STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365794	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pataskala Oaks Care Center	144 East Broad Street Pataskala, OH 43062

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on record review, interview, and facility policy review, the facility failed to complete a bed hold notice within 24 hours of a resident's discharge to the hospital. This affected one resident (Resident #55) out of four residents reviewed for hospitalization . The facility census was 50. Findings Include: Review of Resident #55's medical record revealed Resident #55 was admitted to the facility on [DATE] and was sent to the hospital on 02/03/24 for evaluation of altered mental status and was discharged from the facility on 02/05/24. Review of Resident #55's medical record revealed Resident #55 primary payer was Ohio Medicaid which requires notification to resident's representative the option to hold the resident's bed at the facility following a discharge to the hospital. There was no bed hold notice found in Resident #55's medical record. Interview on 04/23/24 at 10:02 A.M. with the Business Office Manager (BOM) # 472 confirmed Resident #55 did not have a bed hold notification sent to the resident's representative due to having been discharged to the hospital on a weekend day (Saturday). BOM #472 stated, I do send the bed hold notices out within 24 hours of a resident being sent to the hospital. In this case, the resident was sent to the hospital on a Saturday. I would have sent the bed hold notice on the Monday after her discharge to the hospital. On that Monday, the resident's family had come in and informed the facility the resident would not be returning to the facility, so I did not complete the bed hold notice for the resident. Review of the facility's policy titled, Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail the rights and limitations of the resident regarding bed-holds.

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 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** 47569 Based on observation, record review, interviews, and facility policy review the facility failed to apply and document the use of a left elbow brace to decrease the decline of contracture. This affected one resident (Resident #5) out of two residents reviewed for position and mobility. The facility census was 50. Findings Include: Review of Resident #5's medical record revealed Resident #5 was admitted to the facility on [DATE] with the diagnoses including Cerebral Palsy, high blood pressure, and type two diabetes mellitus. Resident #5 required assistance from staff to complete personal care tasks, transfers, and bathing. Resident #5 had mild cognitive impairment and used a wheelchair for mobility. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed in section O - Special Treatments, Procedures, and Programs splint or brace assistance was not marked. Review of Resident #5's signed physician orders for 04/2024 revealed an order dated 02/02/24 for Resident #5 to wear a left elbow extension brace/splint up to 6 to 8 hours daily, staff to don and doff the brace/splint. Review of Resident #5's Treatment Administration Record (TAR) dated 02/01/24 to 02/29/24, 03/01/24 to 03/31/24 and 04/01/24 to 04/23/24 revealed no documentation entries for the placement of Resident #5's left elbow brace. Review of the occupational therapy summary of skilled service notes dated 02/01/24 at 3:27 P.M. authored by Occupational Therapist Assistant (OTA) #725 revealed therapist placed left elbow brace on Resident #5 without complication. Resident #5 able to doff the brace with assistant from the OTA. Care giver education was completed for correct placement on Resident #5's left elbow to decrease contracture development. Review of staff education for correct left elbow placement dated 02/01/24 revealed six staff members had completed the education by the OTA. Review of Resident #5's Activities of Daily Living (ADL) care plan revised date of 03/13/24 revealed Resident #5 has limited range of motion and hemiparesis to left extremities. Resident #5 has an ADL intervention of a left elbow brace to be worn daily. Review of Resident #5's Point of Care (POC) task documentation for the last 30 days dated 03/23/24 to 04/23/24 revealed no entries documented for the placement of Resident #5's left elbow brace. An observation on 04/22/24 at 9:18 A.M. revealed Resident #5 was sleeping in bed, there was a brace laying on the over the bed table. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 04/22/24 at 1:53 P.M. revealed the brace was laying top of the three drawer dresser at the foot of Resident #5's bed. Resident #5 was out of the room participating in activities. An observation on 04/23/24 at 8:58 A.M. revealed Resident #5 was resting in bed watching television, the brace was laying on the top of the three drawer dresser at the foot of the bed. An observation on 04/23/24 at 1:30 P.M. revealed Resident #5 sitting in a wheelchair watching television in her room, the brace was still laying on top of the three drawer dresser at the foot of the bed. Interview on 04/23/24 at 1:55 P.M. with Resident #5 revealed the staff sometimes apply the brace to her left elbow. Resident #5 stated Yes, sometimes they put that on me. Interview on 04/23/24 at 2:01 P.M. with State tested Nursing Assistant (STNA) #413 confirmed Resident #5's left elbow brace was laying on top of the three drawer dresser at the foot of the bed instead of being applied to Resident #5's left elbow. STNA #413 applied the left elbow brace to Resident #5's left elbow. Interview on 04/24/24 at 10:25 A.M. with Licensed Practical Nurse (LPN) Unit Manager #400 revealed when the order was originally written the task option was not activated for the order to be viewed on the POC task screen for the STNAs to be able to document application and removal of the left elbow brace for Resident #5. LPN Unit Manager #400 confirmed there was not documentation in Resident #5's medical record to reflect the application or removal of the left elbow brace by the STNAs. Review of the facility's policy titled, Resident Mobility and Range of Motion dated 07/2017 revealed, Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in range of motion.

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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** 43064 Based on interview, record review, and review of facilities investigative report, the facility failed to ensure Resident #39 received the appropriate assistance, resulting in a fall. This affected one resident (#39) of two residents reviewed for falls. The facility census was 50. Findings include: Review of the medical record for Resident #39 revealed an admitted [DATE] with diagnoses including traumatic hemorrhage of cerebrum, anxiety, depression, epilepsy, neuromuscular dysfunction of bladder, quadriplegia, anoxic brain damage, chronic obstructive pulmonary disease, and chronic respiratory failure. Review of Resident #39's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed he had moderately impaired cognition. Resident #39 was dependent on staff for all activities of daily living. Review of Resident #39's plan of care dated 10/16/23 revealed he was at risk for falls related to poor communication, impaired vision, impaired mobility, weakness, impaired cognition, anoxic brain injury, and quadriplegia. Interventions included using a blow call light, bolster mattress, anticipate and meet needs, therapy evaluation as needed, and added on 02/22/24 bariatric air mattress. Review of Resident #39's plan of care dated 10/16/23 revealed he had an activity of daily living self-care performance deficit related to diagnoses including anoxic brain injury, quadriplegia, and hydrocephalus. Interventions included two-person total assistance for bed mobility and transfers. Review of Resident #39's progress note dated 02/22/24 revealed the State tested Nursing Assistant (STNA) assisted the resident to the floor from his bed when he was getting changed and turned to the opposite side. The resident was assessed, and no injuries were noted. Review of Resident #39's investigation report dated 02/22/24 revealed the floor nurse was told by the STNA providing care for Resident #39 that he was assisted to the floor during routine care, when he was getting changed and attempted to be turned to the opposite side. No injuries were identified, and he denied pain. The interdisciplinary team reviewed the event and indicated Resident #39 had been receiving Botox injections and had changed muscle tone, additionally he had a significant weight gain over the previous six months. It was noted that a larger bed would decrease the risk of another fall due to the resident being so close to the edge of the bed when being turned and repositioned during care and create a safer environment for bed mobility, transfers, and positioning. The new intervention was a bariatric air mattress. Interview on 04/23/24 at 4:39 P.M. with the Director of Nursing (DON) revealed during care a STNA rolled the resident away from her and he started sliding. The DON verified one aide was providing care at the time of the fall when it 'probably should have been two.' The DON verified Resident #39's plan of care indicated he required two-person assistance for bed mobility.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on observation, record review, interview, and facility policy review, the facility failed to change oxygen and nebulizer tubing as ordered. This affected one resident (Resident #14) out of two residents reviewed for respiratory care. The facility census was 50. Findings Include: Review of Resident #14's medical record revealed Resident #14 was admitted to the facility on [DATE] with diagnoses including asthma, high blood pressure, dementia, and weakness. Resident #14 had severe cognition impairment, required staff assistance for personal hygiene cares, transfers, and bathing. Review of Resident #14's signed physician orders revealed an order dated 01/11/23 Oxygen at 2 liters (L) as needed to maintain blood oxygen levels (SP02) greater than 90%, an ordered dated 09/29/23 for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3 milligrams (mg) per 3 milliliters (ml) via nebulizer every four hours as needed for congestion, and an order dated 02/04/24 for Oxygen (02) tubing to be change every week on Sunday night shift. Review of Resident #14's Asthma care plan dated 07/18/23 revealed interventions to use oxygen with setting at 2 liters (L) via nasal cannula (NC) and to administer nebulizer medications as ordered. An observation on 04/22/24 at 9:32 A.M. revealed Resident #14 sitting in a wheelchair receiving oxygen via nasal cannula with tubing attached to the oxygen concentrator. Oxygen concentrator setting at 2 liters with the tubing dated 04/14/24. A nebulizer (breathing treatment machine) was noted sitting on top of the three-drawer dresser at bedside with tubing dated 04/14/24. An observation on 04/23/24 at 9:27 A.M. revealed Resident #14 sitting in a wheelchair in the unit lounge area. Oxygen concentrator was noted in Resident #5's room, [NAME] running, with the oxygen tubing laying on the bed and still dated 04/14/24. The nebulizer was still sitting on top of the three-drawer dresser and the tubing still dated 04/14/24. An interview on 04/23/24 at 9:30 A.M. with Licensed Practical Nurse (LPN) #419 confirmed Resident #14's oxygen tubing and nebulizer tubing was dated 04/14/24. LPN #419 stated, The oxygen and nebulizer tubing and supplies are changed on Sunday nights during night shift and then the order is signed off on the Treatment Administration Record (TAR) when completed. The dates are from Sunday night a week ago. Review of the facility policy titled, Oxygen Administration dated 03/2023 revealed, Staff shall change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49794 Based on staff interview, review of medical records, and facility policy, the facility failed to provide non-pharmacological interventions, properly document pain location and indicators of pain, with the administration of as needed pain medication. This affected one resident (Resident #46) of five residents reviewed for unnecessary medications. The facility census was 50. Findings include: Review of medical record for Resident #46 revealed an admitted [DATE], diagnoses included ventilator dependent, pressure ulcer, chronic pain syndrome, anxiety disorder, insomnia, depression, dysphagia, chronic respiratory failure with hypoxia and hypercapnia, paraplegia, obstructive and reflex uropathy, pressure induced deep tissue damage of head, amyotrophic lateral sclerosis. Review of Resident #46's care plan dated 01/17/24, revealed Resident #46 was at risk for pain due to diagnoses of amyotrophic lateral sclerosis (ALS) and multiple pressure ulcers. Interventions included administering medications as ordered, monitoring respiratory rate, depth, and effort, monitoring documenting and reporting adverse reactions to analgesic therapy (altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, pruritis, respiratory distress sedation, urinary retention), and reviewing pain medication efficacy by routinely, monitoring, recording, and reporting any signs or symptoms of non-verbal pain such as changes in breathing (noisy, deep/shallow, labored, fast/slow), vocalizations (grunting, moans, yelling out, silence), mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion), eyes (wide open/narrow slits/shut, glazed, tearing, no focus), face (sad, crying, worried, scared, clenched teeth, grimacing) and body (tense, rigid, rocking, curled up, thrashing). Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #46 was nonverbal and unable to be fully evaluated for cognition, but recognized staff faces and names. MDS revealed Resident #46 was on pain management regimen, received as needed pain medications, and was not receiving non medicated interventions for pain. Indicators for pain included facial grimacing and ability to make noises, with pain indicated three to four days weekly. Review of Resident #46's physicians' orders dated 04/19/24 revealed Resident #46 had an order for Dilauded (Hydromorphone HCL) 1 milligram (mg)/milliliter (ml) oral liquid, eight ml dose to be given in percutaneous endoscopic gastrostomy- tube (PEG)-tube, (a tube going directly into the stomach for feeding purposes) every four hours as needed for pain. Review of Resident #46's Medication Administration Record (MAR) for March 2024 and April 2024 revealed Resident #46 received Dilauded oral liquid one milligram/ milliliter (mg/ml) on 03/05/24 03/08/24, 03/09/24, 03/10/24, 03/13/24, 03/15/24, 03/16/24, 03/17/24, 03/20/24, and 03/24/24. Additional review revealed no non-pharmacological interventions or description and location of pain were documented prior to administration of the as needed medication. Review of medication administration progress notes from 03/05/24 to 03/24/24 revealed there were no non-pharmacological interventions and no descriptions or locations given for pain upon administration of Dilauded. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of 'Pain Assessment and Management' policy dated March 2019 revealed staff should ask residents about pain and identify characteristics of pain such as location, intensity, pattern and frequency. Interview on 04/24/24 at 2:45 P.M. with the Director of Nursing (DON) verified there was no indication non-pharmacological interventions had been attempted and no description of the location of pain. The DON verified that descriptions of pain should have been given and non-pharmacological interventions should have been attempted for every as needed administration.

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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** 49794 Based on staff interview, medical record review, and review of facility policy, the facility failed to ensure an end date was documented for an as needed psychotropic drug order, document behaviors and ensure non-pharmacological interventions were attempted prior to administration of as needed psychotropic drug for Resident #46, and to complete Abnormal Involuntary Movement Scale (AIM) assessments as scheduled for two residents (#19 and #38). This affected three residents (#46, #38, #19) of five residents reviewed for unnecessary medications. The facility census was 50. Findings include: 1. Review of medical record for Resident #46 revealed an admitted [DATE], diagnoses included ventilator dependent, pressure ulcer, chronic pain syndrome, anxiety disorder, insomnia, depression, dysphagia, chronic respiratory failure with hypoxia and hypercapnia, paraplegia, obstructive and reflex uropathy, pressure induced deep tissue damage of head, amyotrophic lateral sclerosis. Review of Resident #46's care plan dated 01/17/24 revealed Resident #46 was at risk for anxiety related to diagnosis of amyotrophic lateral sclerosis (ALS). Interventions included administering antianxiety medications as ordered, monitoring for safety related to a risk for confusion, amnesia, loss of balance, and cognition, and monitoring, documenting, and reporting any adverse reactions to antianxiety therapy such as drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion, disorientation, depression, dizziness, light headedness, impaired thinking and judgement, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Review of Resident #46's physician's order dated 04/19/2024 revealed an order for one tablet of Ativan (Lorazepam) 1 milligram (mg) to be given every 12 hours as needed for anxiety. Further review revealed no end date for as needed Ativan order. Review of Medication Administration Record (MAR) for March 2024 and April 2024 revealed Resident #46 received Ativan one mg for anxiety on 03/08/24, 03/10/24, 03/11/24, 03/13/24, 03/25/24, 03/27/24, and 03/29/24. Additional review revealed no non-pharmacological interventions or behavior descriptions were documented prior to administration of the as needed medication. Review of medication administration progress notes from 03/08/24 to 03/29/24 revealed there were no non-pharmacological interventions and no descriptions of behavior given upon administration of Ativan. Interview on 04/24/24 at 2:45 P.M. with the Director of Nursing (DON) verified there was no indication non-pharmacological interventions had been attempted and no description of resident behaviors documented prior to giving as needed Ativan. The DON verified that non-pharmacological interventions should have been attempted and behaviors documented for every as needed administration. 47569 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #38's medical record revealed Resident #38 was admitted to the facility on [DATE] with the diagnoses including schizophrenia, major depressive disorder, anxiety, psychotic disorder, and dementia. Resident #38 had severe cognitive impairment and required assistance from staff for Activities of Daily Living (ADL) tasks. Review of Resident #38's signed physician orders revealed an order dated 09/29/23 for antidepressant medication of Zoloft 50 milligrams (mg) give one tablet daily for depression, an order dated 09/30/23 for antipsychotic medication of Donepezil 10 mg one tablet daily for Psychotic Disorder with Delusions, an order dated 09/29/23 for antipsychotic medication of Seroquel 25 mg one tablet two times a day for schizophrenia. Review of Resident #38's Annual [NAME] Data Set (MDS) dated [DATE] revealed Section I - Active Disease Diagnosis was marked as Resident #38 having the diagnoses of schizophrenia, major depression disorder, psychotic disorder, and dementia. Section N - Medications was marked as Resident #38 receiving the following medications an antipsychotic and an antidepressant. A gradual dose reduction (GDR) was attempted for Seroquel and Zoloft on 03/13/24 results were medically contraindicated due to Resident #38 was stable on the current medication regimen and an GDR had the potential for target behaviors of verbal and physical aggression with refusal of care to return. Review of Resident #38's person centered care plan revealed Resident #38 had the following problems with interventions in place to address impaired cognition dated 04/28/23, antipsychotic medication use dated 04/28/23, mood disorder dated 05/06/22, depression 12/06/21, and antidepressant medication use dated 03/18/22. Review of Resident #38's assessments revealed on 04/04/23 an Abnormal Involuntary Movement Scale (AIMS) was completed by Licensed Practical Nurse (LPN) #401 with the results reflecting Resident #38 had no abnormal movements due to the use of antipsychotic medications. There were no further AIMS assessments since 04/04/23. Review of Resident #38's psychiatric note dated 04/12/24 authored by Nurse Practitioner (NP) #710 revealed Nursing staff report patient behaviors of intermittent verbal aggression towards others. Overall, her psychiatric diagnosis are chronic, intermittent, and moderate in severity. An interview on 04/24/24 at 1:37 P.M. with MDS LPN #440 revealed the AIMS assessments are completed by the unit managers and are scheduled by following the MDS schedule for completion of the required quarterly and annual per each resident. An interview on 04/24/24 at 1:50 P.M. with unit manager for rooms 1-31 Registered Nurse (RN) #415 confirmed Resident #38 had only one AIMS assessment completed since 04/04/23. RN #415 stated, When our new system went into effect Resident #38's order for completion of the AIMS assessment was not carried over to the new system to alert the floor nurses to complete the scheduled assessment and no one caught the mistake. The AIMS assessment should be completed at least quarterly following the MDS schedule for the resident. 47059 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #19's medical record revealed an admitted [DATE] with diagnoses that included Alzheimer's disease, atrial fibrillation, depression, dementia, metabolic encephalopathy, anxiety disorder, osteoarthritis, and disease of the pancreas. Resident #19 is on Seroquel 75 milligrams (mg) oral tablet once a day for dementia that was decreased to 50mg once a day on 04/07/23. The only Abnormal Involuntary Movement Scale (AIMS) evaluation documented in the medical record for Resident #19 was completed on 04/24/24. Interview on 04/25/24 at 11:20 A.M. with LPN #400 revealed there were no AIMS evaluations documented for Resident # 19 prior to 04/24/24. Review of policy titled Antipsychotic Medication Use dated December 2016 revealed the policy outlines acceptable use of antipsychotic medications. The policy discusses daily monitoring for side effects of antipsychotic medications but does not address the use of AIMS evaluations or the frequency the evaluations should be completed. Review of the Resident Assessment Instrument (RAI) manual indicates residents on antipsychotic medications should be monitored for potential adverse consequences at least during the quarterly care plan review if not more frequently. Review of the policy 'Behavioral Assessment, Intervention and Monitoring' dated March 2019, revealed non-pharmacological approaches will be utilized to the extent possible and documentation will include rationale for use, potential underlying causes of the behavior, other approaches and interventions tried prior to use of antipsychotic medication, potential risks and benefits of medications as discussed with resident and/ or family members, specific target behaviors and expected outcomes. Review of 'Use of Psychotropic Medication (UPM) policy' dated March 2023, revealed staff should attempt non- pharmacological interventions prior to administration of as needed psychotropic drugs and document non- pharmacological interventions and targeted symptoms. UPM policy revealed as needed orders for all psychotropic drugs will be limited in duration to 14 days or have a documented rationale and duration in the medical record if beyond the 14 days.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47569 Based on observation, interview, review of manufacture guidelines, and facility policy review the facility failed to date a multi-dose vial of Tubersol tuberculin solution when opened for use. This deficient practice had the potential to affect all 50 residents residing at the facility. The facility census was 50. Findings Include: An observation on 04/23/24 at 7:43 A.M. revealed an in use opened multi-dose vial of Tubersol tuberculin solution in the medication refrigerator located in the facility medication room. There was a yellow sticker on the bottom of the vial with the word date written on it. There was no opened date written on the sticker, on the vial or on the box were the vial was stored. The storage box had a label from the pharmacy with a delivery date to the facility of 03/07/24. Interview on 04/23/24 at 7:50 A.M. with Licensed Practical Nurse (LPN) Unit Manager #400 confirmed the opened multi-dose vial Tubersol tuberculin solution did not have an opened date on the yellow sticker, the vial or the box where the vial was stored. She stated, Once the vial is opened then there is 30 days in which we use the solution and then the vial is discarded. There is no open date on this vial to show when it as started being used. Review of the manufacture guidelines for Tubersol tuberculin solution dated 10/2021 revealed, A vial of Tubersol which has been entered and in use for 30 days should be discarded. Review of the facility's policy titled, Storage of Medications dated 04/2019 revealed, The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation, interview, review of facility policy, and medical record review, the facility failed to ensure puree food was served according to the menu and at an appropriate texture. This affected one resident (#35) of one resident on a puree diet. The facility census was 50. Findings include: Review of the medical record for Resident #35 revealed an admitted [DATE] with diagnoses including dementia, depression, and diabetes mellitus. Review of Resident #35's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed severely impaired cognition. Review of the physician's order dated 03/21/24 revealed Resident #35 was to receive a puree texture diet. Observation on 04/24/24 from 10:45 A.M. to 12:19 P.M. revealed Dietary Staff #466 preparing puree chicken lasagna for the one resident on a puree diet. Dietary Staff #466 added one serving of chicken lasagna to the food processor and an unmeasured amount of milk from a carton. She started the blender and added three more unmeasured amounts of milk. When Dietary Staff #466 was done it was a soupy consistency with visible chunks. Dietary Staff #466 and Dietary Manager #459 determined the lasagna could not be pureed and decided to make chicken breast instead and include green beans and tomato soup. Observation on 04/24/24 from 10:45 A.M. to 12:19 P.M. revealed Dietary Staff #466 preparing puree chicken breast. She put one plain chicken breast in the food processor and added an unmeasured amount of broth. Dietary Staff #466 allowed the processor to run and then determined the chicken was too thin, she added an unmeasured amount of thickener, allowed it for a moment and then poured the mixture into a serving bowl. The chicken was the consistency of applesauce and immediately began separating in the bowl, with thin liquid observed around the edges of the bowl. Dietary Staff #466 then began to prepare green beans. She added four ounces of green beans to the food processor, added an unmeasured amount of water, and blended. Dietary Staff #466 reported the mixture was too thin and then added an unmeasured amount of thickener. Dietary Staff #466 blended the mixture and then poured it into a serving bowl. The green beans were thinner than the consistency of applesauce. Observation revealed Dietary Staff #466 begin to hand the bowls to the server. Interview on 04/24/24 following the puree observation with Dietary Staff #466 and Dietary Manager #459 verified the food was a thinner consistency than pudding or mashed potatoes. Dietary Staff #466 and Dietary Manager #459 reported they did not follow a recipe for puree food they were looking for the consistency of baby food. Review of the lunch menu for 04/24/24 revealed residents were to receive a bacon lettuce tomato (BLT) with potato cakes, green beans, and a cookie. The alternate meal was chicken lasagna and a breadstick. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy 'Consistency Modified Diets' undated revealed puree food should be homogenous and cohesive. The food should be 'pudding like' with no coarse textures.

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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** 43064 Based on observation, interview, and review of facility policy the facility failed to ensure five residents (#11, #27, #28, #37, and #49) on a mechanically altered diet were served food at an appropriate texture. This affected five residents (#11, #27, #28, #37, and #49) of 15 residents on a mechanically altered or soft diet. The facility census was 50. Findings include: 1. Review of the medical record for Resident #27 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, dysphagia, hypertension, and cognitive communication deficit. Review of Resident #27's diet order dated 09/29/23 revealed an order for a soft texture diet. 2. Review of the medical record for Resident #37 revealed an admitted [DATE] with diagnoses including cerebral infarction, respiratory disorders, depression, and diabetes mellitus. Review of Resident #37's diet order dated 09/09/23 revealed she was to receive a mechanically altered diet. 3. Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses including dysphagia, cerebral infarction, schizoaffective disorder, and diabetes mellitus. Review of Resident #11's diet order dated 04/21/23 revealed an order for a mechanically altered diet. 4. Review of the medical record for Resident #49 revealed an admitted [DATE] with diagnoses including vascular dementia, depression, spondylolysis, and hypertension. Review of Resident #49's diet order dated 09/20/23 revealed an order for a mechanical soft diet. 5. Review of the medical record for Resident #28 revealed an admitted [DATE] with diagnoses including dysphagia, depression, diabetes mellitus, and chronic respiratory failure. Review of Resident #28's diet order dated 02/21/24 revealed an order for a mechanically altered diet. Observation on 04/24/24 from 10:45 A.M. to 12:19 P.M. of the lunch meal revealed residents on a mechanically altered diet were offered the meal alternate chicken lasagna or an always available item. During meal service five residents (#11, #27, #28, #37, and #49) on a mechanically altered diet were observed to receive the chicken lasagna. The lasagna was observed to have large chunks of chicken, one piece of chicken leftover in a pan was observed to be slightly larger than a quarter. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/24/24 following the lunch meal with Dietary Manager #459 verified residents on a mechanically altered diet received the chicken lasagna. She reported the lasagna came frozen and she was told by the previous cook that it was appropriate for residents on a mechanically altered diet without alterations. Dietary Manager #459 asked Speech Language Pathologist (SLP) #500 about the size of meat and SLP #500 indicated that she expected meat for those on a mechanically altered diet to be the size of a quarter (0.955 inches) or less. Dietary Manager #459 indicated she had used the frozen lasagna many times and 'just knew' the chicken was the size of a quarter or less. Interview on 04/25/24 at 9:40 A.M. with Dietary Manager #459 verified the facility policy indicated meat should be 1/4 an inch or less. Review of the facility policy 'Mechanical Soft Diet' undated, revealed a mechanical soft diet included chopped, ground and pureed foods as well as foods that break apart without a knife. It indicated foods to avoid included casseroles with large chunks of meat. All foods must be in pieces that are no longer than 1/4 of an inch. This may mean using a blender, food processor, grinder, or potato masher.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43064 Based on observation, interview, and review of facility policy, the facility failed to use appropriate hand hygiene during meal service. This had the potential to affect 46 of 46 residents who consumed food from the kitchen. The facility identified four residents (#25, #42, #46, #51) who were unable to eat by mouth. The facility census is 50. Findings include: Observation on 04/24/24 from 10:45 A.M. to 12:19 P.M. of the kitchen revealed Dietary Staff #466 doing a variety of tasks including the following: preparing puree food, putting gloved and ungloved hands into oven mitts to pull food out of the oven, setting up the steamtable, obtaining food temperatures, going in and out of the walk-in refrigerator, and serving food. Meal service included a bacon,lettuce,tomato (BLT) sandwich, Dietary Staff #466 was observed touching the bread for the BLT and the bread for grilled cheese sandwiches. During the entire observation Dietary Staff #466 was observed changing her gloves multiple times, however, she was not observed washing her hands during the entire observation. Observation on 04/24/24 between 10:45 A.M. to 12:19 P.M. revealed Dietary Staff #460 enter the kitchen from the dining room, put on gloves, and began preparing grilled cheese. Dietary Staff #460 did not wash her hands. Interview on 04/24/24 at 12:19 P.M. with Dietary Staff #466 and Dietary Manager #459 verified the observation. Review of the policy 'Hand Washing' undated, revealed employees were to wash hands in the following instances: when entering the kitchen, after handling soiled equipment or utensils, during food preparation as often as necessary to remove soil or contamination and to prevent cross contamination when changing tasks, before donning disposable gloves for working with food and after gloves are removed, and after engaging in other activities that contaminate hands.

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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** 47569 Based on observation, record review, and interview the facility failed to accurately document a physician order by signing that an order had been completed when the order had not been completed by not changing oxygen and nebulizer tubing as documented. This affected one resident (Resident #14) out of two residents reviewed for respiratory care. The facility census was 50. Findings Include: Review of Resident #14's medical record revealed Resident #14 was admitted to the facility on [DATE] with diagnoses including asthma, high blood pressure, dementia, and weakness. Resident #14 had severe cognition impairment, required staff assistance for personal hygiene cares, transfers, and bathing. Review of Resident #14's signed physician orders revealed an order dated 01/11/23 Oxygen at 2 liters (L) as needed to maintain blood oxygen levels (SP02) greater than 90%, an ordered dated 09/29/23 for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3 milligrams (mg) per 3 milliliters (ml) via nebulizer every four hours as needed for congestion, and an order dated 02/04/24 for Oxygen (02) tubing to be change every week on Sunday night shift. Review of Resident #14's Asthma care plan dated 07/18/23 revealed interventions to use oxygen with setting at 2 liters (L) via nasal cannula (NC) and to administer nebulizer medications as ordered. Review of Resident #14's Treatment Administration Record (TAR) revealed the order dated 02/04/24 for Oxygen (02) tubing to be changed every week on Sunday night shift was signed off as being completed on the night shift dated 04/21/24. An observation on 04/22/24 at 9:32 A.M. revealed Resident #14 sitting in a wheelchair receiving oxygen via nasal cannula with tubing attached to the oxygen concentrator. Oxygen concentrator setting at 2 liters with the tubing dated 04/14/24. A nebulizer (breathing treatment machine) was noted sitting on top of the three-drawer dresser at bedside with tubing dated 04/14/24. An observation on 04/23/24 at 9:27 A.M. revealed Resident #14 sitting in a wheelchair in the unit lounge area. Oxygen concentrator was noted in Resident #5's room, [NAME] running, with the oxygen tubing laying on the bed and still dated 04/14/24. The nebulizer was still sitting on top of the three-drawer dresser and the tubing still dated 04/14/24. An interview on 04/23/24 at 9:30 A.M. with Licensed Practical Nurse (LPN) #419 confirmed Resident #14's oxygen tubing and nebulizer tubing was dated 04/14/24 and the order on the TAR for 02 tubing to be changed every Sunday night shift was signed off on 04/21/24 as being completed. LPN #419 stated, The oxygen and nebulizer tubing and supplies are changed on Sunday nights during night shift and then the order is signed off on the Treatment Administration Record (TAR) when completed. The order was signed off on 04/21/24 as being completed, but the tubing was not changed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 04/23/24 at 3:05 P.M. with the Director of Nursing (DON) stated the expectation for the nurses are to accurately follow the physician orders and to only sign off the order when the task as been completed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on observation, record review, interview, and facility policy review the facility failed to perform hand hygiene during wound care. This affected one resident (Resident #34) out of four residents reviewed for pressure ulcer/injury. The facility census was 50. Findings Include: Review of Resident #34's medical record revealed Resident #34 was admitted to the facility on [DATE] and readmitted from a hospital stay on 04/19/24 with diagnoses including pressure injury to sacrum, bacteremia (blood infection), high blood pressure, depression, and bilateral above the knee amputations. Resident #34 had minimal cognitive impairment and required assistance from staff for Activities of Daily Living (ADL) tasks, transfers, and medical treatments. Review of Resident #34's signed physician orders revealed an order dated 04/20/24 for sacrum pressure injury treatment of packing wound with half strength Dakins solution soaked kerlix gauze and secure with a foam dressing. Change daily and as needed when soiled, an order dated 04/21/24 for enhanced barrier precautions for the use of foley catheter, colostomy and sacrum wound every shift. Review of Resident #34's Treatment Administration Record (TAR) dated 04/01/24 to 04/24/24 revealed Resident #34's sacrum wound dressing being completed per physician's order. Review of Resident #34's care plan dated 03/15/24 revealed Resident #34 with pressure injury to sacrum and receives interventions including low air lost mattress and treatment per physician order. An observation on 04/24/24 at 2:25 P.M. revealed Licensed Practical Nurse (LPN) #419 performing wound dressing change for Resident #34's pressure injury to sacrum. LPN #419 placed wound dressing supplies at the foot of Resident #34's bed without a barrier between the supplies and the bed sheets. LPN #419 washed her hands prior to donning a pair of gloves and removed the heavily saturated dressing for Resident #34's sacrum wound. LPN #419 then cleansed the wound with normal saline and gauze pads. Following cleansing of the wound, LPN #419 did not change gloves or wash her hands. LPN #419 immediately began to moisten gauze packing material with Dankins solution and applied the moistened gauze to the sacrum wound, packing the gauze into the wound area with her fingers and hand. LPN #419 then removed the clean sacrum dressing from the package and applied the sacrum dressing to the wound securing the packed gauze. LPN #419 removed her gloves, removed the remaining dressing supplies from Resident #34's bed, placed them on the cart outside of the room and then washed her hands at the sink in Resident #34's room. LPN #419 did not change gloves or wash/sanitize hands during the dressing change to the sacrum wound for Resident #34. An interview on 04/24/24 at 2:45 P.M. with LPN #419 confirmed hand washing and changing of gloves did not happen during Resident #34's dressing change to sacrum wound. LPN #419 stated, I washed my hands and put on gloves prior to starting the dressing change and then I removed my gloves and washed my hands after I had completed the dressing change. I did not wash my hands or change my gloves during the dressing change. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Wound care dated 10/2010 revealed, Steps in the Procedure: #2 - wash and dry your hands thoroughly, #4 - put on exam gloves and loosen tape and remove dressing, #5 - Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly, #6 - put on gloves, #7 - Use no-touch technique to cleanse the wound bed and surrounding tissue, #12 - apply treatment as ordered, #16 - discard disposable items in the designated container. Discard all soiled laundry. Remove disposable gloves and discard them into designated container. Wash and dry your hands thoroughly.