STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365740	A. Building B. Wing	03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Astoria Place of Clyde, LLC	700 Helen Street Clyde, OH 43410

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 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** 35033 Based on review of the medical record, interview, and policy review, the facility failed to notify the physician of medications not administered. This affected one resident (#42) of five residents reviewed for a change in condition. The facility census was 56. Findings include: Review of the medical record for Resident #42 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, hypertension, and chronic obstructive pulmonary disease. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had intact cognition. Review of a physician order dated 03/08/24 revealed the resident was ordered Ozempic (two milligram/dose) subcutaneous solution pen-injector eight milligrams/three milliliters, inject two mg subcutaneously one time a day every Friday for diabetes mellitus. Review of the medication administration record (MAR) dated 01/01/25 through 02/28/25 revealed Resident #42 was not administered the medication on 01/10/25, 01/17/25, 01/24/25, 01/31/25, 02/07/25, and 02/22/25 per physician orders. Review of the electronic medication administration record notes revealed the Ozempic was not available 01/10/25, 01/17/25, 01/24/25, 01/31/25, 02/07/25, and 02/22/25. The physician was not notified when the medication was not administered on 01/10/25, 01/24/25, 02/07/25, and 02/22/25. Interview on 03/13/25 at 8:50 A.M., the Director of Nursing (DON) verified Resident #42 was not administered the weekly Ozempic injections on 01/10/25, 01/17/25, 01/24/25, 01/31/25, 02/07/25, and 02/22/25. The DON verified the physician was not notified the medication was not administered on 01/10/25, 01/24/25, 02/07/25, and 02/22/25. Interview on 03/13/25 at 1:14 P.M., Resident #42 revealed she was aware the facility had not administered her weekly injections of Ozempic but they never told her why. (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 Medication Administration, dated 01/02/24, revealed medications would be administered as ordered by the physician in accordance with professional standards of practice. The physician would be notified timely of medication omissions. Review of the facility policy Change in Condition Physician Notification, dated 01/02/24, revealed the nursing staff would notify the physician or nurse practitioner of medication omissions/errors. Notifications would be made within 24 hours and the nurse would document notifications.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 31638 Based on observation, staff interviews, and policy review revealed the facility failed to maintain a clean and sanitary environment for residents. This had the ability to affect all residents (#36, #37, #38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65) who resided on the west unit. The facility census was 56. Findings include: Observation of the west shower room on 03/12/25 at 11:22 A.M. with Certified Nurses Aide (CNA) #458 revealed the shower room was very hot and humid with a musty odor. Continued observation revealed the west wall, right side shower stall where the wall and ceiling joined, both the wall and ceiling had a black irregular shaped area with moist spots (on white wall) approximately two feet long and two inches wide. The spots resembled black dust. Interview with CNA #458 at the time of observation verified the musty odor, and the black irregular shaped area on the white wall and ceiling of the west shower room. Observation of the west shower room on 03/12/25 at 2:35 P.M. with Maintenance Director #469 verified the black irregular shaped area on the white wall and ceiling of the west shower room, in addition, a dinner plate size black stain on the ceiling near the window and also along the wall/ceiling area on the north wall of the shower room was identified. Maintenance Director #469 verified moisture was observed on all areas of the west shower room and he verified no knowledge of the mold, stating staff had failed to notify him. In verifying the findings, Maintenance Director #469 stated there failed to be an exhaust fan in the room which may have lead to the mold in addition to the left side shower on the west wall having constantly running water due to the inability of the water to be shut off. Review of the facility Infection Control information dated 01/01/25 through 03/12/25 revealed there was one respiratory illnesses in the facility which was diagnosed as pneumonia. Review of the facility policy titled Safe and Homelike Environment dated 01/02/24 revealed housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. This violation represents non-compliance investigated under Complaint Numbers OH00163559 and OH00162562.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on review of the medical record, review of documented staff interviews, review of self-reported incidents, interview, and policy review, the facility failed to report and thoroughly investigate an allegation of abuse and immediately protect residents by removing the alleged perpetrator. This affected Resident #22 and had the potential to affect 22 resident residing on the memory care unit. Additionally, the facility failed to report and thoroughly investigate al allegation of misappropriation of the medication Ozempic. This affected three residents (#42, #39, #49) of five residents reviewed for misappropriation of medication. The facility identified five residents as receiving the medication Ozempic. The facility census was 56. Findings include: 1. Review of the medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction, atrial fibrillation, hypertension, and anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had mild cognitive impairment. Review of the care plan initiated 10/19/24 revealed the resident had cognitive impairment and would yell out for assistance instead of using the call light. Further review of the care plan noted no behavioral symptoms of physical aggression or rejection of care. An intervention was revised on 02/25/25 if the resident was agitated during care then back off and try to calm the resident with soothing word. If the resident remained agitated then inform him care would be provided when he was feeling better. Assure the resident he was safe and protected. Review of an Investigation Collection Form, dated 01/19/25 revealed Certified Nurse Aide (CNA) #450 reported Alleged Perpetrator Certified Nursing Assistant (APCNA) #566 physically abused Resident #22 in his room on 01/19/25 around 4:30 A.M. APCNA #566 was suspended on 01/21/25. Review of the facility self-reported incidents revealed the allegation of abuse was not reported to the state agency. Review of the medical record including review of nurse progress notes dated 01/19/25 revealed no documentation of the incident or immediate assessment of the resident after the alleged incident. There was no documentation the resident was assessed for injuries until two days after the alleged incident. Review of a skin assessment dated [DATE] revealed the Director of Nursing (DON) completed a skin assessment for Resident #22 with no abnormal findings. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an interview statement dated 01/21/25, CNA #450 revealed Resident #22 began hitting APCNA #566 during care but not hard. APCNA #566 then grabbed Resident #22's arm and wrist and brought them up against his chest and threatened the resident. CNA #450 told APCNA #566 to leave the room. APCNA #566 then swore at the resident then walked back into the room and did the same thing to the resident's ankles. CNA #450 stated APCNA #566 and herself took the linen down and trash out and APCNA #566 kept following her so she told him she had to leave to speak to another nursing assistant then went and told Licensed Practical Nurse (LPN) #425 on the other unit what happened. LPN #425 then called and told LPN #455 to come down to the other unit and told her what happened. LPN #455 and CNA #450 then called the Administrator and reported the incident. Review of an interview statement dated 01/21/25 by APCNA #566 revealed Resident #22 freaked out about him coming in the room with the nurse. APCNA #566 revealed he was changing the resident and pushed the resident's arms away because he was swinging at him. APCNA #566 revealed he had not put the resident in a hold and had not sworn at the resident. Review of an interview statement dated 01/24/25 by the Administrator revealed on 01/19/25 at 4:42 A.M. CNA #450 reported APCNA #566 responded inappropriately to a combative resident by grabbing his arms and pushing them into the bed. CNA #450 was asked if this was abuse or the aide had overresponded. CNA #450 responded APCNA #566 had overreacted. CNA #450 was informed the Administrator would speak with APCNA #566 regarding his behavior. The Administrator revealed she followed up with the nurse of the unit (LPN #455) who reported Resident #22 was aggravated stating those two kept coming in all night. The nurse reported Resident #22 denied pain and no bruising or red marks were noted and the resident was comfortable. Review of an interview statement dated 01/24/25 LPN #455 revealed Resident #22 had denied pain. LPN revealed she was not looking for marks but had not seen any bruises or red marks. Further review of LPN #455's statement revealed no documentation when she was notified of the incident or what action was taken. Review of an interview statement on 01/24/25 with LPN #425 revealed no documentation if she was notified of the incident, when the incident occurred or the follow up actions taken if any. Review of a corrective action form dated 02/25/25 revealed the Administrator received coaching action for failure to report to the state board of health for an incident in January involving a nursing assistant and a resident. The nursing assistant was physically abusive to the resident and this allegation was not reported to the state board of health nor was a complete investigation done. The Administrator was educated on reporting guidelines by the regional nurse consultant to immediately notify supervisors of the occurrence of any unusual incident. Review of the employee timecard for APCNA #566 revealed the employee clocked in on Saturday 1/18/25 at 4:38 P.M. and clocked out on 01/19/25 Sunday at 5:07 A.M. APCNA #566 had not worked again and was terminated from the facility on 01/28/25 for violation of code of conduct and not performing job duties. Interview on 03/12/25 at 7:54 A.M., Resident #22 revealed the resident had confusion and was not oriented to time, date, or place. Resident #22 denied mistreatment by staff. Resident #22 had no recollection of the incident on 01/19/25. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/12/25 at 10:29 A.M., the Administrator revealed CNA #450 reported on 01/19/25 Resident #22 was combative and APCNA #566 had grabbed his arms and put him on the bed. The Administrator revealed APCNA #566 denied the allegation. The Administrator revealed Resident #22 had no bruises and no red marks and no recollection of the event. The Administrator verified the incident alleging abuse was not reported to the state agency and a thorough investigation had not been completed timely. Interview on 03/13/25 at 12:45 P.M., the Regional Director of Operations (RDO) #700 verified the Administrator had failed to report and thoroughly investigate the allegation of physical abuse. Interview on 03/13/25 at 2:21 P.M., CNA #450 revealed she was working with APCNA #566 on 01/19/25 to care for Resident #22 around 4:00 A.M. and provided incontinence care for the resident. CNA #450 revealed a little later the resident was yelling out and she had asked APCNA #566 to check the resident. APCNA #566 reported the resident legs were hanging out of the bed like he was trying to get up. CNA #450 revealed they went around 4:25 A.M. or 4:30 A.M. to reposition the resident and the resident was calling APCNA #566 names and then hitting APCNA #566. CNA #450 told APCNA #566 he could leave and she would finish up with the resident. CNA #450 revealed APCNA #566 then grabbed Resident #22's arms and wrists with his hands, crossed the resident's arms over his chest and was pushing and pulling the resident up and down in the bed like he was trying to shake him. CNA #450 revealed she went around to the other side of the bed to stop APCNA #566 but he let go of the resident. CNA #450 told APCNA #566 to get out of the room now and she opened the door for him to leave. CNA #450 revealed APCNA #566 then went back to Resident #22 and grabbed the residents legs by the ankles with his hands and was pushing and pulling the resident's legs while holding his ankles. CNA #450 revealed she started yelling at APCNA #566 and he let go of the resident before she got to him. CNA #450 revealed she told APCNA #566 to get the expletive out of the room now. CNA #450 asked Resident #22 if he was okay. CNA #450 stated as APCNA #566 was leaving the room he was swearing at the resident and threatening him. CNA #450 revealed she apologized to Resident #22 for the APCNA #566's behavior and went to the nurses station where APCNA #566 was with the nurse. CNA #450 revealed she was trying to figure out how to report the incident since APCNA #566 was with the nurse. CNA #450 revealed she left the memory care unit and went and reported the incident to LPN 425. LPN #425 then called LPN #455 to come out of the unit. CNA #450 revealed we then called the Administrator to report the incident. CNA #450 verified APCNA #566 was left alone in the memory care unit with the vulnerable residents while they were on the phone with the Administrator around 4:45 P.M. reporting the abuse. CNA #450 revealed the Administrator felt APCNA #566 had just overreacted, provided no instruction on what to do or for APCNA #566 to leave the facility. CNA #450 revealed the Administrator never asked her to write a statement. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/13/25 at 3:50 P.M., the Director of Nursing (DON) revealed Resident #22 was not assessed for injuries until 01/21/25 at which time no injuries were observed. The DON revealed APCNA #566 was not interviewed until 01/21/25 and claimed he was not rough with the resident. The DON revealed the witness CNA #450 was also not interviewed until 01/21/25. The DON revealed residents on the memory care unit had not received skin assessments for signs of abuse until 02/12/25 and were not interviewed until 02/26/25. The DON revealed she had not been notified of the incident until 01/20/25. The DON revealed she felt abuse occurred and told the Administrator she thought abuse occurred. The DON revealed the Administrator thought staff were embellishing the incident as they had not liked APCNA #566 as he could not care for the female residents. The DON revealed the Administrator thought it was a customer service concern and the staff needed education. The DON revealed she told the Administrator the incident needed reported and APCNA #566 needed suspended. The DON verified the residents in the memory care unit should not have been left unprotected in the care of APCNA #566 while LPN #455 and CNA #450 left the memory care unit to report the incident. Interviews by telephone on 03/13/25 at 10:28 A.M. and on 03/16/25 at 3:44 P.M. were attempted with APCNA #566. Interviews by telephone on 03/13/25 at 2:10 P.M. and on 03/16/25 at 3:38 P.M. were attempted with LPN #455. 2. Review of the medical record for Resident #42 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, hypertension, peripheral vascular disease, and chronic obstructive pulmonary disease. Review of the quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. Review of a physician order dated 03/08/24 revealed the resident was ordered Ozempic (two milligram (mg)/dose) subcutaneous solution pen-injector eight mg/three milliliters (ml), inject two mg subcutaneously one time a day every Friday for diabetes mellitus. Review of a pharmacy receipt dated 01/02/25 revealed the facility received Ozempic two mg/dose (eight mg/three ml pen) for Resident #42. Each pen supplied one two mg dose per week for four weeks. Review of the medication administration record (MAR) revealed the resident was administered one dose of the medication on 01/03/25. The resident should have had three remaining doses from the pen. The resident was never administered the medication on 01/10/25, 01/17/25, and 01/24/25 and 01/31/25, and 02/07/25. The medication was noted as unavailable. Review of a pharmacy receipt dated 02/14/25 revealed the facility received Ozempic two mg/dose (eight mg/three ml pen) for Resident #42. Review of the MAR revealed Resident #42 was administered one dose on 02/15/25 with three remaining doses in the pen. Resident #42 was not administered the Ozempic on 02/22/25. Review of an administration note dated 02/22/25 at 11:18 A.M. revealed the box in the refrigerator was empty and the pen could not be found and delivery was on 02/14/25. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record for Resident #39 revealed an admitted [DATE] and a readmitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, type two diabetes mellitus, hypertension, and chronic kidney disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Review of physician orders dated 05/22/24 revealed the resident was ordered Ozempic eight mg/three ml solution pen-injector, two mg/dose, inject two mg weekly on Wednesdays. Review of a pharmacy receipt dated 02/08/25 revealed the facility received Ozempic two mg/dose (eight mg/three ml pen). Each pen supplied one two mg dose per week for four weeks. Review of the MAR revealed the resident was administered Ozempic on 02/12/25 and 02/19/25. There should have been two remaining doses left in the pen. Review of the medical record for Resident #49 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, chronic obstructive pulmonary disease, and atrial fibrillation. Review of the quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. Review of a pharmacy invoice dated 02/01/25 revealed the facility received Ozempic four mg/three ml for Resident #49. Review of the physician orders dated 02/03/25 revealed an order for Ozempic (one mg/dose) subcutaneous solution pen-injector four mg/three ml, inject one mg subcutaneously one time a day every Friday related to type two diabetes mellitus. Review of the MAR revealed the resident was administered one dose on 02/07/25, and 02/14/25, and 02/21/25. There should have been one dose remaining in the pen. Review of an electronic communication dated 02/24/25 at 1:13 P.M. revealed the facility paid to replace one pen each for Resident #39 and Resident #42. The facility provided no documentation Resident #42 was reimbursed for the missing pen in January or Resident #49 was reimbursed for the one remaining dose left in the pen on 02/22/25 later found missing on 02/24/25. Interview on 03/12/25 beginning at 10:29 A.M., the Administrator revealed a nurse went to administer Ozempic for a resident and the resident's Ozempic pen was missing and later three Ozempic pens were discovered as missing. The Administrator revealed the facility paid to replace two Ozempic pens. The Administrator revealed the Director of Nursing (DON) handled the investigation with pharmacy. The Administrator revealed a self-report incident was not submitted to the state agency for the missing medications. Review of the facility self-reported incidents revealed the missing Ozempic pens were not reported. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/12/25 at 2:33 P.M., Registered Nurse (RN) #434 revealed on 02/22/25 Licensed Practical Nurse (LPN) #427 reported Resident #42's Ozempic pen was missing and just the box was in the refrigerator. RN #434 revealed LPN #427 checked the Ozempic pens for four additional residents and the pens were present in the refrigerator on 02/22/25. RN #427 revealed she reported the missing Ozempic pen to the Director of Nursing on 02/22/25. RN #427 revealed when she returned to work on 02/24/25 two more Ozempic pens were missing for Resident #39 and Resident #49 and the empty boxes were in the refrigerator. RN #427 revealed three of five Ozempic pens were missing for three of the five residents with orders for Ozempic and the DON was notified again on 02/24/25 of the additional missing pens. RN #427 revealed none of the five residents were not scheduled for administration of Ozempic from 02/22/25 through 02/24/25. RN #427 revealed each pen administers four doses (one dose weekly.) RN #427 also revealed she had reported Resident #42 was missing her Ozempic pen in January. RN #427 revealed only the nurses and unit managers had keys to access the medication room refrigerator. RN #434 revealed all Ozempic pens and doses administered were now recorded and counted each shift. Interview on 03/12/25 at 03:29 P.M., LPN #427 revealed on 02/22/25 Resident #42's Ozempic pen and needles were missing but the empty box was in the refrigerator. LPN #427 revealed she checked the other boxes of Ozempic to see if the medication had been misplaced but the other boxes contained Ozempic pens on 02/22/25. LPN #427 revealed she notified RN #434 of the missing Ozempic pen and told her she thought someone took the Ozempic. LPN #427 revealed all Ozempic pens were now counted each shift. Interview on 03/13/25 at 8:50 A.M. and 3:50 P.M. the DON revealed she had no documentation of staff statements or interviews conducted with the nursing staff regarding the missing Ozempic pens. The DON revealed she had spoken with four nurses and had left a voicemail with a fifth nurse. The DON revealed she had not completed a thorough investigation and had not interviewed all the nurses as another abuse investigation was taking place at the same time. The DON revealed the nurses who were interviewed had no knowledge of the missing pens. The DON revealed she investigated as if someone took the pens but was not wanting to accuse anyone without concrete evidence. The DON revealed the missing Ozempic pens were reported to herself and the Administrator on 02/22/24 and 02/24/24. The DON could not recall with certainty but said it was possible RN #434 had reported Resident #42's Ozempic pen missing in January. Interview on 03/13/25 at 12:45 P.M., the Regional Director of Operations (RDO) #700 revealed the Administrator should have reported the missing Ozempic pens to the state agency. RDO #700 revealed it was not company practice to not report and moving forward the Administrator was educated to inform regional of what was going on in the building. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Abuse, Mistreatment, Neglect, Exploitation and Misappropriation, last revised 09/06/24 revealed all allegations involving neglect, exploitation, and misappropriation of resident property would be reported to the Department of Health immediately with the submission on an online Self-Reported Incident form, but no later than 24 hours from the time the incident/allegation was made known to the care team member. If the facility suspects a crime had been committed, it would report the suspicion to law enforcement. The nurse would perform an initial assessment of the resident including range of motion, full body assessment for signs of injury and vital signs. If a care team member was accused or suspected, the facility should immediately remove the care team member from the facility and the schedule pending the outcome of the investigation. Documentation in the nurses' notes should include the results of the resident's assessment, notification of the physician and resident representative and any treatment provided. Once the Administrator and Department of Health were notified, an investigation of the allegation would be conducted and completed within five working days and submitted to the Department of Health. The investigation should include interviews with the resident, the accused, and all witnesses and expanded to include care team members on the shift and residents on the unit. This violation represents non-compliance investigated under Complaint Number OH00162176.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on review of the medical record, review of documented staff interviews, review of self-reported incidents, interview, and policy review, the facility failed to report and thoroughly investigate an allegation of abuse and immediately protect residents by removing the alleged perpetrator. This affected Resident #22 and had the potential to affect 22 resident residing on the memory care unit. Additionally, the facility failed to report and thoroughly investigate al allegation of misappropriation of the medication Ozempic. This affected three residents (#42, #39, #49) of five residents reviewed for misappropriation of medication. The facility identified five residents as receiving the medication Ozempic. The facility census was 56. Findings include: 1. Review of the medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction, atrial fibrillation, hypertension, and anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had mild cognitive impairment. Review of the care plan initiated 10/19/24 revealed the resident had cognitive impairment and would yell out for assistance instead of using the call light. Further review of the care plan noted no behavioral symptoms of physical aggression or rejection of care. An intervention was revised on 02/25/25 if the resident was agitated during care then back off and try to calm the resident with soothing word. If the resident remained agitated then inform him care would be provided when he was feeling better. Assure the resident he was safe and protected. Review of an Investigation Collection Form, dated 01/19/25 revealed Certified Nurse Aide (CNA) #450 reported Alleged Perpetrator Certified Nursing Assistant (APCNA) #566 physically abused Resident #22 in his room on 01/19/25 around 4:30 A.M. APCNA #566 was suspended on 01/21/25. Review of the facility self-reported incidents revealed the allegation of abuse was not reported to the state agency. Review of the medical record including review of nurse progress notes dated 01/19/25 revealed no documentation of the incident or immediate assessment of the resident after the alleged incident. There was no documentation the resident was assessed for injuries until two days after the alleged incident. Review of a skin assessment dated [DATE] revealed the Director of Nursing (DON) completed a skin assessment for Resident #22 with no abnormal findings. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an interview statement dated 01/21/25, CNA #450 revealed Resident #22 began hitting APCNA #566 during care but not hard. APCNA #566 then grabbed Resident #22's arm and wrist and brought them up against his chest and threatened the resident. CNA #450 told APCNA #566 to leave the room. APCNA #566 then swore at the resident then walked back into the room and did the same thing to the resident's ankles. CNA #450 stated APCNA #566 and herself took the linen down and trash out and APCNA #566 kept following her so she told him she had to leave to speak to another nursing assistant then went and told Licensed Practical Nurse (LPN) #425 on the other unit what happened. LPN #425 then called and told LPN #455 to come down to the other unit and told her what happened. LPN #455 and CNA #450 then called the Administrator and reported the incident. Review of an interview statement dated 01/21/25 by APCNA #566 revealed Resident #22 freaked out about him coming in the room with the nurse. APCNA #566 revealed he was changing the resident and pushed the resident's arms away because he was swinging at him. APCNA #566 revealed he had not put the resident in a hold and had not sworn at the resident. Review of an interview statement dated 01/24/25 by the Administrator revealed on 01/19/25 at 4:42 A.M. CNA #450 reported APCNA #566 responded inappropriately to a combative resident by grabbing his arms and pushing them into the bed. CNA #450 was asked if this was abuse or the aide had overresponded. CNA #450 responded APCNA #566 had overreacted. CNA #450 was informed the Administrator would speak with APCNA #566 regarding his behavior. The Administrator revealed she followed up with the nurse of the unit (LPN #455) who reported Resident #22 was aggravated stating those two kept coming in all night. The nurse reported Resident #22 denied pain and no bruising or red marks were noted and the resident was comfortable. Review of an interview statement dated 01/24/25 LPN #455 revealed Resident #22 had denied pain. LPN revealed she was not looking for marks but had not seen any bruises or red marks. Further review of LPN #455's statement revealed no documentation when she was notified of the incident or what action was taken. Review of an interview statement on 01/24/25 with LPN #425 revealed no documentation if she was notified of the incident, when the incident occurred or the follow up actions taken if any. Review of a corrective action form dated 02/25/25 revealed the Administrator received coaching action for failure to report to the state board of health for an incident in January involving a nursing assistant and a resident. The nursing assistant was physically abusive to the resident and this allegation was not reported to the state board of health nor was a complete investigation done. The Administrator was educated on reporting guidelines by the regional nurse consultant to immediately notify supervisors of the occurrence of any unusual incident. Review of the employee timecard for APCNA #566 revealed the employee clocked in on Saturday 1/18/25 at 4:38 P.M. and clocked out on 01/19/25 Sunday at 5:07 A.M. APCNA #566 had not worked again and was terminated from the facility on 01/28/25 for violation of code of conduct and not performing job duties. Interview on 03/12/25 at 7:54 A.M., Resident #22 revealed the resident had confusion and was not oriented to time, date, or place. Resident #22 denied mistreatment by staff. Resident #22 had no recollection of the incident on 01/19/25. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/12/25 at 10:29 A.M., the Administrator revealed CNA #450 reported on 01/19/25 Resident #22 was combative and APCNA #566 had grabbed his arms and put him on the bed. The Administrator revealed APCNA #566 denied the allegation. The Administrator revealed Resident #22 had no bruises and no red marks and no recollection of the event. The Administrator verified the incident alleging abuse was not reported to the state agency and a thorough investigation had not been completed timely. Interview on 03/13/25 at 12:45 P.M., the Regional Director of Operations (RDO) #700 verified the Administrator had failed to report and thoroughly investigate the allegation of physical abuse. Interview on 03/13/25 at 2:21 P.M., CNA #450 revealed she was working with APCNA #566 on 01/19/25 to care for Resident #22 around 4:00 A.M. and provided incontinence care for the resident. CNA #450 revealed a little later the resident was yelling out and she had asked APCNA #566 to check the resident. APCNA #566 reported the resident legs were hanging out of the bed like he was trying to get up. CNA #450 revealed they went around 4:25 A.M. or 4:30 A.M. to reposition the resident and the resident was calling APCNA #566 names and then hitting APCNA #566. CNA #450 told APCNA #566 he could leave and she would finish up with the resident. CNA #450 revealed APCNA #566 then grabbed Resident #22's arms and wrists with his hands, crossed the resident's arms over his chest and was pushing and pulling the resident up and down in the bed like he was trying to shake him. CNA #450 revealed she went around to the other side of the bed to stop APCNA #566 but he let go of the resident. CNA #450 told APCNA #566 to get out of the room now and she opened the door for him to leave. CNA #450 revealed APCNA #566 then went back to Resident #22 and grabbed the residents legs by the ankles with his hands and was pushing and pulling the resident's legs while holding his ankles. CNA #450 revealed she started yelling at APCNA #566 and he let go of the resident before she got to him. CNA #450 revealed she told APCNA #566 to get the expletive out of the room now. CNA #450 asked Resident #22 if he was okay. CNA #450 stated as APCNA #566 was leaving the room he was swearing at the resident and threatening him. CNA #450 revealed she apologized to Resident #22 for the APCNA #566's behavior and went to the nurses station where APCNA #566 was with the nurse. CNA #450 revealed she was trying to figure out how to report the incident since APCNA #566 was with the nurse. CNA #450 revealed she left the memory care unit and went and reported the incident to LPN 425. LPN #425 then called LPN #455 to come out of the unit. CNA #450 revealed we then called the Administrator to report the incident. CNA #450 verified APCNA #566 was left alone in the memory care unit with the vulnerable residents while they were on the phone with the Administrator around 4:45 P.M. reporting the abuse. CNA #450 revealed the Administrator felt APCNA #566 had just overreacted, provided no instruction on what to do or for APCNA #566 to leave the facility. CNA #450 revealed the Administrator never asked her to write a statement. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record for Resident #39 revealed an admitted [DATE] and a readmitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, type two diabetes mellitus, hypertension, and chronic kidney disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Review of physician orders dated 05/22/24 revealed the resident was ordered Ozempic eight mg/three ml solution pen-injector, two mg/dose, inject two mg weekly on Wednesdays. Review of a pharmacy receipt dated 02/08/25 revealed the facility received Ozempic two mg/dose (eight mg/three ml pen). Each pen supplied one two mg dose per week for four weeks. Review of the MAR revealed the resident was administered Ozempic on 02/12/25 and 02/19/25. There should have been two remaining doses left in the pen. Review of the medical record for Resident #49 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, chronic obstructive pulmonary disease, and atrial fibrillation. Review of the quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. Review of a pharmacy invoice dated 02/01/25 revealed the facility received Ozempic four mg/three ml for Resident #49. Review of the physician orders dated 02/03/25 revealed an order for Ozempic (one mg/dose) subcutaneous solution pen-injector four mg/three ml, inject one mg subcutaneously one time a day every Friday related to type two diabetes mellitus. Review of the MAR revealed the resident was administered one dose on 02/07/25, and 02/14/25, and 02/21/25. There should have been one dose remaining in the pen. Review of an electronic communication dated 02/24/25 at 1:13 P.M. revealed the facility paid to replace one pen each for Resident #39 and Resident #42. The facility provided no documentation Resident #42 was reimbursed for the missing pen in January or Resident #49 was reimbursed for the one remaining dose left in the pen on 02/22/25 later found missing on 02/24/25. Interview on 03/12/25 beginning at 10:29 A.M., the Administrator revealed a nurse went to administer Ozempic for a resident and the resident's Ozempic pen was missing and later three Ozempic pens were discovered as missing. The Administrator revealed the facility paid to replace two Ozempic pens. The Administrator revealed the Director of Nursing (DON) handled the investigation with pharmacy. The Administrator revealed a self-report incident was not submitted to the state agency for the missing medications. Review of the facility self-reported incidents revealed the missing Ozempic pens were not reported. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/12/25 at 2:33 P.M., Registered Nurse (RN) #434 revealed on 02/22/25 Licensed Practical Nurse (LPN) #427 reported Resident #42's Ozempic pen was missing and just the box was in the refrigerator. RN #434 revealed LPN #427 checked the Ozempic pens for four additional residents and the pens were present in the refrigerator on 02/22/25. RN #427 revealed she reported the missing Ozempic pen to the Director of Nursing on 02/22/25. RN #427 revealed when she returned to work on 02/24/25 two more Ozempic pens were missing for Resident #39 and Resident #49 and the empty boxes were in the refrigerator. RN #427 revealed three of five Ozempic pens were missing for three of the five residents with orders for Ozempic and the DON was notified again on 02/24/25 of the additional missing pens. RN #427 revealed none of the five residents were not scheduled for administration of Ozempic from 02/22/25 through 02/24/25. RN #427 revealed each pen administers four doses (one dose weekly.) RN #427 also revealed she had reported Resident #42 was missing her Ozempic pen in January. RN #427 revealed only the nurses and unit managers had keys to access the medication room refrigerator. RN #434 revealed all Ozempic pens and doses administered were now recorded and counted each shift. Interview on 03/12/25 at 03:29 P.M., LPN #427 revealed on 02/22/25 Resident #42's Ozempic pen and needles were missing but the empty box was in the refrigerator. LPN #427 revealed she checked the other boxes of Ozempic to see if the medication had been misplaced but the other boxes contained Ozempic pens on 02/22/25. LPN #427 revealed she notified RN #434 of the missing Ozempic pen and told her she thought someone took the Ozempic. LPN #427 revealed all Ozempic pens were now counted each shift. Interview on 03/13/25 at 8:50 A.M. and 3:50 P.M. the DON revealed she had no documentation of staff statements or interviews conducted with the nursing staff regarding the missing Ozempic pens. The DON revealed she had spoken with four nurses and had left a voicemail with a fifth nurse. The DON revealed she had not completed a thorough investigation and had not interviewed all the nurses as another abuse investigation was taking place at the same time. The DON revealed the nurses who were interviewed had no knowledge of the missing pens. The DON revealed she investigated as if someone took the pens but was not wanting to accuse anyone without concrete evidence. The DON revealed the missing Ozempic pens were reported to herself and the Administrator on 02/22/24 and 02/24/24. The DON could not recall with certainty but said it was possible RN #434 had reported Resident #42's Ozempic pen missing in January. Interview on 03/13/25 at 12:45 P.M., the Regional Director of Operations (RDO) #700 revealed the Administrator should have reported the missing Ozempic pens to the state agency. RDO #700 revealed it was not company practice to not report and moving forward the Administrator was educated to inform regional of what was going on in the building. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy Abuse, Mistreatment, Neglect, Exploitation and Misappropriation, last revised 09/06/24 revealed all allegations involving neglect, exploitation, and misappropriation of resident property would be reported to the Department of Health immediately with the submission on an online Self-Reported Incident form, but no later than 24 hours from the time the incident/allegation was made known to the care team member. If the facility suspects a crime had been committed, it would report the suspicion to law enforcement. The nurse would perform an initial assessment of the resident including range of motion, full body assessment for signs of injury and vital signs. If a care team member was accused or suspected, the facility should immediately remove the care team member from the facility and the schedule pending the outcome of the investigation. Documentation in the nurses' notes should include the results of the resident's assessment, notification of the physician and resident representative and any treatment provided. Once the Administrator and Department of Health were notified, an investigation of the allegation would be conducted and completed within five working days and submitted to the Department of Health. The investigation should include interviews with the resident, the accused, and all witnesses and expanded to include care team members on the shift and residents on the unit. This violation represents non-compliance investigated under Complaint Number OH00162176.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 31638 Based on observation, record review, staff interviews, and policy review the facility failed to provide adequate grooming care for a dependent resident (#45). This had the ability to affect all residents. The facility census was 56. Findings include: Review of Resident #45's medical record revealed an admitted [DATE]. Diagnosis included Parkinson's disease, bipolar disorder, peripheral vascular disease, and chronic obstructive pulmonary disease. Review of Resident #45's Minimum Data Set (MDS) regarding a significant change dated 02/28/25 revealed the resident had an intact cognitive function, was dependent on staff for activities of daily living, and was under hospice care. Review of Resident #45's most recent care plan revealed she had an activity of daily living self-care performance deficit related to Parkinson's disease and required a one person assist with all personal hygiene and care. Observation of Resident #45's toenails on 03/12/25 at 4:05 P.M. with Licensed Practical Nurse #427 revealed the residents right foot contained a long toenail on her second toe. The nail curved down around the top of her toe. Observation of Resident #45's left foot revealed all toenails except the small toe were long and in need of trimming. The large toenail grew straight out, the second, third, and fourth toe nails were curved around the tops of her toes. Interview with LPN #427 on 03/12/25 at 4:05 P.M. verified the resident was in need of a nail trim and that the care should have been completed on shower days. LPN #427 stated the resident was not diabetic. Interview with Resident #45 on 03/12/25 at 4:07 P.M. revealed she was in need of getting the toenails trimmed, and staff had failed to do so. Resident #45 also stated her daughter would attempt to complete nail trimming when she visited. Review of the facility policy titled Activities of Daily Living dated 01/02/24 revealed care and services would be provided for grooming. A resident who was unable to carryout the activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This violation represents non-compliance investigated under Complaint Numbers OH00162562.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on review of the medical record, staff and resident interview, and policy review, the facility failed to timely clarify incorrect medication orders before administration and failed to ensure medications were administered per physician orders. This affected two residents (#64 and #42) of five residents reviewed for medications. The facility census was 56. Findings include 1. Review of the medical record for Resident #64 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, hypertension, and hyperlipidemia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had mild cognitive impairment. Review of the care plan last revised 01/21/25 revealed the resident had diabetes mellitus with an intervention to administer diabetes medication as ordered by the physician. Monitor/document side effects and monitor for effectiveness. Review of the physician orders dated 01/16/25 revealed an order for Ozempic (0.25 milligrams (mg) or 0.5 mg/dose) subcutaneous solution pen-injector two mg/three milliliter (ml), inject 0.25 mg subcutaneous one time a day every Saturday for diabetes mellitus for four weeks and inject 0.5 mg subcutaneously one time a day following four weeks of the 0.25 mg for diabetes mellitus. The order was incorrectly entered as a daily injection instead of a weekly injection. Review of the medication administration record (MAR) for 02/2025 revealed Resident #64 was administered Ozempic (0.25 or 0.5 mg/dose) subcutaneous solution Pen-Injector two mg/three ml, inject 0.5 mg subcutaneous one time a day for diabetes mellitus on 02/15/25, 02/16/25, 02/17/25, and 02/18/25. Review of an incident report dated 02/18/25 at 10:20 A.M. revealed the physician order for the Ozempic was put in daily instead of weekly. Resident stated, yeah I've been given that shot the last couple of days. The physician was notified and ordered for Ozempic to be administered weekly. Due to resident not having any side effects or other issues related to the medication, the physician gave no further orders. Review of an interdisciplinary (IDT) progress note dated 02/19/25 at 9:33 A.M. revealed the IDT team met to discuss event on 02/18/25. New orders from physician to change medication to once a week and not one a day. No new orders from the physician as he would see the resident when he came into the facility. Resident was evaluated and no signs or symptoms of side effect or adverse reactions to the medication. The resident and responsible party were notified. Interview on 03/12/25 at 2:42 P.M., Registered Nurse (RN) #434 revealed after checking the resident's order for Ozempic, realized the order had been entered into the electronic record as a daily injection instead of a weekly injection. RN #434 revealed she notified the physician and no new orders were given. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/13/25 at 9:12 A.M., the Director of Nursing (DON) verified Resident #64 was administered daily doses of Ozempic instead of once a week injections. The DON revealed the pharmacy also had not questioned the daily dose. 2. Review of the medical record for Resident #42 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, hypertension, and chronic obstructive pulmonary disease. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had intact cognition. Review of the care plan last revised 01/21/25 revealed the resident had diabetes mellitus with an intervention to administer diabetes medication as ordered by the physician. Monitor/document side effects and monitor for effectiveness. Review of a physician order dated 03/08/24 revealed the resident was ordered Ozempic (two milligram/dose) subcutaneous solution pen-injector eight milligrams/three milliliters, inject two mg subcutaneously one time a day every Friday for diabetes mellitus. Review of the medication administration record (MAR) dated 01/01/25 through 02/28/25 revealed Resident #42 was administered Ozempic on 01/03/25, 01/15/25, and 02/14/25. The resident was not administered the medication on 01/10/25, 01/17/25, 01/24/25, 01/31/25, 02/07/25, and 02/22/25 per physician orders. Review of the electronic medication administration record notes revealed the Ozempic was not available 01/10/25, 01/17/25, 01/24/25, 01/31/25, 02/07/25, and 02/22/25. The physician was notified the resident was not administered the medication on 01/10/25, 01/24/25, 02/07/25, and 02/22/25. Interview on 03/13/25 at 8:50 A.M., the Director of Nursing (DON) verified Resident #42 was not administered the weekly Ozempic injections on 01/10/25, 01/17/25, 01/24/25, 01/31/25, 02/07/25, and 02/22/25. The DON verified the physician was not notified the medication was not administered on 01/10/25, 01/24/25, 02/07/25, and 02/22/25. Interview on 03/13/25 at 1:14 P.M., Resident #42 revealed she was aware the facility had not administered her weekly injections of Ozempic but they never told her why. Review of the facility policy Medication Administration, dated 01/02/24, revealed medications would be administered as ordered by the physician in accordance with professional standards of practice. The physician would be notified timely of medication omissions.