STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365699	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Club Retirement Ctr IV	55801 Conno-Mara Drive Bellaire, OH 43906

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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 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** 33019 Based on record review, interview, and policy review, the facility failed to notify the resident representative and the physician of a change in health status. This affected one resident (#35) of three residents reviewed for notification of change. The facility census was 51. Findings include: Review of the medical record revealed Resident #35 was admitted to the facility on [DATE] with diagnoses including cardiomyopathy, hypertension, dementia, diabetes mellitus, and history of Coronavirus (COVID)-19. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 08/13/24, revealed a Brief Interview for Mental Status (BIMS) score of 05, which indicated severely impaired cognition. The MDS further revealed Resident #35 required staff assistance with activities of daily living (ADLs). The resident had no chewing or swallowing difficulties. Review of the admission record revealed Family Representative #500 was listed as the resident's emergency contact. Review of nursing progress note, dated 09/13/24 at 2:08 A.M., revealed Resident #35 was sitting up on the side of her bed and stated she was having a hard time laying down as it caused shortness of breath. Oxygen saturation was 86% on room air, respiratory rate was 24 breaths per minute, and audible wheezing was noted. Oxygen was applied at 2 liter per min via nasal cannula. During interview on 09/30/24 at 9:20 A.M., the Director of Nursing (DON) confirmed Resident #35's family/emergency contact and physician should have been notified of the resident's increased shortness of breath and need for supplemental oxygen and according to the nursing progress note, proper notification was not made to Resident #35's family representative or physician. The DON further stated that after this incident, Resident #35's granddaughter (Family Member #501) requested to be added to the list of emergency contacts. (continued on next page)

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

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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, Resident Condition Changes, (dated 04/01/23), revealed the nurse will contact the resident's physician immediately when any resident has a perceived change in condition. A change in condition includes but is not limited to, a change in physical or mental status, refusal of medications or treatment, a need to alter treatment, an accident, need to transfer or discharge, development of wounds or other new condition, inability to provide an ordered medication or treatment, lab or radiology results. The nurse will notify the resident's responsible party of condition change. This deficiency represents non-compliance investigated under Complaint Number OH00158236.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28701 Based on observation, medical record review, and staff interview, the facility failed to ensure physician's orders were in place prior to the use of a reclining safety and enabling chair. This affected one resident (#34) of one resident reviewed for potential restraint use. The facility census was 51. Findings include: Observation of Resident #34 throughout the annual survey from 09/23/24 to 09/30/24 revealed the resident utilizing a reclining geri chair (a large, reclining, mobile and padded chair that's designed to help people with limited mobility sit and stand comfortably). Review of Resident #34's medical record revealed an admitted [DATE] with diagnoses that included chronic obstructive pulmonary disorder, white matter disease and diabetes mellitus. Further review of Resident #34's medical record including Minimum Data Set (MDS) 3.0 assessment with a reference date of 07/03/24 indicated the resident had a significantly impaired cognition level and no restraints were used. Review of Resident #34's physician's orders revealed no evidence of any physician's order in place for the use of the reclining geri chair. On 06/06/24 an assessment was completed for the use of the geri chair which indicated the chair was utilized for increased comfort and safety. Interview with Registered Nurse (RN) #110 on 09/25/24 at 10:50 A.M. verified no physician's order currently in place for the use of a reclining geri chair as per facility policy. Interview with the Director of Nursing on 09/30/24 at 2:10 P.M. revealed the facility had no policy in place related to physician's orders needed for the use of a reclining geri chair.

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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 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** 33019 Based on medical record review and staff interview, the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR) documents accurately reflected a new diagnosis and medications. This affected two residents (#38 and #16) of four residents reviewed for PASRR documents. The census was 51. Findings Include: 1. Medical record review revealed Resident #38 was admitted to the facility on [DATE] with diagnoses including bipolar disorder, dementia, diabetes mellitus, muscle weakness, and asthma. Review of the admission Minimum Data Set (MDS) 3.0 assessment, dated 08/31/24, revealed the resident had intact cognition and a diagnosis of dementia. Review of Resident #38's PASRR document, dated 08/29/24, revealed under Section D, no was selected incorrectly indicating there was not a diagnosis of dementia. Review of the diagnosis list revealed Resident #38 was diagnosed with dementia on 06/26/24. During interview on 09/24/24 at 5:29 P.M., Corporate Registered Nurse #201 confirmed Resident #38's PASRR document was not accurate and did not indicate the diagnosis of dementia. 32801 2. Review of Resident #16's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses of schizophrenia and Parkinson disease. Review of Resident #16's admission history and physical (H&P) note dated 08/01/24 revealed the resident had a past history of anxiety disorder and schizophrenia. Review of Resident #16's psychiatric note dated 08/13/24 revealed Resident #16 reported she had sadness, hopelessness, or worthlessness and was worried about things. The resident was started on Lexapro 5 milligrams (mg) daily for adjustment disorder with anxiety and depression. Review of Resident #16's nursing progress note dated 08/13/24 revealed the resident was seen by psych due to new diagnoses of adjustment disorder with depression and anxiety. Review of Resident #16's psych note dated 08/28/24 revealed the resident reported depression and anxiety in relationship to her recent admission to the facility. The resident reported sadness, increased worrying, and lack of motivation. She has had increased movements since starting the Lexapro. The plan included to stop Lexapro. (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 Resident #16's orders revealed on admission the resident was ordered 400 mg daily for Seroquel schizophrenia and Valium 5 mg every 12 hours as needed for anxiety. From 08/14/24 to 08/28/24 the resident was ordered Lexapro 5 mg daily for depression. On 09/04/24 the resident was ordered Hydroxyzine 25 mg three times a day for anxiety. Review of Resident #16's PASRR's revealed there was only one PASRR completed for Resident #16 on 07/11/24 (prior to the resident admission) that was completed by the local hospital social worker. The PASRR only indicated the resident had schizophrenia and was prescribed Seroquel (anti-psychotic). There was no evidence a PASRR was completed for the new diagnoses of depression or adjustment disorder that required anti-depressants or anti-anxiety medication. Review of Resident #16's cumulative diagnoses list revealed no evidence anxiety, depression, or adjustment disorder. Interview on 09/25/24 at 10:14 A.M., with Corporate Registered Nurse (CRN) #201 confirmed the facility didn't complete a new PASRR when the resident received the new diagnoses of depression and adjustment disorder that required a new medication on 08/13/24 nor was the cumulative diagnoses list updated to reflect the resident past history of anxiety per the resident H&P or the new diagnoses of depression and adjustment disorder on 08/13/24.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28701 Based on medical record review and staff interview the facility failed to ensure Pre-Admission Screening and Resident Review assessments were completed accurately upon admission to the facility. This affected two residents (#16 and #20) of four residents reviewed for admission assessments. The facility census was 51. Findings include: 1. Review of Resident #20's medical record revealed an admitted [DATE] with diagnoses that included bipolar disorder, chronic kidney disease and hypertension. Review of the Pre-Admission Screening and Resident Review (PASRR) completed on 04/05/24 revealed Resident #20 had a prior diagnosis which included a mood disorder. No psychotropic medications were identified as currently prescribed for the resident. Review of Resident #20's admission medication orders on 04/04/24 revealed the use of Lamictal (mood stabilization medication) 25 milligrams two tablets every day. Further review of the PASRR dated 04/05/24 indicated no current use of medications. On 09/24/24 at 1:15 P.M. interview with Social Services Designee (SSD) #178 verified Resident #20's admission PASRR was completed incorrectly and mood stabilization medication use should have been identified. 32801 2. Review of Resident #16's medical record revealed the resident was admitted to the facility on [DATE] with diagnose of schizophrenia and Parkinson's disease. Review of Resident #16 hospital discharge note dated 07/16/24 revealed the resident had history of anxiety since 05/28/24 and a diagnosis of schizophrenia with mood disorder. Further review revealed the resident was ordered Valium 5 milligrams every 12 hours as needed for anxiety and Seroquel 400 mg daily for schizophrenia. Review of Resident #16's cumulative diagnoses list revealed the residents' diagnoses included Parkinson's Disease, neoplasm of uncertain behavior, anemia, hypertension, hyperlipidemia, schizophrenia, and muscle weakness. There was no evidence mood disorder or anxiety. Review of Resident #16's admission PASRR's dated 07/11/24 revealed the PASRR was completed by the local hospital staff. The PASRR only indicated the resident had schizophrenia and was only prescribed Seroquel (anti-psychotic). There was no evidence regarding the resident being ordered Valium (anti-anxiety) or diagnoses of mood disorder and anxiety per the hospital notes. Review of Resident #16's Minimum Data Set (MDS) dated [DATE] revealed no evidence of a diagnoses of anxiety or mood disorder. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #16's admission history and physical (H&P) note dated 08/01/24 revealed the resident had a past history of anxiety disorder and schizophrenia. Interview on 09/25/24 at 10:14 A.M., with Corporate Registered Nurse (CRN) #201 confirmed the admission PASRR completed on 07/11/24 was inaccurate due to it didn't reflect the resident's diagnoses of mood disorder or anxiety nor did it include the resident was prescribed an anti-anxiety medication (Valium). The CRN confirmed the facility did not complete a new PASRR to reflect the mood disorder and anxiety or the resident was prescribed an anti-anxiety medication.

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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 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** 33019 Based on record review, interview, and policy review, the facility failed to provide timely treatment as ordered by the physician. This affected one resident (#35) of three residents reviewed for change of condition. The facility census was 51. Findings include: Review of the medical record revealed Resident #35 was admitted to the facility on [DATE] with diagnoses including cardiomyopathy, hypertension, dementia, diabetes mellitus, and history of Coronavirus (COVID)-19. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 08/13/24, revealed a Brief Interview for Mental Status (BIMS) score of 05, which indicated severely impaired cognition. Review of a physician order, dated 09/13/24 at 4:00 P.M., revealed the order for Furosemide 40 milligrams (mg), to be injected intramuscularly (IM) one time a day for swelling, for three days. Review of nursing progress note, dated 09/13/24 at 4:02 P.M., revealed Resident #35 had continued swelling of bilateral legs and was not compliant with elevating her legs. The resident sat up while sleeping throughout the night. Family Member #500 was notified and voiced understanding and asked for his daughter be placed on the contact list for updates on the resident's condition. Resident #35 continued with slight, labored breathing. The physician was notified and ordered Lasix 40 mg IM to be administered daily for three days. New medication discussed with family members. Review of the Medication Administration Record (MAR), dated September 2024, revealed the resident did not receive her scheduled dose of Furosemide 40 mg injection IM until the morning of 09/14/24. Review of the facility's Emergency Medication Supply List revealed Furosemide Injection 40 mg/4ml was available. During interview on 09/30/24 at 8:29 A.M., the Director of Nursing (DON) confirmed Resident #35 did not receive the Furosemide 40 mg injection timely on 09/13/24 as ordered by the physician.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on observation, record review, policy review, and interview, the facility failed to ensure a dependent resident received appropriate services to maintain mobility and prevent further decrease in range of motion. This affected one resident (#9) of two residents reviewed for mobility. The census was 51. Findings include: Review of the medical record revealed Resident #9 was admitted to the facility on [DATE] with diagnoses including dementia, osteoporosis, chronic kidney disease, chronic obstructive pulmonary disease, tremor, and difficulty walking. Review of the Minimum Data Set (MDS) annual assessment, dated 08/05/24, indicated Resident #9's Brief Interview for Mental Status (BIMS) score was 03, which indicated the resident was severely cognitively impaired. The resident was totally dependent on staff for putting on/taking off footwear, lower body dressing, and transfers. The resident had impairment of both lower extremities. Review of the Care Plan, dated 07/07/23, revealed Resident #9 had the potential for alteration in comfort related to osteoporosis with interventions including to assist resident with repositioning as needed. During observations on 09/23/24 at 3:05 P.M., 09/24/24 at 8:40 A.M., and 09/24/24 at 10:43 A.M., revealed Resident #9 was observed sitting in her wheelchair, in the common area. Both lower legs were dangling and not supported on the footrests of the wheelchair. Interview on 09/24/24 at 10:44 A.M., the Assistant Director of Nursing (ADON) confirmed Resident #9's lower legs were dangling and supported and not properly placed on the footrests of her wheelchair. The ADON proceeded to position the resident's lower legs and feet on the footrests. Review of the facility policy titled, Positioning of Patients, (dated 07/27/21), revealed each patient will be positioned appropriate to his/her specific condition to ensure patient comfort and to maximize the benefits of therapy.

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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** 33019 Based on record review and interview, the facility failed to obtain a physician order for oxygen therapy. This affected one resident (#35) of three residents reviewed for respiratory care. The facility census was 51. Findings include: Review of the medical record revealed Resident #35 was admitted to the facility on [DATE] with diagnoses including cardiomyopathy, hypertension, dementia, diabetes mellitus, and history of Coronavirus (COVID)-19. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 08/13/24, revealed a Brief Interview for Mental Status (BIMS) score of 05, which indicated severely impaired cognition. There were no behaviors or rejection of care. The resident did not receive oxygen therapy. Review of physician orders, dated September 2024, revealed no order for oxygen therapy. Review of nursing progress note, dated 09/13/24 at 2:08 P.M., revealed Resident #35 was sitting up on the side of her bed and stated she was having a hard time laying down as it caused shortness of breath. Oxygen saturation was 86% on room air, respiratory rate was 24 breaths per minute, and audible wheezing was noted. Oxygen was applied at 2 liter per min via nasal cannula. During interview on 09/30/24 at 9:20 A.M., the Director of Nursing (DON) confirmed Resident #35 did not have a physician order for oxygen therapy. The DON further stated the nurse should have notified the physician and obtained an order for oxygen.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review and interview the facility failed to ensure laboratory results were performed to ensure adequate monitoring of medication and failed to ensure abnormal laboratory results were addressed appropriately. This affected two residents (#28 and #47) of six resident reviewed for medication review. Findings included: 1. Medical record review revealed Resident #28 was admitted to the facility on [DATE] with diagnoses including hyperlipidemia and hypothyroidism. Review of Resident #28's cumulative current diagnoses list revealed the resident had hyperlipidemia on admission, however there was no documented evidence of the diagnosis of hypothyroidism. Review of Resident #28's Minimum Data Set (MDS) dated [DATE] revealed the resident had hyperlipidemia however there was no documented evidence of diagnosis of hypothyroidism. Review of Resident #28's medication orders dated 01/10/23 to 09/26/24 revealed on admission the resident was ordered pravastatin 80 milligrams (mg) daily for hyperlipidemia and Synthroid 25 micrograms (mcg) since 04/20/23 for hypothyroidism. Review of Resident #28's medication administration records revealed the resident had been receiving pravastatin 80 mg daily for hyperlipidemia since 01/10/23 and Synthroid 25 mcg daily for hypothyroidism since 04/20/23. Review of Resident #28's laboratory results dated [DATE] to 09/2024 revealed no evidence the resident had a lipid panel completed to monitor the pravastatin and the last thyroid test for the Synthroid monitoring was completed on 06/26/23. The resident thyroid results were high at 4.99. The normal thyroid range was 0.46 to 4.68 uIU/ml (milliunits) There was no evidence the thyroid levels were re-checked after 06/26/23 or the resident Synthroid medication were adjusted. Review of Resident #28's physician progress note dated 07/11/24 revealed the resident had hypothyroidism and he was to continue Synthroid and monitor his TSH (thyroid-stimulating hormone) and to continue pravastatin for hyperlipidemia. Review of Resident #28's pharmacy recommendation dated 09/2023 to 09/2024 revealed no evidence of recommendation for laboratory monitoring for hyperlipidemia or hypothyroidism. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/25/24 at 1:31 P.M. and 4:09 P.M. with Corporate Registered Nurse (CRN) #201 confirmed he had reached out to the facility's pharmacy and the recommendation was to check a TSH level and lipid panel annually. The CRN confirmed there was no record that Resident #28 had a lipid panel done and the last TSH level done was on 06/26/23 and the resident levels were high. The CRN also confirmed the resident cumulative diagnoses list and the MDS failed to reflect the diagnosis of hypothyroidism. The CRN reported the facility had reached out to the provider to obtain order to check the resident's TSH and lipid panel tomorrow and the facility was going to initiate an audit on all records. Interview on 09/30/24 at 8:37 A.M., with the Director of Nursing (DON) revealed Resident #28's TSH that was completed on 09/26/24 came back at 17.7 (high) and the normal range was 0.45 to 4.5 uIU/ml. The resident's lipid panel was also completed on 09/26/24 and the triglycerides were 175 mg/dL (milligrams per deciliter) (high) normal range (less than 150 mg/dL) and HDL (high-density lipoprotein) were 31 mg/dL (low) normal less than 40 mg/dL. The physician increased the dose of Synthroid to 50 mcg daily and repeat the TSH in six weeks and no new orders for the pravastin. 2. Medical record review revealed Resident #47 was admitted to the facility on [DATE] with diagnoses of hypothyroidism, depression, and anxiety. Review of Resident #47's orders and MAR's revealed Resident #47 received Synthroid 50 mcg from 01/23/24 to 09/26/24. The Synthroid was decreased to 25 mcg on 09/27/24. Review of Resident #47's progress note dated 09/04/24 revealed the resident had become more agitated and confused. The physician was notified, and new orders were received to obtain and complete blood count (CBC), complete metabolic profile (CM), and TSH to rule out infection. Review of Resident #47's TSH laboratory results dated [DATE] revealed the resident TSH was 0.010 (low) (normal range 0.4001-4.049). Review of Resident #47's progress note dated 09/06/24 revealed laboratory results were reviewed and no new orders. Interview on 09/25/24 at 1:31 P.M. and 4:09 P.M. with Corporate Registered Nurse (CRN) #201 confirmed Resident #47's TSH was low, and the resident was currently on thyroid medication and the previous Nurse Practitioner (NP), who was let go, did not address the low TSH level. Review of Resident #47's progress note dated 09/26/24 revealed the facility had reached out to the current NP and reviewed the laboratory results from 09/05/24 and new orders were received to adjust Synthroid dose and recheck TSH level. Review of Resident #47's laboratory test dated 09/26/24 revealed the resident thyroid level was still low 0. 0200 mU/L. Review of resident orders dated 09/29/24 and 09/30/24 revealed to recheck TSH on 11/11/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/30/24 at 8:37 A.M., with the Director of Nursing (DON) revealed Resident #47's TSH came back on 09/27/24 and it was still low, and the NP was notified, and new orders were received to recheck the TSH in six weeks. The DON confirmed the previous NP did not adequately treat the resident's low TSH level on 09/05/24 to ensure the resident was within normal range.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365699	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Club Retirement Ctr IV	55801 Conno-Mara Drive Bellaire, OH 43906

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28701 Based on medical record review, hospital record review, resident interview and staff interview, the facility failed to ensure medications had an appropriate indication for use. This affected one resident (#50) of five residents reviewed for medications. The facility census was 51. Findings include: Review of Resident #50's medical record revealed an admitted [DATE] with diagnoses that included schizophrenia, anxiety, dementia and diabetes mellitus. Review of the medications for Resident #50 revealed on 08/05/24 Depakote (seizure medication and for mood stabilization) 250 milligram (mg) twice daily was prescribed. Further review of the medical record revealed no evidence of any physician or certified nurse practitioner evaluation which indicated a diagnosis of seizure disorder or why the medication was initiated. Review of hospital records prior to transfer to the facility revealed no evidence of any prior seizure disorder or use of Depakote. Review of the Medication Administration Record (MAR) for the months of August and September 2024 for Resident #50 revealed Depakote was used for seizure disorder from 08/05/25-09/06/24 and then changed indication to hallucinations on 09/07/24. Review of the Minimum Data Set (MDS) 3.0 assessment with a reference date of 08/01/24 indicated Resident #50 had an independent and intact cognition level and no diagnosis of seizure disorder was found. On 09/26/24 at 8:15 A.M. interview with the Director of Nursing (DON) verified Depakote was initiated for Resident #50 on 08/05/24 for seizure activity. DON further verifies there is no evidence of any seizure diagnosis or seizure activity in the facility or prior to admission at the hospital. On 09/26/24 at 8:25 A.M., interview with Resident #50 revealed no prior diagnosis or seizure activity.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28701 Based on medical record review and staff interview the facility failed to administer psychotropic medications as ordered. This affected one resident (#8) of five residents reviewed for medications. The facility census was 51. Findings include: Review of Resident #8's medical record revealed an admitted [DATE] with admission diagnoses that include chronic obstructive pulmonary disease, mood disorder, depression and anxiety. Further review of Resident #8's medical record revealed on 09/23/24 the psychiatric certified nurse practitioner (CNP) evaluated Resident #8 and increased the dosage of Depakote (medication for mood disorders) from 250 milligrams (mg) twice daily to 250 mg two tablets in the morning and 250 mg every night. Review of Resident #8's Medication Administration Record (MAR) revealed after the increased Depakote order was initiated by the CNP on 09/23/24, the new order was transcribed incorrectly into the medical record medication orders and MAR which resulted in Resident #8 to receive two 250 mg tablets in the morning, 250 mg at night and 500 mg every day. No order for Depakote 500 mg every day was found in the medical record. The extra Depakote 500 mg every day was documented as administered to Resident #8 on 09/24/24 and 09/25/24 in error. Review of the psychiatric CNP evaluation on 09/23/24 indicated to only increase the Depakote to two 250 mg tablets in the morning and 250 mg at night. No evidence of an additional 500 mg every day was found. On 09/25/24 at 10:10 A.M. interview with psychiatric CNP #202 revealed she had evaluated Resident #8 on 09/23/24 and ordered an increase in the Depakote to two 250 mg tablets in the morning and 250 mg at night. She denied any order for Depakote 500 mg every day. On 09/25/24 at 11:00 A.M. interview with Registered Nurse (RN) #110 verified a transcription/medication order entry error for Resident #8. RN #110 verified a new ordered received on 09/23/24 to increase Depakote to two 250 mg tablets in the morning and 250 mg at night and the order for Depakote 500 mg every day should not have been entered into the physician's orders and MAR resulting in Resident #8 receiving two doses of extra medication in error on 09/24/24 and 09/25/24.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review and interview the facility failed to ensure a resident received dental care timely for ill-fitting dentures and dentures were readily accessible to the resident. This affected one resident (#21) of two reviewed for dental. Findings included: Medical record review revealed Resident #21 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dysphagia, needing assistance with personal care, gastro-esophageal reflux, and heart disease. Review of Resident #21's census revealed the resident was admitted on [DATE] and was hospitalized from 09/12/24 to 09/17/24. Interview and observation on 09/23/24 at 1:30 P.M., with Resident #21 revealed he had sores on his gums related to his upper dentures were ill fitting and his bottom dentures have been missing since he returned from the hospital last week (09/17/24). The resident removed his upper denture to show the surveyor the sores he had on the top gum line and that he had no bottom dentures. The surveyor observed two red bumps on the upper gumline where the front teeth would have been and there was no evidence of bottom dentures visible in the room. The resident denture cup was on the bedside table, and it was empty. Review of Resident #21's admission oral assessment dated [DATE] revealed the resident had upper and lower dentures. The resident had sores from the dentures and tongue pain. Review of Resident #21's nursing note dated 09/03/24 revealed the reporting nurse reported the resident was upgraded to a puree diet before discharge. Speech had stated he could eat a mechanical soft as well but due to the sores in his mouth from the dentures it was hard for him to chew. Review of Resident #21's Minimum Date Set (MDS) dated [DATE] revealed the resident had no broken or loose fitting full or partial dentures, no pain, discomfort or difficulty chewing. Review of Resident #21's dental plan of care dated 09/09/24 revealed the resident was at risk for oral complications related to edentulous and wore upper and lower dentures. Interventions included to assist with oral care, dental consult as needed, observe dentures for proper fit, and observe residents' mouth and gums for any redness, ulcerations, pain or bleeding during daily mouth care and report any abnormalities. Review of Resident #21's re-admission oral assessment dated [DATE] revealed the resident had upper and lower dentures. The resident had sores from the dentures and tongue pain. Review of Resident #21's orders and medication record dated 09/2024 revealed the resident was ordered Lidocaine viscous solution 2% 10 milliliters (ml) four times a day for throat pain. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/24/24 at 9:45 A.M. with the Assistant Director of Nursing (ADON) #110 revealed the resident's bottom dentures were missing and the resident removed his upper dentures and reported he had two sores in his mouth to the surveyor and ADON. The resident reported he used to get sores in the past and would put a cream on them. The ADON told the resident she would have staff call the doctor and she would call his wife regarding his missing lower dentures. The ADON reported she was not aware the dentures were missing; however, she could not find them in his room at the time of the observation. Interview on 09/24/24 at 10:58 AM with Corporate Registered Nurse (CRN) #210 revealed staff were interviewed and were unaware the resident bottom dentures were missing; however, the facility found the resident dentures in the bathroom medicine cabinet. The CRN reported the resident had received Lidocaine Viscous HCl Mouth/Throat Solution 2 % 10 ml by mouth four times a day for throat pain, however the order should have been for the mouth sores since admission on 09/03/24. The CRN confirmed on admission the resident refused the facility's dental services, however there was no documented evidence the facility had inquired if the resident wanted to see a dentist of his choice to adjust the dentures since they were ill fitting. Interview on 09/24/24 at 1:36 P.M., with CRN #201 revealed the facility was going to talk to the resident to see if he would like to see a dentist and the facility received new orders Anbesol to the red areas on his gums. The CRN reported he has spoken to the MDS nurse regarding the MDS on 09/06/24 that indicated the resident had no dental issues and she reported to him the assessment was just her observation that day and it was not the record review, or a review of the seven days look back period. The MDS reported to CRN at the time of her observation on 09/06/24 the resident didn't have sores on his gum. Review of Resident #21's nursing note dated 09/26/24 revealed an appointment was made with an dental office in the community for 10/01/24 at 10:30 A.M.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28701 Based on infection control log review, medical record review, policy review and staff interview the facility failed to ensure residents had an appropriate indication for the use of antibiotics. This affected three residents (#3, #16 and #44) of eight residents reviewed for antibiotic use. The facility census was 51. Findings include: Review of the facility infection control log for the months of July, August and September 2024 revealed 28 resident infections which did not meet McGeer's criteria (assessment to determine if antibiotics are appropriate to be utilized). Review of the following resident records revealed the following: 1. Review of Resident #3's medical record revealed an admitted [DATE] with diagnoses that included Parkinson's disease, chronic obstructive pulmonary disease and congestive heart failure. Review of the infection control log revealed on 07/17/24 Resident #3 had a urinary tract infection which did not meet McGeer's criteria. Physician's orders on 07/17/24 revealed Resident #3 was prescribed Macrobid (antibiotic) 100 milligrams (mg) twice daily for seven days for a UTI. Review of the antibiotic assessment completed on 07/17/24 indicated Resident #3 did not meet criteria for use of any antibiotics. A nurse's note on 07/17/24 indicated Resident #3 did not meet criteria for use of an antibiotic, the physician was notified of not meeting criteria and indicated to continue the antibiotic. 2. Review of Resident #16's medical record revealed an admitted [DATE] with diagnoses that included Parkinson's disease, hypertension and hyperlipidemia. Review of the infection control log revealed on 08/22/24 Resident #16 had a UTI which did not meet McGeer's criteria. Physician's orders on 08/22/24 revealed Resident #16 was prescribed Macrobid 100 mg twice daily for five days for a UTI. Review of the antibiotic assessment completed on 08/22/24 indicated Resident #16 did not meet criteria for use of any antibiotic. A nurse's note on 08/22/24 and 08/25/24 indicated Resident #16 did not meet criteria for antibiotic use, the physician was notified of not meeting criteria and indicated to continue the antibiotic. 3. Review of Resident #44's medical record revealed an admitted [DATE] with diagnoses that included hypothyroidism, hypertension and hyperlipidemia. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the infection control log revealed on 09/04/24 and 09/10/24 Resident #44 had a UTI which did not meet McGeer's criteria. Physician's orders on 09/04/24 revealed Resident #44 was prescribed Macrobid 100 mg twice daily for seven days for a UTI. And on 09/10/24 Resident #44 was prescribed Augmentin 500-125 mg twice daily for five days for a UTI. Review of the antibiotic assessment completed on 09/04/24 and 09/10/24 indicated Resident #44 did not meet criteria for use of any antibiotic. A nurse's note on 09/04/24 and 09/10/24 indicated Resident #44 did not meet criteria for antibiotic use, the physician was notified of not meeting criteria and indicated to continue the antibiotic. Review of the facility policy titled Antibiotic Stewardship Program with a (revision date of 11/01/19) indicated appropriate utilization of antibiotics will be determined in accordance with McGeer's criteria. Under circumstances in which criteria for infection is not met discontinuance of the antibiotic should be considered by the physician. If the antibiotic treatment course is continued a clinical rationale must be provided through the physician's documentation supporting continued use. On 09/26/24 at 1:15 P.M. interview with the Director of Nursing (DON) verified Residents #3, #16 and #44 did not meet McGeer's criteria for appropriate use of an antibiotic. The DON indicated the physician was notified, but wanted the antibiotic continued.