STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365686	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbus Healthcare Center	4301 Clime Road North Columbus, OH 43228

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** 32654 Based on medical record review, observation, resident interviews and the facility failed to ensure residents were dressed in an appropriate and dignified manner. This affected one (Resident #43) of two residents reviewed for dignity. The facility census was 96 residents. Findings include: Review of the medical record for Resident #43 revealed an initial admitted [DATE] with the latest readmission of 01/25/24 with diagnoses including acute kidney failure, spina bifida, diseases of spinal cord, diabetes mellitus, asthma, severe morbid obesity, hypertensive heart disease with heart failure, congestive heart failure, cerebrospinal fluid drainage device, neuromuscular dysfunction of bladder, urinary incontinence, incontinence of feces, major depressive disorder, anxiety disorder, radiculopathy lumbar region, hydrocephalus and gastroesophageal reflux disease. Review of the plan of care dated 09/29/23 revealed the resident had a self-care deficit related to spina bifida, morbid obesity and refusal of showers. Interventions included the staff would assist the resident with upper and lower body dressing. Review of the Minimum Data Set (MDS) assessment for Resident #43 dated 04/18/24 revealed the resident had no cognitive deficit and was always incontinent of both bowel and bladder. Review of the resident's medical record revealed it did not include an inventory sheet of the resident's belongings. Interview 06/03/24 at 3:53 P.M. with Resident #43 confirmed the facility lost his clothing so he had to wear a hospital gown daily, but resident preferred to be dressed in clothing instead of the hospital gown. Observation on 06/04/24 at 3:06 P.M. revealed Resident #43 was attending the resident council meeting in the common area and was wearing a hospital gown instead of regular clothing. Interview on 06/04/24 at 3:09 P.M. with Licensed Practical Nurse (LPN) #91 confirmed Resident #43 did not have very many items of clothing and the State tested Nursing Assistants (STNA) didn't go down and get clothes from laundry or look through the clothing that had been donated to see if there was any clothing the resident could wear. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/04/24 at 3:10 P.M. of Resident #43's closet with LPN #91 revealed the only item of clothing available was one long sleeved gray sweatshirt. Interview on 06/06/24 at 3:25 P.M. with the Administrator confirmed the resident's clothing was missing and the facility had not ensured the resident was dressed in a dignified manner when he left his room. This deficiency represents noncompliance investigated under Complaint Number OH00153744.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on observation, family and staff interview, facility failed to ensure call lights were within reach for one (Resident #88) of one resident reviewed for call lights. The facility also failed to ensure resident choice to go outside when not medically contraindicated. This affected one (Resident #30) of two residents reviewed for dignity and respect. The facility census was 96 residents. Findings include: 1. Review of the medical record for Resident #88 revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis, dysphasia, aphasia, atrial fibrillation, muscle weakness and cognitive communication. Review of the Minimum Data Set (MDS) assessment for Resident #88 dated 05/03/24 revealed Resident #88 was cognitively impaired and required staff assistance with activities of daily living (ADLs.) Review of care plan for Resident #88 dated 05/06/24 revealed the resident required assistance with ADLs. Interventions include staff to ensure the resident's call light was within reach. Observation on 06/03/24 at 11:20 A.M. revealed Resident #88's call light was left on the floor. Interview on 06/04/24 at 9:13 A.M. with Resident #88's representative confirmed the resident's call light was frequently on the floor and out of reach of resident. Observation on 06/04/24 at 4:50 P.M. revealed Resident #88's call light was left on the floor. Observation on 06/06/24 at 8:50 A.M. revealed Resident #88's call light was left on the floor. Observation on 06/06/24 at 9:15 A.M. revealed Resident #88's call light was left on the floor. Interview on 06/06/24 at 9:16 A.M. with State tested Nursing Aide (STNA) #49 confirmed Resident #88 was able to use the call light but the resident's call light was on the floor and out of reach of the resident. 2. Review of the medical record for Resident #30 revealed an admitted [DATE] with diagnoses including rheumatoid arthritis, dysphasia, muscle weakness. Review of the MDS assessment for Resident #30 dated 05/22/24 revealed the resident was cognitively intact and required moderate to dependent assistance with ADLs and transfers. Review of the medical record for Resident #30 revealed it did not include any information regarding resident being assessed to be a wandering or elopement risk. Interview on 06/03/24 around 10:00 A.M. with the Ombudsman confirmed residents had complained about not being allowed to go outside and get fresh air by the front entrance. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/03/24 at 3:36 P.M. with Resident #30 confirmed she was instructed by facility staff she was not allowed to leave the facility and sit outside with her boyfriend and the staff had not explained why she could not go outside. Interview on 06/04/24 at 3:13 P.M. with Administrator confirmed the facility had a rule that if a resident was cognitively impaired or was at risk for falls or needed any assistance from staff, they were not allowed to go outside in the front of the building except for smoke breaks. Interview on 06/04/24 at 11:00 with Regional Clinical Manager (RCM) #137 confirmed facility was having therapy assess residents for safety in going outside and confirmed if a resident wanted to go outside staff should assist them in doing so and monitor for safety. RCM #137 confirmed it was a careful balance to ensure residents were safe while honoring resident rights. RCM confirmed the facility had no clinical rationale regarding why Resident #30 was not allowed to go outside. Review of facility policy titled Resident Leave of Absence undated revealed residents who were cognitively intact and had a physician order could sign themselves out for a leave of absence. This deficiency represents noncompliance investigated under Complaint Number OH00153744.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 41266 Based on review of Resident Council meeting minutes, resident interviews, staff interviews, and facility policy review, the facility failed to timely respond to resident concerns. This affected 16 facility-identified (Residents #3, #8, #13, #17, #22, #26, #30, #38, #42, #43, #44, #46, #51, #52, #74, #79) who attended the Resident Council meetings. The facility census was 96 residents. Findings include: Review of the Resident Council meeting minutes dated 08/08/23 revealed residents voiced concerns related to not receiving clothing back from the laundry and aides not providing showers. There was no response to the concerns provided by the facility. Review of the Resident Council meeting minutes dated 09/12/23 revealed residents voiced concerns related to aides not helping with providing toileting/incontinence care, aides stating they would return and then not returning to provide requested care, call lights not being answered, and insufficient staff on the weekends. There was no response to the concerns provided by the facility. Review of the Resident Council meeting minutes dated 11/07/23 revealed residents voiced concerns related to receiving clothing that did not belong to them or not receiving clothing back from laundry (same concern voiced in August 2023) and night shift aides not doing their jobs (similar to concern voiced in September 2023). A concern form dated 11/07/23 was provided to address night shift aides not doing their jobs. The Director of Nursing (DON) agreed to in-service the staff and complete unannounced checks on the staff. A lost and found would be implemented for each hall. The Administrator and DON signed off on the interventions dated 11/07/23. There was no evidence provided by the facility that the night shift aides were in-serviced or unannounced checks were completed on the staff as indicated. Review of the Resident Council meeting minutes dated 12/05/23 revealed residents voiced concerns related to aides not responding to call lights in a timely manner (same concern voiced in September 2023). A concern form dated 12/06/23 was provided to address aides not responding to call lights. The DON agreed to educate the staff during scheduled in-services in December. The DON and Administrator signed and dated the Concern Form 12/11/23. There was no evidence provided by the facility that the staff were educated as indicated. Review of the Resident Council meeting minutes dated May 2024 revealed residents voiced concerns related to night shift staff not checking on them (similar to concerns voiced in September, November, and December 2023). A response to Resident Council form dated 05/07/24 was provided to address night shift staff not checking on the residents. The intervention was to provide education at the next staff meeting and complete checks with the residents. There was no evidence provided by the facility that the staff were educated or checks with residents were conducted as indicated. Interview on 06/04/24 at 2:56 P.M. with Residents #3, #22, #30, #42, and #43 confirmed they did not receive any follow up from the facility staff related to their concerns discussed during monthly meetings. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/10/24 at 12:41 P.M. with the Administrator confirmed the facility had no evidence of follow-up to concerns brought up during the Resident Council meetings. The Administrator stated there had been a plan to complete education with staff in December 2023, but something came up and it just did not get done. Review of the facility policy Resident Rights undated revealed residents had the right to have grievances resolved and the facility must make prompt efforts to resolve any grievances the residents might have.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on record review, staff interview, and review of the facility policy, the facility failed to ensure accurate advanced directives and code status were reflected in the resident medical record. This affected two (Residents #14 and #30) of two reviewed for advanced directives. The facility census was 96 residents. Findings include: 1. Review of the medical record for Resident #14 revealed an admitted [DATE] with diagnoses including aneurysm, hemiplegia and hemiparesis, convulsions, diabetes, polyneuropathy, and muscle wasting and atrophy. Review of the signed advanced directive paperwork for Resident #14 dated 07/13/20 revealed the resident's code status was do not resuscitate comfort care arrest (DNRCC-A.) Review of physician's orders for Resident #14 revealed an order dated 05/02/23 to change resident's code status to do not resuscitate comfort care (DNRCC.) Review of the Minimum Data Set (MDS) assessment for Resident #14 dated 05/22/24 revealed the resident was cognitively intact. Review of the plan of care for Resident #14 dated 05/23/24 revealed resident's code status was a DNRCC with interventions to educate on advanced directives and living will and obtain a physician order. Interview on 06/04/24 at 10:06 A.M. with Human Resources (HR) #110 confirmed Resident #14 had a signed form from the physician dated 07/13/20 indicating a code status of DNRCC-A, but the physician order dated 05/02/23 was for DNRCC. HR #110 confirmed the signed form and the physician's order for Resident #14 did not match and two different code statuses were documented in the resident's record. 2. Review of the medical record for Resident #30 revealed an admitted [DATE] with diagnoses including rheumatoid arthritis, dysphasia, muscle weakness. Review of the signed advanced directive paperwork for Resident #30 dated 03/10/23 revealed the resident's code status was DNRCC-A. Review of physician's orders for Resident #30 revealed an order dated 03/14/23 to change resident's code status to DNRCC. Review of the MDS assessment for Resident #30 dated 04/13/24 revealed the resident was cognitively intact. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/04/24 at 10:06 A.M. with HR #110 confirmed Resident #30 had a signed form from the physician dated 03/10/23 indicating a code status of DNRCC-A, but the physician order dated 03/14/23 was for DNRCC. HR #110 confirmed the signed form and the physician's order for Resident #30 did not match and two different code statuses were documented in the resident's record. Review of facility policy titled Advanced Directive Resident Right to Choose undated, revealed if resident had an advanced directive, copies would be made available and placed on the hard chart medical record and communicated accurately to the staff.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on medical record review, staff interview and facility policy review, the facility failed to notify the primary care physician of resident blood glucose level outside of the physician-ordered parameters. This affected one (Resident #27) of one residents reviewed for insulin. Additionally, the facility failed to notify resident representatives of discontinuation of enteral tube feeding. This affected one (Resident #88) of eight residents reviewed for nutrition. The facility census was 96 residents. Findings Include: 1. Review of the medical record for Resident #27 revealed an admitted [DATE] with diagnoses including acute kidney failure, chronic obstructive pulmonary disease, obstructive sleep apnea, severe morbid obesity, diabetes mellitus, gastro-esophageal reflux disease, hypertension, hyperlipidemia, adult failure to thrive, history of malignant neoplasm of prostate and osteoarthritis. Review of the plan of care for Resident #27 dated 05/17/24 revealed the resident had diabetes. Interventions included the following: administer insulin injections as ordered, rotate injection sites, educate resident/resident representative on medication management and importance of adherence, observe for signs and symptoms of hyperglycemia and hypoglycemia, obtain and monitor lab/diagnostic studies as ordered, obtain blood sugars per physician orders, offer bedtime snacks, provide diet as ordered, offer substitutes per preference, weekly skin checks. Review of the Minimum Data Set (MDS) assessment for Resident #27 dated 05/22/24 revealed the resident had no cognitive impairment, and the resident received insulin on a daily basis. Review of the monthly physician's orders for Resident #27 dated June 2024 revealed an order dated 05/16/24 for blood sugar checks before meals and at bed time with the special instructions to notify the physician if the resident's blood sugar was less than 70 and greater than 250, an order dated 05/16/24 for Lantus solution 100 units/milliliters (ml) inject 10 units subcutaneously at bedtime, an order dated 05/16/24 for Insulin Aspart before meals, and an 05/24/24 for Trulicity solution 0.5 ml subcutaneously weekly on Monday. Review of the Medication Administration Record (MAR) for Resident #27 dated May 2024 revealed the resident's blood sugar was outside of the physician ordered parameters on the following dates and times: 05/17/24-P.M. blood sugar was 363, 05/18/24- P.M. blood sugar was 363, 05/19/24- A.M. blood sugar was 251 and P.M. blood sugar was 290, 05/28/24- A.M. blood sugar was 276 and P.M. blood sugar was 262, 05/29/24-A.M. blood sugar was 254 and P.M. blood sugar was 297, 05/30/24- P.M. blood sugar was 262, 05/31/24- A.M. blood sugar was 266 and P.M. blood sugar was 254. Review of the MAR for Resident #27 dated June 2024 MAR revealed the resident's A.M. blood sugar was 400 on 06/02/24. Review of the resident's medical record revealed it did not include documentation of physician notification of the elevated blood sugars for May and June 2024 per the physician-ordered parameters. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/06/24 at 4:00 P.M. with Regional Clinical Nurse (RCN) #137 confirmed the facility had not notified Resident #27's primary care physician of the blood sugars outside of the physician-ordered parameters for May and June 2024 Review of the facility policy titled Notification of Change in Condition dated 2022 revealed the facility was required to have processes in place for physician notification of acute changes such as poor glycemic control. The attending practitioner must be promptly notified of significant changes in condition and the medical record must reflect the notification response and interventions implemented to address the resident's condition. 44070 2. Review of the medical record for Resident #88 revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis, dysphasia, aphasia, atrial fibrillation, muscle weakness and cognitive communication. Review of the MDS assessment for Resident #88 dated 05/03/24 revealed the resident was cognitively impaired and required supervision or touching assistance with eating. Review of the nutrition assessment for Resident #88 dated 03/11/24 revealed the Resident #88 continued to be relied on enteral nutrition to complement her oral intake and meet her needs. Resident #88 had an average meal intake of 77 percent (%). Resident #88 had an order for Isosource 1.5 at 80ml/hour for 10 hours and the resident received 26-50% of her calories through tube feeding. The recommendation was made to discontinue the resident's nocturnal tube feeding and to monitor weekly weights. The assessment did not include notification to the resident or family related to removing the tube feed. Review of progress notes for Resident #88 dated 03/01/24 to 03/13/24 revealed they did not include notification to the resident's representative of the discontinuation of the resident's tube feeding. Interview on 06/04/24 at 9:13 A.M. with Resident #88's representative confirmed the facility did not speak with them prior to discontinuing the tube feeding and they found out when asking staff while visiting that the tube feeds had been discontinued. Interview on 06/06/24 at 3:02 P.M. with Dietician #143 confirmed the facility had no documentation of communication with Resident #27's family that the tube feeding was discontinued. Dietician #143 confirmed the facility should have discussed the discontinuation of the tube feeding with the resident's family. Interview on 06/06/24 at 5:40 P.M. with Registered Nurse (RN) #141 confirmed she was unable to find evidence of a discussion with Resident #27's family prior to the discontinuation of the resident's tube feeding. Interview on 06/10/24 at 1:10 P.M. with Corporate Dietician (CD) #147 confirmed facility had no documentation of communication with Resident #27's family until after the resident had been on the tube feed trial and lost weight. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Notification of Change in Condition dated 2022 revealed resident representatives should be notified of significant changes to treatment.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on medical record review, observation, resident representative interview, and staff interview, the facility to ensure privacy curtains were kept clean. This affected one (Resident #88) of 31 sampled residents. The facility census was 96 residents. Findings Include: Review of the medical record for Resident #88 revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis, dysphasia, aphasia, atrial fibrillation, muscle weakness and cognitive communication. Review of the Minimum Data Set (MDS) assessment for Resident #88 dated 05/03/24 revealed the resident was cognitively impaired and required assistance with activities of daily living, (ADLs.) Observation on 06/03/24 at 11:20 A.M. revealed Resident #88's privacy curtain was dirty with brown splatter and food crumbs stuck to it. Interview on 06/04/24 at 9:13 A.M. with Resident #88's representative confirmed the resident's privacy curtain was dirty with splatter and food on it. Observation on 06/04/24 at 4:50 P.M. revealed Resident #88's privacy curtain was dirty with brown splatter and food crumbs stuck to it. Observation on 06/06/24 at 8:50 A.M. revealed Resident #88's privacy curtain was dirty with brown splatter and food crumbs stuck to it. Interview on 06/06/24 at 9:15 A.M. with State tested Nursing Aide (STNA) #49 confirmed Resident #88's privacy curtain was dirty with brown splatter and food crumbs stick to it. STNA further confirmed it was not part of the aide's job to address the dirty privacy curtain and said the Surveyor should tell housekeeping about the dirty privacy curtain. This deficiency represents noncompliance investigated under Complaint Number OH00153744.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on medical record review, resident interview, staff interview, review of Pre-Admission and Resident Review (PASARR) results letter, and facility policy review, the facility failed to educate, offer, or implement Level II services for residents. This affected one (Resident #39) of two residents reviewed for PASARR screenings. The facility census was 96 residents. Findings include: Review of the medical record for Resident #39 revealed an admitted [DATE] with medical diagnoses including bipolar disorder, depression, dementia, alcohol abuse, anxiety disorder, and post-traumatic stress disorder (PTSD). Review of the PASARR screening for Resident #39 dated 10/24/23 completed prior to the resident's admission to the facility revealed the resident required ongoing case management from a mental health agency, emergency mental health services, and had an inpatient psychiatric hospitalization in the last two years. Review of the Notice of PASARR Level II Outcome letter for Resident #39 dated 10/25/23 revealed the resident was approved with specialized services for nursing home placement. The letter indicated Resident #39 would need to be provided with an initial psychiatric evaluation, ongoing medication review by a psychiatrist or similarly credentialed professional and recommended contacting the county regarding substance abuse treatment options. Review of the Minimum Data Set (MDS) assessment for Resident #39 dated 11/13/23 revealed the resident had intact cognition and required assistance with activities of daily living (ADLs.) Review of the plan of care for Resident #39 dated 11/13/23 revealed the resident had alcohol abuse disorder. Interventions included the following: administer medications as ordered, assist with attendance to acquired appointments and meetings outside of the center, coordination of care with substance abuse treatment program and encourage participation in the program, educate the resident on following the prescribed treatment plan, and encourage the resident to explore and identify triggers and feelings regarding addiction. The care plan did not include any specialized service recommendations for Resident #39. Interview on 06/04/24 at 9:11 A.M. with Resident #39 confirmed she had not been offered any specialized services such as substance abuse treatment options and had not received any services to her knowledge. Interview on 06/04/24 at 5:48 P.M. with Social Services Director (SSD) #82 confirmed she had only been in the position for approximately two months. SSD #82 was not aware Resident #39 qualified for specialized services. SSD #82 stated the resident had not been educated or offered any of the specialized services as recommended. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled PASARR dated 01/01/20, revealed the PASARR program required states to identify and evaluate all residents for evidence of severe mental illness (SMI) to ensure needs were met in the most appropriate setting and prohibited facilities from admitting or retaining an individual with SMI unless the individual required the level of services of a nursing facility and received adequate services to meet the needs in the least restrictive setting. Specialized services were services above and beyond what was provided.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36648 Based on medical record review, review of Self-Reported Incidents, staff interview, and review of the facility policy, facility failed to ensure resident care plans were updated regarding behavioral changes. This affected one (Resident #81) of two residents reviewed for behaviors. Based on medical record review, resident representative interview, staff interview, and review of the facility policy, the facility also failed to ensure care conferences were completed for residents. This affected five (Residents #14, #30, #73, #78, #88) of five residents reviewed for care conferences. The census was 96 residents. Findings include: 1. Review of medical record for Resident #81 revealed an admitted [DATE] with diagnoses including altered mental status, cognitive communication deficit, type two diabetes mellitus, and transient ischemic attack (TIA) with cerebral infarction. Review of Minimum Data Set (MDS) assessment for Resident #81 dated 04/15/24 revealed the resident was cognitively impaired. Review of facility Self-Reported Incidents (SRIs) #246403 dated 04/15/24 and #247016 dated 05/01/24 revealed Resident #81 had physically slapped two different residents across the face on two different occasions. Review of the care plan for Resident #81 dated 4/15/24 revealed the resident had impaired cognitive functioning related to altered mental status and anti-depressant medication usage related to depression. Interventions included the following: administer medications as ordered, monitor for behavior changes, keep a consistent routine, monitor for medication side effects. The care plan did include Resident #81's behaviors of hitting and or slapping other residents with interventions to prevent the behavior. Interview on 06/06/24, at 11:11 A.M. with Clinical Regional Nurse (CRN) #137 confirmed Resident #81's care plan had not been updated to include the change in resident's behavior, physical aggression towards other residents. Review of the facility policy titled Plan of Care Overview undated revealed care plans should be resident specific and resident focused. The facility would review care plans quarterly or when there was a significant change in care. 41266 2. Review of the medical record for Resident #78 revealed an admitted [DATE] with diagnoses including malignant neoplasm of left choroid (vascular layer of the eye), type two diabetes mellitus, dementia, dysphagia-oropharyngeal phase, cognitive communication deficit, and depression. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessment for Resident #78 revealed the resident had impaired cognition and was totally dependent on the staff to complete activities of daily living (ADLs). Review of the medical record for Resident #78 revealed the notes did not include documentation of any care conferences for the resident from July 2023 to June 2024. Interview on 06/03/24 at 3:25 P.M. via telephone with Resident #78's representative confirmed the facility had not invited him to attend quarterly care conferences to discuss the resident's care and goals and he would like to attend care conferences. Interview on 06/04/24 at 5:36 P.M. with Social Services Director (SSD) #82 confirmed she had started in her position approximately two months ago. SSD #82 documented care conference notes on a care conference sheet. SSD #82 stated the facility was out of compliance with completing care conferences and she was currently working on scheduling overdue care conferences. SSD #82 stated care conferences should be completed upon admission, readmission, quarterly, and upon request. Interview on 06/05/24 at 8:49 A.M. with SSD #82 confirmed Resident #78 had a care conference on 03/20/24, but there was no evidence the resident or resident's representative were invited. SSD #82 confirmed there was not any evidence the resident had received any additional care conferences in the last year. 44070 3. Review of the medical record for Resident #14 revealed an admitted [DATE] with diagnoses including aneurysm, hemiplegia and hemiparesis, convulsions, diabetes, polyneuropathy, and muscle wasting and atrophy. Review of the MDS assessment for Resident #14 dated 05/22/24 revealed the resident was cognitively intact and required assistance with ADLs. Review of the care conference forms for Resident #14 dated July 2023 to June 2024 revealed the only care conference held for the resident occurred on 05/07/24. 4. Review of the medical record for Resident #30 revealed an admitted [DATE] with diagnoses including rheumatoid arthritis, dysphasia, and muscle weakness. Review of the MDS assessment for Resident #30 dated 05/22/24 revealed the resident was cognitively intact with and required moderate to extensive assistance with ADLs. Review of the care conference forms for Resident #30 dated July 2023 to June 2024 revealed the only care conference held for the resident occurred on 05/17/24. 5. Review of the medical record for Resident #73 revealed an admitted [DATE] with diagnoses including cystitis without hematuria, muscle wasting, and bipolar disorder. Review of the MDS assessment for Resident #73 dated 04/25/24 revealed the resident was cognitively intact. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care conference forms for Resident #73 dated July 2023 to June 2024 revealed the only care conferences held for the resident occurred on 04/01/24 and 04/24/24. 6. Review of the medical record for Resident #88 revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis, dysphasia, aphasia, and atrial fibrillation. Review of the MDS assessment for Resident #88 dated 05/03/24 revealed the resident was cognitively impaired and required assistance with ADLs. Review of the care conference forms for Resident #88 dated July 2023 to June 2024 revealed the only care conference held for the resident occurred on 05/10/24. Interview on 06/04/24 at 5:35 P.M. with Director of Social Services #82 confirmed the facility had no record of care conferences being done upon admission or quarterly as required for Residents #14, #30, #73, and #88. Review of the facility policy titled Plan of Care Overview undated, revealed residents and their representatives would be offered opportunities to voice their views and would have the right to participate in the development and implementation of the plan of care. The facility would review care plans quarterly and/or with significant changes to care. The facility should support and encourage resident and representatives' participation and would work cooperatively to hold meetings at a time when the resident was functioning at his or her best and schedule meetings to accommodate the resident's representative.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on medical record review, observation, staff interview, resident interview, and facility policy review, the facility failed to ensure residents who were dependent on staff assistance with personal hygiene received routine nail care. This affected five (Residents #14, #20, #24, #50, #92) of seven residents reviewed for activities of daily living (ADLs.) The facility also failed to ensure dependent residents received routine bathing assistance. This affected two (Residents #27 and #92) of seven residents reviewed for ADLs. The facility census was 96 residents. Findings include: 1. Review of the medical record for Resident #24 revealed an admitted [DATE] with diagnoses including multiple sclerosis, functional quadriplegia, neuromuscular dysfunction of bladder, major depressive disorder, convulsions, contracture of right hand, contracture of right upper arm, contracture of right ankle and foot, voice and resonance disorder and status colostomy. Review of the Minimum Data Set (MDS) assessment for Resident #24 dated 03/28/24 revealed the resident had no cognitive deficit and required extensive assistance with ADLs. Observation on 06/03/24 at 12:25 P.M. of Resident #24 revealed the resident's fingernails were long and jagged with a brown substance under the nails. Interview on 06/03/24 at 12:25 P.M. with Resident #24 confirmed the long nails were digging into his palms and they needed to be trimmed. Observation on 06/04/24 at 3:00 P.M. of Resident #24 revealed the resident's fingernails were long and jagged with a brown substance under the nails Interview on 06/04/24 at 3:03 P.M. with Licensed Practical Nurse (LPN) #91 confirmed Resident #24's fingernails were long and jagged with a brown substance under them and needed to be trimmed. Review of the facility policy titled Nail and Hair Hygiene Services undated revealed residents would have routine nail hygiene as part of the bath or shower. Nails should be trimmed immediately after bathing or alternatively, soaking nails in warm soapy water prior to trimming or filing to reduce tearing and provide ease of trimming and filing. Daily hand washing would be completed with nail care to include cleaning and trimming or filing of sharp edges to prevent infection and damage to skin from scratching. 2. Review of the medical record for Resident #27 revealed an admitted [DATE] with diagnoses including acute kidney failure, chronic obstructive pulmonary disease (COPD), obstructive sleep apnea, severe morbid obesity, diabetes mellitus, gastro-esophageal reflux disease, hypertension, hyperlipidemia, adult failure to thrive, history of malignant neoplasm of prostate and osteoarthritis. Review of the plan of care for Resident #27 dated 05/15/24 revealed the resident had a self-care deficit related to COPD, morbid obesity and osteoarthritis. Interventions included staff would provide assistance with bathing and personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the shower schedule for Resident #27 revealed the resident's showers were scheduled every Wednesday and Saturday on dayshift. Resident #27 had seven opportunities for bathing (05/15/24, 05/18/24, 05/22/24, 05/25/24, 05/29/24, 06/01/24 and 06/05/24) since being admitted to the facility. Review of the bathing documentation for Resident #27 revealed the resident had not received scheduled bathing on 05/15/24, 05/18/24, 05/25/24, 05/29/24 and 06/01/24. Interview on 06/03/24 at 3:32 P.M. with Resident #27 confirmed he did not consistently receive his showers as scheduled. Interview on 06/06/24 at 3:46 P.M. with Registered Nurse (RN) #141 confirmed Resident #27 had not received bathing consistently as scheduled. 41266 3. Review of the medical record for Resident #20 revealed an admitted on 03/18/14 with diagnoses including type two diabetes mellitus, hemiplegia and hemiparesis following cerebrovascular disease affecting left non-dominant side, contracture of muscle in left hand, contracture of left ankle, dementia, reduced mobility, and need for assistance with personal care. Review of the podiatry visit note for Resident #20 dated 01/25/24 revealed the podiatrist trimmed the resident's nails and recommended follow up care in nine to ten weeks. Review of the MDS assessment for Resident #20 dated 04/05/24 revealed the resident had impaired cognition and was totally dependent on staff to complete ADLs. Review of the podiatry list dated 04/08/24 revealed Resident #20 was on the list of residents to be seen by the podiatrist. Review of the progress notes for Resident #20 dated 04/08/24 revealed the notes did not include documentation of the resident being seen or refusing to be seen by the podiatrist. Review of the care plan for Resident #20 revised 04/11/24 revealed the resident had a self-care performance deficit and required assistance with ADLs. Interventions included consults with podiatry as needed and two staff to assist with completing ADLs. Observations on 06/03/24 at 4:53 P.M. and 06/05/24 at 8:26 A.M. revealed Resident #20's fingernails were long and discolored with dirt under them. The resident's toenails were long, jagged, yellowish color, and thick in appearance. Interview on 06/05/24 at 2:13 P.M. with State tested Nurse Aide (STNA) #133 confirmed Resident #20's fingernails and toenails needed to be trimmed and cleaned. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/06/24 at 3:54 P.M. with Regional Clinical Manager (RCM) #137 confirmed Resident #20's fingernails and toenails were long and needed to be trimmed and cleaned. RCM #137 stated the aides were able to complete nail care for simple trimming and cleaning and it should be offered and completed on scheduled shower or bath days. The nurse was able to trim toenails for residents who were diabetic or had a risk of bleeding and would not require a podiatrist to complete nail care unless the nurse did not feel comfortable. In that case the facility should schedule an emergency podiatry visit. RCM #137 confirmed Resident #20 was last seen by the podiatrist on 01/25/24 and was not seen by the podiatrist on 04/08/24 and had not refused podiatry on 04/08/24. 4. Review of the medical record for Resident #50 revealed an admitted [DATE] with diagnoses including dementia with anxiety and type two diabetes mellitus. Review of the quarterly MDS assessment for Resident #50 dated 05/11/24 revealed the resident had impaired cognition. Review of the care plan for Resident #50 revised 03/25/24 revealed the resident had a self-care performance deficit and required assistance with completion of ADLs. Interventions included Resident #50 was dependent on staff to complete personal hygiene. Review of the podiatry visit note for Resident #50 dated 12/20/23 revealed the resident received treatment and requested continued care for discomfort from mycotic toenails. Further review of the note revealed without continued treatment there would be a marked limitation of ambulation and dystrophic/mycotic toenails which could lead to an infection and could result in an amputation. Follow-up care was recommended in nine to ten weeks. Review of the podiatry visit list dated 04/08/24 revealed Resident #50 was not on the list to be seen by the podiatrist. Observations on 06/03/24 at 12:37 P.M. and 06/05/24 at 3:58 P.M. revealed Resident #50 had long and dirty fingernails. Resident #50 also had long, jagged, discolored, and dirty toenails. The resident's toenails were so long that they had started to curve over the top of a few of his toes. Interview on 06/05/24 at 3:58 P.M. with State tested Nurse Aide (STNA) #87 confirmed Resident #50's fingernails were long and dirty and needed to be trimmed. STNA #87 also confirmed the resident's toenails were long, jagged and had started to curl over the top of his toes and needed to be cleaned and trimmed. Interview on 06/06/24 at 3:54 P.M. with RCM #137 confirmed Resident #50's fingernails and toenails were long and needed to be trimmed and cleaned. RCM #137 confirmed Resident #50's last podiatry visit was on 12/20/23 and the facility had not scheduled the resident for a follow up visit. 44070 5. Review of the medical record for Resident #14 revealed an admitted [DATE] with diagnoses including aneurysm, hemiplegia and hemiparesis, convulsions, diabetes, polyneuropathy, muscle wasting and atrophy. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessment for Resident #14 dated 05/22/24 revealed the resident was cognitively intact and required moderate to dependent assistance for personal hygiene and bathing. Review of the plan of care for Resident #14 dated 05/23/24 revealed the resident had a self-care performance deficit and staff were to provide moderate assistance with personal hygiene. Review of the progress notes for Resident #14 dated 04/01/24 to 06/05/24 revealed they did not include documentation of resident refusal of nail care. Observation on 06/03/24 at 3:11 P.M. of Resident #14 revealed the resident's fingernails had black material under them and some of her nails were jagged and broken. Resident #14's toenails were also long and had black and brown material under the nails. Interview on 06/03/24 at 3:11 P.M. with Resident #14 confirmed she had last received nail care about three months ago and staff did not offer to clean her nails and/or trim them often. Observation on 06/05/24 at 7:54 A.M. of Resident #14 revealed the resident's fingernails and toenails did not appear to have been cleaned or trimmed by staff since the observation on 06/03/24. Interview on 06/05/24 at 7:54 A.M. with Resident #14 confirmed she was agreeable to receiving nail care assistance from the staff. Interview on 06/05/24 at 8:14 A.M. with STNA #74 confirmed Resident #14's fingernails and toenails were long and jagged, and dirt and she would provide nail care to the resident during the shift. Observation on 06/06/24 at 8:45 A.M. of Resident #14 revealed the resident's fingernails and toenails did not appear to have been cleaned or trimmed by staff since the observations on 06/03/24 and 06/05/24. Interview on 06/06/24 at 8:45 A.M. with Resident #14 confirmed staff did not clean or trim her nails on 06/05/24. 49794 6. Review of medical record for Resident #92 revealed an admitted [DATE] with diagnoses including multiple sclerosis, complete lesion at T2-T6 level of thoracic spine, encephalopathy, diabetes mellitus type two with neuropathy, fracture left femur, malignant neoplasm of left kidney, malignancy neoplasm of right kidney, malignant neoplasm of bone, and muscle weakness. Review of the MDS assessment for Resident #92 dated 05/27/24 revealed the resident was cognitively intact and was totally dependent on staff for ADLs including toileting, showering or bathing, and dressing. Review of shower schedule for 200 hallway confirmed Resident #92 was scheduled to receive showers on Tuesdays and Fridays. Review of shower record for Resident #92 dated 05/07/24 to 06/04/24 revealed Resident #92 did not receive a shower on 05/09/24, 5/16/24, and 05/28/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of progress notes for Resident #92 dated 05/07/24 to 06/04/24 revealed they did not include documentation of refusal of showers for the resident. Interview on 06/03/24 at 2:51 P.M. with Resident #92 confirmed shower days were Fridays and Tuesdays but she did not always get her shower as scheduled. Interview on 06/05/24 at 06:45 AM with STNA #87 confirmed sometimes staff were unable to complete all showers scheduled within a shift. Interview on 06/05/24 at 11:18 AM with Regional Clinical Manager #137 confirmed Resident #92 did not receive showers on 05/09/24, 5/16/24, and 05/28/24, and the resident's record did not include documentation of refusal of the showers, nor did it include a rationale for the showers not being provided. Review of the facility policy titled Routine Resident Care undated, revealed staff should provide routine ADL to the residents for quality of life and to promote resident dignity. This deficiency represents noncompliance investigated under Complaint Number OH00154396 and Complaint Number OH00153872.

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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** 41266 Based on medical record review, observation, staff interview, resident interview, and review of the facility policy, the facility failed to timely evaluate and treat a rectal fistula, failed to timely schedule an outside gastroenterology (GI) follow-up appointment, and failed to ensure precertification for hospice services was completed. This affected three (Residents #11, #64, and #73) of 31 residents sampled. The facility census was 96 residents. Findings include: 1. Review of the medical record for Resident #11 revealed an admitted on [DATE] with diagnoses including paraplegia, encounter for attention to other artificial openings of urinary tract, encounter for attention to ileostomy, irritable bowel syndrome, and anal fistula (added on [DATE]). Review of the care plan for Resident #11 revised [DATE] revealed the resident had impaired skin integrity. Interventions included complete at skin risk assessment upon admission, readmission, quarterly and as needed, complete weekly skin checks, and provide peri-care as needed to avoid skin breakdown due to incontinence. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #11 dated [DATE] revealed the resident had intact cognition and was dependent on staff to complete toileting and required substantial assistance from staff to complete showering/bathing. Review of the Treatment Administration Records (TARs) for Resident #11 dated May and [DATE] revealed a weekly skin assessment was completed every Friday with a start dated of [DATE]. Review of the physician's orders for Resident #11 dated [DATE] revealed there were no wound treatment orders for the area to Resident #11's rectum. Observation [DATE] at 12:18 P.M. of incontinence care for Resident #11 per State tested Nurse Aide (STNA) #115 revealed there was a small amount of light brown drainage noted on the resident's depends from a wound. The wound was approximately the size of a finger point and looked like it was tunneling. Interview on [DATE] at 12:18 P.M. with STNA #115, confirmed Resident #11 had this small wound to his rectum for a while. STNA #115 confirmed she had not reported the area to a nurse. Interview on [DATE] at 4:15 P.M. with Regional Clinical Manager (RCM) #137 confirmed Resident #11 had what appeared to be a rectal fistula (an open area on her rectum) that measured approximately two centimeters long by two centimeters wide. The area appeared to be where a previously healed pressure area had healed, and scar tissue had developed. RCM #137 confirmed there was a brown substance draining from the area. RCM #137 stated Resident #11 would be transferred to the hospital for further evaluation of the area, because the facility had just become aware of the area. (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 facility policy titled Skin Care & Wound Management Overview undated, revealed staff would identify and document skin impairment and would notify the physician to determine appropriate treatment. 36648 2. Review of the medical record for Resident #73 revealed an admitted [DATE] with diagnoses including bipolar disorder, stroke, hypothyroidism and chronic obstructive pulmonary disease. Review of the nurses' progress note for Resident #73 dated [DATE] revealed the nurse called to set up a gastrointestinal (GI) appointment for the resident evaluate and treat blood stool and diarrhea and to have her annual endoscopy. Resident #73 was scheduled for a GI consult on [DATE]. Review of the nurse progress note for Resident #73 dated [DATE] revealed the facility scheduled a GI consult for the resident on [DATE]. Review of the nurse practitioner (NP) note for Resident #73 dated [DATE] revealed the NP wanted the facility to contact additional GI doctors to see if the resident could get an appointment earlier than [DATE]. Review of the progress notes for Resident #73 dated [DATE] to [DATE] revealed they did not include documentation of attempts to find an earlier GI appointment for the resident. Interview on [DATE] at 9:45 A.M. with Resident #73 confirmed the resident was supposed to have a colonoscopy on [DATE] because she had diarrhea with blood in it several times. Resident #73 went to the scheduled appointment on [DATE] but did not see a doctor, because the office did not take her insurance. The doctor's office called the facility and recommended they schedule a new colonoscopy appointment with a provider who took Resident #73's insurance. Resident #73 confirmed the staff had not rescheduled the appointment. Interview on [DATE] at 3:49 P.M. with the DON confirmed Resident #73 did not see a gastroenterologist on [DATE]. The DON confirmed on [DATE] the staff scheduled a GI appointment for Resident #73 on [DATE]. The DON confirmed the staff did not reach out to other practices to schedule an earlier GI appointment for Resident #73 per the instructions of the NP on [DATE]. 32654 3. Review of the medical record for Resident #64 revealed an initial admitted [DATE] with the latest readmission of [DATE] with the diagnoses including diffuse traumatic brain injury (TBI), convulsions, protein calorie malnutrition, hypertension, anxiety disorder, major depressive disorder, personal history of COVID-19, gastro-esophageal reflux disease post-traumatic stress disorder. (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 plan of care for Resident #64 dated [DATE] revealed the resident was on hospice services related to diffuse TBI without loss of consciousness. Interventions included the following: adjust level of activities of daily living assistance to compensate for resident's changing abilities, encourage participation to the extent able and that they wish to participate, administer medications per medical provider's order, observe for side effects and effectiveness, report abnormal findings to medical provider, resident/resident representative, hospice company, assist in providing pastoral care as needed or request. Review of the MDS assessment for Resident #64 dated [DATE] revealed the resident had no cognitive deficit and received hospice services. Review of the monthly physician's orders for Resident #64 dated [DATE] revealed an order dated [DATE] for the resident to admit to hospice services with an admitting diagnosis of diffuse TBI. Review of the hospice binder kept at the nurses' station revealed the recertification, plan of care and assessment for Resident #64 expired on [DATE]. There was no current hospice recertification, plan of care or assessment on file for Resident #64 Interview on [DATE] at 11:25 A.M. with the DON confirmed the facility had not arranged for Resident #64 to have an updated hospice certification, plan of care and assessment. Review of the facility policy titled Coordination of Care for Hospice Services undated revealed the interdisciplinary team (IDT) facility member or designee would be responsible for obtaining the following information from the hospice provider: the most recent hospice plan of care specific to each resident, hospice election form, physician certification and recertification of the terminal illness specific to each resident, names and contact information for hospice personnel involved in hospice care for each resident receiving services, instructions on how to access the hospice's 24 hour on call system, hospice medication information specific to each resident, hospice physician and attending physician orders specific to each resident.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on medical record review, resident representative interview, and staff interview, the facility failed to ensure timely follow up for ophthalmology (vision) services. This affected one (Resident #88) of one resident reviewed for ophthalmology services. The facility census was 96 residents. Findings include: Review of the medical record for Resident #88 revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis, dysphasia, aphasia, atrial fibrillation, muscle weakness and cognitive communication. Review of the Minimum Data Set (MDS) assessment for Resident #88 dated 05/03/24 revealed the resident was cognitively impaired. Review of the progress note for Resident #88 dated 04/25/24 revealed the resident returned from a doctor appointment with a referral for ophthalmology services. Review of the facility vision provider list dated July 2023 to June 204 revealed Resident #88 was not seen during any of the visits. Interview on 06/04/24 at 9:36 A.M. with Resident #88's representative revealed they wanted resident to see an ophthalmologist and were unsure if this had been arranged. Resident #88's representative confirmed the resident had swelling in her eyes sometimes when she woke up. Interview on 06/10/24 at 4:50 P.M. with Social Services Director (SSD) #82 confirmed it was her role to arrange for vision services for the residents but was not aware that the doctor had referred Resident #88 for ophthalmology/vision services on 04/25/24 and the resident had not been seen by an ophthalmologist/vision service provider.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on medical record review, observation, staff interview and facility policy review, the facility failed to comprehensively assess resident pressure ulcers upon admission/readmission to the facility. This affected three (Residents #24, #27, #43) of six residents reviewed for pressure ulcers. The facility census was 96 residents. Findings include: Review of the medical record for Resident #24 revealed an admitted [DATE] with diagnoses including multiple sclerosis, functional quadriplegia, neuromuscular dysfunction of bladder, stage IV pressure ulcer to left buttocks, major depressive disorder, convulsions, contracture of right hand, contracture of right upper arm, contracture of right ankle and foot, voice and resonance disorder and status colostomy. Review of the nursing admission evaluation for Resident #24 dated 02/18/24 revealed the resident was readmitted to the facility with pressure ulcers to the coccyx, and right and left buttocks. The assessment contained no staging, measurements, description of the wound or exudate present. Review of the assessment contained within the admission evaluation revealed Resident #24 was at risk for skin breakdown. Review of the plan of care for Resident #24 dated 02/18/24 revealed the resident had impaired skin integrity, immobility related to MS. Interventions included staff should complete weekly skin checks and evaluate existing wounds daily for changes. Review of the wound Nurse Practitioner (NP) progress note for Resident #24 dated 02/21/24 revealed the resident had a stage IV pressure ulcer to the right buttocks measuring 1.0 centimeter (cm) in length by 1.0 cm. in width by 0.5 cm. in depth. The note described the wound bed to be 100 percent (%) granulation tissue with no exudate present. The stage IV pressure ulcer to the resident's left buttocks measured 6.0 cm in length by 2.2 cm. in width by 0.2 cm. in depth with100% granulation tissue with a scant amount of serosanguinous drainage. Observation on 06/05/24 at 11:52 A.M. of wound care for Resident #24 per Licensed Practical Nurse (LPN) #149 and State tested Nursing Assistant (STNA) #56 revealed the resident had stable, healing pressure ulcers to the right and left buttocks. Interview on 06/06/24 at 4:30 P.M. with Regional Clinical Nurse (RCN) #137 confirmed the staff had not comprehensively assessed Resident #24's stage IV pressure ulcers to the right and left buttocks upon admission to the facility. 2. Review of the medical record for Resident #27 revealed an admitted [DATE] with the diagnoses including acute kidney failure, chronic obstructive pulmonary disease, obstructive sleep apnea, severe morbid obesity, diabetes mellitus, gastro-esophageal reflux disease, hypertension, hyperlipidemia, adult failure to thrive, history of malignant neoplasm of prostate and osteoarthritis. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the acute care discharge summary for Resident #27 dated 05/15/24 revealed the resident had a pressure injury to the right heel, left heel, sacrum, moisture associated skin damage (MASD) to the left upper posterior leg, right upper posterior leg and a wound to the left anterior/posterior upper leg. The summary contained no assessments of the wounds. Review of the nursing admission evaluation for Resident #27 dated 05/15/24 revealed the resident was admitted to the facility with pressure ulcers to the right buttocks, left buttocks, right heel, left heel, right and left gluteal fold. The assessment did not include no staging, measurements, or a description of the wound or exudate present. Review of the pressure ulcer risk assessment contained within the admission evaluation revealed the resident was at risk for skin breakdown. Review of the plan of care for Resident #27 dated 05/15/24 revealed the resident had impaired skin integrity related to unstageable pressure ulcer to left heel, stage II pressure ulcer to left lateral thigh, stage II pressure ulcer to left ischium, left lateral foot, stage II pressure ulcer to sacrum. Interventions included staff to complete weekly skin checks and notify resident/family and medical provider of any decline in wound healing. Review of the wound NP progress note for Resident #27 dated 05/20/24 revealed the resident had an unstageable pressure ulcer to the left heel which measured 2.9 cm. in length by 2.5 cm in width by 0.3 cm. in depth with slough and eschar to the wound bed. The resident was also admitted with a stage II pressure ulcer to the left lateral thigh measuring 2.2 cm. in length by 2.0 cm. in width by 0.1 cm. in depth with 100% epithelial tissue and a scant amount of serosanguinous drainage. The resident was admitted to the facility with a stage II pressure ulcer to the left ischium measuring 3.5 cm. in length by 3.2 cm. in width by 0.2 cm. in depth with 100% epithelial tissue with a scant amount of serosanguinous drainage. The resident was admitted with a stage II pressure ulcer to the right ischium measuring 3.1 cm. in length by 2.0 cm. in width by 0.20 cm. in depth with 100% epithelial tissue and a scant amount of serosanguinous drainage. Interview on 06/06/24 at 4:30 P.M. with RCN #137 confirmed the facility had not comprehensively assessed Resident #27's pressure ulcers upon admission. 3. Review of the medical record for Resident #43 revealed an admitted [DATE] with diagnoses including spina bifida, diabetes mellitus, asthma, severe morbid obesity, hypertensive heart disease with heart failure, congestive heart failure, and neuromuscular dysfunction of bladder. Review of the acute care hospital discharge summary for Resident #43 dated 01/25/24 revealed the resident had a pressure injury to the right heel. The document contained no measurements but was present on admission to the acute care hospital. The pressure injury was described as being maroon and non-bleachable. The resident was also found to have a pressure injury to the left heel. The wound had no measurements and was described as being red. Review of the nursing admission evaluation for Resident #43 dated 01/26/24 revealed the resident's skin was not reassessed on admission. Review of the pressure ulcer risk assessment contained within the admission evaluation revealed the resident was at risk for skin breakdown. Review of the progress note for Resident #43 dated 01/26/24 revealed a treatment was ordered for wounds to the left and right heels. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the wound NP progress note for Resident #43 dated 01/31/24 revealed the resident had a healed deep tissue injury (DTI) to the left heel was healed. Resident #43 had a DTI to the right heel which measured 3.5 cm. in length by 3.5 cm. in width and was 100% epithelial tissue with no exudate. Review of the MDS assessment for Resident #43 dated 04/18/24 revealed the resident had no cognitive deficit and was always incontinent of both bowel and bladder. Observation on 06/06/24 at 11:30 A.M. of wound care for Resident #43 per LPN #149 revealed the resident had a healing stable pressure ulcer to the right heel. Interview 06/06/24 at 4:30 P.M. with RCN #137 confirmed Resident #43's pressure ulcers were not comprehensively assessed upon readmission to the facility. Review of the facility policy titled Skin Care & Wound Management Overview undated revealed each resident was evaluated upon admission and weekly thereafter for changes in skin condition. Resident skin condition is reevaluated with change in clinical condition, prior to transfer to the hospital and upon return from the hospital. This deficiency represents noncompliance investigated under Complaint Number OH00154396.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on medical record review, observation, resident interview, and staff interview the facility failed to ensure splints were placed appropriately and orders for fitting of diabetic shoes were completed timely. This affected four (Residents #20, #24, #14 and #47) of four residents reviewed for range of motion. The facility census was 96 residents. Findings include: 1. Review of the medical record for Resident #47 revealed an admitted [DATE] with diagnoses including diabetes mellitus, muscle wasting, atrophy and difficulty in walking. Review of Minimum Data Set (MDS) assessment for Resident #47 dated 04/15/24 revealed the resident was cognitively intact, required supervision with ambulation, and was independent with dressing. Review of the physician visit note for Resident #47 dated 04/29/24 revealed the resident needed to be fitted for appropriate diabetic footwear. Review of the nurse practitioner (NP) progress note for Resident #47 dated 04/30/24 revealed patient had seen specialist at spine and joint regarding leg pain and knees buckling. The doctor ordered the resident to be evaluated by the podiatrist and be fitted for diabetic shoes. Review of the NP progress note for Resident #47 dated 05/15/24 revealed the resident the resident was not wearing shoes when ambulating, only non-skid socks. Further review of the note revealed the resident needed to be fitted for diabetic shoes. Review of the physician's orders for Resident #47 revealed an order dated 05/21/24 for the resident to be fitted for diabetic shoes. Observation on 06/04/24 at 9:57 A.M. of Resident #47 revealed the resident was wearing non-skid socks and did not have diabetic shoes in his room. Interview on 06/04/24 at 9:57 A.M. with Resident #47 confirmed he did not have any supportive or appropriate shoes and he was unstable when ambulating. Resident #47 further confirmed he had informed the nursing staff that he wanted diabetic shoes, but he had no update on when he would receive them. Interview on 06/05/24 at 5:20 P.M. with the Director of Nursing (DON) confirmed the facility NP had ordered Resident #47 to be fitted for diabetic shoes on 05/21/24 due to initial orthopedic recommendations on 04/29/24, but the facility had not yet had the resident fitted for diabetic shoes. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/10/24 at 10:32 A.M. with the DON confirmed the facility had not yet arranged for Resident #47 to be fitted for diabetic shoes and the resident was scheduled to see the podiatrist on 06/17/24. Interview on 06/10/24 at 12:40 P.M. with Certified Nurse Aide (CNA) #56 confirmed Resident #47 did not have appropriate diabetic shoes and wore nonskid socks. 44070 2.Review of the medical record for Resident #14 revealed an admitted [DATE] with diagnoses including aneurysm, hemiplegia and hemiparesis, convulsions, diabetes, polyneuropathy, muscle wasting and atrophy. Review of the MDS assessment for Resident #14 dated 05/22/24 revealed the resident was cognitively intact and required moderate to dependent assistance for personal hygiene. Review of the plan of care for Resident #14 dated 05/23/24 revealed the resident had a contracture and limited range of motion of the left hand with interventions to wear a splint for four hours from 6:00 A.M. to 10:00 A.M. daily. Review of the progress notes for Resident #14 dated 04/01/24 to 06/05/24 revealed there no documented refusals of care for the resident. Observation on 06/03/24 at 3:11 P.M. of Resident #14 revealed the resident had paralysis to the left side with minimal use of her left hand. Resident #14 was not wearing a splint and there was not splint found in her room. Interview on 06/03/24 at 3:11 P.M. with Resident #14 confirmed she had minimal use of her left hand and she used to wear a splint, but she thought it had gotten lost in the laundry months ago. Resident #14 further confirmed she was agreeable to wear a splint if the medical team recommended it. Interview on 06/05/24 at 8:19 A.M. with Registered Nurse (RN) #77 confirmed Resident #14 did not have a splint on her left hand. RN #77 further confirmed she was unaware if Resident #14 should have a splint, but confirmed it was on the resident's care plan to wear a splint from 6:00 A.M. to 10:00 A.M. daily. Observation on 06/06/24 at 8:45 A.M. of Resident #14 revealed she was not wearing a splint. Interview on 06/06/24 at 8:45 A.M. Resident #14 confirmed she was not wearing a splint and confirmed staff had not talked with her about wearing a splint. Interview on 06/06/24 at 2:00 P.M. with Regional Clinical Manager (RCM) #137 confirmed therapy had assessed Resident #14 and a physician order was made for the resident to wear the hand splint daily. RCM #137 was unable to provide information on where hand splint was or why it had not been in use for Resident #14. 41266 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the medical record for Resident #20 revealed an admitted on 03/18/14 with diagnoses including type two diabetes mellitus, hemiplegia and hemiparesis following cerebrovascular disease affecting left non-dominant side, contracture of muscle in left hand, contracture of left ankle, dementia, reduced mobility, and need for assistance with personal care. Review of the physical therapy evaluation for Resident #20 dated 01/03/24 revealed the resident had severe left hand and ankle contractures. Splints were provided for the left hand and bilateral feet during previous bouts of therapy with written instructions on the schedule for wear time and passive range of motion (PROM.) Further review of the evaluation revealed staff should comply with wear time for splints to prevent further impairments and debility. Review of the MDS assessment for Resident #20 dated 04/05/24 revealed the resident had impaired cognition and was totally dependent on staff to complete activities of daily living (ADLs). Review of the care plan for Resident #20 revised on 04/11/24 revealed the resident had contractures/impaired functional range of motion (ROM) of left and right feet and left hand. Interventions included to apply splints to left hand and left and right ankles as tolerated and to wear left palm protector on at 8:00 A.M. and off at 2:00 P.M. Review of the Treatment Administration Records (TARs) for Resident #20 dated May and June 2024 revealed the splint orders were not included on the TARs for Resident #11. Review of the June 2024 physician orders for Resident #20 revealed an order dated 01/03/24 to place a left palm protector to resident's left hand as tolerated, an order dated 11/25/22 to apply splints to left hand and left and right ankles on eight hours daily as tolerated. Review of the progress notes for Resident #20 for May and June 2024 revealed there were no documented refusals of splints or the palm protector for the resident. Observations on 06/04/24 at 9:53 A.M., 06/05/24 at 8:26 A.M., 06/05/24 at 11:45 A.M., 06/05/24 at 1:17 P.M. , and 06/05/24 at 2:13 P.M. revealed Resident #20 did not have left palm protector, left hand splint, or bilateral splints on feet in place at the time of any of the observations. There were two hard-sided boots observed on Resident #20's nightstand next to her bed at each observation. The left-hand palm protector or hand splint were not observed in the resident's room. Interview on 06/05/24 at 4:03 P.M. LPN #131 confirmed Resident #20 was not wearing any of the ordered splints on her left hand or either foot. LPN #131 confirmed there were boot splints on the table next to the resident's bed. LPN #131 searched for Resident #20's left hand splint but could not locate it in the resident's room. Observation and interview on 06/06/24 at 2:35 P.M. with LPN #45 confirmed Resident #20 was not wearing any of the ordered splints on her left hand or either foot. LPN #45 confirmed she had never seen Resident #20 wearing any splints. LPN #45 stated she would follow up with therapy because she could not locate the left palm protector in the resident's room. LPN #45 confirmed Resident #20 had not been offered to have splints placed on her and had not worn any of the splints at all during her shift which started on 06/06/24 at 7:00 A.M. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/06/24 at 2:40 P.M. with STNA #114 confirmed she was regularly assigned to care for Resident #20 and also confirmed she did not know the resident should have been wearing a palm protector or foot/ankle splints at all. STNA #114 confirmed she had never placed any of the splints on Resident #20. STNA #114 confirmed she had not offered or placed any of the splints on Resident #20 since her shift started on 06/06/24 at 6:00 A.M. 32654 4. Review of the medical record for Resident #24 revealed an initial admitted [DATE] with the latest readmission of 02/18/24 with diagnoses including multiple sclerosis, functional quadriplegia, neuromuscular dysfunction of bladder, stage IV pressure ulcer to left buttocks, major depressive disorder, convulsions, contracture of right hand, contracture of right upper arm, contracture of right ankle and foot, voice and resonance disorder and status colostomy. Review of the clinical admission evaluation for Resident #24 dated 06/16/21 revealed the resident was admitted to the facility had contractures to bilateral arms. Review of the plan of care for Resident #24 dated 06/28/21 revealed the resident had a self-care deficit and required assistance with activities of daily living (ADL) related to MS, functional quadriplegia, right arm and bilateral ankle/foot contractures, refused ankle braces at times. Interventions included the following: apply bilateral ankle brace for eight hours a day as ordered, monitor skin around ankle area, check skin for breakdown, redness or irritation before applying brace and after removal, place bilateral WHFO splints daily five days a week for two to three hours as tolerated, resident to wear right elbow and hand splint on at 9:00 A. M., and off at 1:00 P.M. for contracture management, wash cloth placed in both hands to prevent skin breakdown to be changed every shift and monitor nail length, clip if needed. Review of the MDS assessment for Resident #24 dated #03/28/24 revealed the resident had no cognitive deficit and required extensive assistance of two staff for bed mobility, transfers, eating and was dependent on staff for toilet use. Observation on 06/04/24 at 3:00 P.M. revealed Resident #24's splints to his bilateral hands/wrists were not in place. Interview on 06/04/24 at 3:00 P.M. with Resident #24 confirmed the staff had not put the splints on as care planned. Interview 06/04/24 at 3:03 P.M. with LPN #91 confirmed Resident #24 did not have his bilateral hand/wrist splints on as care planned. Observation on 06/05/24 at 11:52 A.M. observation of Resident #24 revealed the resident's splints to bilateral hands/wrists splints were not on as care planned. Interview on 06/05/24 at 12:05 P.M. with LPN #149 confirmed the bilateral hand splints for Resident #24 were not on as care planned. Observation on 06/06/24 at 11:40 A.M. of Resident #24 revealed the resident's splints to bilateral hands/wrists splints were not on as care planned. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/06/24 at 11:43 A.M. with LPN #47 confirmed the bilateral hand splints for Resident #24 were not on as care planned. This deficiency represents noncompliance investigated under Complaint Number OH00153872.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to ensure incontinence care was provided timely and upon request. This affected one (Resident #14) of one resident reviewed for incontinence care. The facility census was 96 residents. Findings include: Review of the medical record for Resident #14 revealed an admitted [DATE] with diagnoses including aneurysm, hemiplegia and hemiparesis, convulsions, diabetes, polyneuropathy, muscle wasting and atrophy. Review of the Minimum Data Set (MDS) assessment for Resident #14 dated 05/22/24 revealed the resident was cognitively intact and required moderate to dependent assistance for personal hygiene and bathing. Review of the plan of care for Resident #14 dated 05/23/24 revealed the resident was incontinent of bowel and bladder with the intervention to check resident every care round for incontinence, toilet upon rising, before and after meals, prior to bedtime and as needed. Review of the progress notes for Resident #14 dated 04/01/24 to 06/05/24 revealed there were no notes documenting the resident refusing incontinence care. Observation on 06/06/24 at 8:45 A.M. of Resident #14 revealed the resident's room and the adjoining hall had a strong smell of urine and feces. Interview on 06/06/224 at 8:45 A.M. with Resident #14 confirmed she had been incontinent of bowel and bladder, and she needed staff to provide incontinence care. Resident #14 further confirmed the room smelled badly to her and she had used her call light to request assistance and staff had told her she would have to wait until after breakfast. Observation on 06/06/24 at 8:48 A.M. revealed State tested Nursing Assistant (STNA) #49 was collecting trays and when she entered Resident #14's room, the resident asked to be cleaned up and for incontinence care to be provided. STNA #49 turned off the resident's call light and told the resident she would come back to provide care when she had time. Observation on 06/06/24 at 9:09 A.M. revealed STNA #49 was filling water pitchers on the resident hallway. Resident #14 remained soiled, and the room and the hall smelled of urine and feces. Observation on 06/06/24 at 9:20 A.M. revealed Resident #14 again put her call light on for incontinence care. STNA #74 responded to the call light and informed Resident #14 that STNA #49 had gone on break. STNA #74 turned off resident's call light and left the room. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/06/24 at 9:23 A.M. with Licensed Practical Nurse (LPN) #47 confirmed if a resident asked for assistance with incontinence care it should be provided immediately or within five minutes. LPN #47 further confirmed Resident #14 was in need of incontinence care and that she was unaware the resident had been requesting assistance since during breakfast. Review of facility policy titled Routine Resident Care undated revealed facility should promote resident centered care and maintain skills in providing bowel and bladder management. Further review of the policy revealed the facility should provide routine daily care including toileting and incontinence care with dignity and to maintain skin integrity. This deficiency represents noncompliance investigated under Complaint Number OH00154396.

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F 0692 Level of Harm - 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** 44070 Based on medical record review, staff interview, family interview, and review of the facility policy, the facility failed to ensure staff monitored resident nutritional status to prevent unplanned weight loss during a tube feed discontinuation trial. This resulted in Actual Harm for one (Resident #88) who experienced an unplanned weight loss of 4.6 percent (%) in three weeks and had ongoing severe weight loss of 8.5% over less than three months. The facility also failed to monitor weights and nutritional supplements for three (Residents #14, #20, and #56) of seven residents reviewed for nutrition. The facility census was 96 residents. Findings include 1.Review of the medical record for Resident #88 revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis, dysphasia, aphasia, atrial fibrillation, muscle weakness and cognitive communication. Review of the nutrition assessment for Resident #88 dated 12/14/23 revealed the resident had received a percutaneous endoscopic gastrostomy tube (PEG) tube at the hospital and was on tube feeding. Review of the nutrition assessment for Resident #88 dated 03/11/24 revealed the resident relied on enteral nutrition to complement her oral intake and meet her needs. Resident #88 received 26 to 50% of her nutrition from her tube feed formula. Resident consumed an average of 77% at meals with ranges from 0% to 100%. Resident #88 had an order with for Isosource 1.5 at 80 milliliters per hour per PEG tube for ten hours daily. Further review of the assessment revealed the dietitian recommended Isosource to be discontinued for Resident #88 and to monitor the resident's weight weekly. Review of the weight records for Resident #88 revealed the following dates/weights: - 02/07/24 weight of 180.3 pounds (lbs.) - 03/07/24 weight of 181.0 lbs. - 04/02/24 weight of 172.6 lbs. - 05/07/24 weight of 168.2 lbs. - 05/14/24 weight of 168.0 lbs. - 05/20/24 weight of 165.6 lbs. - 06/01/24 weight of 166.0 lbs. Review of weights revealed from 03/07/24 to 04/02/24 Resident #88 had a 4.64% weight loss in about three weeks. Review of weights revealed from 03/07/24 to 05/20/24 Resident #88 had a severe weight loss of 8.51% in under three months. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of progress note per nurse practitioner for Resident #88 dated 03/13/24 and 03/14/24 revealed the resident's tube feeding was on hold and the dietician would follow and monitor the resident. Review of nutrition progress note for Resident #88 per Dietitian #144 dated 04/03/24 revealed the resident had a weight loss of 4.6% during a trial discontinuation of nocturnal tube feeding. Resident #88 resumed nocturnal tube feeding as previously ordered on 04/03/24 after weight loss was identified. Resident's oral intake for 03/11/24 to 04/02/24 was an average of 53% of mechanical soft meals by mouth. Review of the Minimum Data Set (MDS) assessment for Resident #88 dated 05/03/24 revealed the resident was cognitively impaired and required supervision or touching assistance for eating. Resident received an enteral feeding. Review of care plan dated for Resident #88 dated 05/06/24 revealed the resident had a nutrition problem related to dysphasia from cerebrovascular accident (CVA) and was on a mechanically altered diet and enteral nutrition. Interventions included the following: notify the medical provider and resident representative of unplanned weight loss, nutritional consult, obtain labs, obtain weights as ordered. Review of the care plan for Resident #88 dated 05/06/24 revealed the resident received tube feeding related to dysphasia from CVA. Interventions included the following: monitor intake, notify medical provider and resident representative of unplanned weight changes, nutrition consult quarterly and as indicated, obtain weights as ordered. Interview on 06/04/24 at 9:13 A.M. with Resident #88's representative confirmed the facility stopped Resident #88's tube feed on 03/11/24 and because the resident lost weight the facility needed to restart the tube feeds. Interview on 06/06/24 at 3:02 P.M. with Dietician #143 confirmed residents should be weaned from tube feed intakes by cutting the dose over several days and monitoring intake and weights before stopping tube feeds completely. Dietitian #143 confirmed she would typically request weekly weights for residents receiving tube feeding and residents should be monitored closely during tube feed weaning trials. Dietician #143 confirmed Resident #88's record did not include monitoring of resident's weight and nutritional status following the discontinuation of resident's nocturnal tube feeding from 03/11/24 to 04/02/24 per the previous Dietitian #144. Dietician #143 confirmed there were no additional nutritional progress notes or documentation of additional nutritional interventions as Resident #88 continued to lose weight. Dietitian #143 confirmed Resident #88 had an 8.5% weight loss from 03/07/24 to 05/20/24. Interview on 06/10/24 at 1:10 P.M. with Corporate Dietician (CD) #147 confirmed facility had no documentation of Resident #88's weight being monitored from 03/11/24 to 04/02/24 during the tube feed discontinuation trial. CD #147 confirmed weights were not taken weekly as recommended and acknowledged resident was stopped from tube feeding nutrition without weaning and when resident was still obtaining 26 to 50% of her nutrition from her tube feed formula. Review of facility policy titled Diet and Nutrition Care Manual dated 2019 revealed weight changes were considered significant per the following parameters: 1-2% weight loss in one week, 5% weight loss in one month, 7.5% weight loss in three months and 10% weight loss in six months. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	2. Review of the medical record for Resident #14 revealed an admitted [DATE] with diagnoses including aneurysm, hemiplegia and hemiparesis, convulsions, diabetes, polyneuropathy, muscle wasting and atrophy. Review of progress note for Resident #14 dated 04/10/24 revealed the resident had a weight change due to possibly due to declining intakes. The dietitian recommended Resident #14's diet to be changed from carb controlled to regular to liberalize choices and to monitor weights weekly for four weeks. Review of weight records for Resident #14 revealed the following dates/weights: - 04/22/24 weight of 188.9 lbs. - 05/17/24 weight of 181.5 lbs. - 05/20/24 weight of 185.4 lbs. Review of nutritional assessment for Resident #14 dated 05/19/24 revealed staff should continue to weigh the resident weekly. Review of the MDS assessment for Resident #14 dated 05/22/24 revealed the resident was cognitively intact required set up assistance with eating. Review of the plan of care for Resident #14 dated 05/23/24 revealed the resident had a potential nutrition problem with interventions to monitor and address significant weight changes and weigh per facility order. Interview on 06/06/24 at 3:02 P.M. with Dietician #143 confirmed the facility had no evidence of weekly weights being obtained and monitored as recommended by the dietitian on 04/10/24. Dietitian #143 confirmed resident went three and a half weeks without updated weights. 41266 3. Review of the medical record for Resident #20 revealed an admitted [DATE] with diagnoses including type two diabetes mellitus without complications, hemiplegia and hemiparesis following cerebrovascular disease affecting left non-dominant side, contracture of muscle in left hand, contracture of left ankle, dementia, reduced mobility, and need for assistance with personal care. Review of the MDS assessment for Resident #20 dated 04/05/24 revealed the resident was cognitively impaired and depended on staff assistance with eating. Review of the physician's orders for Resident #20 revealed orders dated 02/12/24 for the resident to be weighed weekly on Mondays and offer fortified pudding with lunch and dinner and an order dated 04/01/24 for a pureed textured diet. Review of the weight record for Resident #20 revealed the following dates/weights: -11/08/23 weight of 177 lbs. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-01/04/24 weight of 169 lbs. -02/07/24 weight of 156 lbs. -03/07/24 weight of 158 lbs. -03/31/24 weight of 151 lbs. -04/05/24 weight of 153 lbs. -05/07/24 weight of 157 lbs. Review of the progress note for Resident #20 dated from 01/08/24 revealed the resident had lost weight from 11/08/23 to 01/04/24 and a reweight was requested. Review of the progress note for Resident #20 dated 02/08/24 timed at 1:00 P.M. revealed the resident weighed 156 lbs. on 02/07/24 and there had been no reweight following the weight on 01/04/24. This reflected an unplanned weight loss of 7.7% or 13 lbs. in 30 days. The dietitian recommend the addition of fortified pudding with lunch and dinner. Review of progress note for Resident #20 dated 03/11/24 timed at 4:09 P.M. revealed the resident weighed 158 lbs. on 03/07/24 which indicated the resident's weight was stabilizing. No additional new interventions were recommended. Review of the progress note for Resident #20 dated 04/01/24 timed at 3:30 P.M. revealed the resident weighed 151 lbs. on 03/31/24 which reflected an unplanned significant weight loss of 10.7% or 18 lbs. over 90 days. The recommendation was to monitor with weekly weights for four weeks. Review of the progress note for Resident #20 dated 05/19/24 timed at 4:56 P.M. revealed the resident weighed157 lbs. on 05/07/24 which reflected a significant weight loss of 11.4% over 180 days. The resident's meal intakes varied from 26-100%. No additional interventions were recommended. Review of the medical record for Resident #20 revealed it did not include documentation regarding the resident's acceptance of the fortified pudding that was added as a nutritional intervention for significant weight loss which was noted separately from the rest of the resident's meal tray. Interview on 06/05/24 at 2:27 P.M. with Regional Clinical Manager (RCM) #137 confirmed Resident #20 had a physician's order for fortified pudding at lunch and dinner to help stabilize the resident's weight, but the facility had not documented the resident's acceptance of the pudding. RCM #137 further confirmed the facility had not obtained reweights or weekly weights as ordered/recommended for Resident #20. Review of the facility policy titled Resident Height and Weight undated weights would be obtained monthly or as ordered by the physician or practitioner. Staff should compare weight to previous weights obtained. If a variance of five pounds or more was noted staff should reweigh the resident to verify weight. Nutritionally unstable residents would be reviewed by interdisciplinary team (IDT) to determine frequency of obtaining weight. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy titled Fortified Food Program undated, revealed the goal of the fortified food program was to be able to provide a higher calorie and or higher protein food item to residents if the intake of regular foods or beverages were estimated to be unable to meet the resident's nutritional needs. 49039 4. Review of the medical record for Resident #56 revealed an admitted [DATE] with diagnoses including absence of right and left leg above the knee, severe protein calorie malnutrition, depression and muscle weakness. Review of the care plan for Resident #56 care plan dated 11/06/23 revealed the resident had the potential for altered nutrition status related to diagnoses with interventions including nutritional consult, obtaining weights as ordered and monitoring meal intakes. Review of the MDS assessment for Resident #56 dated 02/07/24 revealed the resident was cognitively intact and required staff assistance with feeding. Review of the nutritional assessment for Resident #56 dated 02/07/24 the resident had an average meal intake of 75%. Resident weights had not been obtained for 60 days. Review of the progress note for Resident #56 progress dated 02/08/24 revealed the resident had a weight change from 136.8 pounds on 12/04/23 to 94.6 pounds on 02/08/24 related to bilateral leg amputations. The resident's weight was to be obtained weekly following the amputations. Record of the physician orders for Resident #56 revealed an order dated 02/08/24 to obtain weekly weights. Record of the weight record for Resident #56 from 02/11/24 to 03/18/24 revealed there were no weights obtained for the resident. Interview on 06/06/24 at 8:13 A.M. with Central Supply Coordinator (CSC) #115 confirmed she was responsible for obtaining weekly weights. CSC #115 confirmed Resident #56 had a significant weight loss and was supposed to be weighed weekly, but she had not weighed the resident weekly. Interview on 06/06/24 at 4:00 P.M. with Dietician #143 confirmed Resident #56 was on the weekly weight list due bilateral leg amputations which resulted in a significant weight loss. Dietician #143 confirmed the facility did not obtain required weights. Interview on 06/06/24 at 8:13 A.M. with the Administrator confirmed Resident #56's weekly weights were not obtained per physician order between 02/08/24 to 03/18/24. Interview on 06/10/24 at 1:24 P.M. with Resident #56 confirmed she had weight loss due to surgery and not due to lack of appetite. Review of facility policy titled Resident Height and Weight undated revealed weights would be obtained monthly or as ordered by the physician.

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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** 32654 Based on medical record review, observation, staff interview and review of the facility policy, the facility failed to ensure oxygen equipment was stored appropriately and oxygen nasal cannula tubing was changed as ordered by the physician. This affected two (Residents #27 and #64) of two residents reviewed for respiratory services. The facility census was 96. Findings Include: 1. Review of the medical record for Resident #27 revealed an admitted [DATE] with diagnoses including acute kidney failure, chronic obstructive pulmonary disease (COPD), obstructive sleep apnea (OSA), severe morbid obesity, diabetes mellitus, gastro-esophageal reflux disease, hypertension, hyperlipidemia, adult failure to thrive, history of malignant neoplasm of prostate and osteoarthritis. Review of the plan of care for Resident #27 dated 05/17/24 revealed the resident received bilevel positive airway pressure (BiPap) therapy for obstructive sleep apnea. Interventions included to educate resident/representative on the importance of BiPap therapy and encourage resident to use the BiPap. Review of the monthly physician orders for Resident #27 dated June 2024 revealed an order dated 05/15/24 to apply the BiPap at 9:00 P.M. and remove at 6:00 A.M. Observation on 06/03/24 at 3:32 P.M. of Resident #27's BiPap machine revealed the delivery mask was laying on the nightstand outside the plastic bag. Observation on 06/04/24 at 3:00 P.M. of Resident #27's BiPap machine revealed the delivery mask was laying on the nightstand outside the plastic bag. Interview on 06/04/24 at 3:01 P.M. with the Director of Nursing (DON) confirmed Resident #27's BiPap delivery mask was improperly stored outside the plastic bag. 2. Review of the medical record for Resident #152 revealed an initial admitted [DATE] with diagnoses including COPD, chronic respiratory failure with hypoxia, congestive heart failure (CHF), and diabetes mellitus. Review of the Minimum Data Set (MDS) assessment for Resident #152 dated 05/30/24 revealed the resident had no cognitive deficit, and the resident utilized oxygen. Review of the plan of care for Resident #152 dated 05/31/24 revealed the resident had oxygen therapy related to CHF and COPD. Interventions included staff to administer oxygen at two liters per nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the monthly physician orders for Resident #152 dated June 2024 revealed an order dated 05/28/24 to change oxygen tubing and humidifier every seven days and as needed and an order dated 05/30/24 for oxygen at two liters continuously via nasal cannula as needed for shortness of breath or signs/symptoms of hypoxia and an order dated 06/03/24 to clean oxygen concentrator filter every seven days and as needed. Review of the Treatment Administration Record (TAR) for Resident #152 dated June 2024 revealed the oxygen delivery nasal cannula tubing was not initialed as being changed. Observation on 06/03/24 at 12:10 P.M. of Resident #152 revealed the resident's oxygen tubing was not dated. Interview on 06/04/24 at 3:01 P.M. with Licensed Practical Nurse (LPN) #56 confirmed Resident #152's oxygen tubing had no date indicating when the tubing had been changed. Observation on 06/10/14 at 10:19 A.M. of Resident #152 revealed the resident's oxygen tubing was dated 06/03/24 and the tubing was laying directly on the floor. Interview on 06/10/24 at 10:22 A.M. with the DON confirmed Resident #152's oxygen tubing was dated 06/03/24 and was due to be changed. The DON further confirmed the oxygen tubing was laying directly on the floor and should be stored in a sanitary manner when not in use. Review of the facility policy titled Supplemental Oxygen using Nasal Cannula undated revealed a nasal cannula would be used when the physician ordered supplemental oxygen to be administered by this route and at a specific rate of flow. Nasal cannula tubing should be labeled and dated when opened. Nasal cannulas and tubing should be changed weekly or when soiled and should be labeled with the date opened.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 36648 Based on review of staff schedules, review of the facility assessment, staff interview, and review of the facility policy, the facility failed to ensure there was a Registered Nurse (RN) on duty for at least eight consecutive hours a day. This had the potential to affect all residents residing in the facility. The facility census was 96 residents. Findings include: Review of the staff schedules for the weekends (Saturdays and Sundays) dated from 10/01/23 through 12/31/23 revealed the facility did not have an RN on duty for at least eight consecutive hours a day on 10/15/23, 11/12/23, 11/26/23, 12/09/23, 12/10/23, 12/23/23, and 12/24/23. Review of the facility assessment completed for the facility from 10/01/22 through 09/30/23 revealed the facility would be staffed with six to eight licensed nurses providing direct care per day for 12-hour shifts. Interview on 06/12/24 at 4:26 P.M. with the Administrator confirmed the facility did not have a RN on duty for at least eight consecutive hours a day on the following dates: 10/15/23, 11/12/23, 11/26/23, 12/09/23, 12/10/23, 12/23/23, 12/24/23. Review of the facility policy titled Nurse Staffing Information undated, revealed the facility would provide the sufficient number of staff to care for the residents.

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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. 32654 Based on employee file review and staff interview, the facility failed to ensure State tested Nursing Assistants (STNAs) received annual performance reviews and 12 hours of continuing education annually. This had the potential to affect all residents residing in the facility. The facility census was 96 residents. Findings include: 1. Review of STNA #43's employee file revealed a date of hire of 10/25/22. STNA #43's file did not include an annual performance appraisal or documentation of completion of 12 hours of continuing education annually. Review of STNA #94's employee file revealed a date of hire of 01/30/23. STNA #94's file did not include an annual performance appraisal. Review of STNA #96's employee file revealed a date of hire of 01/11/23. STNA #96's file did not include an annual performance appraisal or documentation of completion of 12 hours of continuing education annually. Interview on 06/10/24 at 4:45 P.M. with Human Resources Director (HRD) #110 confirmed STNAs #43, #94, and #96 had not received annual performance reviews. HRD #110 confirmed STNAs #43 and #96 had not completed 12 hours of continuing education annually.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49039 Based on observation, staff interview and review the facility policy the facility failed to ensure loose improperly stored medications were discarded and failed to ensure multi use vials of tuberculin purified protein derivative (PPD) were dated when they were opened. This had the potential to affect all 96 residents residing in the facility. Findings include: 1 Observation on 06/05/24 at 10:50 A.M. of the medication cart in the 300-hallway revealed there were eight loose pills in the drawer of the cart below the prepackaged medication cards. Interview on 06/05/24 at 10:50 A.M. with Assistant Director of Nursing (ADON) #77 confirmed there eight loose pills in the medication cart and they should have been discarded. Observation on 06/05/24 at 10:55 A.M. of the medication cart in the 400-hallway revealed there were three loose pills in the drawer of the cart below the prepackaged medication cards. Interview on 06/04/24 at 10:50 A.M. with ADON #77 confirmed there three loose pills in the medication cart and they should have been discarded. Review of facility policy titled Storage of Medications dated August 2020 revealed medications without secure closures were immediately removed from inventory and disposed of according to procedures for medication disposal. 2. Observation on 06/05/24 at 11:10 A.M. of the medication room refrigerator located behind the main nurse's station revealed an opened box with an open vial of tuberculin PPD solution which had not been dated upon opening. Interview on 06/05/24 at 11:11 A.M. with ADON #77 confirmed the tuberculin PPD solution was opened but neither the box nor the vial had a date, so she was unsure when the solution needed to be discarded. ADON #77 further confirmed PPD solution was to be discarded 30 days after opening. Review of manufacturer's guidelines for tuberculin PPD solution dated October 2017 revealed vials in use for more than 30 days should be discarded. Review of facility policy titled Storage of Medications dated August 2020 revealed the nurse should place a date opened sticker on the medication and record the open date and the date of expiration.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on observation, staff interview, and review of the facility policy, the facility failed to ensure safe and sanitary storage of food items in the kitchen. This affected all residents residing in the facility. The facility census was 96 residents. Findings include: Observation on [DATE] at 9:13 A.M. of the refrigerator revealed it contained the following items: a bag of undated shredded cheese, a bag of lettuce undated and left open to air, three pitchers of undated and unlabeled juice. Interview on [DATE] at 9:15 A.M. with Kitchen Worker (KW) #25 confirmed the undated and unlabeled food and that the lettuce had been left open to air. KW #25 further confirmed all foods should be labeled and should be dated upon opening and food should be stored in airtight packaging. Observation on [DATE] at 9:18 A.M. of the dry storage revealed there were three large, dented cans of tomatoes and two large, dented cans of fruit salad. Interview on [DATE] at 9:19 A.M. with KW #40 confirmed the dented cans should not be used and should have been discarded. Review of facility policy titled Storage of Resident Foods undated revealed dietary staff should monitor the kitchen for food safety concerns and should dispose of expired or unsafe food, food exposed to incorrect temperatures or other environmental contaminants.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49794 Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to follow infection control practices for residents with dressings to peripherally inserted central catheters (PICC) line site. This affected one (Resident #87) of one resident reviewed for intravenous (IV) therapy. The facility also failed to ensure medications were administered using proper infection control practices. This affected two (Residents #5 and #27) of five residents observed for medication administration. The facility also failed to ensure staff wore proper personal protective equipment (PPE) when providing hands-on care to residents on enhanced barrier precautions (EBP) This affected two (Residents #24 and #43) of 25 facility-identified residents who required EBP. The facility also failed to provide proper wound care in a sanitary manner to prevent cross-contamination. This affected three (Residents #24, #27, and #43) of six residents reviewed for pressure ulcers. The facility census was 96. Findings include: 1. Review of medical record for Resident #87 revealed an admitted [DATE] with diagnoses including dorsalgia, muscle wasting and atrophy, abnormalities of gait and mobility, and hydronephrosis. Review of orders for Resident #87 revealed order dated 5/14/24 for linezolid intravenous (IV) solution every 12 hours for infection per peripherally inserted cardiac catheter (PICC) line to the right arm, an order dated 05/14/24 for EBP related to the PICC line, and an order dated 06/03/24 to change the PICC line dressing weekly and as needed. Observation on 06/03/24 at 11:42 AM of Resident #87 revealed the PICC line dressing to the resident's right arm was not intact. The insertion site was covered by gauze and not visible, part of the clear occlusive dressing was rolled up with some of the gauze sticking out from under it and the dressing was no longer sealed all the way around (intact). The dressing was not dated or initialed. Interview on 06/03/24 at 11:42 A.M. with Resident #87 confirmed the PICC line dressing was not sealed, and it was not dated or initialed. Observation on 06/04/24 at 03:21 P.M. revealed Resident #87's PICC line dressing was not intact, and it was not dated or initialed. Interview on 06/04/24 at 3:21 P.M. with Resident #87 confirmed the staff administered antibiotics via the PICC line on 06/03/24 but they had not changed the dressing. Interview on 06/04/24 at 4:22 P.M. with Regional Clinical Manager (RCM) #137 confirmed the PICC line dressing for Resident #87 was not intact and was not dated. Review of the facility policy titled Central Venous Catheter dated February 2009 revealed PICC line dressings should be initialed and dated at the time of treatment and dressings should be replaced when they became loose or soiled. 49039 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the medical record for Resident #5 revealed an admitted [DATE] with diagnoses including diabetes mellitus, hypertensive heart and chronic kidney disease, anxiety and vascular disease. Review of the MDS assessment for Resident #5 dated 05/08/24 revealed the resident #5 was cognitively intact and received antianxiety, antiplatelet and hypoglycemic medications. Observation of medication administration for Resident #5 on 06/05/24 at 7:32 A.M. per Registered Nurse (RN) #73 revealed the nurse did not perform hand hygiene prior the preparing the resident's medications. RN #73 removed Gabapentin from the medication card and popped the pill onto the nurse's ungloved unwashed hand and then deposited the pill into the medication cup. RN #73 continued to prepare Resident #5's medications including Sennosides, Jardiance, duloxetine, sertraline, and Tradjenta by popping each pill into the nurse's hand and then into the medication cup. RN #73 then administered the pills to Resident #5. 3. Review of the medical record for Resident #47 revealed an admitted [DATE] with diagnoses including diabetes mellitus, muscle wasting, atrophy and difficulty in walking. Review of the MDS assessment for Resident #47 dated 04/15/24 revealed the resident was cognitively intact and received antidepressants, antiplatelets and hypoglycemics. Observation on 06/05/24 at 8:00 A.M. with RN #73 revealed after preparing and administering Resident #5's medications RN #73 did not conduct hand hygiene. RN #73 began preparing Resident #47's medications and popped each pill including omeprazole, atenolol, clopidogrel, sertraline, loratadine, and guaifenesin out of the medication card directly into the nurse's hand and then into the medication cup. RN #73 then administered the medications to Resident #47. Interview on 06/05/24 at 8:10 A.M. with RN #73 confirmed the nurse had not performed hand hygiene prior to or during medication administration. RN #47 further confirmed the nurse popped medications out of the medication cards and directly into the nurse's hand before placing the pills in the cup for administration to the residents. Interview on 06/05/24 at 11:30 A.M. with the Administrator confirmed nurses should perform hand hygiene prior to medication administration and in between residents. The Administrator confirmed nursing staff should not pop medications directly into the nurse's hands. Review of facility policy titled Medication Administration undated revealed staff were required to perform appropriate hand hygiene before beginning medication administration and after each resident's medication was administered. 32654 4. Review of the medical record for Resident #24 revealed an initial admitted [DATE] with a readmitted [DATE] with diagnoses including multiple sclerosis (MS), functional quadriplegia, neuromuscular dysfunction of bladder, stage IV pressure ulcer to left buttocks, and major depressive disorder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the plan of care for Resident #24 dated 02/18/24 revealed the resident had impaired skin integrity related to immobility, MS, and dependence on staff with positioning. Interventions included to administer wound treatments as ordered. Review of the MDS assessment for Resident #24 dated 03/28/24 revealed the resident was cognitively intact and was dependent on staff for activities of daily living (ADLs.) Review of the resident's monthly physician's orders for Resident #24 revealed an order dated 05/15/24 to cleanse right buttocks wound with wound cleanser, pat dry, apply medical grade honey to wound bed and cover with bordered gauze daily and as needed, an order dated 05/18/24 to cleanse left buttocks wound with wound cleanser, pat dry, apply medical grade honey to wound bed, cover with border gauze, apply triad to peri-wound daily and as needed, and an order dated 05/21/24 for resident to be on enhanced barrier precautions and an order dated Observation of wound care for Resident #24 on 06/05/24 at 11:52 A.M. per Licensed Practical Nurse (LPN) #149 and State tested Nursing Assistant (STNA) #56 the staff did not don gowns prior to performing wound care. Further observation revealed LPN #149 removed the dressings to the right and left buttock wounds and cleansed both wounds with wound cleanser. LPN #149 then sanitized his hands and donned a pair of gloves and patted the wounds to the left and right buttocks dry with gauze. LPN #149 then used a sterile Q-Tip and placed Medi-honey on gauze and applied dressings to the wounds to the left and right buttocks. LPN #149 then sanitized his hands and donned gloves and covered each wound with a bordered gauze. Interview on 06/05/24 at 12:05 P.M. with LPN #149 confirmed he had performed the treatment to the pressure ulcers to the left and right buttocks together introducing the potential for the spread of infection. LPN #149 confirmed each wound treatment should have been done separately. LPN #149 further confirmed Resident #24 was on EBP and they should have worn gowns while performing wound care. 5. Review of the medical record for Resident #27 revealed an initial admitted [DATE] with diagnoses including acute kidney failure, chronic obstructive pulmonary disease, obstructive sleep apnea, severe morbid obesity, diabetes mellitus, gastro-esophageal reflux disease, hypertension, hyperlipidemia, adult failure to thrive, history of malignant neoplasm of prostate and osteoarthritis. Review of the monthly physician's orders Resident #27 revealed an order dated 06/05/24 to cleanse the wound to left upper posterior leg with normal saline or soap and water, and apply Triad daily, an order dated 06/05/24 to cleanse the wound to the sacrum with wound cleanser, apply calcium alginate to wound bed, cover with bordered gauze daily and as needed, an order dated 06/05/24 to cleanse the wound to the left lateral foot with wound cleanser, pat dry, apply calcium alginate to wound bed and cover with ABD pad, wrap with kerlix daily and as needed, an order dated 06/05/24 to cleanse the wound to the back of left knee/leg with wound cleanser, pat dry, apply Medi-honey to wound bed and cover with bordered gauze daily and as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/05/24 at 1:28 P.M. of wound care for Resident #27 per LPN #125 and RN #77 the staff washed their hands, donned gloves and RN #77 removed the Prevalon boots to the left foot. LPN #125 placed a sheet under the resident's left foot and removed the soiled dressing. LPN cleansed the wound to the left heel and left lateral foot with wound cleanser using the same gloves. The LPN changed her gloves without washing or sanitizing her hands and the RN washed her hands and applied calcium alginate to the wound to left heel and left lateral foot, covered both wounds with an ABD pad, wrapped with Kerlix and secured with tape. The LPN then changed her gloves without washing or sanitizing her hands. The LPN removed the soiled dressing to the left lateral thigh and cleansed the wound with wound cleanser and a gauze while reaching in the multi-use package of gauze with soiled gloves. The LPN then applied Medi-honey to the resident using the same gloves. The LPN then changed her gloves without washing her sanitizing her hands and covered the left lateral wound with a bordered dressing. The LPN the changed her gloves without washing or sanitizing her hands and provided incontinence care with a towel. The LPN then applied Triad to the resident's groins and under the resident's abdominal folds. The LPN changed her gloves without washing or sanitizing her hands and cleanse the wound to the rectum and to the left and right buttocks with soap and water. Dried feces was observed on the incontinence brief. The wounds to the buttocks had no dressings. The LPN then cleansed the wound on the left and right buttocks with wound cleanser using the same gloves as providing incontinence care. The LPN then changed her gloves without washing or sanitizing her hands. The LPN then applied calcium alginate to the rectal wound and one wound to the left buttocks and one wound to the right buttocks then covered the three wounds with a bordered gauze dressing. The LPN then changed the glove to the right hand without washing or sanitizing her hand and applied Triad to her buttocks and upper thighs. The LPN then changed her gloves without washing or sanitizing her hands and placed a clean incontinence brief on the resident. Interview on 06/06/24 at 1:55 P.M. with LPN #125 confirmed the nurse did not perform appropriate hand hygiene during wound care and incontinence care for Resident #27 and also increased the potential for wound infection by completing multiple treatments at once. 6. Review of the medical record for Resident #43 revealed an initial admitted [DATE] with the latest readmitted [DATE] with diagnoses including but not limited to acute kidney failure, spina bifida, diseases of spinal cord, diabetes mellitus, asthma, severe morbid obesity, hypertensive heart disease with heart failure, congestive heart failure, cerebrospinal fluid drainage device, neuromuscular dysfunction of bladder, urinary incontinence, incontinence of feces, major depressive disorder, anxiety disorder, radiculopathy lumbar region, hydrocephalus and gastroesophageal reflux disease. Review of the MDS assessment for Resident #43 dated 04/18/24 revealed the resident had no cognitive deficit and was always incontinent of both bowel and bladder. Review of the June 2024 physician's orders for Resident #43 revealed the resident was to be on EBP due to draining wounds. Observation on 06/06/24 at 11:30 A.M. of wound care for Resident #43 per LPN #149 revealed the nurse did not don a gown while performing wound care. Interview on 6/05/24 at 12:05 P.M. with LPN #149 confirmed Resident #43 was on EBP and the nurse should have worn a gown when performing wound care for the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Enhanced Barrier Precautions undated revealed staff should wear gowns and gloves when performing high contact activities such as transferring, dressing, bathing, and providing wound care. This deficiency represents noncompliance investigated under Complaint Number OH00154396.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 44070 Based on observation, staff interview, review of pest control logs, and review of the facility policy, the facility failed to ensure proper pest control interventions were in place in the kitchen. This affected all residents residing in the facility. The facility census was 96 residents. Findings include Observation on 06/03/24 at 9:13 A.M. revealed there were dozens of gnats in the dry storage area of the kitchen. There was an uncovered bowl of vinegar placed on the shelf near the entrance to the dry storage area. Interview on 06/03/24 at 9:15 A.M. with Kitchen Worker (KW) #25 confirmed the kitchen had a gnat problem which the facility had not treated by a professional pest control company. KW #25 further confirmed the sink near the cooking area had a clog and was slow to drain and the slow drain had not been treated by pest control professionals. Observation on 06/05/24 at 11:55 A.M. revealed during lunch preparation there were gnats flying around the food preparation area. Interview on 06/05/24 at 2:54 P.M. with Maintenance Director (MD) #107 revealed he had not heard of any pest control issues with the kitchen including gnats and had not scheduled any pest control services to spray for gnats. MD #107 confirmed the kitchen sink frequently got clogged due to staff putting food down the drain. MD #107 confirmed the clogged drain and standing water in kitchen probably led to the gnat problem in the kitchen. . Review of the facility pest control logs date January to June 2024 revealed the facility had not treated the kitchen for gnats. Review of facility policy titled Pest Control dated 09/15/21 revealed if a pest control problem should develop, the facility should contact pest control services for an additional visit and staff should report any problems or changes to facility. This deficiency represents noncompliance investigated under Complaint Number OH00153744.