STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365780	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Marietta	5001 State Route 60 Marietta, OH 45750

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, review of camera footage, medical record review, interview and policy review, the facility failed to ensure residents were treated with respect and dignity. This affected two residents (#18 and #42) of 31 sampled residents. The census was 57. Findings include: 1. Medical record review revealed Resident #18 revealed the resident was admitted on [DATE] with diagnoses including major depressive disorder. On 03/04/25 at 8:09 A.M., observation revealed Certified Nurse Aide (CNA) #201 and CNA #202 both entered the main dining room and knocked on the Kitchen door. CNA #201 asked for dry cereal for Resident #18 as it had not been on her breakfast tray. CNA #202 was heard calling Resident #18 a hateful old lady while talking to CNA #201 and dietary staff. CNA #202 continued talking about Resident #18, in a not respectful way. When CNA #202 saw the surveyor sitting at one of the dining room tables, she acknowledged the above, stated the resident was moody and said I probably should not have said that, huh? No residents were in the dining room at the time of the observation. On 03/04/25 at 8:19 A.M., interview with the Director of Nursing stated staff should not make those types of comments about residents, it was inappropriate and was not acceptable. 47985 2. Record review revealed Resident #42 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder bipolar type, Alzheimer's disease, intermittent explosive disorder, and hypertension. Review of a care plan dated 08/16/24 revealed Resident #42 had an activity of daily living self-care mobility performance deficit related to Alzheimer's, dementia, impaired balance and pain. The goal was to improve the current functional status. Interventions included and were not limited to set-up and supervision for eating with occasional voice command for task follow-through. The resident required extensive assistance with transfers and toilet use. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a care plan dated 08/16/24 revealed Resident #42 was incontinent of bladder due to Alzheimer's, confusion, dementia, and impaired mobility with a goal to remain free of skin breakdown due to incontinence and brief use through 02/04/25. Interventions included but were not limited to assessing bladder continence quarterly and as needed, check resident and offer to assist with toileting, remove wet or soiled clothes and provide incontinence care, monitor for signs and symptoms of UTIs, note any changes in urine. On 03/10/25 at approximately 10:10 A.M. observation of camera video footage from the camera located in the resident's room, that was provided by Family Member #999, revealed Resident #42 was laying down in bed with the head of the bed elevated. Staff, identified as Certified Nursing Assistant (CNA) #222, entered the room and placed a lunch tray with spaghetti on the far-left side of Resident #42's over-the-bed table, and did not cut the spaghetti or place the plate in an easy reaching distance for Resident #42. CNA #222 left the room, and Resident #42 attempted to feed himself, dropping large amounts of spaghetti on his shirt and bed. After approximately five minutes, Registered Nurse (RN) #234 entered the room and removed a large chunk of spaghetti from Resident #42's shirt and took his tray out of the room. An additional clip of the video revealed two new CNA's (one identified as CNA #201) entered the room to assist Resident #42 get cleaned up and out of bed. Interview on 03/10/25 at 10:16 A.M. with Resident #42's daughter revealed she had a camera installed in his room and was upset because on 03/09/25 he was wearing a brief and t-shirt all morning (this is not a typical thing to occur) and no one had helped him get up and ready for the day. She said the video clips began around 7:00 A.M. Additionally, when CNA #222 brought in Resident #42's lunch, did not cut up the spaghetti, did not place the plate within reach of the resident and Resident #42 was dropping spaghetti everywhere. After calling the facility, two different aides were assigned to the hallway and came in to clean up Resident #42 and wash his face at 12:30 P.M. Interview on 03/10/25 at 4:07 P.M. with CNA #258 revealed she was working on 03/09/25 during dayshift but she refused to go into Resident #42's room alone to provide any care because his daughter watches the camera all day and is out to get her. CNA #258 stated CNA #222 was providing care for Resident #42 and knew if he needed assistance, she would help. Interview on 03/10/25 at 5:36 P.M. with CNA #201 revealed she had been working another unit on 03/09/25 when she was pulled to the memory care unit to care for Resident #42 due to his daughter being unhappy with the care resident was receiving. CNA #201 stated she entered the room as soon as she was assigned at approximately 12:30 P.M. and Resident #42 was a total bed change with urine up to his shoulders, he was laying on his back with the head of bed slightly inclined, and he had spaghetti on his hands, face, and blankets. CNA #201 stated Resident #42 usually eats meals in the dining room unless he is really tired and declines to get up, then they assist with feeding him in his room because he is a messy eater. CNA #201 indicated due to only having seven residents to care for and two aides on the hall, Resident #42 should never have been left as messy as he was (from the lunch meal) and it wasn't dignified. Interview on 03/11/25 at 11:26 A.M. with RN #234 revealed she spoke with Resident #42's daughter on 03/09/25 because she was not happy with the care she saw her father receiving via video in his room. Resident #42's family was concerned he was not up, dressed, his face was not washed. RN #234 stated she saw Resident #42 a few times during her shift and he was wearing a t-shirt and a brief but she did not see that he was wet up to his neck and she did not think he looked neglected. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a policy titled Dignity dated 02/2021 revealed each resident should be cared for in a manner that promotes and enhances their sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents should be treated with dignity and respect at all times, and staff are expected to treat cognitively impaired residents with dignity and sensitivity by addressing the underlying motives or root causes for behaviors and not challenging or contradicting the resident's beliefs or statements.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, staff interview, and policy review, the facility failed to ensure a resident's desired code status was consistent between what was identified in the electronic medical record (EMR) and what was identified in the hard chart of the medical record. This affected one (Resident #51) of one residents reviewed for advanced directives. Findings include: Review of Resident #51's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included adult onset diabetes mellitus, sleep apnea, chronic kidney disease, and asthma. Review of Resident #51's advanced directives in the hard chart of her medical record revealed the resident was a Do Not Resuscitate Comfort Care- Arrest (DNRCC-A). The DNR order form was signed by a physician on [DATE] (prior to her initial admission into the facility). The DNR form indicated the provider would treat the resident as any other, without a DNR order, until the point of cardiac or respiratory arrest at which point all interventions would cease and the DNR Comfort Care protocol would be implemented. The DNR protocol indicated providers would not perform CPR, would not administer resuscitation medications with the intent of restarting the heart or breathing, would not insert an airway adjunct, would not defibrillate, cardiovert, or initiate pacing, and would not initiate continuous cardiac monitoring. Review of a hospital discharge summary for a hospitalization between [DATE] and [DATE] revealed the resident was sent to the hospital on [DATE] for shortness of breath. She was diagnosed and treated for pneumonia. Her hospital discharge summary identified her code status as being a full code, which was different than her code status when she was originally admitted to the facility. Review of Resident #51's active physician's orders in the EMR revealed the resident's advanced directive was CPR- Full Code. The order for the resident to be a full code originated on [DATE]. Review of Resident #51's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. She did not display any behaviors and was not known to reject care during the seven days of the assessment period. Review of Resident #51's active care plans revealed the resident had chosen the advanced directive of DNRCC-Arrest. The date the care plan was initiated was [DATE]. The goal was to honor the resident/ family wishes regarding her advanced directives. The interventions included reviewing her advanced directive status with plan of care meetings. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:20 A.M., an interview with LPN #244 revealed a resident's code status was identified in the EMR on the computer. It could also be found in the hard chart of the medical record found at the nurses' station. If she was down the hall and found a resident unresponsive with no pulse or respirations and did not have access to her computer, she could have an aide bring the resident's hard chart to the room so they could verify her code status. She reported the code status in the hard chart should match the code status in the EMR. She confirmed Resident #51's physician's orders in the EMR had the resident as a full code, while the hard chart at the nurses' station had the resident's code status as a DNRCC-A. She was asked to check with the resident to confirm what her desired code status was. On [DATE] at 10:31 A.M., a follow up interview with LPN #244 revealed she spoke with Resident #51 regarding her desired code status. She reported the resident told her she wanted to be a full code. On [DATE] at 10:38 A.M., an interview with the Director of Nursing (DON) confirmed Resident #51's code status was not consistent between the EMR and the hard chart of her medical record. She acknowledged the potential of the resident not being provided CPR, as desired, in the event of a cardiac or respiratory arrest, if the nurse went by what was indicated under her advanced directives in the hard chart of her medical record. She indicated both the EMR and the hard chart should be consistent to reflect her desired code status. A review of the facility's policy on Advanced Directives revised [DATE] revealed advanced directives would be respected in accordance with state law and facility policy. Prior to or upon admission of a resident to the facility, the social service director (SSD) or designee would provide written information to the resident concerning his/ her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives. Prior to or upon admission of a resident, the SSD or designee would inquire of the resident, and/ or his/ her family members, about the existence of any written advanced directives. The plan of care for each resident would be consistent with his or her documented treatment preferences and/ or advance directive. The DON or designee would notify the attending physician of advanced directives so that appropriate orders could be documented in the resident's medical record and plan of care.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review and interview, the facility failed to maintain resident privacy during the administration of insulin. This affected one resident (#7) of nine residents seated in the dining room during a meal observation. The census was 57. Findings include: Medical record review revealed Resident #7 was admitted on [DATE] with diagnoses including diabetes mellitus and depression. Review of the electronic Physician Order Sheet dated March 2025 revealed Resident #7 was to receive glucose monitoring before meals and NovoLOG Solution 100 units per milliliter (Insulin Aspart) administer five (5) units subcutaneously before meals and at bedtime. On 03/04/25 at 11:25 A.M., observation of the lunch meal in the main dining room revealed Resident #1, #2, #6, #7, #15, #16, #28, #45 and #46 were seated at dining tables and were being served their lunch. On 03/04/25 at 11:40 A.M., observation revealed Licensed Practical Nurse (LPN) #203 approached Resident #7 while she was eating lunch and told the resident she needed to check her blood glucose level. LPN #203 completed an accu-check and stated her blood glucose level was 197. LPN #203 commented not bad since you had already started eating. LPN #203 told the resident she would have to go to look to see how much insulin she would need. At 11:42 A.M., LPN #203 returned to the dining room, approached the resident, asked the resident where she wanted her insulin and administered it to her in the right arm. During the above observation, the nurse did not offer to take the resident to a private area to receive her injection. On 03/04/25 at 1:15 P.M., interview with the Director of Nursing verified LPN #203 should not have administrated insulin to a resident in the dining room. On 03/04/25 at 4:22 P.M., interview with LPN #203 verified she administered insulin to Resident #7 while the resident was eating lunch in the dining room but she didn't see why this was a problem. Review of the policy: Resident Rights revised August 2009 revealed employees shall treat all residents with kindness, respect, and dignity. These rights included privacy and confidentiality.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 47985 Based on personnel file review, interview and policy review, the facility failed ensure staff hired to work at the facility did not have a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property. This had the potential to affect all residents. The census was 57. Findings include: 1. Review of the personnel file for Medical Records #272 revealed a hire date of 10/14/24. There was no evidence MR #272 was checked against the Nurse Aid Registry (NAR) prior to hire to ensure the employee did not have a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property. 2. Review of the personnel file for Social Worker #254 revealed a hire date of 10/21/24. There was no evidence SW #254 was checked against the NAR prior to hire to ensure the employee did not have a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property. 3. Review of the personnel file for Director of Rehabilitation (RD) #256 revealed a hire date of 10/01/24. There was no evidence RD #256 was checked against the NAR prior to hire to ensure the employee did not have a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property. Interview on 03/10/25 at 3:15 P.M. with Human Resources #241 confirmed the above staff members, who had the ability to provide direct resident care, were not checked against the nurse aide registry prior to hire to ensure the employee(s) did not have a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property. Review of a policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated 04/2021 revealed the facility should not employee a staff who had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on medical record review and interview, the facility failed to ensure comprehensive assessments were accurate. This affected two residents (#7 and #16) of 31 residents reviewed. The census was 57. Findings include: 1. Medical record review revealed Resident #16 was admitted on [DATE] with diagnoses including vascular dementia, hypothyroidism, anemia, hypertension, insomnia, falls, depression and cognitive communication deficit. Review of the admission Dental Record - V 1.0 dated 01/23/25 revealed the resident had full upper and lower dentures. Comments indicated the resident's upper dentures were not in her mouth and the resident stated she had misplaced them. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #16's dental section was marked 'no' for no natural teeth or tooth fragments (edentulous). On 03/05/25 at 5:55 P.M. interview with the Director of Nursing (DON) verified Resident #16's admission MDS dental section was inaccurately coded. 2. Medical record review revealed Resident #7 was admitted on [DATE] with diagnoses including diabetes mellitus and dysphagia, oropharygeal phase. Review of the care plan dated 12/01/23 revealed Resident #7 had poor fitting dentures. Review of the Dental Treatment Note dated 01/15/25 revealed a comprehensive oral evaluation was completed. Resident #7 was completely edentulous and patient reports dentures not fitting well. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #7 had no broken or loosely fitting full or partial denture. On 03/03/25 at 2:10 P.M., interview with Resident #7 stated her lower denture was loose and she could not find her upper denture. At the time of the interview, Resident #7 was observed to be edentulous. On 03/06/25 at 3:01 P.M., interview with the DON verified Resident #7's quarterly MDS, dated [DATE], dental section was inaccurate.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on medical record review and interview, the facility failed to complete baseline care plans within 48 hours of admission to the facility. This affected two residents (#16 and #256) of 31 residents reviewed for care plans. The census was 57. Findings include: 1. Medical record review revealed Resident #16 was admitted on [DATE] with diagnoses including vascular dementia, hypothyroidism, anemia, hypertension, insomnia, falls, depression and cognitive communication deficit. Review of the Baseline Care Plan Person-Centered Care Planning - V 3.1 dated 01/24/25 and one dated 01/27/25 revealed the assessments were not completed and were marked as pending. There was no evidence the Baseline Care plan was finished or provided to the resident/responsible party as required. On 03/05/25 at 5:55 P.M., interview with the Director of Nursing (DON) verified Resident #16's Baseline Care plan was not completed as required. 51519 2. Record review revealed Resident #256 was admitted to the facility on [DATE] with diagnoses including rhabdomyolysis, metabolic encephalopathy, non-ST elevated myocardial infarction, acute kidney failure, muscle weakness, and cognitive communication deficit. Review of the baseline care plan revealed it was currently in progress for Resident #256 but due to be completed on 02/22/25. Assessments including bowel and bladder and the Braden Score for predicting pressure sore risk were also incomplete. Interview on 03/06/25 at 1:07 P.M. with the DON confirmed Resident #256's baseline care plan was not completed but should have been completed within 48 hours of admission.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51519 Based on record review, and interviews, the facility failed to ensure Residents #42 and #45 and/or their representatives provided input during review and revision of care plans by participating in care conferences. The facility also failed to ensure care plans for Resident #7 were accurate. This affected three residents (#7, #42 and #45) of 31 residents reviewed for care planning. The facility census was 57. Findings include: 1. Record review revealed Resident #45 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation, dementia with behavioral disturbances, chronic obstructive pulmonary disease (COPD), difficulty walking, pressure ulcer of the right buttock, cognitive communication deficit, need for assistance with personal care, and persistent mood disorder. Review of the Minimum Data Set (MDS) section C, completed 02/06/25, revealed a brief interview for mental status (BIMS) score of 06, indicating severe cognitive impairment. Further review of the medical record revealed no documentation of care plan conferences completed with Resident #45 or his representative. Interview on 03/06/25 at 1:05 P.M. with the Director of Nursing (DON) confirmed Resident #45 had no care conferences completed since admission. The DON stated care conferences should be completed in correlation with the MDS and as needed. 50538 2. Review of Resident #42's medical record revealed an admitted [DATE] with diagnoses including schizoaffective disorder bipolar type, Alzheimer's disease, hypertension, unspecified dementia, wandering, and age-related cognitive decline. Review of the quarterly MDS, dated [DATE], revealed Resident #42 had a BIMS score of zero indicating severely impaired cognition. Further review of the MDS revealed Resident #42 required substantial assistance with his activities of daily living except for eating, which he required supervision or touching assistance. Further review of Resident #42's medical record revealed he had care conferences completed on 08/07/24 and 11/01/24. No care conference was completed with the 02/13/25 MDS. An interview with Resident #42's daughter on 03/03/25 at 11:59 A.M. revealed there had not been a recent care conference completed for Resident #42. In an interview on 03/06/25 at 11:12 A.M. with the MDS RN #207 verified the care conference was not completed in February 2025, when it was due to be completed for Resident #42. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28704 3. Medical record review revealed Resident #7 was admitted on [DATE] with diagnoses including diabetes mellitus, pressure ulcers and chronic pain. Review of the quarterly MDS 3.0 assessment, dated 01/29/25, revealed Resident #7 had one Stage III (involves full-thickness skin loss, exposing subcutaneous tissue ((fat)) but not bone, tendon or muscle) pressure ulcer. Review of the medical record revealed no evidence the resident had pressure ulcers to the bilateral heels. Review of the care plan: Risk for pain/discomfort revised 01/25/24 included the resident had ulcers to the left and right heel. On 03/10/25 at 12:33 P.M., interview with MDS RN #207 verified Resident #7's at risk for pain/discomfort care plan had not been revised to reflect the left and right heel pressure ulcers had resolved. RN #207 stated she observed the resident's heels and the skin was intact.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review, observations, interviews and policy review the facility failed to ensure residents were assisted with activities of daily living to maintain appropriate hygiene. This affected five residents (#6, #25, #27, #35, and #46) of five residents reviewed for activities of daily living (ADLs). The facility census was 57. Findings include: 1. Record review revealed Resident #25 was admitted to the facility on [DATE] with diagnoses including dementia, cognitive communication deficit, and muscle weakness. Review of a care plan dated 04/04/24 revealed Resident #25 was at risk for activities of daily living (ADL) deficit related to obesity, dementia, and anxiety. Interventions included limited assistance with bathing, supervision or touching assistance for dressing, and supervision with maximum encouragement for grooming. Review of a minimum data set (MDS) assessment completed on 12/16/24 revealed Resident #25's cognition was moderately impaired, he had no behaviors, required supervision or touching assistance with bathing, and was independent for dressing, oral hygiene, and personal hygiene. Review of the lookback of dressing over 30 days revealed Resident #25 was independent on 02/04/25 through 02/07/25, required set-up or clean up help on 02/08/25, was independent from 02/09/25-02/16/25, set-up or clean up help on 02/17/25, was independent on 02/18/25, required set-up or clean up help on 02/19/25-02/20/25, was independent on 02/21/25 and 02/22/25, required set-up or clean up help on 02/23/25, was independent on 02/24/25, required set-up or clean up on 02/25/25, no documentation for 02/26/25, was independent on 02/27/25-03/01/25, required set-up or clean up on 03/02/25-03/03/25, was independent on 03/04/24, and moderate assistance on 03/05/25. Observation on 03/04/25 at 8:33 A.M. revealed Resident #25 was standing in the hallway wearing a red sweat suit, hair was not combed, and he had a slight body odor. Additional observations on 03/04/25 at 11:04 A.M., 2:24 P.M., and 4:24 P.M. revealed Resident #25 was still wearing the red sweat suit with disheveled hair and a slight body odor. Interview on 03/05/25 at 8:26 A.M. with Housekeeping Supervisor (HS) #252 confirmed Resident #25 was still wearing the same outfit he had on yesterday and he had body odor. Interview on 03/05/25 at 8:45 A.M. with Infection Preventionist (IP) #223 revealed Resident #25 is care planned as refusing bathing and care, and he is independent with care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/05/25 at 3:59 P.M. with Certified Nursing Assistant (CNA) #205 revealed Resident #25 is able to independently dress himself but he often refused to so and that's why the documentation is marked as independent. CNA #205 stated he thought Resident #25 actually needed supervision but since he declined and was able to dress himself, staff have to mark independent. CNA #205 stated Resident #25 would do better with verbal cues but he always says he will get around to doing it himself. Interview on 03/05/25 at 4:47 P.M. with Director of Nursing (DON) confirmed staff should be marking Resident #25 as refused instead of independent since he is declining to change his clothes. Interview on 03/10/25 at 8:56 A.M. with Resident #25 revealed he was still wearing the red sweat suit. Resident #25 stated he does not want to change until he showers, but he was not ready to shower yet. 2. Record review revealed Resident #46 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), congestive heart failure, and need for assistance with personal care. Review of a care plan dated 09/28/24 revealed Resident #46 had an ADL self-care deficit related to COPD, limited mobility, need for assistance with personal care, and non-compliance. Interventions included moderate assistance for lower body bathing and minimum assistance for upper body bathing. Review of an MDS assessment completed 12/17/24 revealed Resident #46's cognition remained intact, she had no behaviors, and required maximum assistance with bathing. Review of a shower schedule dated 12/31/24 revealed Resident #46 was to have showers on Tuesday, Friday, and as needed. Review of shower sheets for February 2025-March 2025 revealed Resident #46 had a shower on 02/04/25, declined shower on 02/11/25 and 02/18/25, refused a shower on 02/21/25, and had a shower on 03/04/25. There was no evidence of a shower being offered on 02/07/25, 02/14/25, 02/25/25, 02/28/25, or 03/07/25. Interview on 03/10/25 at 11:26 A.M. with Resident #46 revealed she could not recall the last time she had a shower. Interview on 03/10/25 at 3:30 P.M. with Infection Preventionist (IP) #223 confirmed there was no additional evidence Resident #46 was offered a shower on 02/07/25, 02/14/25, 02/25/25, 02/28/25, or 03/07/25. Review of a policy titled Bath, Shower/Tub dated February 2018 revealed documentation of the shower should include date and time, name and title of who assisted resident, assessment completed during shower. If residents refuse, the nurse should be notified. 28923 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #27's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included adult onset diabetes mellitus, unspecified dementia, age related cognitive decline, muscle weakness, and need for assistance with personal care. Review of Resident #27's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues. His cognition was severely impaired. He was not known to display any behaviors or reject care during the seven days of the assessment period. He was dependent on staff for bathing/ showers and a substantial/ maximum assist was needed with personal hygiene. Review of Resident #27's active care plans revealed the resident had a care plan in place for an activities of daily living (ADL) performance deficit related to dementia, impaired balance, and the use of psychotropic medications. The care plan did not address personal hygiene or the need to provide the resident with nail care. Review of Resident #27's bathing documentation provided by the facility revealed a bed bath was documented as having been provided to the resident on 02/28/25. There was no indication on that paper shower/ bed bath sheet that nail care had been provided as part of that bathing activity. Bathing documentation was also documented under the task tab of the electronic medical record (EMR). The last documented bathing activity found in the EMR revealed the resident was provided a bed bath on 03/01/25. Again, there was no indication that the resident was provided nail care as part of that bathing activity. On 03/03/25 at 2:56 P.M., an observation of Resident #27 noted him to be lying in his bed in his room. He was noted to have long fingernails and there was a dark colored substance at the end of and under his fingernails. On 03/04/25 at 1:40 P.M., an interview with Certified Nursing Assistant (CNA) #269 revealed Resident #27 was total care for his personal care. She reported she provided personal hygiene care to the resident that morning, which included shaving him. She denied that she had provided him any nail care as part of the personal care services she provided to him that morning. She indicated her assignment sheet showed the resident was to be showered on the evening shift every Tuesday and Friday. She confirmed nail care was to be provided as part of their bathing activity and any other time when the resident's nails were long or dirty. She was asked to accompany the surveyor to the resident's room to check his fingernails. She confirmed the resident's nails were long and dirty and in need of being cleaned/ trimmed. She stated she would trim the resident's nails for him and clean them. Review of the facility's policy on Care of Fingernails/ Toenails revised October 2010 revealed the purpose of the procedure was to clean the nail bed, to keep nails trimmed, and to prevent infection. Nail care was to include daily cleaning and regular trimming. Proper nail care could aid in the prevention of skin problems around the nail bed. They were to document nail care in the resident's medical record to include the date and time that nail care was provided. 4. Review of Resident #35's medical record revealed revealed she was admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease, dementia, contracture of an unspecified hand, contracture of the left elbow, muscle weakness, and need for assistance with personal care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #35's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had unclear speech. She was rarely/ never able to make herself understood and was rarely/ never able to understand others. She had short and long term memory impairment and her cognitive skills for daily decision making was severely impaired. She was not known to have displayed any behaviors or reject care during the seven days of the assessment period. The resident had a functional limitation in one side of her upper extremities. She was dependent with the assist of two for transfers and was dependent on staff for personal hygiene. Review of Resident #35's active care plans revealed she had a care plan in place for an ADL self care deficit related to an activity Intolerance, dementia, impaired balance, limited mobility, shortness of breath, weakness, and need for assistance with personal care. The interventions included the need for staff to assist with the completion of ADL's on a daily basis so needs were met. Nail care was to be provided as needed (prn). Review of Resident #35's bathing documentation revealed bathing activities provided were documented under the task tab of the EMR. They were also documented on paper shower/ bed bath sheets. The resident's last bathing activity documented under the task tab in the EMR revealed the resident received a bed bath on 02/27/24. It did not indicate if nail care had been provided to the resident as part of that bathing activity. The paper shower/ bed bath sheets revealed the resident was last provided a bed bath on 03/03/25. There was no indication nail care had been provided to the resident as part of that bathing activity. On 03/03/25 at 9:28 A.M., an observation of Resident #35 noted her to be lying in bed in a supine position. Her fingernails were long and in need of being trimmed. On 03/04/25 at 1:36 P.M., an interview with CNA #269 revealed Resident #35 was a total assist for personal care. She reported the resident did well with personal care and did not typically refuse care as long as you talked to her while providing care. She reported the resident received bed baths as her bathing activity provided. She checked the assignment sheet and noted the resident was to receive her bathing activity every Monday and Thursday on the day shift. She stated the staff should be checking the resident's fingernails during her bed bath or shower. She recalled she trimmed the resident's fingernails not long ago. She was asked to go to the resident's room to check her fingernails, since they were noted to be long the day before. She verified the resident's fingernails on her right hand were long and in need of being trimmed. She further verified the thumbnail on the left hand was also long and needed to be trimmed. 51519 5. Record review revealed Resident #6 was admitted to the facility on [DATE] with diagnoses including unspecified cerebral infarction, hemiplegia and hemiparesis, aphasia, lupus, and depression. Review of Resident #6's MDS, completed 12/12/24, revealed a brief interview for mental status score of 14 indicating intact cognition. Review of section G: functional status revealed the resident needed extensive assistance with moving, turning and positioning with one-person physical assist. The resident was totally dependent on transfers including to or from bed, chair, wheelchair, and standing position, needing a two plus person assist. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan completed 02/07/24 revealed Resident #6 was at risk for oral/dental problems related to missing natural teeth. The goal was to provide appropriate oral hygiene. Interventions included providing assistance with oral hygiene. Review of Resident #6's tasks for hygiene revealed the resident's ability to use suitable items to clean teeth/ dentures if applicable. The task sheet revealed resident received oral hygiene twice on 02/03/25, twice on 02/04/25, twice on 02/05/25, three time on 02/6/25, twice on 02/8/25, once on 02/9/25, twice on 02/10/25, twice on 02/11/25, three time on 02/13/25, once on 2/14/25, once on 02/15/25 and refused on 02/15/25, three times on 02/18/25, once on 02/19/25 and refused once on 02/19/25, once on 02/20/25, once on 02/21/25, once on 02/22/25, once on 02/23/25, twice on 02/24/25, twice on 02/25/25, twice on 02/26/25, once on 02/27/25, and once on 02/28/25. Review of Resident #6's tasks for hygiene revealed no documentation Resident #6 received or refused oral hygiene care on 02/07/25, 02/12/25, 03/01/25 or 03/02/25. Review of tasks for personal hygiene revealed no documentation of Resident #6 receiving or refusing assistance in completing personal hygiene on 02/07/25, 02/11/25, 02/20/25, 03/01/25, or 03/02/25. Interview with Certified Nursing Assistant (CNA) #257 on 03/05/25 at 8:47 A.M. revealed the CNA routine for Resident #6 was to go into her room in the morning and provide privacy. She stated Resident #6 was able to remove her clothes from the night before and start a bed bath. The CNA gives Resident #6 a warm cloth to clean her face and provide incontinence care, if needed. CNA #257 stated they will then get her dressed for the day, CNA #257 will hand Resident #6 her toothbrush ready for oral care and Resident #6 will independently brush her teeth. The CNA then will, with another staff member, use the Hoyer lift to get her up for breakfast and into her chair or pull her up in bed, whichever Resident #6 requests, at that time and then staff will do her hair. Interview on 03/05/25 with CNA #257 revealed ADL care is to be done daily on all residents including oral care, clothing change, and hair care. Each resident is different, depending on their level dependence or independence. CNA #257 stated if a resident refused care, she would ask why and then would report the refusal to the nurse. The CNA stated, later on she would ask the resident again if they would like care completed and if the resident still refused, update the nurse and document it as refused. CNA #257 stated she doesn't have issues with specific staff not completing tasks as expected but, at times, she will notice when she comes in for a shift after a long stretch of days off, some residents will not have their hair combed and they'll be in the same clothes. She stated its very hit or miss and its a fifty fifty chance if it will happen. Interview with the DON on 03/05/25 revealed the expectation is for every resident to be offered or receive oral care daily, bathing is twice a week for each resident. If residents refuse care, it should be documented in the electronic medical record of the refusal. The DON confirmed there was no documentation for oral care completed on 03/01/25 or 03/02/25 for Resident #6. Interview on 03/03/25 at 9:19 A.M. with Resident #6 revealed she had no help with brushing her teeth all weekend, Saturday or Sunday (03/01/25 & 03/02/25). She stated she feels gross and would like to brush her teeth.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review, observation, interview, and policy review, the facility failed to ensure (non-pressure ulcer related) dressings were changed per physician orders and the bowel protocol was followed. This affected one (#46) of three residents reviewed for bowel and bladder continence and two residents (#7 and #8) of four residents reviewed for general skin conditions. The facility census was 57. Findings include: 1. Record review revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including toxic encephalopathy, type II diabetes, acute kidney failure, and altered mental status. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had mild cognitive impairment, no behaviors, and had no venous ulcers. Review of a provider note dated 03/05/25 at 12:00 A.M. by Nurse Practitioner (NP) #505 revealed Resident #7 was receiving wound care to her sacrum and left trochanter (hip). There was no evidence of treatment or assessment of a venous wound to the right lower leg. Review of a nursing note dated 03/05/25 at 6:14 A.M. by Licensed Practical Nurse (LPN) #225 revealed Resident #7 was resting in bed with no new concerns. Review of orders revealed Resident #7 had an order in place dated 03/05/25 to cleanse venous wound to the right lower leg with in-house would cleanser and pat dry, apply puracol (a collegen based dressing with antimicrobial properties) with tetracyte and apply kerlix (gauze wrap) daily for wound care. Review of a care plan last revised on 03/05/25 revealed Resident #7 had an alteration to skin integrity related to pressure state III (full thickness ski loss, exposing subcutaneous tissue ((fat)) but not exposing bone, tendon or muscle) to the sacrum, a boil to the left hip, and a venous wound to the right lower leg. Interventions included complete treatments to wounds per orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continuous observation on 03/06/25 from 1:49 P.M. to 2:21 P.M. revealed Registered Nurse (RN) #313 prepared to enter Resident #7's room to complete wound care. Hand hygiene was completed, a gown was applied, and RN #313 donned five pairs of gloves. Upon entering the room, RN #313 began to remove Resident #7's personal items from her over the bed table. Without taking off her gloves or gown, RN #313 left the room to obtain a trash bag. RN #313 returned to the room and, with the same gloves and gown, began using bleach wipes to clean the over bed table then obtained a blue drape and applied it to the table and began to lay out supplies. RN #313 then removed one pair of gloves, lifted Resident #7's blanket, and left the room, wearing the gloves and gown to retrieve wound cleanser from the treatment cart. Upon returning to the room, RN #313 did remove one pair of gloves, leaving three pairs of gloves remaining on her hands. RN #313 removed Resident #7's sock and used scissors to cut off the old dressing. Resident #7 reported to the nurse she has had the wound to her right leg for a while. RN #313 removed another pair of gloves then attempted to remove the puracol from Resident #7's leg, but it was adhered to the wound, so she used wound cleanser to moisten the puracol to make it easier to remove. Once the puracol was removed, RN #313 rolled the kerlix from the soiled dressing under Resident #7's leg to use as a barrier between Resident #7's leg and the pillow her leg was resting on, which had a large area of drainage the size of a grapefruit. RN #313 removed the remaining gloves, went to the restroom and washed her hands, then applied a new pair of gloves. RN #313 removed the soiled pillow and dressing from underneath Resident #7's leg then laid down a fresh drape under her leg. RN #313 sprayed the wound with wound cleanser. The wounds were on Resident #7's right leg and were two quarter-sized open areas and a smaller dime-seized open area, all of which were red in appearance. RN #313 then pat the area dry with gauze and applied puracol with silver to the open areas. When asked, RN #313 stated silver and tetracyte were the same thing and interchangeable. The area was then wrapped with kerlix and the drape removed from underneath Resident #7's leg. RN #313 taped the kerlix together, then signed and dated the dressing. RN #313 removed Resident #7's other sock due to her request and removed the soiled pillow case from the pillow. RN #313 removed her gloves, washed her hands, and applied a new pair of gloves, then wiped Resident #7's pillow down with bleach wipes. RN #313 then grabbed the trash bags with soiled gloves, dressings, and pillow case and walked out of the room still wearing a pair of gloves and her gown. RN #313 paused in the hallway to doff the gown and gloves and put them into the trash bag as well, then carried the trash bags to the shower room to dispose of them, without completing hand hygiene. Resident #7 was on contact precautions due to Methacillin Resistant Staphylococcus Aureus (MRSA) infection in a wound to her left hip. RN #313 confirmed she had worn five pairs of gloves at the same time for convenience of not having to perform hand hygiene between removal of each pair of gloves. RN #313 stated she had not yet started actual wound care while wearing and removing the five pairs of gloves so it does not matter. Interview on 03/06/25 at 4:31 P.M. with the Director of Nursing (DON) confirmed observations made during wound care had infection control concerns. The DON also stated tetracyte and silver can be used as substitutes for each other, but only if the ordered treatment was not available. Interview on 03/06/25 at 4:50 P.M. with Unit Manager (UM) #242 confirmed tetracyte was available on the treatment cart for Resident #7's treatment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a policy titled Wound Care dated October 2010 revealed the process for completing wound care includes verifying the physician order for treatment, gather equipment and supplies, then use a disposable cloth to establish a clean filed on resident's over the bed table, place all items to be used during procedure on the clean field and arrange the supplies so they are within reach. Wash and dry hands thoroughly, position the resident, place a disposable cloth next to the resident under the wound to serve as a barrier to protect the bed linen and other body sites, put on exam gloves, loosen tape and remove the soiled dressing. The glove should be pulled over the dressing then discarded into an appropriate receptacle, then wash and dry hands thoroughly. Apply gloves, use no-touch technique by using sterile applicators to remove ointments and creams from containers, pour liquid solutions directly on gauze sponges on their papers, we exam gloves for holding gauze to catch irrigation solutions poured directly over the wound, wear sterile gloves when physically touching the wound or holding a moist surface over the wound. Place one gauze to cover all broken skin, wash tissue around the wound that is usually covered by the dressing, tape or gauze with antiseptic or soap and water. Remove the dry gauze then apply treatments as indicated, dress the wound, mark tape with initials, time and date. Discard disposable items into the designated container and all linens/clothing into the laundry container, remove disposable gloves and discard into trash. Wipe reusable items with alcohol as indicated and return to cart, take only the disposable items that will be needed for the treatment into the room because disposable items cannot be returned to the cart. Wash and dry hands thoroughly. 2. Record review revealed Resident #46 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, congestive heart failure, and major depression. Review of a care plan dated 09/28/24 revealed Resident #46 was at risk for pain related to depression and weakness. Interventions included, but were not limited to, administering pain medications as ordered and monitor for side effects of medication including constipation. Review of orders revealed Resident #46 had orders dated 10/01/24 in place for rectal enema insert one dose rectally every 24 hours as needed for constipation and milk of magnesia suspension 400 milligrams per five milliliters (ml), give 30 ml by mouth every 24 hours as needed for constipation at bedtime if no bowel movement in three days, active bowel sounds heard in all four quadrants, abdomen soft, non-distended, and non-tender. Review of orders revealed Resident #46 had an order dated 12/12/24 in place for enulose (laxative) solution 10 grams/15 milliliters (ml) give 30 ml by mouth one time a day for constipation. Review of an MDS assessment completed on 12/17/24 revealed Resident #46's cognition remained intact, she had no behaviors, and was always continent of bowel. Review of the medication administration record for February 2025 revealed Resident #46 did not receive as needed milk of magnesia or an enema on 02/27/25 or 02/28/25. Review of bowel continence documentation for 30 days revealed Resident #46 did not have a bowel movement on 02/27/25 or 02/28/25, and was not documented on 03/01/25 through 03/02/25. Review of the medication administration record (MAR) for March 2025 revealed Resident #46 refused a dose of enulose on 03/02/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of bowel continence documentation for March 2025 revealed Resident #46 did not have a bowel movement on 03/03/25 through 03/04/25. Review of a nursing note dated 03/04/25 at 10:28 A.M. by LPN #203 revealed Resident #46 did not have a bowel movement in 72 hours and milk of magnesia was given per orders. There was no follow up indicating if administration of milk of magnesia was effective. Review of the MAR for March 2025 revealed Resident #46 received a dose of as needed milk of magnesia on 03/04/25. The administration was marked as ineffective. Additionally, on 03/04/25, Resident #46 refused a dose of enulose. Review of bowel continence documentation for Resident #46 revealed she did not have a bowel movement from 03/05/25-03/06/25. Review of the MAR for March 2025 revealed Resident #46 refused a dose of enulose on 03/06/25. Review of the MAR for March 2025 revealed Resident #46 received a dose of milk of magnesia on 03/07/25. There was no indication if the administration was effective. No additional administrations of milk of magnesia were documented in the medical record. Review of bowel continence documentation for March 2025 revealed Resident #46 did not have a bowel movement from 03/07/25-03/09/25. Review of the MAR for March 2025 revealed Resident #46 refused a dose of enulose on 03/09/25. Review of the MAR for March 2025 revealed Resident #46 did not receive an as needed enema. Interview on 03/10/25 at 12:10 P.M. with RN #317 revealed he had just recently started at the facility, but typically the bowel protocol for a nursing facility would start after three days of no bowel movement, then administer milk of magnesia, if that does not work follow up with a suppository. Interview on 03/10/25 at 12:11 P.M. with Certified Nursing Assistant (CNA) #257 revealed Resident #46 had not had a bowel movement since at least 03/04/25 but she does not have bowel movements very often. CNA #257 stated if she has not been able to use the restroom, she will ask for medicine to help. CNA #257 stated if someone is not going to bathroom, she is to report it to the nurse. Interview on 03/10/25 at 12:13 P.M. with NP #505 revealed Resident #46 may have had a bowel movement, but staff did not document it. NP #505 stated if not, she would like schedule a stool softener for her. Interview on 03/10/25 at 12:16 P.M. with Resident #46 revealed she had a very small bowel movement on 03/08/25 and she was headed to the bathroom to try. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/10/25 at 12:17 P.M. with the DON revealed bowel protocol is if a resident has not had a movement in 72 hours, administer milk of magnesia and if it's not effective within eight hours, give a suppository. If the suppository is not effective, an enema should be given. The DON stated bowel protocol should have been started if a resident had not been documented as having a bowel movement in nine days. The DON stated a staff member should have gone to talk to Resident #46 to ask if she had a bowel movement and entered a note if nothing was documented after that long. Review of an undated policy titled Bowel Management Protocol revealed it is the policy of the facility to ensure residents are free from complications secondary to constipation which would be accomplished through adequate assessment, tracking and treatment as indicated. A normal bowel pattern is once every day up to three times per day. Residents with constipation should have stool softeners administered per orders, encourage activity as tolerated, encourage fluid intakes as tolerated including prune juice, aides are to document bowel movements each shift, nurses should review the flow record daily and compose a list of resident who did not have a bowel movement in three days, medications should be given as ordered or obtained and documented on the MAR. Medications could consist of milk of magnesia, biscodyl, and an enema. The nurse is to follow up on those residents on the bowel care list for results. The nurse should document the results on the bowel care list and on the MAR. 50538 3. Review of Resident #8's medical record revealed an admitted [DATE], a reentry date of 03/18/23 and diagnoses including moderate protein-calorie malnutrition, chronic venous hypertension, non-pressure chronic ulcer of the left lower leg, rheumatoid arthritis, chronic venous hypertension, anemia, pain in spine, anxiety, and hypertension. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #8 had Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. Further review of the MDS revealed Resident #8 required supervision or touching assistance with her activities of daily living except for personal hygiene where she required partial assistance and putting on footwear where she required substantial assistance and indicated that Resident #8 had one venous ulcer. Further review of Resident #8's medical record revealed an order to cleanse the venous wound to the left lower leg with normal saline and pat dry, apply adaptic with melgisorb (a brand of alginate wound dressing designed for managing moderately to heavy exudating wounds), cover with abdominal gauze pad and apply [NAME] boot and secure with coban once per week on Thursday. Review of Resident #8's treatment administration record (TAR) for February 2025 revealed the treatment was documented as completed on the 02/06/25, 02/13/25, 02/20/25 but was not documented as completed on 02/27/25. Review of the progress notes revealed no mention of the Resident's left lower leg dressing from 02/27/25 through 03/05/25. Review of Resident #8's care plan revealed the facility was to check the dressing every shift for placement and to monitor the wound for signs and symptoms of infection including a change in drainage. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation made on 03/05/25 at 2:33 P.M. revealed a dressing on Resident #8's left lower extremity with a wad of gauze covering an area on the dressing and held in place by medical netting. Resident #8 indicated that drainage was coming through the dressing in that area. Dark areas were noted on the outer covering of the dressing, the coban wrap that secured the dressing, where drainage had come through above and below the wad of gauze. Resident #8 indicated the dressing was not changed on the 27 th as she was unable to go to the wound center because of illness. In an interview on 03/05/25 at 3:03 P.M. the Director of Nursing (DON) verified Resident #8's dressing was not changed on 02/27/25 and that a of gauze was covering an area on the dressing and held in place by medical netting. The DON verified that dark areas were noted on the outer covering of the dressing, the coban wrap that secured the dressing, where drainage had come through above and below the gauze. The DON confirmed the dressing should have been changed by the facility staff if Resident #8 was unable to attend her appointment at the wound center.

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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** 28923 Based on record review, observation, staff interview, and policy review, the facility failed to ensure a resident with contractures had orthotics applied daily for contracture management, as per their plan of care. This affected one (Resident #35) of four residents reviewed for limited range of motion (ROM). Findings include: Review of Resident #35's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease, dementia, contracture of an unspecified hand, contracture of the left elbow, muscle weakness, and need for assistance with personal care. Review of Resident #35's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had unclear speech. She was rarely/ never understood and was rarely/ never able to understand others. She had short and long term memory impairment and her cognitive skills for daily decision making was severely impaired. She was not known to have any behaviors and was not known to reject care during the seven days of the assessment period. The resident had a functional limitation in ROM in one side of her upper extremities. The resident was totally dependent on two for transfers and was dependent on staff for personal hygiene. Review of Resident #35's active care plans revealed the resident had a care plan in place for an Activities of Daily Living (ADL's) self care deficit related to activity intolerance, dementia, impaired balance, limited mobility, weakness, and need for assistance with personal care. The goal was for the resident to maintain her current functional functional status related to ADL's. The interventions included the need to wear a left hand/ wrist orthotic for up to four hours twice daily as tolerated. The intervention was initiated on 09/20/24. Review of an Occupational Therapy Discharge Summary for a date of service between 08/28/24- 09/20/24 revealed occupation therapy was working with Resident #35 for contracture management. She met her goal with tolerating the wearing of a resting hand splint to the left hand for up to four hours consistently. Recommendations at the time of discharge included recommending restorative nursing program to continue with left hand/ wrist orthotic and passive range of motion (PROM) bilaterally to the upper extremities for contracture management. They recommended the resident to wear the left hand/ wrist orthotic for up to four hours twice daily as tolerated for contracture management. Review of Resident #35's physician's orders revealed the resident did not have an active order in place for the use of any orthotics/ splints to her left hand/ wrist for contracture management. Review of Resident #35's treatment administration record (TAR) for March 2025 revealed the nursing staff were not signing off the use of any orthotics/ splints to the resident's left hand/ wrist as part of contracture management. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #35's medical record revealed there was no documentation under the task tab to show any evidence orthotics/ splinting was applied to the resident's left hand/ wrist as part of contracture management. On 03/03/25 at 9:29 A.M., observations of Resident #35 noted her to be lying in bed in a supine position. She had her bilateral hands in a clenched fist and was not noted to have any orthotics/ splints in place to her left hand/ wrist. On 03/04/25 at 3:00 P.M., ongoing observations of Resident #35 noted her to remain in bed with no evidence of an orthotic/ splint being applied to her left hand/ wrist. An orthotic/ splint was not found out in the open in the resident's room. On 03/04/25 at 3:04 P.M., an interview with LPN #244 revealed she was not aware of Resident #35 having any contractures that she was aware of. She was also not aware of the resident having any use of orthotics or splints for contracture prevention. She was asked if the resident had an orthotic/ splint in her room that was being used for contracture management. She accompanied the surveyor back to the resident's room to look for an orthotic. She was able to locate the left hand/ wrist orthotic in the top drawer of one of the resident's dressers. The hand/ wrist orthotic was found towards the back of the drawer. The nurse denied that she had ever seen the orthotic on the resident, while she had been working. She checked the resident's orders and confirmed the use of the orthotic was not included on her orders. She stated, without it being in her physician's orders, it would not be on the TAR for them to sign off on. On 03/04/25 at 4:05 P.M., an interview with Certified Nursing Assistant (CNA) #269 revealed Resident #269 had something going on with one of her hands. She thought it was the right hand, when it was actually the left. She reported the resident was able to open her hand with assist, but liked to keep it clenched. She was asked to accompany the surveyor to the resident's room and she verified the resident did have a contracture to her left hand. She assisted the resident with opening her hand and reported it was no worse than it had been. She denied she was aware the resident was to wear an orthotic on her left hand for up to four hours twice a day. She was not aware the orthotic was being kept in the top drawer of her dresser. On 03/04/25 at 4:20 P.M., an interview with RN #207 was conducted to inform her Resident #35's care plans had her using a left hand/ wrist orthotic. She was informed the nursing staff were not aware the resident was supposed to be wearing it for up to four hours twice a day as tolerated. She was further informed the orthotic had not been observed to be in place and was found in the back of the top drawer of her dresser. She was told the aide attempted to put it on the resident's left hand when it was brought to their attention and had difficulty applying the orthotic. She stated she would have occupational therapy (OT) evaluate the resident to see if there was a different orthotic that could be used or if the current orthotic should be continued. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/06/25 at 1:58 P.M., an interview with the Director of Nursing (DON) revealed they did not have a restorative aide per say, but if therapy made a referral for restorative nursing then the aides on the floor would be educated on the program to carry that out. Any restorative programs that were being provided would be documented under the task tab of the EMR. She confirmed the resident's OT Discharge Summary referred the resident to restorative nursing for PROM of her bilateral upper extremities and for a left hand/ wrist orthotic to be used for contracture management. She confirmed they did not have any documentation to support the restorative nursing program recommended by OT was being followed through with. Review of the facility's policy on Resident Mobility and Range of Motion revised July 2017 revealed residents would not experience an avoidable reduction in ROM and residents with limited ROM would receive treatment and services to prevent a further decrease in ROM. Care plans should include specific interventions, exercises, and therapies to maintain, prevent avoidable decline in, and/ or improve mobility and ROM.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, observation, review of a facility investigation, review of an employee personnel file, staff interview, and policy review, the facility failed to ensure a resident's fall prevention interventions were implemented as per plan of care. They also failed to ensure another resident's medication that was mixed and attempted to be administered in a snack was taken by the resident it was intended for and not left unattended, which resulted in the medication being partially ingested by the resident's visiting family member. This affected two (Resident #23 and #42) of seven residents reviewed for accidents. Findings include: 1. Review of Resident#23's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included weakness, need for assistance with personal care, and a history of falls. Review of Resident #23's progress notes revealed a nurse's note dated 12/09/24 at 6:50 A.M. that indicated the nurse was called to the resident's room due to the resident sliding out of his wheelchair and onto the floor. The resident was attempting to stand and his feet slid on his blanket causing him to land on his buttocks onto the floor. No injuries were noted as a result of the fall. The resident was educated to use his call light when needing assistance and Dycem (a non-slip pad) was to be added to his wheelchair. Review of Resident #23's active care plans revealed the resident had a care plan in place for being at risk for falls related to a history of falls, impaired balance, impaired mobility, noncompliance with mobility aide use and fall prevention devices. The care plan was initiated on 02/07/24 and last revised on 10/05/24. The goal was to maintain safety and reduce fall occurrences and possibility of injury through staff intervention. The interventions included the use of anti-tippers to the back of his wheelchair, non-slip footwear, and to reinforce the need to call for assistance. The care plan did not include the use of Dycem to the seat of his wheelchair as part of the resident's fall prevention interventions. Review of Resident #23's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. No behaviors or rejection of care was noted. He had a functional limitation in range of motion (ROM) of his bilateral upper and lower extremities. A wheelchair was listed as a mobility device used. He was dependent on staff for toileting and bed to chair/ chair to bed transfers. He was not identified as having had any falls since his prior assessment. Review of Resident #23's physician's orders revealed they did not include any of the resident's fall prevention interventions that was included in his care plans. Dycem was not included in his orders and did not show on the treatment administration record to allow the staff to document it being used as one of the resident's fall prevention interventions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/10/25 at 12:22 P.M., Certified Nursing Assistant (CNA) #325 was asked to assist the surveyor in determining if Resident #23 had all his fall prevention interventions in place as per his plan of care. Resident #23 was observed to be sitting in his room in his wheelchair. She identified the resident as required the assist of two for transfers and the use of a mechanical lift. She stated she would have to go get help from another staff member. Activity Director #204 was the staff member she summoned to help her. Resident #23 was raised up over his wheelchair seat to allow the staff to check for the presence of Dycem to the seat of his wheelchair. They did not find any Dycem under the resident on top of the cushion or below the cushion he was sitting on. Findings were verified by the two staff members and the Director of Nursing (DON) that the resident did not have Dycem in place under the resident when up in his wheelchair as per his plan of care. Review of the facility's fall policy revised March 2018 revealed staff and the physician would identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. Staff would try various relevant interventions , based on the assessment of the nature or category of falling, until falling reduces or stops. If interventions had been successful in fall prevention, the staff would continue with current approaches. 2. Review of Resident #42's medical record revealed the resident was admitted to the facility on [DATE]. He resided on the facility's memory care unit. His diagnoses included Alzheimer's disease, unspecified dementia, schizo-affective disorder, intermittent explosive disorder, noncompliance with medication regimen, and wandering in disease classified elsewhere. Review of a facility investigation file revealed an investigation was completed on 02/20/25 regarding Resident #42 and medications that were attempted to be given to the resident in a cookie. Included in the investigation file were written statements obtained from two staff members and a written statement from the facility's Director of Nursing (DON). Also included was a copy of Resident #42's medication administration record (MAR's) for February 2025. Review of a written statement from LPN #400 dated 02/20/25 revealed she was preparing Resident #42's medication and under the recommendation of the resident's family she placed the medication in a cookie. Resident #42 did not want to eat the cookie that the medication had been put in. The nurse reported she was watching the resident the whole time and CNA #270 was also sitting next to the resident. CNA #270 asked the nurse a question and, as the nurse looked away, the resident's daughter picked the cookie up and started screaming at the nurse. She asked the nurse her name and went to the DON's office. Review of a written statement from CNA #270 dated 02/20/25 revealed LPN #400 had her get a snack for Resident #42 so she could put his medication in it. The nurse crushed up the pills and put them in the middle of a Fudge Round. Resident #42 had refused the Fudge Round and then the resident's daughter walked in as the aide went to assist another resident. LPN #400 then came and got her and told the aide to tell the resident's daughter she could not share the Fudge Round with another resident because it had Resident #42's medication in it. The resident's daughter became upset and asked for the nurse. The daughter then proceeded to yell at the nurse for leaving the Fudge Round unattended, as she claimed she had ate the Fudge Round to encourage Resident #42 to eat it. The daughter told the nurse that she was going to report her. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a written statement from the facility's DON dated 02/20/25 revealed Resident #42's daughter approached the desk and was yelling about medication. The DON took her to her office to discuss her concern. The daughter reported LPN #400 put Resident #42's medication in a Fudge Round and walked away from it and the resident. The daughter reported she took a bite of the Fudge Round and tasted the medicine. The DON pulled up the medication list and verified the Resident #42's morning medications were signed off by LPN #400. The medications included Aspirin, Aldactone (a diuretic) Depakote (a mood stabilizer) and Seroquel (an antipsychotic). Review of Resident #42's MAR for February 2025 revealed the morning medications administered to the resident on 02/20/25 included Aspirin 81 mg, Aldactone 12.5 milligrams (mg), Depakote Sprinkles 125 mg, Metoprolol 12.5 mg, and Seroquel 100 mg. LPN #400 signed off the MAR to reflect all medications had been given to the resident. On 03/10/25 at 1:00 P.M., an interview with Certified Nursing Assistant (CNA) #258 revealed she had not seen any nurses administer medications to residents by adding the medication to a cookie. She has heard that a nurse had put a resident's medication in a cookie that was eaten by the resident's family member. She was not sure who the resident or family member was that that happened to. On 03/10/25 at 1:15 P.M., an interview with the facility's DON confirmed she did complete an investigation that pertained to a resident's medication being put in a cookie that was consumed by the resident's family member. She verified Resident #42 was the resident involved and LPN #400 was the nurse that was administering the medication to the resident. She reported LPN #400 was terminated as a result of that incident and was no longer employed by the facility. Review of the employee personnel file for LPN #400 revealed she was terminated from her employment at the facility on 02/20/25. The reason for her termination included violations of company policy and safety rules. Review of the facility's policy on Administering Medications revised April 2019 revealed medications were to be administered in a safe and timely manner, and as prescribed. The DON supervised and directed all personnel who administered medications. The policy did not provide any directive to remain with the resident until the medication was taken or the need to dispose of the medication at the time it was refused. This deficiency represents non-compliance investigated under Master Complaint Number OH00163355.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, national institute of health review and interview, the facility failed to provide ordered care and services for an indwelling urinary catheter. This affected one resident (#7) of four reviewed for Urinary Catheter or UTI (Urinary Tract Infection). The facility identified seven residents with the use of an urinary catheter. The census was 57. Findings include: Medical record review revealed Resident #7 was admitted on [DATE] with diagnoses including diabetes mellitus, neuromuscular disorder of bladder, acute kidney failure, urinary retention unspecified, history of UTI, pyelonephritis (kidney infection), bacteremia and neurogenic bladder. Review of the Urology Note dated 04/22/24 revealed Resident #7 was seen related to a UTI with an indwelling catheter. The resident had recurrent UTI's and the urologist's plan was to continue methenamine (antibiotic long term use to prevent infection) and vaginal estrogen per infectious disease recommendations, and change the indwelling urinary catheter every four weeks and as needed. Review of the electronic Physician Orders revealed Estradiol 0.1 milligram (mg)/gram cream was ordered on 04/17/24. The order was discontinued on 05/24/24. Review of the Urology Note dated 10/22/24 revealed to continue methenamine, vaginal estrogen and orders provided to change catheter every four weeks and as needed. Review of the care plan: Alteration in Elimination: Indwelling Catheter related to functional incontinence and neurogenic bladder revised 11/09/24 revealed interventions including to change the catheter every four weeks and PRN (as needed). Review of the quarterly Minimum Data Set assessment dated [DATE] revealed the resident had an indwelling urinary catheter and had no UTI in the last 30 days. Review of the electronic Medication Administration Record dated October 2024 through March 2025 revealed no evidence vaginal estrogen had been ordered as recommended by the resident's urologist. Review of the medical record including Treatment Administration Records and Nurse's Notes revealed Resident #7's indwelling catheter was changed on 10/22/24, 10/29/24, 01/27/25 and 02/09/25. There was no evidence the resident's indwelling catheter was changed during November or December 2024. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #7 was moderately impaired for daily decision-making and had an indwelling urinary catheter. On 03/03/25 at 2:04 P.M., observation revealed Resident #7 was in bed and an indwelling urinary catheter was observed draining yellow urine with thick sediment in the catheter tubing. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/04/25 at 11:38 A.M., observation revealed Resident #7 was in the dining room eating lunch and an indwelling catheter bag with think yellow sediment was observed in the catheter tubing. On 03/10/25 at 9:35 A.M., interview with the Director of Nursing (DON) stated indwelling catheters were changed per physician orders. On 03/10/25 at 1:41 P.M., interview with Registered Nurse #207 stated Resident #7's primary physician discontinued Estradiol Vaginal cream 0.1 mg/gm twice a week in May 2024. On 03/10/25 at 1:50 P.M., interview with the DON verified the primary care physician discontinued the vaginal estradiol from the urologist and there was no supporting information as to why. The DON verified there was no evidence Resident #7 had the indwelling catheter changed in November 2024 and will address with the resident's physician if he wants to follow the urology and infectious disease recommendations. The DON also verified urology had seen the resident again since the primary care physician had discontinued the estrogen and the urologist stated to continue the vaginal estrogen per infectious disease recommendation. Review of the NIH: National Library of Medicine dated 2020 revealed vaginal estrogen therapy is safe and extremely efficacious in lowering the risk of UTI's. It can be used safely in most women, even in those already on systemic hormone replacement therapy.

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Legacy Marietta	5001 State Route 60 Marietta, OH 45750

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51519 Based on record review, staff interview, observation, and policy review the facility failed to provide care and services to maintain acceptable parameters of nutritional status by monitoring resident meal intakes and failed to ensure residents who experienced weight loss were properly monitored and changes were reported to the physician. This affected two (Resident #45 and Residents #25) of five residents reviewed for nutritional status. The census was 57. Findings include: 1. Record review revealed Resident #45 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation, dementia with behavioral disturbances, chronic obstructive pulmonary disease (COPD), difficulty walking, pressure ulcer of the right buttock, need for assistance with personal care, and persistent mood disorder. Review of the Minimum Data Set (MDS) section C completed 02/06/25 revealed a brief interview for mental status (BIMS) score of 06 indicating cognitive impairment. Review of the MDS section D: the resident had no poor appetite. Section K of the MDS revealed a weight loss of 5% or more in the last month or loss of 10% or more in the last six months without a prescribed weight-loss regimen. Record review revealed a weight of 266.0 pounds (lbs) upon admission on 08/09/24, and the most recent weight on 01/28/25 revealed a weight of 227.5 lbs, a 14.47% weight loss in five months. Review of the care plan completed 01/25/25 revealed the resident was at risk of nutritional decline due to significant weight loss, goal for resident to receive and tolerate diet as ordered and consume adequately to maintain weight with no significant changes. Interventions and tasks included to alert Registered Dietician (RD) if consumption is poor for more than 72 hours. Provide diet per RD and physician recommendation. Encourage adequate oral (po) intake. Monitor and record resident's intake of food/fluids after each meal. Offer and provide appropriate meal substitutions or dietary supplement when the resident consumes less than 50% of a meal or when the resident refused a meal Review of the meal intake revealed no intakes were documented for 02/09/25, 02/23/25, 02/28/25, and 03/01/25. Record review revealed the resident was offered a supplement on 02/07/25 and 02/08/25. A supplement was not offered any other days in February of 2025. Interview with the DON on 03/06/25 at 1:05 P.M. confirmed there were no intakes recorded on 02/09/25, 02/23/25, 02/28/25, 03/01/25 or supplements documented as given or offered for those days. She confirmed Resident #45 was not out of the facility on the days listed. 47985 2. Record review revealed Resident #25 admitted to the facility on [DATE] with diagnoses including morbid obesity, type II diabetes, and dementia. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician orders revealed Resident #25 had an order in place dated 02/26/24 for a consistent carbohydrate diet with no added salt and regular texture. The resident was not ordered a diuretic. Review of weights revealed Resident #25 weighed 346 pounds on 09/06/24. Review of a care plan revised on 09/16/24 revealed Resident #25 was at potential risk for nutritional decline related to need for a therapeutic diet, advanced age, and medical diagnoses of type II diabetes, dementia, hypertension, hyperlipidemia, sleep apnea, hypothyroidism, coronary artery disease, kidney cancer, anxiety, and depression. Resident #25's goal was to receive and tolerate diet as ordered and consume with no significant weight changes. Interventions included monitor and evaluate for significant weight loss and notify physician, monitor intakes of meals, and offer an evening snack. Review of weight from 10/17/24 revealed Resident #25 weighed 311.4 pounds. Review of a provider note dated 11/20/24 by Nurse Practitioner (NP) #505 revealed Resident #25's appetite was adequate and weights were stable. Review of a nutrition note dated 11/25/24 by Dietician #501 revealed Resident #25 weighed 310.2 pounds and had a 35.8 pound weight loss in two and a half months. Gradual weight loss may be beneficial. No new interventions were implemented. Review of weight dated 12/11/24 revealed Resident #25 weighed 306.6 pounds. Review of a Nutrition assessment dated [DATE] revealed Resident #25 had a 10% weight loss in the past 180 days an he was not on a prescribed weight loss regimen. Review of an MDS assessment completed on 12/16/24 revealed Resident #25 had moderately impaired cognition, had no behaviors, and had a weight loss of 5% or more in the last month or loss of 10% or more in the last six months. Review of weight dated 01/08/25 revealed Resident #25 weighed 299.4 pounds. Review of a nutrition note dated 01/10/25 by dietician #501 revealed Resident #25 had an 11.4% weight loss in three months and the goal was for weight maintenance. A diuretic was in place. No new recommendations. Review of a nutrition note dated 02/10/25 by Dietician #501 revealed Resident #25 had a significant weight loss of 13.4% over six months, but his weight was stable and the goal was for weight maintenance. Diuretic was in place and no new interventions. Review of a physician note dated 02/12/25 by Medical Director (MD) #600 revealed Resident #25's appetite was adequate and his weights were stable. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Nutritional Risk assessment dated [DATE] revealed the assessment was completed for a significant change due to a 13.9% weight loss in six months. During the review period, Resident #25 had teeth extracted and COVID. The goal was for weight maintenance but a gradual weight loss over time would be appropriate due to high body mass index. Excellent intakes were noted and diuretic therapy in place. No new interventions in place. Review of meal intakes from 02/04/25 through 03/05/25 revealed Resident #25's meal intakes ranged from 51-100%. Review of weights revealed Resident #25 weighed 297.8 pounds on 02/06/25. Interview on 03/04/25 at 8:33 A.M. with Resident #25 revealed he is losing weight due to the food served at the facility because when he was at home he ate junk food and whatever he wanted, but here he gets good meals. Resident #25 stated he would like to lose weight. Interview on 03/05/25 at 10:43 A.M. with LPN #244 revealed Resident #25 had lost a lot of weight and did not appear to be getting anything medication wise which would cause a weight loss. LPN #244 stated Resident #25 was eating well so maybe some labs needed to be done to make sure something else was not going on. Interview on 03/06/25 at 10:20 A.M. with Dietician #501 revealed she had been aware of resident having a significant weight loss from 09/2024 to 10/2024 and questioned if the weight was accurate, but then he continued to lose weight. Dietician #501 stated she did not realize Resident #25 was not on a diuretic, but had attributed his rapid weight loss to diuretic therapy. Additionally, Dietician #501 stated Resident #25 had teeth extracted in 09/2024 and she should have ordered a shake. Dietician stated she missed his teeth extractions despite completing an assessment on him that day. Interview on 03/06/25 at 11:49 A.M. with NP #505 revealed Resident #25 did have a very quick weight loss and he does not take a diuretic. NP #505 stated Resident #25 had been up and getting more exercise and would like to continue losing weight. Interview on 03/10/25 at 8:04 A.M. with DON confirmed the dietician was documenting a diuretic, but Resident #25 had not had a diuretic since June 2024 and there was no documentation of physician notification of weight loss.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on interview, observation, policy review, and record review the facility failed to timely identify, treat, monitor, and manage Resident #6 pain, and provide appropriate pain interventions during care to Resident #7. This affected two (Resident #6 and Resident #7) of four residents reviewed for pain management. The census was 57. Findings include: 1. Medical record review revealed Resident #7 was admitted on [DATE] with diagnoses including diabetes mellitus, stage III pressure ulcer (full thickness tissue loss without bone, tendon or muscle exposed) and chronic pain. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #7 was moderately impaired for daily decision-making, had one Stage III pressure ulcer, received scheduled pain medications and complained of occasional pain rated a four out of 10. Observation of Resident #7 revealed the following: On 03/03/25 at 2:17 P.M., interview with Resident #7 revealed leg pain rated an eight out of 10 from where a cup of coffee spilled on her. Resident #7 denied pain to her buttock and coccyx at the time of the interview. On 03/04/25 at 10:15 A.M. and 3:00 P.M., Resident #7 was observed up in a specialized wheelchair with a pressure relief cushion. Resident #7 had no verbal or non-verbal signs of pain. On 03/04/25 at 4:15 P.M., Resident #7 was observed laying in bed on her back with an alternating pressure relief mattress. Resident #7 complained of pain rated an eight out of 10. The resident stated she had some relief when she raised up (off the mattress) and stated she had received some Tylenol. The Director of Nursing (DON) asked the resident if she would like a pain pill and she stated ok. The resident was observed to have some facial grimacing during the observation. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/04/25 at 4:25 P.M., Licensed Practical Nurse (LPN) #203 stated Resident #7 had been given something for pain and she was getting ready to complete Resident #7's pressure ulcer dressing change prior to starting the rest of her medication pass. Between 4:30 P.M. and 4:45 P.M., observation of the treatment revealed LPN #203 and Certified Nurse Aide (CNA) #257 rolled the resident onto her left side and the resident yelled out in pain complaining of leg pain. The resident was observed to have facial grimacing and was crying. CNA #257 informed the resident she was incontinent of bowel and had to be cleaned up prior to changing the wound dressing. Resident #7 continued to grimace and yell out asking when it would be over as CNA #257 completed bowel incontinence care. LPN #203 was preparing the wound supplies during this time and did not offer any pain relief interventions. The resident was then rolled onto her right side and was observed to yell out in pain stating my leg, my leg with no pain relief interventions attempted. LPN #203 cleansed the wound, applied the ordered treatment and assisted CNA #257 to position Resident #7 in bed on her back. After the above observation, interview with LPN #203 verified the resident had verbal and non-verbal complaints of pain, she did not stop to assess or implement pain relief interventions because she thought she had to complete the treatment at that time. Review of the electronic Medication Administration Record dated 03/04/25 revealed Resident #7 received aspercreme lidocaine patch 4% to the left hip at 7:56 A.M.; scheduled Tylenol 650 milligrams (mg) between 7:00 A.M. and 1:00 P.M. for pain rated an eight out of 10; Tylenol 650 (mg) once in the afternoon (no time documented) for pain rated a seven out of 10; Diclofenac sodium gel 1% at 2:43 P.M. and 4:57 P.M. to both knees; and one PRN (as needed) tablet of Norco 5/325 (mg) for pain rated an eight out of 10 at 4:57 P.M. Review of the Norco (opioid) 5-325 mg (C-II) Controlled Drug Record revealed Resident #7 received one Norco tablets at 5:01 P.M. on 03/04/25. Review of the care plan: Risk for Pain/Discomfort revised 01/25/24 revealed goals including the resident would display a decrease in behaviors of inadequate pain control as evidence by no irritability, agitation, restlessness, grimacing, perspiring, hyperventilation, groaning or crying through the review date of 04/20/25. Interventions included to acknowledge the presence of pain and discomfort, listen to resident's concerns, administer pain medication per physician order, assess for pain, if experiencing pain rate pain per faces pain scale, and encourage non-medicinal interventions to control pain and decrease use of analgesic therapy: repositioning, stretching, exercise, relaxation techniques to assist with pain control. 51519 2. Record review revealed Resident #6 was admitted to the facility on [DATE] with diagnoses including unspecified cerebral infarction, hemiplegia and hemiparesis, lupus, generalized anxiety, and depression. Review of Resident #6's Minimum Data Set (MDS) completed 12/12/24 revealed a brief interview for mental status score of 14 which indicated intact cognition. Further review revealed the resident needed extensive assistance with moving, turning and positioning one person physical assist. The resident was totally dependent on transfers including to or from bed, chair, wheelchair, and standing position needing a two plus person assist. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record reviews of the medication administration record (MAR) and treatment administration record (TAR) revealed a pain rating of 3 out of 10 on a 0-10 pain rating scale (zero meaning no pain and 10 meaning the worst pain the resident has felt) on 02/02/25, a pain rating of 2/10 on 02/15/25, and 6/10 on 02/21/25. All other pain ratings for the month of February were 0/10 up until 02/25/25 Review of Resident #6 MAR revealed Tylenol 325 milligrams (mg) given on 02/25/25 at 8:33 A.M. by Licensed Practical Nurse (LPN) #203 for a pain rating of 10/10. Further review of the medical record revealed no additional documentation regarding the resident's pain such as intensity, location or any type of pain assessment for 02/25/25. Record review revealed a progress note on 03/01/25 at 11:11 P.M. by Registered Nurse (RN) #372 stating During nighttime med pass, patient stated, I got hurt in the Hoyer lift a few days ago and no one has done anything about it! My left shoulder is killing me. Incident with Hoyer lift may have happened 02/23/25 or 02/24/25. Pain rating of 8/10 prior to medication administration. Certified nurse practitioner (CNP) #505 gave verbal order for x-ray of left upper extremity (LUE) (2 view). Staff nurse to assist in placing order for x-ray. Record review revealed an X-ray order placed on 03/01/25 at 11:48 P.M. for Resident #6 to receive a 2-view x-ray of the left shoulder for moderate to severe pain ordered by CNP #500. Review of facility incident log for February 2025 and March 2025 revealed no documentation of an incident with the Hoyer lift for Resident #6. Interview on 03/03/25 at 9:22 A.M. with Resident #6 revealed they had pain in their left arm for a few days, maybe since Tuesday (02/25/25). The resident stated no one had come in to see it, they've had no one come in to x-ray or look at it. Resident #6 stated she is scared because the pain is going up to her neck. Record review revealed a progress note from 3/3/25 at 2:59 P.M. CNP #505 stating Resident #6 reports left shoulder pain present for a few days. She reports difficulty lifting her left arm. Resident #6 reports she has been unable to get out of bed and get therapy services due to pain. CNP #600 ordered X-ray of left shoulder 2 views. Biofreeze to left shoulder BID x 7 days. Tylenol 650mg PO TID for pain. Record review revealed an order placed 03/03/25 Norco Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for pain by Medical Director #600. Record review revealed an order placed 03/04/25 at 9:00 A.M. by CNP #505 for Biofreeze Professional External Gel 5 % (Menthol (Topical Analgesic) Apply to Left Shoulder topically two times a day for pain for seven days. Record review revealed an order placed 03/05/25 at 9:00 P.M. by CNP #505 for Lidocaine External Patch 5 % (Lidocaine) Apply to posterior neck topically apply every night and remove every morning for pain. Review of x-rays completed 03/04/25 revealed no findings for Resident #6. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/05/25 with Certified Nursing Assistant CNA #257 stated she has heard Resident #6 talk about hurting her arm while in the Hoyer. CNA #257 stated she does not believe what hurt her arm was caused by the Hoyer but she is unsure what the pain is caused from. Interview on 03/05/25 at 10:11 A.M. with the director of nursing (DON) revealed Resident #6 told her that thing hurt her but she wasn't sure what that thing was. She confirmed that x-rays were taken on 03/04/25 but were ordered on 03/01/25 at 11:48 P.M. She also verified the resident had a pain rating of a 10 on 02/25/25 and received tylenol. Review of the policy: Pain Assessment and Management revised October 2022 revealed the procedure was to help the staff identify pain in the resident and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. The pain management program is based on a facility wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan and resident's choices related to pain management. Pain management was a multidisciplinary care process that includes the following: assessing the potential for pain recognizing the presence of pain; identifying the characteristics of pain, addressing the underlying causes of the pain; developing and implementing approaches to pain management; identifying and using specific strategies for different levels and sources of pain; monitoring for the effectiveness of interventions and modifying approaches as necessary. Acute pain (or significant worsening of chronic pain) should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained. Procedure in recognizing pain included observe during rest and movement for physiologic and behavioral (non-verbal) signs of pain. Possible Behavioral Signs of Pain include: negative verbalizations and vocalizations such as groaning, crying, screaming; facial expressions such as grimacing, frowning, clenching of the jaw, etc; guarding rubbing or favoring a particular part of the body. Assessment of Pain included to assess the resident during ongoing assessments to help identify the resident who is experiencing pain or for whom pain may be anticipated during specific procedures, care or treatment. Monitor the resident for the presence of pain and the need for further assessment when there is a change of condition. Assess the resident whenever there is a suspicion of new pain or worsening of existing pain. A treatment regimen that is specific to the resident based on the medical condition, current medication regimen, nature, severity and cause of pain, course of illness and treatment goals. Non-pharmacological interventions may be appropriate alone or in in conjunction with medications. Pharmacological interventions may be prescribed to manage pain; however, they do not usually address the cause of pain and can have adverse effects on the resident. When opioid's are used for pain and can have adverse effects on the resident. Considerations when establishing the medication regimen included to reducing or preventing anticipated adverse consequences of medications (e.g. bowel regimen to preventing constipation related to opioid analgesics).

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, diet guide review, education/in-service review and interview, the facility failed to ensure certified nurse aides (CNAs) had the knowledge to identify mechanically altered food. This affected one resident (#45) of three reviewed for accidents. The census was 57. Findings include: Medical record review revealed Resident #45 was admitted on [DATE] with diagnoses including atrial fibrillation, dementia with behavioral disturbances, hypertension cognitive communication deficit and chronic kidney disease. Review of the electronic Physician Orders dated 03/03/25 revealed Resident #35 was ordered to receive a pureed diet. Review of the Diet Guide Sheet (Day 5) Breakfast for 03/06/25 revealed pureed breakfast meal included pureed buttermilk pancakes, pureed sausage patty, two ounces of brown gravy and oatmeal cereal, four ounces of orange juice, six ounces of coffee or hot tea and eight ounces of milk. On 03/06/25 between 7:52 A.M. and 8:10 A.M., observation revealed Resident #45 was observed eating breakfast in the hallway. His meal tray was observed on an overbed table consisting of ground pancakes, ground sausage with gravy, six ounce hot cream of rice cereal, four ounces of nectar thickened orange juice and nectar thickened cranberry juice. The resident was observed eating the ground pancake and ground sausage at a fast rate without alternating liquids. The pancake and sausage was observed to be the consistency of cooked oatmeal. The resident ate 100% of the meal and coughed twice during the meal. At the time of the observation, interview with Certified Nurse Aide (CNA) #257 stated he was disruptive to other residents and ate in the hallway so staff could monitor him. CNA #257 stated she delivered Resident #45 his breakfast tray and verified the food was the consistency of oatmeal when served. CNA #257 verified the food was not a smooth pudding consistency and asked the surveyor how would you puree pancakes and sausage. CNA #257 asked the surveyor to explain what pureed food consistency should look like and verified the meal served was not a smooth, pudding consistency. CNA #257 verified Resident #45 coughed through the meal but stated he had been coughing like that that for a couple days. Review of the Education/In-Service Attendance Record dated 02/05/25 revealed CNA #257 was educated on diets.

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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** 50538 Based on record review and interview the facility failed ensure assess/monitor Resident #40 for side effects and behaviors to prevent unnecessary use of psychotropic medications. The facility also failed to ensure Resident #48 did not receive psychotropic medications without an appropriate diagnosis and documentation of necessity. This affected two residents (#40 and #48) of six sampled for unnecessary psychotropic medications. The facility census was 57. Findings include: 1. Review of Resident #40's medical record revealed an admitted [DATE], a re-entry date of 01/08/25 and diagnoses including unspecified psychosis, dementia, delusional disorders, visual hallucinations, panic disorder, essential tremor, anxiety disorder, hypertension and Major depressive disorder. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #40 had Brief Interview for Mental Status (BIMS) score of 10 indicating mildly impaired cognition. Further review of the MDS revealed Resident #40 was independent or required set up for her activities of daily living was continent of her bowel and bladder and had received antipsychotic, antidepressant and anticonvulsant medications in the MDS look back period. Review of Resident #40's medical record revealed the resident was receiving citalopram 20 mg daily and risperdal one (1) mg daily. Further review of Resident #40's medical record revealed no side effect monitoring for psychotropic medications or behavior monitoring in the orders or on the medication administration record. Review of the tasks assigned to the Certified Nursing Assistants revealed no entries in the behavior charting task for the past 30 days. Review of Resident #40's care plan revealed no care plans for side effect monitoring for psychotropic medications or behavior monitoring for the resident. In an interview on 03/05/25 at 10:08 A.M. the Director of Nursing (DON) verified there was no side effect monitoring for psychotropic medications or behavior monitoring for the resident. 2. Review of Resident #48's medical record revealed an admitted [DATE] and diagnoses including Alzheimer's disease, dementia in other diseases, osteoarthritis, depression hyperlipidemia, and hypertension. Review of the significant change Minimum Data Set (MDS) dated [DATE] revealed Resident #48 had Brief Interview for Mental Status (BIMS) score of 04 indicating severe cognition impairment. Further review of the MDS revealed Resident #48 had no pain indicated in the lookback period and the use of antipsychotic medication in the lookback period was indicated. Review of Resident #48's medical record revealed an order for olanzapine 10 mg at bed time for a sleep aide. Olanzapine, also known as Zyprexa, is an antipsychotic medication used to treat mental disorders such as schizophrenia and bipolar disorder. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/05/25 at 12:00 P.M. the DON confirmed Resident #48 did not have an appropriate diagnosis for the use of olanzapine.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, dietary meal card review, medical record review, policy review and interview, the facility failed to serve double portions when indicated. This affected one resident (#50) who required double portions during observation of trayline. The facility identified two residents that required double portions. The census was 57. Findings include: Medical record review revealed Resident #50 was admitted on [DATE] with diagnoses including unspecified dementia, aphasia and depression. Review of the diet order dated 10/21/24 revealed the resident receives a regular diet with large portions. Review of the quarterly Nutritional Risk Review dated 01/24/25 revealed continues on regular diet, large portion. Weight on 01/08/25 was 154 pounds, likely meeting estimated nutrient needs with meal and snack intakes as evidence by gradual beneficial/desirable weight gain. Goal for weight maintenance. Review of Resident #50's Meal Card dated 03/05/25 revealed a regular diet with double portions. The resident was to receive two open-faced roast pork sandwiches and four ounces of gravy On 03/05/25 between 10:50 A.M. and 11:42 A.M., observation of the lunch tray line revealed Resident #50's meal card indicated he was to receive double portions including four ounces of brown gravy. [NAME] #300 was observed serving the resident 1/2 cup of carrots, 1/2 cup of mashed potatoes, one piece of pork between two slices of white bread and half of a two ounce ladle (one ounce) brown gravy over the bread and mashed potatoes. Upon completion of serving food portions for Resident #50's meal, the surveyor asked if the resident was to receive double portions. [NAME] #300 stated yes but double portions were only provided for the entree, and the entree today would just be an extra slice of bread, not meat. Regional Dietary #304, who was also present for the meal service, stated a double portion meal ticket should be served two slices of pork with two slices bread. [NAME] #300 stated if she did that, she would not have enough cooked pork patties to serve for other residents. Regional Dietary #304 instructed [NAME] #300 to put another pork patty on the bread in order to meet the double portion order. [NAME] #300 placed a second pork patty on top of the sandwich and covered the pork patty with one ounce of gravy. [NAME] #300 verified double portions of the main entree was not provided per meal ticket for Resident #50. Only two ounces of brown gravy was observed being placed over the food. Review of the policy: Diet and Nutrition Care Manual Altered Portion Sizes dated 2021 revealed suggested portion sizes per serving for double portions included six to eight ounces of meat, two sandwiches, one cup of vegetable, 2 slices of bread, and one cup of potato.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, menu review and interview, the facility failed to provide meals that were palatable and attractive. This affected one resident (#7) of three residents reviewed for food. The census was 57. Findings include: Medical record review revealed Resident #7 was admitted on [DATE] with diagnoses including diabetes mellitus, pressure ulcer, and depression. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed the resident was moderately impaired for daily decision-making. Review of the Diet Guide Sheet (Day 3) for 03/04/25 revealed lunch meal consisted of three Sweet & Sour Meatballs, Sweet & Sour sauce, garlic green beans, steamed rice, mandarin oranges, dinner roll and margarine. On 03/03/25 at 2:08 P.M., interview with Resident #7 stated the food did not taste good especially the meat. On 03/04/25 at 11:45 A.M., observation of Resident #7's lunch meal revealed two of three meatballs were black and burnt on half of the meatball. The burnt portion of the meatballs was peeled away from the meatball and placed on her napkin. The remaining meatball appeared dry and unappealing. The resident was also observed trying to cut a green bean in half with her fork without success. On 03/04/25 at 11:48 A.M., observation revealed Activity Director #204 approached Resident #7 and asked her how her lunch was. Resident #7 stated the meatballs were dry, burnt and she wouldn't give you two-cents for those things. The green beans are rubbery, hard and not seasoned. Resident #7 continued to state she could not cut them in half or chew them. Observation revealed Resident #7 ate approximately 1/4 cup of rice and 1/2 cup of mandarin oranges from the meal tray. Activity Director #204 verified the meatballs were burnt on one side, not sure why they were served to the resident and offered Resident #7 a substitute meal. Resident #7 declined. On 03/04/25 at approximately 12:00 P.M., observation of Resident #7's meal tray with Dietary Manager #300 and Regional Dietary #304 revealed they felt the meatballs were not burnt just dark brown where they had been crisped up in the oven. The resident stated again they were burnt.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, diet guide sheet review, medical record review, policy review and interview, the facility failed to ensure pureed food was the correct consistency. This affected two residents (#35 and #45) of six residents receiving pureed diets. The census was 57. Findings include: 1. Medical record review revealed Resident #35 was admitted on [DATE] with diagnoses including Alzheimer's disease. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #35 was severely impaired for daily decision-making and received a mechanically altered diet. Review of the Physician Orders dated March 2025 revealed Resident #35 was ordered to receive a pureed diet. Review of the Diet Guide Sheet (Day 4) revealed the lunch meal consisted of an open faced roast pork sandwich, brown gravy, mashed potatoes, glazed carrot, mashed potatoes, a dinner roll and lemon cake with lemon icing. Marinated chicken breast with poultry gravy, parsley cauliflower and buttered noodles were also on the menu to be served. On 03/05/25 at 10:52 A.M., interview with Regional Dietary #304 stated no one had requested the marinated chicken or buttered noodles; therefore, this was not prepared or available as an alternative. On 03/05/25 between 10:50 A.M. and 11:40 A.M., observation of lunch trayline revealed [NAME] #300 scooped out chopped bread for Resident #35 who was ordered a pureed diet. [NAME] #300 verified the pureed bread was not the consistency of pureed (not smooth or pudding consistency) and stated it just needed some water added. The chopped bread was the consistency of dry bread dressing. Dietary Manager #400 obtained some water and [NAME] #300 added an unknown amount to the chopped bread and put it on Resident #35's meal plate. [NAME] #300 verified the bread still did not have a smooth consistency. Resident #35 was initially served two ounces of ground pork instead of pureed consistency as ordered. [NAME] #300 was asked if the correct consistency was served and she stated no and prepared a new plate for Resident #35. The bread was still not pureed to a smooth consistency. 2. Medical record review revealed Resident #45 was admitted on [DATE] with diagnoses including atrial fibrillation, dementia with behavioral disturbances, hypertension cognitive communication deficit and chronic kidney disease. Review of the electronic Physician Orders dated 03/03/25 revealed Resident #35 was ordered to receive a pureed diet. Review of the Diet Guide Sheet Day 5 Breakfast for 03/06/25 revealed pureed breakfast meal included pureed buttermilk pancakes, pureed sausage patty, two ounces of brown gravy and oatmeal cereal, four ounces of orange juice, six ounces of coffee or hot tea and 8 ounces of milk. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/06/25 between 7:52 A.M. and 8:10 A.M., observation revealed Resident #45 was observed eating breakfast in the hallway. His meal tray was observed on an overbed table consisting of ground pancakes, ground sausage with gravy, six ounce hot cream of rice cereal, four ounces of nectar thickened orange juice and nectar thickened cranberry juice. The resident was observed eating the ground pancake and ground sausage at a fast rate without alternating liquids. The pancake and sausage was observed to be the consistency of cooked oatmeal. The resident ate 100% of the meal and coughed twice during the meal. At the time of the observation, interview with Certified Nurse Aide (CNA) #257 stated he was disruptive to other residents and ate in the hallway so staff could monitor him. CNA #257 stated she delivered Resident #45 his breakfast tray and verified the food was the consistency of oatmeal when served. CNA #257 verified the food was not a smooth pudding consistency and asked the surveyor how would you puree pancakes and sausage. CNA #257 asked the surveyor to explain what pureed food consistency should look like and verified the meal served was not a smooth, pudding consistency. CNA #257 verified Resident #45 coughed through the meal but stated he had been coughing like that that for a couple days. Review of the Employee Corrective Action dated 03/06/25 revealed [NAME] #300 did not puree the breakfast to the correct consistency on 03/06/25 and was served to residents. Review of the policy: Therapeutic Diets revised October 2022 revealed all residents have a diet order, including regular, therapeutic, and texture modification, that is prescribed by the attending physician, physician extender, or credentialed practitioner in accordance with applicable regulatory guidelines. A Mechanically altered diet means one in which the texture of the diet is altered. When the texture is modified, the type of texture must be specific and part of the physicians' or delegated registered or licensed dietitian's order. Procedures included to prepare diets in accordance with the guidelines in the approved diet manual and the individualized plan of care.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, dietary snack summary review, medical record review and interview, the facility failed to ensure residents received evening snacks. This affected two residents (#3 and #28) of 13 residents ordered an evening/bedtime snack from the dietary department. The census was 57. Findings include: Medical record review revealed Resident #3 was readmitted on [DATE] with diagnoses including diabetes mellitus, mild intellectual disabilities and cerebral infarction. Medical record review revealed Resident #28 was admitted on [DATE] with diagnoses including non-Alzheimer's dementia and anxiety disorder. Review of the dietary department Snack Summary for the week of 03/04/25 revealed Resident #3 was to receive vanilla ice cream at bedtime and Resident #28 was to receive nectar thickened cranberry juice. On 03/05/25 between 6:50 P.M. and 7:07 P.M., observation revealed a cafeteria-style tray was delivered and was sitting on the ledge at the nurses' station. Maintenance Director #243, Activity Director #204, Dietary Manager #500 and Staff #252 reviewed the snacks labeled with the resident's name on it and proceeded to distribute the bedtime snacks that were provided on the snack tray. Resident #3 was observed waving at staff as they passed her room to deliver bedtime snacks to Resident #10. The above staff continued to deliver the bedtime snacks that were on the cafeteria-style tray until all were distributed. Resident #3's vanilla ice cream and Resident #28's nectar thickened cranberry juice were not on the snack tray to be delivered or offered. After the last snack was delivered, the surveyor asked if there were any other snacks from the dietary department to be delivered to residents and Dietary Manager #500 stated 'no' all bedtime snacks had been delivered. Review of the Snack Summary list with Dietary Manager #500 verified Resident #3 and #28's snack was not on the snack tray to be distributed. Dietary Manager #500 verified they did not get their bedtime snack as ordered from the dietary department because he did not put their snack on the snack tray. This deficiency represents non-compliance investigated under Master Complaint Number OH00163355 and Complaint Number OH00162745.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, meal ticket review and interview, the facility failed to provide assistive eating equipment as needed. This affected one resident (#2) of eight residents who ate meals in the dining room. The census was 57. Findings include: Record review revealed Resident #2 was admitted on [DATE] with diagnoses including unspecified dementia, dysphagia, and traumatic brain injury. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #2 was cognitively intact for daily decision making. Review of the electronic Physician Orders dated March 2025 revealed Resident #2 received a regular diet, thin liquids consistency, and a divided plate to increase independence. Review of the Meal Ticket for Resident #2 revealed divided plate and scoop plate was to be used. On 03/05/25 at 11:20 A.M., observation of the lunch tray line revealed [NAME] #300 placed a slice of bread in a scooper bowl and placed a pork patty with gravy and mashed potatoes and carrots all in the same bowl. The meal was placed on the serving cart. Review of the meal ticket revealed Resident #2 was to receive food on a divided plate and a scoop plate. [NAME] #300 verified a divided plate was not used.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, policy review and interview, the facility failed to maintain a clean and sanitary kitchen. This had the potential to affect all 57 residents who were served meals from the kitchen. Findings include: On [DATE] between 8:13 A.M. through 8:35 A.M., observation of the kitchen revealed [NAME] #300 and [NAME] #490 were cleaning up from breakfast. The following observations were made: 1. Observation of the walk-in freezer revealed large icicles from the back coils and laying on the shelf against the back of the freezer. There was no thermometer observed in the walk-in freezer. [NAME] #300 verified the freezer did not have a thermometer in it. [NAME] #300 verified items in the walk-in freezer included an open box of 25 frozen biscuits, a 13.5 pound box of mild pork sausage patties, a ,d+[DATE]-full 13.5 pound box of french toast, a sealed 10 pound box of Salisbury steak, one 48 pack box of vanilla ice cream, one 48 pack box of chocolate ice cream and nine individual magic cup desserts. The ice cream cups were soft when held and when squeezed, the plastic ice cream cup left an indent from the surveyor's finger. The freezer did not feel cold when in the freezer. [NAME] #300 stated the freezer was being worked on and the rest of the frozen food was outside in a rental unit. 2. Observation of the walk-in cooler next to the freezer revealed no thermometers. [NAME] #490 verified there were milk crates sitting on the floor and black debris under the shelving units along the back and two sides of the walk-in where the wall and floor met. [NAME] #490 stated milk cartons had leaked previously and had not cleaned it up yet. 3. Observation of the reach-in cooler revealed a container with ham slices dated shelf [DATE], a Nepro shake (nutritional supplement) Homemade vanilla flavor eight ounce container with an expiration date of [DATE], and two opened 48 ounce containers of applesauce dated [DATE]. Both containers of applesauce had red and black flakes throughout the lower portion of the container. The following items were on a cafeteria-style tray that was not dated and none of the following dishes were dated: three six-ounce dishes of crushed pineapple, two six-ounce containers of fruit cocktail, one two-ounce dish with pineapple chunks, two two-ounce dish with fruit cocktail, a bowl with two hard boiled eggs and three four-ounce containers of sliced pears. On [DATE] at 8:20 A.M., the above observation was verified by [NAME] #490. 4. Observation of the Dry Stock room revealed a 6.5 pound can of sliced apples and a 6.5 pound can of diced tomatoes that were both dented along the seam. On [DATE] at 8:25 A.M., interview with [NAME] #490 verified the dented cans and stated staff were not supposed to accept these; however, they were on the ready-for-use cart. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. On [DATE] at 8:49 A.M., interview with Registered Dietitian (RD) #492 stated she was unaware of any cooler or freezer concerns, expired foods in the reach-in coolers and dry stock concerns. RD #492 stated sounds like I need to spend more time in the kitchen. 6. On [DATE] between 9:45 A.M. and 10:18 A.M., observation of the pureed process revealed the following: [NAME] #300 stated she had to puree roasted pork and glazed carrots for the lunch meal today. [NAME] #300 washed her hands at the sink, obtained six servings of pork from the holding oven, gloved and placed the pork in the food processor. [NAME] #300 was not observed cleaning prep table prior to puree process. [NAME] #300 placed the pork in the food processor, after approximately 30 seconds, [NAME] #300 used a spatula to mix the pork and reprocessed the pork. [NAME] #300 placed the spatula on the prep table without a barrier. Using the same spatula, [NAME] #300 mixed the pork with three tablespoons of broth and two ladles of pork gravy. [NAME] #300 placed the spatula back on the prep table without a barrier. Pork was observed on the prep table from the spatula. [NAME] #300 removed a large piece of fat/gristle from the pureed pork until she obtained a smooth, pudding-like consistency. The pureed pork was then transferred to a metal steamtable pan using the same spatula resting on the prep table. On [DATE] at 10:18 A.M., interview with [NAME] #300 verified the above. 7. On [DATE] at 9:05 A.M. to 9:15 A.M., observation of the only facility ice machine was located in the main dining room with unrestricted access to visitors, residents and staff. Maintenance Director (MD) #243 removed a screw releasing the cover panel. Upon removing the cover panel, a rubber 90 degree angle with black speckled debris on the fitting and the finger clips was observed. There was black debris in the bottom tray and drains with standing water, crumbs and debris was observed on the electrical side of the ice machine. MD #243 stated the facility only had one ice machine. MD #243 verified the above observation and notified the DON who came back to observe the ice machine. Black debris was easily wiped off by the DON using a paper towel and stated she was contacting the contractor who cleaned it last week. MD #243 stated he would get ice to use in coolers/ice chest until the unit could be cleaned. On [DATE] at 9:21 A.M., observed Resident #3 obtain ice from the main dining room. Review of the electronic mail dated [DATE] at 10:41 A.M. revealed a hired contractor stated that on [DATE] 'the icemaker was cleaned and sanitized. All drains and fittings were taken off and sanitized, and ran through sanitation on the dishwasher. A few of the lines look black. They are just stained.' On [DATE] at 10:59 A.M., interview with the Director of Nursing verified this morning the ice maker front cover was removed and a black substance was on the water bushing and finger clamp with a black residue that was able to be wiped off when the DON wiped it with a paper towel. On [DATE], the facility heating and cooling contractor was at the facility and verified the presence of black areas between the upper white pipes in the ice machine. The piping was removed and sanitized, water flushed through the system left black flakes of debris in the water holding container of the unit. The contractor verified the black residue was not a stain. Review of the policy: Environment revised [DATE] revealed all food preparation areas, food service areas and dining areas will be maintained in a clean and sanitary condition. Review of policy: Ice revised [DATE] revealed ice will be prepared and distributed in a safe and sanitary manner. Review of the policy: Food Storage Cold Foods revised February 2023 revealed all time/temperature control for safety foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code. An accurate thermometer will be kept in each refrigerator and freezer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the policy: Food Storage Dry Goods revised February 2023 revealed all dry goods will be appropriately stored in accordance with the FDA Food Code. Procedures included all packaged and canned food items will be kept clean, dry and properly sealed. This deficiency represents non-compliance identified under Complaint Number OH00162745.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on medical record review and interview, the facility failed to maintain comprehensive and accurate medical record. This affected one resident (#26) of 31 residents sampled. The census was 57. Findings include: Medical record revealed Resident #26 was admitted on [DATE] with diagnoses including end stage renal disease requiring hemodialysis, hypertension and constipation. A. Review of the electronic Physician Orders dated 11/24/24 revealed to administer amlodipine desylate 10 milligrams daily for hypertension. The medication was to be held if systolic blood pressure (SBP) was less than 90 mmHg and/or heart rate was less than 90 (beats per minute) and notify the physician. The medication was to also be held on dialysis days (Monday-Wednesday-Friday). Review of the electronic Medication Administration Record (eMAR) dated February and March 2025 revealed the following regarding the administration of amlodipine: a. On 02/01/25 through 02/10/25, the medication was not held per physician instructions when the heart rate/pulse was less than 90 beats per minute. b. On 02/11/25 through 02/27/15, the medication was decreased to administer 5 milligrams on Tuesday, Wednesday, Thursday, Saturday and Sunday. The physician instructions included to hold if SBP was less than 90 mmHg and/or heart rate was less than 90 (beats per minute), and hold on dialysis days on Monday, Wednesday, Friday. Review of the eMAR dated February and March 2025 revealed Resident #26's physician instructions to hold for HR less than 90 (beats per minute) was not followed as ordered. B. Review of the eMAR dated February 2025 revealed indwelling catheter output was to be documented every shift. There was no evidence indwelling urinary catheter output was documented on the day shift on 02/04/25, 02/17/25, 02/18/25, 02/20/25, 02/21/25, 02/22/25, 02/23/25, 02/24/25, 02/27/25 or 02/28/25. There was no evidence Resident #26's indwelling urinary catheter output was documented on the night shift on 02/01/25 or 02/07/25. On 03/06/25 at 10:00 A.M., interview with the Director of Nursing (DON) verified the physician instructions were not followed as written and was going to call the physician for clarification. The DON stated she believed it was a transcription error as the resident had other BP medications with physician parameters to hold the medication if less than 60 (beats per minute) and verified urine output for a catheter was not documented.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, observation, staff interview, and policy review, the facility failed to develop and implement a comprehensive and effective infection control program to decrease the risk of infection. The facility failed to ensure staff applied (donned) appropriate personal protective equipment (PPE) when entering the room of a resident in transmission based precautions (TBP's), failed to ensure staff performed proper hand hygiene during wound care and during meal delivery processes, and failed to ensure nephrostomy bags were maintained off the floor to help prevent infection. This affected one resident (#27) of three residents reviewed for TBP's, one resident (#7) of one resident reviewed for pressure ulcers, one resident (#256) of four residents reviewed for urinary catheters, three residents (#22, #39, and #156), who received their lunch meals in their rooms on the 300 hall on 03/03/25, and nine residents (#1, #2, #6, #7, #15, #16, #28, #45, and #46) who received their lunch meal in the dining room on 03/04/25. Findings include: 1. Review of Resident #27's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included unspecified dementia, muscle weakness, and the need for assistance with personal care. Review of Resident #27's physician's orders revealed the resident was placed in droplet precautions on 03/05/25, after he had been exposed to another resident known to have Influenza A and started showing signs and symptoms of Influenza A, which included a cough. The order directed the staff to post a sign that read See Nurse Before Entering on the resident's door. Staff were also directed to wear gloves, mask, and gown as needed. They were further instructed to wash hands when touching environment and with direct patient care. On 03/05/25 at 11:56 A.M., an observation noted Social Service Director (SSD) #254 to enter the room of Resident #27 to pass his lunch meal tray. The resident was noted to have a sign posted at his door to See Nurse Before Entering. He was also noted to have a personal protective equipment (PPE) cart in the hall outside his room. SSD #254 entered the room, without donning any PPE, while delivering the resident's meal tray. SSD #254 was observed to place the tray on the resident's bedside table using his ungloved hands to provide set up help and to position the bedside table directly in front of the resident. He was also noted to be handling the resident's bed linen with his ungloved hands as he was searching for the bed controls. Resident #27 was noted to coughing while SSD #254 was standing next to the bed and providing set up help. SSD #254 did use hand sanitizer on his way out of the room, before being stopped in the hallway. On 03/05/25 at 12:00 P.M., an interview with SSD #254, after he left Resident #27's room, revealed he was not aware Resident #27 was on TBP's. When asked if he did not see the sign posted outside his door or the PPE cart that was in the hall outside his room, SSD #254 stated Resident #27 was not in TBP's when he was in his room the day before. He then thought the sign posted outside the door and the PPE cart in the hall was for the resident that was previously in that room before the other resident was moved across the hall to a private room, after testing positive for Influenza A. (continued on next page)

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	365780	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Marietta	5001 State Route 60 Marietta, OH 45750

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/05/25 at 12:15 P.M., an interview with the facility's Director of Nursing (DON) confirmed Resident #27 was in droplet precautions for suspicions of a possible Influenza A infection. She stated the resident's roommate tested positive for Influenza A the day prior to and Resident #27 had since displayed symptoms, which included a cough. They had tested the resident for Influenza A, but were still awaiting the results. She further confirmed SSD #254 should have been wearing PPE when entering the resident's room. She had been told about the issue by SSD #254, after it had occurred. SSD #254 told her as well, Resident #27 was not in isolation the day before when he was in there. She educated him that things could change on a daily basis and they needed to recognize any signs that may be posted for precautions they needed to follow. 47985 2. Record review revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including toxic encephalopathy, type II diabetes, acute kidney failure, and altered mental status. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had mild cognitive impairment, no behaviors, and had no venous ulcers. Review of a provider note dated 03/05/25 at 12:00 A.M. by Nurse Practitioner (NP) #505 revealed Resident #7 was receiving wound care to her sacrum and left trochanter (hip). There was no evidence of treatment or assessment of a venous wound to the right lower leg. Review of a nursing note dated 03/05/25 at 6:14 A.M. by Licensed Practical Nurse (LPN) #225 revealed Resident #7 was resting in bed with no new concerns. Review of orders revealed Resident #7 had an order in place dated 03/05/25 to cleanse venous wound to the right lower leg with in-house would cleanser and pat dry, apply puracol (a collegen based dressing with antimicrobial properties) with tetracyte and apply kerlix (gauze wrap) daily for wound care. Review of a care plan last revised on 03/05/25 revealed Resident #7 had an alteration to skin integrity related to pressure state III (full thickness ski loss, exposing subcutaneous tissue ((fat)) but not exposing bone, tendon or muscle) to the sacrum, a boil to the left hip, and a venous wound to the right lower leg. Interventions included complete treatments to wounds per orders. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continuous observation on 03/06/25 from 1:49 P.M. to 2:21 P.M. revealed Registered Nurse (RN) #313 prepared to enter Resident #7's room to complete wound care. Hand hygiene was completed, a gown was applied, and RN #313 donned five pairs of gloves. Upon entering the room, RN #313 began to remove Resident #7's personal items from her over the bed table. Without taking off her gloves or gown, RN #313 left the room to obtain a trash bag. RN #313 returned to the room and, with the same gloves and gown, began using bleach wipes to clean the over bed table then obtained a blue drape and applied it to the table and began to lay out supplies. RN #313 then removed one pair of gloves, lifted Resident #7's blanket, and left the room, wearing the gloves and gown to retrieve wound cleanser from the treatment cart. Upon returning to the room, RN #313 did remove one pair of gloves, leaving three pairs of gloves remaining on her hands. RN #313 removed Resident #7's sock and used scissors to cut off the old dressing. Resident #7 reported to the nurse she has had the wound to her right leg for a while. RN #313 removed another pair of gloves then attempted to remove the puracol from Resident #7's leg, but it was adhered to the wound, so she used wound cleanser to moisten the puracol to make it easier to remove. Once the puracol was removed, RN #313 rolled the kerlix from the soiled dressing under Resident #7's leg to use as a barrier between Resident #7's leg and the pillow her leg was resting on, which had a large area of drainage the size of a grapefruit. RN #313 removed the remaining gloves, went to the restroom and washed her hands, then applied a new pair of gloves. RN #313 removed the soiled pillow and dressing from underneath Resident #7's leg then laid down a fresh drape under her leg. RN #313 sprayed the wound with wound cleanser. The wounds were on Resident #7's right leg and were two quarter-sized open areas and a smaller dime-seized open area, all of which were red in appearance. RN #313 then pat the area dry with gauze and applied puracol with silver to the open areas. When asked, RN #313 stated silver and tetracyte were the same thing and interchangeable. The area was then wrapped with kerlix and the drape removed from underneath Resident #7's leg. RN #313 taped the kerlix together, then signed and dated the dressing. RN #313 removed Resident #7's other sock due to her request and removed the soiled pillow case from the pillow. RN #313 removed her gloves, washed her hands, and applied a new pair of gloves, then wiped Resident #7's pillow down with bleach wipes. RN #313 then grabbed the trash bags with soiled gloves, dressings, and pillow case and walked out of the room still wearing a pair of gloves and her gown. RN #313 paused in the hallway to doff the gown and gloves and put them into the trash bag as well, then carried the trash bags to the shower room to dispose of them, without completing hand hygiene. Resident #7 was on contact precautions due to Methacillin Resistant Staphylococcus Aureus (MRSA) infection in a wound to her left hip. RN #313 confirmed she had worn five pairs of gloves at the same time for convenience of not having to perform hand hygiene between removal of each pair of gloves. RN #313 stated she had not yet started actual wound care while wearing and removing the five pairs of gloves so it does not matter. Interview on 03/06/25 at 4:31 P.M. with the Director of Nursing (DON) confirmed observations made during wound care had infection control concerns. The DON also stated tetracyte and silver can be used as substitutes for each other, but only if the ordered treatment was not available. Interview on 03/06/25 at 4:50 P.M. with Unit Manager (UM) #242 confirmed tetracyte was available on the treatment cart for Resident #7's treatment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a policy titled Wound Care dated October 2010 revealed the process for completing wound care includes verifying the physician order for treatment, gather equipment and supplies, then use a disposable cloth to establish a clean filed on resident's over the bed table, place all items to be used during procedure on the clean field and arrange the supplies so they are within reach. Wash and dry hands thoroughly, position the resident, place a disposable cloth next to the resident under the wound to serve as a barrier to protect the bed linen and other body sites, put on exam gloves, loosen tape and remove the soiled dressing. The glove should be pulled over the dressing then discarded into an appropriate receptacle, then wash and dry hands thoroughly. Apply gloves, use no-touch technique by using sterile applicators to remove ointments and creams from containers, pour liquid solutions directly on gauze sponges on their papers, we exam gloves for holding gauze to catch irrigation solutions poured directly over the wound, wear sterile gloves when physically touching the wound or holding a moist surface over the wound. Place one gauze to cover all broken skin, wash tissue around the wound that is usually covered by the dressing, tape or gauze with antiseptic or soap and water. Remove the dry gauze then apply treatments as indicated, dress the wound, mark tape with initials, time and date. Discard disposable items into the designated container and all linens/clothing into the laundry container, remove disposable gloves and discard into trash. Wipe reusable items with alcohol as indicated and return to cart, take only the disposable items that will be needed for the treatment into the room because disposable items cannot be returned to the cart. Wash and dry hands thoroughly. Interview on 03/06/25 at 4:31 P.M. with Director of Nursing (DON) confirmed observations made during wound care had infection control concerns. 51519 3. Record review revealed Resident #256 admitted to the facility 02/21/25 with diagnoses including rhabdomyolysis, metabolic encephalopathy, non ST elevated myocardial infarction, acute kidney failure, muscle weakness, and cognitive communication deficit, indwelling foley catheter and right side nephrostomy tube. Observation on 03/03/25 at 12:00 P.M. Resident #256 sitting in a chair eating lunch with his nephrostomy bag lying on the floor. The nephrostomy bag contained clear yellow urine. An indwelling urinary catheter was also present on the resident, hanging off of the chair but not touching the floor. Interview on 03/03/25 at 12:08 P.M with certified nursing assistant (CNA) #202 confirmed the nephrostomy bag was lying on the floor. They stated the bag should be up off the floor and hanging like the foley catheter bag is. Review of facility policy dated 2001 Infection Prevention and Control Program revealed for infection prevention established general and disease specific guidelines such as those of the Centers for Disease and Control (CDC) should be followed. The CDC recommends foley catheter bags should remain below the level of the bladder and should not rest on the floor. 4. Observation on 03/03/25 at 12:00 P.M. of meal tray delivery on hall 300 revealed CNA #202 not perform hand hygiene passing trays to three residents, Resident #156, Resident #22, and Resident #39. Interview on 03/03/25 at 12:08 P.M with CNA #202 confirmed they should have washed their hands or used an alcohol based hand rub between each meal tray delivery. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of policy assistance with meals revised March of 2022 revealed all employees who provide resident assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling. 28704 5. On 03/04/25 between 11:31 A.M. and 11:45 A.M., observation of the lunch meal in the main dining room revealed Activity Director #204 delivered meal trays to Resident #1, #2, #6, #7, #15, #16, #28, #45 and #46. Activity Director #204 was observed removing the trays from the food delivery cart, setting the items on the table, opening seasonings, straws and then returning to the food delivery cart. Activity Director #204 did not wash her hands at the sink or use hand sanitizer prior to/after the delivery and set-up of the lunch meals for Resident #1, #2, #6, #7, #15, #16, #28, #45 and #46. On 03/04/25 at 11:46 A.M., observation revealed Activity Director #204 was observed getting up from Resident #1's table to go to the sink and wash her hands. At the time of the observation, interview with Activity Director #204 revealed she was the only staff that normally supervises the main dining room. Activity Director #204 stated she touched Resident #1's bowl so she needed to wash her hands. Activity Director #204 verified she did not perform any hand hygiene between meal distribution. Activity Director #204 did not provide any explanation as to why she did not wash her hands during meal distribution. Review of the policy: Assistance with Meals revised March 2022 revealed all employees who provide resident assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling.

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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** 28704 Based on medical record review, infection control log review, policy review and interview, the facility failed to monitor the use of antibiotics and ensure infection criteria was met. This affected three residents (#7, #19 and #46) of three residents reviewed for antibiotic use. Findings include: 1. Medical record review revealed Resident #7 was admitted on [DATE] with diagnoses including diabetes mellitus, acute kidney failure, urinary retention unspecified, pyelonephritis, bacteremia and neurogenic bladder. Review of Laboratory Bloodwork dated 11/24/24 revealed Resident #7 had a white blood cell count of 15.3 uL/mL (normal was 3.5 to 11.0). The nurse practitioner was notified and ordered rocephin (antibiotic) one (1) gram intramuscular daily for three days. There was no evidence or a urinalysis or urine culture obtained. Review of the electronic Physician Orders dated November 2024 revealed Resident #7 had an indwelling urinary catheter and was ordered Ceftriaxone Sodium 1 gram (g) intramuscularly (IM) daily for a urinary tract infection. Review of the electronic Medication Administration Record dated November 2024 revealed Ceftriaxone 1 (g) was administered daily intramuscularly on 11/24/24, 11/25/24 and 11/26/24. Review of the Resident Infection Control Log dated November 2024 revealed no evidence Resident #7 was treated with an antibiotic for a UTI between 11/24/24 and 11/26/24. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed the resident had an indwelling urinary catheter and had no UTI in the last 30 days. On 03/10/25 at 1:02 P.M., interview with Registered Nurse (RN) #207 verified there was no evidence Resident #7 had met criteria for a UTI and no evidence of symptoms documented in the record. On 03/10/25 at 1:22 P.M., interview with RN #207 verified there was no evaluation or culture for review to justify the appropriateness of the administration of three doses of rocephin. RN #207 verified On 03/10/25 at 3:45 P.M., interview with RN #223 stated the nurse practitioner had ordered a daily injection of rocephin 1(mg) intramuscular for three days without knowing exactly what type of infection the resident had. RN #223 stated the resident had an increased white blood cell count and confusion but no other testing to see if she required the antibitoic or if it would even be effective. RN #223 verified this was not on the Infection Control Log and she missed this one. RN #223 stated she was responsible for monitoring infections within the faciity and verified there was no evidence to support the use of rocephin for a UTI when there was no culture or sensitivity obtained. (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 policy: Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes revised December 2016 revealed antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveilA lance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. 1. As part of the facility Antibiotic Stewardship Program, all clinical infections treated with antibiotics will undergo review by the Infection Preventionist (IP) or designee. 2. The IP, or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. Therapy may require further review and possible changes if: -The organism is not susceptible to antibiotic chosen; -The organism is susceptible to narrower spectrum antibiotic; -Therapy was ordered for prolonged surgical prophylaxis; or -Therapy was started awaiting culture, but culture results and clinical findings do not indicate continued need for antibiotics. 3. At the conclusion of the review, the provider will be notified of the review findings. 4. All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include: a. Resident name and medical record number; b. Unit and room number; c. Date symptoms appeared; d. Name of antibiotic (see approved surveillance list); e. Start date of antibiotic; f. Pathogen identified (see approved surveillance list); g. Site of infection; h. Date of culture; i. Stop date; j. Total days of therapy; (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	k. Outcome; and l. Adverse events. Review of the policy: Antibiotic Stewardship revised December 2016 revealed antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. 51519 2. Record review revealed Resident #19 admitted to the facility on [DATE] with diagnoses including Alzheimer's, iron deficiency anemia, overactive bladder, hypercholesterolemia, hypertension, muscle weakness, osteoarthritis, dementia, gastroesophageal reflux disease, dysphagia, personal history of other infectious and parasitic diseases, major depressive disorder, anxiety. Review of the Minimum Data Set (MDS) completed on 01/03/25 revealed a brief interview for mental status (BIMS) score of five indicating severe cognitive impairment. Review of Resident #19's record revealed an admission to the hospital on 12/06/24 with findings of a urinary tract infection (UTI). Upon discharge from the hospital Resident #19 was on cefdinir. Review of Resident #19 record revealed an order placed on 12/06/24 by The Medical Director #600 For Cefdinir 300 milligram (mg) capsule to give 1 capsule by mouth two times a day for seven days. Review of Resident #19 medical record revealed no documentation of a urine specimen Record review revealed McGeer's criteria for Resident #19 was not fully filled out for Resident #19's UTI from 12/06/24. Interview on 03/06/25 at 9:40 A.M. with Infection Preventionist #223 confirmed UA's and C&S should be positive before continuing an antibiotic upon return from the hospital. She stated they had requested the information regarding the UA and C&S for Resident analysis (UA) or urine culture and sensitivity (C&S) being completed by the facility or documentation the facility had received the culture and sensitivity completed at the hospital. The Infection Preventionist confirmed McGeer's criteria paperwork was not filled out and the facility did not confirm the resident met criteria for antibiotic use. Review of the antibiotic stewardship policy dated 2002 revealed when a resident is admitted from an emergency department, acute care facility, or other facility the admitting nurse will receive discharge and transfer paperwork for current antibiotic/ anti-infective orders. Discharge or transfer medical records must include all of the above drug and dosing elements 3. Resident #46 admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disorder (COPD), congestive heart failure (CHF), hypertensive heart disease with heart failure, chronic resp failure with hypoxia, atherosclerotic heart disease of native coronary artery without angina, malignant neoplasm of bladder, benign neoplasm of colon, hypothyroidism, muscle weakness, dyspnea, depression, gastroesophageal reflux disorder (GERD), restless legs syndrome, shoulder lesion right shoulder, sleep apnea, prediabetes, and dysphagia. Review of minimum data set (MDS) completed on 09/26/24 revealed a brief interview for mental status (BIMS) score of14. (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 Resident #46 record revealed an admission to the hospital on 12/17/24 with findings of a urinary tract infection (UTI). Upon discharge from the hospital Resident #45 was on cefdinir and doxycycline. Review of Resident #46 record revealed an order placed on 12/17/24 by Medical Director #600 for Cefdinir 300 mg capsule to give 1 capsule by mouth two times a day for seven days and Doxycycline Hyclate 100 mg tablet give one tablet by mouth two times a day for infection until 01/05/25. Review of Resident #46 medical record revealed no documentation of a urine analysis (UA) or urine culture and sensitivity (C&S) being completed by the facility or documentation the facility had received the culture and sensitivity completed at the hospital. Record review revealed McGeer's criteria for Resident #46 was not fully filled out for the UTI from 12/17/24. Interview on 03/06/25 at 9:40 A.M. with Infection Preventionist #223 confirmed UA's and C&S should be positive before continuing an antibiotic upon return from the hospital. She stated they had requested information regarding the UA and C&S for Resident #46 from the hospital but did not receive it. The Infection Preventionist confirmed McGeer's criteria paperwork was not filled out and the facility did not confirm the resident met criteria for antibiotic use. Review of the antibiotic stewardship policy dated 2002 revealed when a resident is admitted from an emergency department, acute care facility, or other facility the admitting nurse will receive discharge and transfer paperwork for current antibiotic/ anti-infective orders. Discharge or transfer medical records must include all of the above drug and dosing elements

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 28923 Based on observations, review of email correspondence between the facility and an outside heating, cooling, plumbing, and refrigeration company, review of resident council meeting minutes, resident interview, and staff staff interview, the facility failed to ensure the building was free of any offensive odors. This had the potential to affect all 19 residents (#1, #5, #9, #11, #12, #13, #14, #17, #19, #21, #23, #27, #28, #34, #35, #38, #51, #206, and #260) that resided on the 400 hall. Findings include: On 03/03/25 through 03/06/25 and again on 03/10/25, observations of the 400 hall noted there to be an offensive sewage type of odor present that was very noticeable when walking onto the hall. The odor was noted from the front of the hall and extended all the way to the back of the hall. The odor was consistent and not transient in nature and could not be pinpointed to any particular residents' rooms. Observation revealed there were 19 residents, Resident #1, #5, #9, #11, #12, #13, #14, #17, #19, #21, #23, #27, #28, #34, #35, #38, #51, #206, and #260 who resided on the 400 hall. Review of resident council meeting minutes for the past four months revealed the residents attending the 02/17/25 meeting voiced concerns with the 400 hall shower room smelling bad. The concern was sent to the maintenance department and he indicated the contractor fixed the smell in the drain on 02/18/25. On 03/03/25 at 1:50 P.M., an interview with Resident #17 revealed there was an ongoing problem with an odor in the facility's shower room on the 400 hall. She stated she did not even like to take showers in there due to the odor being so bad. On 03/03/25 at 3:03 P.M., an interview with Resident #23 revealed the facility's shower room smelled at times. He was not sure what the source of the odor was, but figured it had something to do with the drain, since it smelled like a sewer in there. On 03/06/25 at 9:20 A.M., an interview with Certified Nursing Assistant #325 revealed she had previously worked at the facility about five months ago and was used as a shower aide. She denied there had been any problems with an odor being present on the 400 hall or in the shower room on the 400 hall the last time she worked there. She had recently came back to work at the facility and the previous weekend was the first time she had been back. She was asked if she was aware of any issues with the facility's shower room. She denied that she was aware of any problems. She was then asked if there had been any odors in the shower room since her return. She commented that you could smell an odor coming from the shower room, as she was being interviewed in the hallway. She accompanied the surveyor to the shower room and reported she has had the water running in the shower stall and into the drain. There was a strong bleach smell present in the shower room. She reported housekeeping had previously been in the shower room and was cleaning. (continued on next page)

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	365780	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Marietta	5001 State Route 60 Marietta, OH 45750

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/06/25 at 9:42 A.M., an interview with Maintenance Director #243 revealed the facility had been dealing with odors in the 400 hall shower room. They had an outside company there doing a couple of different things to help with the odor. They were waiting on them to get a snake with a camera that they could run through the lines. They needed a camera ran through the drain that was located outside at the end of the 400 hall to the front of the hall. He had not followed up with them to see when they were going to be coming back with everything that had been going on that week. He was asked to provide any documentation of them having an outside company come in to address the odor issue on the 400 hall allegedly coming from the shower drains. On 03/06/25 at 10:30 A.M., an interview with Housekeeper #239 revealed she was assigned as the housekeeper for the 300 and 400 halls that day. She denied she had been on the 400 hall yet, but would be over there shortly to clean it. She was asked what was all included in her daily cleaning schedules other than resident rooms. She replied she was also responsible for cleaning the shower rooms. When asked what all she did in the shower room, she reported she moved all the stuff out of the shower stall and would spray the shower walls down with a cleaner. She was not sure what cleaner was being used, as she had only worked there for a few days now. She confirmed she had noted odors from the drain in the shower room that would carry out into the hallway on the 400 hall. She was asked to describe the odor and reported it was more of a sewer odor. She was asked if she was dumping anything into the drain as part of her daily cleaning. She denied that she dumped anything into the shower drain, but she did use the same spray she used to spray the walls down to spray into the drain. On 03/06/25 at 11:30 A.M., the facility's Director of Nursing (DON) provided an email she obtained from the outside company that had been addressing the drain issue on the 400 hall. The email was dated 03/06/25 at 11:12 A.M. and the company indicated they ran a camera from one side of the drain to the other in the bathroom. The line was a little plugged. They put a chemical down to clean the plug up. The smell was still there. It appeared that the main line running down the hallway had been damaged. The DON confirmed they had an ongoing issue with odors on the 400 hall that the residents were complaining about. More was needed to be done to address the odor issue. This deficiency represents non-compliance investigated under Master Complaint Number OH00163355 and Complaint Number OH00162745.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 47985 Based on review of personnel files, interview and policy review, the facility failed to ensure Certified Nursing Assistants (CNAs) received the required 12 hours of in-services annually. This had the potential to affect all 57 residents residing in the facility. Findings include: Review of the personnel files for CNA #257, CNA #269, CNA #274, and Activity Director (AD) #204, who occasionally worked the floor as a CNA, revealed no evidence of 12 hours of annual inservices in 2024 or 2025. Interview on 03/22/25 at 3:15 P.M. with Human Resources (HR) #241 confirmed CNAs #257, #269, #274, and AD #204 did not have evidence of 12 hours of annual in-services. Review of a policy titled In-Service Training, All Staff dated 2001 revealed all staff are required to participate in regular in-service education. The objective of this training is to ensure staff are able to interact in a manner that enhances the resident's quality of life and care and can demonstrate competency in the topic of the training areas. Required trainings include effective communication with residents and family (for direct care staff), resident rights and responsibilities, preventing abuse, neglect, exploitation and misappropriation, information on the QAPI program, infection prevention, behavioral health, and the compliance and ethics program standards. Completed training is documented by the staff development coordinator and includes the date and time of training, topic, method used for training, summary of competency, and hours of training completed.