 revealed Resident #5 no longer smoked. The assessment did not clarify whether Resident #5 could smoke independently. Review of a nursing progress note dated 05/01/24 revealed Resident #5 was reminded to wear a smoking apron when out smoking, Resident #5 was educated on the reasons the smoking apron was needed, and Resident #5 refused to wear a smoking apron. Review of the current care plan for Resident #5 revealed no care area for smoking. Review of the facilities list of residents who smoked provided on 07/22/24 revealed Resident #5 smoked. Interview on 07/22/24 at 2:44 P.M. with Resident #5 revealed she was going outside to smoke. Resident #5 stated she had quit smoking in the past while she was a resident at the facility, but had resumed smoking. Observation and interview on 07/24/24 at 7:23 A.M. with Resident #5 revealed she was getting ready to go outside to smoke. Resident #5 was wearing a blanket over her lap. Resident #5 stated the facility did not offer her a smoking apron, and further indicated she thought the order to wear a smoking apron had been canceled. Interview on 07/24/24 at 8:16 A.M. with the Director of Nursing (DON) confirmed Resident #5 had quit smoking, but started again in the last few months. Observation and interview on 07/24/24 at 10:59 A.M. with Transportation Scheduler #236 confirmed Resident #5 was smoking a cigarette and not wearing a smoking apron. Interview on 07/24/24 at 12:18 P.M. with the DON confirmed Resident #5's order to wear a smoking apron remained active; however, the DON stated the order should have been discontinued. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facilities policy titled Smoking Policy, revised 04/24/24, revealed smoking evaluations would be completed for residents upon admission, change of condition, and annually.

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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 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** 44815 Based on observation, record review, and staff and resident interview, the facility failed to ensure residents received high protein nutritional supplementation per dietary's recommendations. This affected one (#16) of three residents reviewed for nutrition. The facility census was 61. Findings include: Review of the medical record for Resident #16 revealed an admitted [DATE] with diagnoses of type II diabetes mellitus, morbid obesity, and irritable bowel syndrome. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 had intact cognition. Review of the current and discontinued orders dated 07/01/24 through 07/24/24 revealed no current or discontinued order for a high-protein nutrition supplement. Review of a nursing progress note dated 07/12/24 revealed Resident #16 received new orders to start a 1, 200 kilocalorie (kcal) partial liquid diet. Review of a dietary progress note written by Dietary Manager (DM) #237, dated 07/15/24, revealed DM #237 clarified Resident #16's partial liquid diet order to include a high protein shake with fruit for breakfast, high protein shake with lunch and a yogurt. DM #237 recommended high protein shake, Ensure High Protein, could be substituted for the facility's in-house product, Premier Shake. Interview on 07/22/24 at 8:19 A.M. with Resident #16 revealed she was not receiving the Ensure High Protein shake that was recommended for her. Resident #16 stated she did not like the in-house shake and requested the Ensure High Protein shake from DM #237. Observation on 07/22/24 at 8:28 A.M. revealed Resident #16 received one yogurt on her breakfast tray and no additional food items. The yogurt label indicated it contained 60 kcal and four grams of protein. Interview on 07/23/24 at 4:23 P.M. with DM #237 stated she spoke with Resident #16 who stated she did not like the facility's in-house shake. DM #237 stated Resident #16 did not request an alternative high protein shake. DM #237 stated the kitchen continued to send the in-house high-protein shake to Resident #16. Interview on 07/24/24 at 9:16 A.M. with State tested Nurse Aide (STNA) #250 stated she provided Resident #16 her breakfast tray the morning of 07/24/24 and confirmed the only items on her tray were a yogurt, a napkin and silverware. Observation and interview on 07/24/24 at 12:25 P.M. with STNA #214 revealed Resident #16 received a yogurt and an orange on her lunch tray. STNA #214 confirmed the yogurt label indicated it contained 60 kcals and four grams of protein. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and concurrent review of the electronic medical record on 07/24/24 at 12:11 P.M. with the Assistant Director of Nursing (ADON) #208 confirmed Resident #16 did not have an order for a nutrition supplement and confirmed the progress note dated 07/15/24 written by DM #273 indicated Resident #16 should have an order for a high-protein shake with breakfast and lunch meals.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638 Based on record review, staff interview, and review of the facility policy, the facility failed to ensure the resident's nutritional and hydration needs were assessed and monitored after beginning on dialysis and collaborated with the hemodialysis center. This affected one (#10) of three residents reviewed for nutrition. The facility census was 61. Findings include: Review of the medical record for Resident #10 revealed an admitted [DATE] with a diagnosis of kidney failure (05/27/24). Review of the Brief Interview for Mental Status (BIMS) dated 05/31/24 revealed Resident #10 had moderately impaired cognition. Review of a nutrition progress note dated 05/23/24 revealed Resident #10 was hospitalized to establish dialysis. Review of a nutrition progress note dated 05/29/24 revealed Resident #10 was readmitted to the facility. RD #290 recommended a no concentrated sweets (NCS), no added salt diet (NAS) and thickened liquids to continue. RD #290 did not indicate in his note whether Resident #10 should continue to receive double protein portions. No additional assessment or review of Resident #10's condition was documented. No further nutrition progress notes were documented regarding Resident #10 receiving hemodialysis (HD). Interviews on 07/22/24 at 11:30 A.M. with the Director of Nursing (DON) revealed Resident #10 was the only resident in the facility who received HD. On 07/23/24 at 3:31 P.M., the DON stated she called Resident #10's HD clinic to determine Resident #10 began HD on 06/12/24. Telephone interview on 07/24/24 at 12:46 P.M. with Registered Dietitian (RD) #290 revealed he was the RD for the facility for more than [AGE] years and was in the facility every few weeks. RD #290 confirmed the comprehensive nutrition assessments he completed were documented in the progress notes. RD #290 stated he reviewed each resident's medical record before making his assessment; however, RD #290 stated he only documented the pertinent information in his note. RD #290 confirmed residents who begin HD have altered nutritional needs. RD #290 confirmed he did not reassess Resident #10's estimated nutrition needs because RD #290 felt a NCS, NAS diet would meet Resident #10's needs after beginning HD. RD #290 stated he expected the double protein portions would continue although he did not specify they should in his progress note on 05/29/24. RD #290 revealed he coordinated care with the HD clinic solely by reviewing Resident #10's laboratory tests, and at the point of the interview, RD #290 had not received any laboratory tests from the HD clinic and therefore had not coordinated care with the HD clinic since Resident #10 began HD treatments 06/12/24. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Nutrition Service Standards of Practice dated April 2004 revealed the Nutritional Service Coordinator (NSC)/Consult Dietician prepares a list of clinical recommendations at each visit and discusses with the Nutritional Service Director and/or Nursing. The NSC/Dietician Consult prepares a report for the Administrator at least monthly that outlines their activities, findings, and recommendations. The NSC/Dietician Consult reviews the items identified on the report with the Administrator and Nutrition Service Director in an exit interview. The Administrator and Nutrition Service Director acknowledge and/or act on the NSC recommendations as evidenced by a written response to the NSC report or notations to the original report.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on resident interview, record review and staff interview, the facility failed to timely provide a cancer medication to a resident who had a history of cancer. This affected one (#58) of six residents reviewed for medications. The facility census was 61. Findings include: Review of the medical record for Resident #58 revealed a readmitted [DATE] with diagnoses of type II diabetes mellitus and obesity. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #58 had intact cognition. Review of the hospital paperwork dated 07/07/24, provided to the facility during Resident #58's referral for readmission, revealed Resident #58 had a past medical history of prostate cancer. Review of the fax transmission form dated 07/12/24 revealed a nurse identified as N. Nurse documented Resident #58 had a cancer medication at bedside and requested an order for the medication from the physician. Further review revealed the facility's Nurse Practitioner addressed the request 10 days later on 07/22/24. Review of a progress note dated 07/22/24 at 5:46 P.M. revealed the facility obtained an order for Resident #58 to be administered his home supply of medication. Interview on 07/22/24 at 8:24 A.M. with Resident #58 revealed he had a history of prostate cancer and was prescribed a long term anti-cancer medication prior to his admission. Resident #58 stated the medication was delivered to his house and he brought it to the facility upon readmission 07/11/24. Resident #58 stated the facility took it from him and stated they would speak with the physician to obtain an order for him to receive it at the facility. Resident #58 had not received the medication since they removed it from his room shortly after readmission. Resident #58 then stated his wife planned to call the doctor who prescribed the medication later that day to have him send over a prescription. Subsequent interview on 07/24/24 at 7:51 A.M. with Resident #58 confirmed he was receiving his cancer medication. Resident #58 stated he was unhappy he had to wait to receive his medication since admission on 07/11/24 until 07/23/24. Interview on 07/24/24 at 3:00 P.M. with Assistant Director of Nursing (ADON) #208 confirmed the request for an order for Resident #58's prostate cancer medication dated 07/12/24 was not addressed until 07/22/24 and the order for Resident #58's medication order was initiated on 07/23/24.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on review of the medical record, resident and staff interview, and policy review, the facility failed to timely arrange dental services for a resident. This affected one (#56) of three residents reviewed for dental services. The facility census was 61. Findings include Review of the medical record revealed Resident #56 had an admitted [DATE]. Diagnoses included morbid obesity with alveolar hypoventilation, atrial fibrillation, and chronic respiratory failure with hypoxia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #56 had intact cognition. Review of the care plan initiated 04/27/23 revealed Resident #56 had dental problems related to poor oral hygiene. Interventions included to coordinate arrangements for dental care, transportation as needed/as ordered and provide mouth care as per the activities of daily living personal hygiene. Review of a dental note dated 06/28/24 revealed the resident needed extraction of two teeth and would need an oral surgeon to extract the teeth. Review of the medical record from 06/28/24 through 07/23/24 revealed no documentation an appointment was set up with the oral surgeon. Interview on 07/22/24 at 12:07 P.M. with Resident #56 revealed the dentist told her she needed two teeth pulled and needed an appointment with an oral surgeon but the facility had not made the appointment. Interview on 07/22/24 at 2:00 P.M. with the Director of Nursing (DON) verified an appointment had not been made for Resident #56. The DON revealed the facility had attempted to contact three dentists who could not accommodate the resident's size in their offices. The DON revealed the facility would probably need to contact a general surgeon to remove the teeth. Interview on 07/23/24 at 9:05 A.M. with Transportation Staff (TS) #236 stated she had called three oral surgeons who could not extract the resident's teeth. TS #236 verified she had not attempted to call a general surgeon. Review of the undated policy Dental Services revealed the facility would assist resident in obtaining routine and emergency dental care.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638 Based on review of the facility policy, observation, record review, and staff interview, the facility failed to ensure residents received diets as ordered and failed to provide diets as recommended by the registered dietitian. This affected three (#10, #17, and #26) of six residents reviewed for food. The facility census was 61. Findings include: 1. Review of the medical record for Resident #10 revealed an admitted [DATE] with a diagnosis of kidney failure. Review of the Brief Interview for Mental Status (BIMS) dated 05/31/24 revealed Resident #10 had moderately impaired cognition. Review of a physician order dated 05/30/24 revealed Resident #10 received a no-added salt, no concentrated sweets diet with double protein, regular texture food with nectar thickened liquids. Observations in the kitchen on 07/23/24 beginning at 11:53 A.M. revealed [NAME] #227 plating meals. [NAME] #227 plated one scoop of spaghetti for residents who received standard portions. [NAME] #227 proceeded to plate Resident #10's plate and scooped one scoop of spaghetti onto the plate. [NAME] #227 handed the plate the dietary aide who covered the plate and began to place it in the tray cart. Interview with [NAME] #227 confirmed Resident #10 should receive double protein portions, and further confirmed she did not provide double protein portions to Resident #10. [NAME] #227 asked the dietary aide to put cheese on the tray for additional protein. 2. Review of the medical record for Resident #26 revealed an admitted [DATE] with diagnoses of type II diabetes mellitus and dementia. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 had impaired cognition. Review of a physician order dated 08/20/21 revealed Resident #26 received a no-added salt, no concentrated sweets diet with high protein. Continuous observation during meal service on 07/22/24 beginning at 12:03 P.M. revealed STNA #286 removing meal trays from the tray cart and providing the trays to residents. STNA #286 provided two trays to residents before removing Resident #26's tray from the cart. Observation of all three trays revealed each resident received ham and potato casserole as the main dish. Resident #26 received ham and potato casserole as the main dish in the same portion as other residents. Resident #26's tray ticket indicated she should receive a double protein portion. Interview with STNA #286 during the observation confirmed the ticket indicated Resident #26 should receive a double protein portion and the portion on Resident #26's tray was the same size as the portion on the other residents' trays who did not receive double portions. 3. Review of Resident #17's medical record revealed an admitted [DATE]. Diagnoses included chronic respiratory failure, morbid obesity, atrial fibrillation, congestive heart failure, lymphedema, and congestive heart failure. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #17's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and required a therapeutic diet. Review of Resident #17's most recent care plan revealed the registered dietitian (RD) was to evaluate and adjust the diet as appropriate and therapeutic diet orders were to be completed due to being a nutritional risk related to diabetes and morbid obesity. Review of the RD's note dated 12/02/23 revealed the resident had a body mass index of 83 and required 100 to 110 grams of protein per day. Review of Resident #17's physician order dated 06/22/24 revealed she was on a fluid restrictive diet. The diet was to be no added salt and no concentrated sweets. The orders were absent of the required protein. Review of the Dietician Delayed Menu Cycle Nutritional Analysis revealed the residents received 588.7 grams of protein per week. Resident #17 had RD recommendations of 700 to 770 grams of protein per week. Telephone interview with RD #290 on 07/24/24 at 12:52 P.M. verified Resident #17 failed to receive the weekly amount of protein per her diet needs. Review of the facility policy titled Nutrition Service Standards of Practice dated April 2004 revealed the Nutritional Service Coordinator (NSC)/Consult Dietician prepares a list of clinical recommendations at each visit and discusses with the Nutritional Service Director and/or Nursing. The NSC/Dietician Consult prepares a report for the Administrator at least monthly that outlines their activities, findings, and recommendations. The NCS/Dietician Consult reviews the items identified on the report with the Administrator and Nutrition Service Director in an exit interview. The Administrator and Nutrition Service Director acknowledge and/or act on the NSD recommendations as evidenced by a written response to the NSC report or notations to the original report.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on observation, resident and staff interviews, and record review, the facility failed to ensure residents received thickened fluids as physician ordered. This affected one (#10) of six residents reviewed for food. The facility census was 61. Findings include: Review of the medical record for Resident #10 revealed an admitted [DATE] with a diagnosis of kidney failure. Review of the Brief Interview for Mental Status (BIMS) dated 05/31/24 revealed Resident #10 had moderately impaired cognition. Review of a physician order dated 05/30/24 revealed Resident #10 received a no-added salt, no concentrated sweets diet with double protein, regular texture foods and nectar thickened liquids. Observation on 07/23/24 at 8:39 A.M. revealed Resident #10 eating breakfast in his room. Resident #10 had a carton of milk with his breakfast. The milk appeared to be unthickened. Additionally, a pitcher of water was on Resident #10's tray table and the water appeared unthickened. Resident #10 provided a tray card from his garbage can dated 07/20/24 for a breakfast meal. Review of the tray card revealed Resident #10 should receive nectar thickened liquids. Observation and interview on 07/23/24 at 12:17 P.M. with Speech Therapist (ST) #289 during Resident #10's noon meal revealed Resident #10 eating lunch in his room with his meal tray on his tray table. Resident #10 had a bottle of water that was approximately one-fourth full and a second pitcher of water with approximately 600 milliliters (ml) of water in it on the tray table. ST #289 confirmed both bottles of water were not thickened to nectar thick consistency and therefore were not appropriate for Resident #10. ST #289 confirmed she was familiar with Resident #10 and confirmed Resident #10 was at risk for choking with unthickened liquids. Concurrent interview with Resident #10 confirmed he drank some of the unthickened water.

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F 0922 Level of Harm - Potential for minimal harm Residents Affected - Many	Have enough backup water supply for essential areas of the nursing home. 31638 Based on record review and staff interview, the facility failed to follow their procedure to have an adequate emergency water supply for the facility. This had the potential to affect all residents. Facility census was 61. Findings include: Interview with the Director of Nursing and Director of Maintenance #500 on 07/24/24 at 3:36 P.M. verified the facility did not have an emergency water supply on site. The Director of Maintenance stated the emergency water supply was kept off site. Review of the facility's undated policy titled Emergency Water Supply revealed the facility would provide three days of food and water for staff or other persons which will stay at the facility during an emergency. Furthermore, the facility's policy stated the water would be stored in the old assembly hall supply closet.

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F 0947 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 35033 Based on review of personnel files, staff interview, and review of an employee job description, the facility failed to ensure State tested Nursing Assistants (STNAs) received twelve hours of training annually. This had the potential to affect all 61 residents residing in the facility. Findings include: Review of the personnel file for STNA #223 revealed a hire date of 03/29/21. There were no hours of education completed in the past year in the STNA's personnel file. Review of the personnel file for STNA #249 revealed a hire date of 12/15/20. There were no hours of education completed in the past year in the STNA's personnel file. Review of the personnel file for STNA #272 revealed a hire date of 10/10/23. There were no hours of education completed in the past year in the STNA's personnel file. Review of the personnel file for STNA #213 revealed a hire date of 09/01/23. There were no hours of education completed in the past year in the STNA's personnel file. Interview on 07/25/24 at 9:33 A.M. with Human Resources Staff (HRS) #212 revealed the nursing department kept track of the annual inservice hours for the STNAs. Interview on 07/25/24 at 10:54 A.M. with the Director of Nursing (DON) revealed there was no documentation of the annual inservice training hours for the STNAs. The DON revealed human resource department was to keep track of the annual training hours. Review of the job description State tested Nursing Assistant, dated 06/01/05, revealed the position required a minimum of 12 hours of continuing education programs provided by the center in order to maintain certification.