STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365822	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarfield Manor	461 South Canfield Niles Road Youngstown, OH 44515

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, interview and record review, the facility failed to notify Resident #32's representative of a new skin impairment. This affected one resident (#32) of three residents reviewed for changes in condition. The facility census was 67. Findings include: Review of Resident #32's medical records revealed an admitted [DATE]. Diagnoses included Alzheimer's, dementia and muscle weakness. Review of the care plan dated 12/24/24 revealed Resident #32 had self-care deficits. Interventions included assisting Resident #32 with transfers, toileting and bed mobility. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #32 had impaired cognition. Review of progress note dated 02/21/25 timed 6:52 P.M. authored by Licensed Practical Nurse (LPN) #497 that stated during transfer to the toilet, Resident #32 had difficulty standing, and had fallen back into the wheelchair and received a skin tear to her right wrist. The skin tear was cleansed with normal saline and a foam dressing was applied. The progress note did not include notification of the family regarding the skin tear. Observation on 02/24/25 at 9:23 A.M. revealed Resident #32 was in a wheelchair in her room and had a foam bandage to her right wrist. Interview with Resident #32 revealed she was confused and unaware how the injury occurred. Interview with LPN #497 at time of observation revealed on 02/21/25 she was assisting Resident #32 to the toilet, and Resident #32's legs became weak, and Resident #32 flung her arms out and hit her hand on the wheelchair. Telephone interview on 02/24/25 at 10:54 A.M. with Resident #32's daughter revealed she had not been aware of Resident #32 having a skin tear. Follow up interview on 02/24/25 at 1:32 P.M. with LPN #497 revealed she could not recall calling Resident #32's daughter to inform of the skin tear. Review of progress notes with LPN #497 at time of interview confirmed progress note had not included documentation of notification to Resident #32's daughter and stated she should have called to inform of the injury.

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

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, interview and record review, the facility failed to ensure tube feeding and intravenous (IV) poles were clean and sanitary. This affected five residents (#13, #43, #52, #57 and #226) of five residents observed for tube feeding and IV poles. The facility census was 67. Findings include: 1. Review of Resident #13's medical records revealed an admitted [DATE]. Diagnoses included gastrostomy (feeding tube), dysphasia (difficulty swallowing) and malnutrition. Review of the care plan dated 12/24/24 revealed Resident #13 required enteral feeding (nutrition received through a feeding tube). Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #13 had no cognition score due to resident was rarely understood. Review of the physician orders for February 2025 revealed Resident #13 received enteral feedings from 5:00 P.M. to 5:00 A.M. daily. Observation on 02/24/25 at 9:38 A.M. revealed Resident #13 was sleeping in bed with a tube feeding pole positioned at the foot of his bed. Further observation revealed a large amount of dried tube feed on the base of the pole. The observation was confirmed by Certified Nursing Assistant (CNA) #434 on 02/25/25 at 2:25 P. M. She stated she was unsure who was supposed to clean the poles. 2. Review of Resident #43's medical records revealed an admitted [DATE]. Diagnoses included gastrostomy and dysphasia. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #43 had intact cognition and required the use of enteral feeding for nutrition. Review of the physician orders for February 2025 revealed Resident #43 received continuous enteral feeding at 45 milliliters (mL) per hour (hr). Observation on 02/25/25 at 8:50 A.M. revealed Resident #43 was resting in bed with tube feeding infusing. Further observation revealed a large amount of dried tube feed on the pole as well as the base. At time of observation Social Services Designee (SSD) #425 entered Resident #43's room and confirmed the dried tube feed on the pole. SSD #425 stated an outside company was responsible for the cleaning of equipment and stated he would inform the company. 3. Review of Resident #57's medical records revealed an admitted [DATE]. Diagnoses included Methicillin-resistant Staphylococcus aureus (MRSA) (bacterial infection). Review of the MDS 3.0 assessment dated [DATE] revealed Resident #57 had intact cognition. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan dated 02/19/25 revealed Resident #57 received IV therapy related to an acute infection. Review of the physician orders for February 2025 revealed Resident #57 was ordered Vancomycin (antibiotic) IV one time a day. Observation on 02/25/25 at 9:30 A.M. revealed Resident #57 was sleeping in bed with an IV pole at the foot of her bed. The IV pole appeared to have a large amount of dried debris on the bottom portion of the pole. The observation was confirmed by CNA #434 on 02/25/25 at 2:25 P.M. She stated she was unsure who was supposed to clean the poles. 4. Review of Resident #226's medical records revealed an admitted [DATE]. Diagnosis included gastrostomy. Review of the care plan dated 12/24/24 revealed Resident #226 was at risk for nutritional issues and received supplemental tube feedings. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #226 had impaired cognition. Review of the physician orders for February 2025 revealed Resident #226 was ordered tube feed at 50 ml/hr. Observation on 02/24/25 at 9:40 A.M. revealed Resident #226 was in bed sleeping, and a tube feed pole was on the side of Resident #226's bed. Further observation revealed a large amount of dried tube feed on the bottom portion of the pole. The observation was confirmed by CNA #434 on 02/25/25 at 2:25 P.M. She stated she was unsure who was supposed to clean the poles. 42013 5.Review of Resident #52's medical record revealed an admitted [DATE] with diagnoses including type two diabetes mellitus with ketoacidosis without coma, dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, and acute kidney failure. Review of the care plan dated 01/21/25 included Resident #52 had a self-care deficit regarding activity of daily living (ADL) and mobility. Resident #66's dignity would be maintained. Resident #52 would be well-groomed, clean and neat through the next assessment. Resident #52 would participate in therapy and improve ADL, mobility and self-care. Interventions included ambulation, bed mobility, continence and oral care. Review of the Admission MDS 3.0 assessment dated [DATE] included a Brief Interview for Mental Status (BIMS) which was not conducted for Resident #52 due to Resident #52 was rarely or never understood. Resident #52 was dependent on staff for bathing, toileting hygiene, and required substantial to maximal assistance for personal hygiene. Resident #52 received tube feeding through a percutaneous endoscopic gastrostomy (PEG) tube. Review of Resident #52's physician orders dated 01/31/25 revealed enteral feed, two times a day, DiabetaSource (nutritional supplement) at 65 cubic centimeters (cc) per hour, continuous. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/25/25 at 8:50 A.M. with Licensed Practical Nurse (LPN) #446 of Resident #52's IV and tube feeding pole on wheels next to Resident #52's bed revealed the pole appeared to have a large amount of rust or dried tube feeding on the lower one third of the pole and a large amount of rust or dried tube feeding on the base of the pole by the wheels. Interview on 02/25/25 at 8:50 A.M. of LPN #446 confirmed Resident #52's IV and tube feeding pole had either a large amount of rust or dried tube feeding on it. Observation on 02/25/25 at 9:27 A.M. of Housekeeper #515 with LPN #446 revealed he was cleaning Resident #52's IV and tube feeding pole. Housekeeper #515 stated he had to really scrub the pole using a non-scratch cleaning pad and a disinfectant solution on a cloth, and the pole mostly had a large amount of dried tube feeding on it with a little rust. Observation of the IV and tube feeding pole revealed it was clean and the lower third of the pole and the base by the wheels was clean and free of dried tube feeding and rust. LPN #446 confirmed the IV and tube feeding pole was clean and free of dried tube feeding and rust.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview and record review the facility failed to ensure Resident's #52 and #66's care planned interventions for grooming were implemented. This affected two residents (#52 and #66) of three residents reviewed for grooming. The facility census was 67. Findings include: 1. Review of Resident #66's medical record revealed an admitted [DATE] with diagnoses including hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction affecting the left non-dominant side, aphasia (language disorder that affects the ability to communicate effectively) following cerebral infarction, dysphagia (difficulty swallowing), dysarthria (slurred speech) following cerebral infarction, and vascular dementia. Review of the care plan dated 01/08/25 included Resident #66 had a self-care deficit regarding activities of daily living (ADL) and mobility. Resident #66's dignity would be maintained. Resident #66 would be well-groomed, clean and neat through the next assessment. Interventions included bed mobility required assistance of two staff members; Resident #66 preferred to be bathed on day shift on Monday, Wednesday, and Friday. Review of Resident #66's progress notes dated 01/27/25 through 02/26/25 did not reveal any written evidence Resident #66 refused to have his fingernails trimmed or that staff encouraged him to allow his fingernails to be trimmed. Review of the 5-day Medicare Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #66 was cognitively intact. Resident #66 was dependent on staff for toileting hygiene and lower body dressing. Resident #66 required substantial to maximal assistance with bathing. Resident #66 had an indwelling catheter and was always incontinent of bowel. Resident #66 did not reject care during the seven-day assessment look-back period. Interview on 02/25/25 at 2:42 P.M. of Director of Rehab (DOR) #509 revealed Resident #66 had difficulty with expressive and receptive communication, had difficulty with yes and no accuracy, auditory processing and following commands. Review of Resident #66's care plan initiated 02/25/25 included Resident #66 refused, resisted treatment, to comply with safe regulations, and to participate in therapy. Resident #66 would comply with the plan of treatment and care by the next evaluation. Resident #66 would have less than four episodes per week of resisting care. Interventions included determining the reason for refusal; educating regarding health, safety consequences of refusal; encouraging Resident #66 to participate in care. Further review did not reveal evidence a care plan was initiated for Resident #66 being resistive to care prior to 02/25/25. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/26/25 at 9:58 A.M. of Resident #66 with Certified Nursing Assistant (CNA) #462 revealed the resident's fingernails on the right hand were about one half inch to three quarters of an inch long. The fingernails were yellow and had a lot of brownish colored material observed underneath them. CNA #462 confirmed Resident #66's fingernails were long, yellow and had brownish material underneath them and stated the nurse's usually cut resident fingernails because the aides did not know if a resident was a diabetic or on blood thinners or things like that. Interview on 02/26/25 at 9:59 A.M. of Licensed Practical Nurse (LPN) #446 revealed he noticed Resident #66's fingernails were long, dirty and yellow with brown material underneath them. LPN #446 stated he would look at Resident #66's fingernails today and had not got that far yet today. LPN #446 confirmed the nurse's usually cut resident fingernails, but the aides could do it if the resident was not a diabetic. Interview on 02/26/25 at 12:12 P.M. of Certified Occupational Therapy Assistant (COTA) #508 revealed she worked with Resident #66 on simple ADL, simple grooming and hygiene and unsupported sitting. COTA #508 stated Resident #66 had quite a bit of pain in his left arm and left leg and the left leg was drawn in and had a lot of tone. COTA #508 stated Resident #66 babied his left arm because it hurt. COTA #508 indicated Resident #66 wanted to do well but his pain interfered with his therapy and working on things like ADL. Review of Resident #66's Resident Shower Documentation Sheets (provided to the surveyor by email on 03/05/25) dated 02/03/25, 02/11/25, 02/13/25, 02/20/25, 02/24/25, and 02/26/25 revealed Resident #66 refused nail care. (However, the MDS 3.0 assessment stated Resident #66 had not rejected care from 02/08/25 through 02/14/25). There was no further evidence provided by the facility that nail care had been re-attempted by a nurse or certified nursing assistant (CNA) on any other days between 02/03/25 and 02/26/25 to ensure the resident was receiving assistance with nail hygiene and grooming. There was no documented evidence that the physician and/or Resident #66's responsible party were notified that Resident #66 refused nail care. 2. Review of Resident #52's medical record revealed an admitted [DATE] with diagnoses including type two diabetes mellitus with ketoacidosis without coma, dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, and acute kidney failure. Review of the care plan dated 01/21/25 included Resident #52 had a self-care deficit regarding ADL and mobility. Resident #66's dignity would be maintained. Resident #52 would be well-groomed, clean and neat through the next assessment. Resident #52 would participate in therapy and improve ADL, mobility and self-care. Interventions included ambulation, bed mobility, continence and oral care. Review of the Admission MDS 3.0 assessment dated [DATE] included a BIMS was not conducted because Resident #52 was rarely or never understood. Resident #52 was dependent on staff for bathing, toileting hygiene, and required substantial to maximal assistance for personal hygiene. Observation on 02/25/25 at 9:29 A.M. of Resident #52 with LPN #446 revealed Resident #52 had long fingernails on both hands about one half inch to three quarters inch. Resident #52's fingernails were yellow and had a lot of brown material underneath the nails. Three to four of Resident #52's fingernails were short and very thick, and LPN #446 stated he could not cut those, but he would make sure the other long fingernails were clipped. LPN #446 confirmed Resident #52's fingernails were dirty. LPN #446 asked Resident #52 if he could cut his fingernails, and Resident #52 nodded his head yes.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, interview, record review and facility policy review, the facility failed to ensure treatments were administered according to physician orders for Residents #40 and #58. This affected two residents (#40 and #58) of three residents reviewed for physician orders. The facility failed to adequately document abnormal vital signs for Resident #57 exhibiting a change in condition resulting in hospitalization . This affected one resident (#57) of three residents reviewed for change in condition. The facility census was 67. Findings include: 1. Review of Resident #40's medical records revealed an admitted [DATE]. Diagnoses included chronic heart failure (CHF), hypertension and muscle weakness. Review of the care plan dated 01/09/25 revealed Resident #40 was at risk for edema. Interventions included Tubi grips (a tubular bandage that provides compression and support for arms and legs) per physician order. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #40 had intact cognition. Review of the physician orders for February 2025 revealed Resident #40 was ordered Tubi grips to be worn on lower extremities while out of bed and to be removed at bedtime. Interview on 02/24/25 at 9:13 A.M. with Resident #40 revealed she would like her compression stocking applied, and she stated she had been told they had been ordered, and she had not had them for about a week. Observation at the time of the interview revealed Resident #40 was not wearing compression stockings and bilateral legs appeared to be swollen. Interview on 02/25/25 at 8:16 A.M. with Resident #40 stated she had not been given her compression stockings the previous day and she had requested them to be placed on. Observation of Resident #40 at the time of the interview revealed she was not wearing compression stockings. Interview on 02/25/25 at 12:12 P.M. with Licensed Practical Nurse (LPN) #510 revealed she was unaware Resident #40 had not been given Tubi grips. LPN #510 stated the facility had Tubi grips in the supply room and stated she would obtain a pair and place them on Resident #40. Observation at the time of the interview revealed LPN #510 had obtained a box of Tubi grips from the supply room and applied the stocking to Resident #40's bilateral extremities. Review of physician orders with LPN #510 after applying Resident #40's Tubi grips revealed physician orders had been placed in the computer system incorrectly and stated the orders had an indication that documentation was not required regarding Resident #40's Tubi grips. LPN #510 stated due to the incorrect orders, the application of Resident #40's Tubi grips had not shown in the computer system as a treatment that was to be completed daily. 2. Review of Resident #57's medical records revealed an admitted [DATE]. Diagnoses included respiratory failure, chronic obstructive pulmonary disease (COPD) and hypertension. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan dated 12/24/24 revealed Resident #57 required respiratory treatments. Interventions included provide respiratory treatments as ordered. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #57 had impaired cognition. Review of the progress note dated 02/07/25 timed 9:30 A.M. authored by LPN #485 revealed Resident #57 was transported by ambulance to an area hospital, vital signs were unstable with periods of confusion. Review of Resident #57's medical records revealed no documentation of Resident #57's vital signs on 02/07/25. Review of progress note dated 02/17/25 timed 11:30 P.M. authored by Registered Nurse (RN) #472 revealed Resident #57 had arrived to facility at approximately 11:30 P.M. Interview on 03/03/25 at 11:18 A.M. with LPN #485 revealed she could not recall which of Resident #57's vital signs were abnormal and stated she had not recorded Resident #57's vital signs in the electronic medical records. 46195 3. Review of the medical record for Resident #58 revealed an admitted [DATE]. Diagnoses included chronic kidney disease, chronic diastolic (congestive) heart failure (CHF), atherosclerotic heart disease, and hyperlipidemia. Review of the physician orders for Resident #58 revealed a physician order, dated 10/22/24, for Furosemide (generic for Lasix which was a diuretic used to treat fluid overload in adults with CHF) one 40 milligram (mg) tablet with instructions to administer one tablet one time a day; and another physician ordered, dated 01/03/25, for Lasix oral tablet 20 mg with directions to give one 20 mg tablet every 24 hours as needed if the resident's weight increased more than two pounds in a day. Review of the modification of annual MDS 3.0 assessment dated [DATE] revealed Resident #58 was cognitively intact and had received a diuretic during the assessment reference period. Review of the care plan, created on 08/02/24, revealed Resident #58 was at risk for edema related to CHF and renal disease. Interventions included provide medication per physician order. Review of Resident #58's January 2025 and February 2025 Medication Administration Record (MAR) revealed Resident #58 had been substantially weighed daily with some resident refusals. On 01/05/25 the resident weighed 204.6 pounds and on 01/06/24 weighed 206.8, which was a 2.2 pound weight increase in 24 hours; on 02/02/24 the resident weighed 203.1 pounds and on 02/03/25 the resident weighed 205.8 pounds, which was an increase of 2.7 pounds increase in 24 hours; on 02/19/25 the resident weighed 204.2 pounds and on 02/20/25 weighed 208.9 pounds, which was an increase of 4.7 pounds in a 24 hour period; and on 02/25/25 the resident weighed 204.7 pounds and on 02/26/25 weighed 209.4, a weight increase of 4. 7 pounds in a 24 hour period. Resident #58 had been administered the scheduled one 40 mg tablet of furosemide daily but had not been administered one 20 mg tablet of Lasix for a weight increase of more than a two in a day during the months of January and February. (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 03/02/25 at 8:04 P.M. with LPN #487 confirmed on 01/06/25 and on 02/03/25, when she input Resident #58's daily weight in the MAR, she should have administered one 20 mg tablet of Lasix since the resident had gained more than two pounds in a 24 period. She confirmed she had not administered one 20 mg tablet of Lasix for the weight increase on 01/06/25 and 02/03/25 since she hadn't realized the resident had an order to administer one 20 mg tablet of Lasix if the resident gained more than two pounds within a 24-hour period. Interview on 03/03/25 at 5:30 P.M. with Certified Nurse Practitioner (CNP) #500 revealed she was aware Resident #58 had an order in place to administer a diuretic if the resident gained more than two pounds in a day, and she would expect the facility to administer the medications as ordered. Review of the undated facility policy Medication Administration Policy revealed medications would be administered in accordance with written orders of the prescriber.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 46195 Based on observation, interviews, review of facility fall investigation reports, review of hospital records, facility medical record review and facility policy review, the facility failed to ensure fall prevention interventions were in place as ordered for Resident #56 in a timely manner. This affected one resident (#56) out of three residents reviewed for accidents. The facility census was 67. Findings include: Review of the medical record for Resident #56 revealed an admitted [DATE]. Diagnoses included: pneumonia, hemiplegia (paralysis on one side of the body) affecting the left nondominant side, chronic obstructive pulmonary disease (COPD), type two diabetes, paranoid schizophrenia, hypotension (low blood pressure), generalized anxiety disorder, adult failure to thrive, insomnia (a sleep disorder that can make it hard to fall asleep or stay asleep), and history of falling. Review of Resident #56's fall risk assessments between 06/10/24 and 02/25/25 revealed the resident was at moderate risk for falls. Review of Resident #56 care plan, with a creation date of 06/10/24, revealed the resident was at risk for accidents, falls, injury related to gait/balance problems, hypotension, psychoactive drug use, dx hemiplegia affecting left nondominant side, other hypotension, difficulty in walking, history of falling, and weakness. Interventions included avoid repositioning furniture; bed alarm; call light in reach; chair alarm, keep furniture in locked position; keep needed/frequently used items in reach; low bed, mat to bedside floor (updated 10/05/24); perimeter mattress (updated 02/27/25); and two positioning bars up when in bed to aid in positioning. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #56 was rarely/never understood with the staff assessing the resident as having short- and long-term memory problems. The resident did not refuse care during the assessment reference period and required substantial/maximum assistance from staff to roll left to right, to go from a sitting position to a lying position, and to go from a lying position to sitting position. Resident #56 was dependent on staff for transfers and maneuvering his wheelchair. Review of the progress notes in Resident #56's medical record revealed from 01/11/25 to 02/25/25 revealed on 01/11/25 upon entering his room, staff observed the resident had both legs over the side of the bed and before the nurse or aide could reach the resident, his body weight took him to the floor. On 02/17/25 at 11:45 P.M. the nurse observed Resident #56 on the floor next to his bed. The resident stated he had fallen out of bed. On 02/24/25 the resident was observed to have fallen out of his bed and was complaining of left wrist, hip and bilateral knee pain and his blood oxygen level was 87 percent. The nurse practitioner ordered the resident sent to the emergency room for further evaluation. The resident was admitted with a diagnosis of pneumonia and returned to the facility on [DATE] around 7:00 P.M. (continued on next page)

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	365822	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarfield Manor	461 South Canfield Niles Road Youngstown, OH 44515

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of hospital emergency room records dated 02/24/25 revealed Resident #56 presented to the emergency room for evaluation of fall after he had rolled out of bed. Hospital records revealed no injuries from the fall but Resident #56 was found to have pneumonia. Review of the facility document Briarfield Manor Incident Investigation Summary revealed the clinical team on 01/13/25 reviewed Resident #56's fall on 01/11/25 at 1:30 A.M. when the nurse was responding to the alarm and upon entering the room the resident had both legs over side (of bed) and before the nurse and aide could reach the resident, he rolled out of the bed. Resident #56 denied pain and had been behavioral throughout the shift and into the next shift. Current interventions were alarms, low bed, and floor mat. The new intervention was to send Resident #56 to the emergency room and have the scheduler at the facility set up a psychiatric consult when the resident returned. Review of the facility document Briarfield Manor Incident Investigation Summary revealed the clinical team had discussed on 02/18/25 Resident #56's fall on 02/17/25 at 11:45 P.M. when Resident #56 was noted on the floor between bed and window when the aide responded to the alarm. Resident #56 stated he had fallen out of bed and denied pain or injury. Current interventions were bed and chair alarms, low bed and floor mats. The new intervention was going to be a bariatric bed. Review of the facility document Briarfield Manor Incident Investigation Summary revealed the clinical team on 02/25/25 had reviewed Resident #56's fall on 02/24/25 at 7:15 A.M. when Resident #56 was noted to be next to bed, which was in low position, with knees on the floor mat and shoulder still up on bed with pressure still on the bed's safety alarm and the call light was in reach. Prior to the fall, the resident had bed and chair alarms, floor mat, and a bariatric bed interventions were in place to help prevent falls, and the new intervention was going to be a perimeter mattress (a mattress with raised edges that creates a defined boundary). Review of the physician orders for Resident #56 revealed an order dated 02/25/25 for a perimeter mattress. Observation on 02/26/25 at 11:56 A.M. revealed Resident #56 was not in his room but there was no perimeter defining mattress on his bed. Review of the receipt from the equipment supplier for the perimeter mattress revealed on 02/26/25 at 2:14 P.M. Resident #56 signed that the perimeter mattress had been delivered. Observation on 02/26/25 at 4:31 P.M. revealed Resident #56 was awake and lying in his bed. There was no perimeter defining mattress on the bed. Interview at the time of observation with the resident revealed the cause of his last fall was a fall out of his bed. Observation on 02/27/25 at 8:32 A.M. of Resident #56's room, as Registered Nurse (RN) #452 wheeled Resident #56 back in his room after he had eaten breakfast in the dining room, revealed there was a large clear bag which contained a perimeter defining mattress leaning against the chair in his room, and there was no perimeter mattress on Resident #452's bed. Interview on 02/27/25 at 8:33 A.M. with RN #452 confirmed there was no perimeter defining mattress on Resident #56's bed and instead it was in a plastic bag leaning against a chair in his room. RN #452 stated she believed it had been delivered yesterday. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 02/27/25 at 10:44 A.M. with Licensed Practical Nurse (LPN) #421 revealed Resident #56 had a new order for perimeter mattress. She stated if the facility had to order a perimeter defining mattress, it should be put on the bed right after it had been delivered. She stated since Resident #56 wasn't in his bed when she checked on him that morning, she was unsure if the perimeter defining mattress had been put in place since it wasn't a priority. Review of the facility policy titled Fall Prevention Protocol, dated 05/23/12, revealed based on previous evaluations and present information, the staff would identify interventions related to the resident's specific risks and attempt to prevent the resident from falling and/or minimize complications from fallings.

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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** 51525 Based on observation, medical record review and staff interviews, the facility failed to ensure incontinence care was provided in a timely manner for Resident #67. This affected one resident (#67) of two residents reviewed for incontinence care. The facility census was 67. Findings include: Record review revealed Resident #67 was admitted to the facility on [DATE] with diagnoses of displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, other fracture of head and neck of left femur, subsequent encounter for closed fracture with routine healing, difficulty in walking. Review of the Brief Interview for Mental Status (BIMS) dated 12/30/24 revealed Resident #67 scored 14 out of 15, indicating she was cognitively intact. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #67 was always incontinent of bowel and bladder. The care plan dated 01/12/25 stated resident was on a scheduled toileting program and the goal was that the resident's incontinent episodes happen less than once per week; usually continent. The care plan interventions included toileting program: 6:00 A.M., 10:00 A.M., 1:00 P.M., 4:00 P.M. , 7:00 P.M. and prior to bed if up later and as needed, continue to check and change throughout night, *prompt to use bathroom* every shift. An order dated 01/06/25 stated the resident was to be on a scheduled toileting program: 6:00 A.M., 10:00 A.M., 1:00 P.M., 4:00 P.M., 7:00 P.M. and prior to bed if up later and as needed, continue to check and change throughout night, *prompt to use bathroom* every shift. Interview with Resident #67 on 02/25/25 at 9:15 A.M. who stated she was incontinent of bowel and bladder and doesn't understand why. She stated this was new since her admission to the facility. She stated her urine and feces just comes out. She stated she puts on her call light when she needs someone to clean and change her. Interview with Certified Nursing Assistant (CNA) #455 on 02/25/25 at 4:09 P.M. who stated Resident #67 will press her call button if she needed toileting assistance or incontinence care. Observation of Resident #67 on 02/26/25 at 8:17 A.M. showed her sitting up in bed awake and alert. She stated she had not been toileted or checked and changed yet that morning. Observed Resident #67 ask CNA #401 to change her before therapy and asked CNA #401 to let nurse know she wanted something for pain before going to therapy. CNA #401 confirmed she was going to perform incontinence care at that time, and Resident #67 asked the surveyor to check on her later. Interview with Resident #67 on 03/03/25 at 9:15 A.M. who stated she was unaware she was on a scheduled toileting program and that staff was not toileting her per schedule. She stated staff provided incontinence care when she asked for them to do so. Resident #67 further stated that aides do not take her into the bathroom, and that they provide incontinence care to her while she is in bed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of incontinence care provided to Resident #67 on 03/03/25 at 9:23 A.M. by CNA #401. The resident says she is satisfied with her care, always wears an incontinence brief, and stated the femur fracture causes pain. Resident #67 stated she has been incontinent the last ten days but was noticing improvement and was starting to get control back. Observation of bowel movement, formed, brown, no skin breakdown, or redness. CNA #401 stated if the resident requested to go to bathroom she would take her. CNA #401 also stated she did not take the resident to the bathroom on a schedule at 6:00 A.M.,10:00 A.M., 1:00 P.M., 4:00 P.M., 7:00 P.M. She would have Resident #67 sit on toilet midday if she needed changed and does not want to lay her down. Resident #67 stated she was not taken to bathroom on schedule, but hoped it got to that point, urine would just come out and was starting to get control back and was very happy about that. Interview with Certified Occupational Therapy Assistant (COTA) #508 on 03/04/25 8:47 A.M. who stated therapy was aware of Resident #67's scheduled toileting program but therapy was not working on that specifically. COTA #508 stated therapy does work on the toileting task with the resident but not as it directly relates to the schedule. COTA #508 stated the resident does not retain things from one day to the next and needed to be reminded daily how to perform therapy exercises she already learned. Interview with CNA #401 on 03/04/25 at 10:29 A.M. stated she provided incontinence care Resident #67 on 03/04/35 at around 9:00 A.M. and confirmed the resident was wet. CNA #401 also stated the resident was wet at least 90% of the time when incontinence care was provided. Interview with Licensed Practical Nurse (LPN) #510 on 03/04/25 at 10:30 A.M. confirmed the order for toileting schedule in Medication Administration Record (MAR)/Treatment Administration Record (TAR) for 03/03/25 was marked complete; she stated she asked her aides who stated the toileting schedule was followed. The incontinence task in Resident #67's chart for 03/03/25 stated incontinence care was provided at 6:41A.M., 10:07 A.M., 4:46 P.M.

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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 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** 46195 Based on record review, interviews, and review of facility policy, the facility failed to accurately and consistently monitor and record a physician ordered fluid restriction for Resident #58 and #29. This affected two residents (#29 and #58) out of nine residents reviewed for nutrition. The facility census was 67. Findings include: 1. Review of the medical record for Resident #58 revealed an admitted [DATE] with diagnoses including chronic kidney disease, chronic diastolic (congestive) heart failure (CHF), atherosclerotic heart disease, and hyperlipidemia. Review of the modification of the annual Minimum Data Set (MDS) 3.0 assessment, dated 12/13/24, revealed Resident #58 was cognitively intact, received a therapeutic diet, had no significant weight changes, and had received a diuretic during the assessment reference period. Review of the care plan, created on 08/02/24, revealed Resident #58 was at risk for nutritional issues secondary to impaired medical status. Interventions included: provide medical nutrition therapy interventions per order and monitor, document, and evaluate meal and fluid intakes consumed. Review of the document titled After Visit Summary, date 12/26/24, revealed Resident #58 had a visit with a cardiologist who gave instructions for her to restrict fluid intake to less than 2.2 liters (the equivalent of 2200 milliliters) per day. Review of Resident #58's physician orders revealed an order dated 12/26/24 for a 2,000 milliliter (ml) fluid restriction with dietary providing 1080 ml a day and nursing providing 920 ml a day. Review of Resident #58's January 2025 and February 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed there was no documentation of the actual fluid amounts offered and consumed from the 920 ml nursing portion of the fluid restriction for Resident #58. An interview on 02/27/25 at 8:24 A.M. with Resident #58 confirmed she needed a fluid restriction due to congestive heart failure and the facility staff brought her fluids. Interview on 02/27/25 at 8:47 A.M. with Certified Nursing Assistant (CNA) #426 revealed the aides were aware of who was on a fluid restriction by their report sheets. CNA #426 indicated Resident #58 was on a 2, 000 ml fluid restriction. He stated dietary was providing the fluids which were listed on her meal ticket, and he would usually give Resident #58 one four-ounce plastic cup (120ml) of water three to four times a day (360 ml to 480 ml/day), and he would let the nurse know what fluids he had provided. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/27/25 at 10:04 A.M. with Licensed Practical Nurse (LPN) #466 revealed Resident #58 was on a 2,000 ml fluid restriction and nursing was allowed to give 920 ml/day. She stated she usually gave 60 ml with medications twice a day (120 ml/day) during her shift and the aides would tell her if they had given fluids. After reviewing Resident #58's February 2025 MAR and TAR during the interview, LPN #466 confirmed the 920 ml fluid allotment for nursing was not being documented anywhere on the MAR, and without nursing documenting how much they had provided, there was no way to determine if nursing had adhered to the fluid restriction. LPN #466 confirmed the MAR was where it should be documented, but the fluid restriction was not listed on the MAR. Review of undated facility policy titled Fluid Restriction, revealed the total fluid restriction amount would be divided between nursing and dietary. The dietary allotment was provided to the resident according to their beverage preferences and was noted specifically by the amount on their meal card, and the nursing allotment would be found on MAR. 2. Review of the medical record for Resident #29 revealed an admitted [DATE] with diagnoses including heart failure, old myocardial infarction, depressive disorder, and attention-deficit hyperactivity disorder. Review of Resident #29's quarterly Minimum Data Set (MDS) 3.0 assessment, dated 02/18/25, indicated the resident was cognitively intact, was able to feed self after tray set up, had no significant weight changes, and was on a therapeutic diet. Review of the care plan, created on 01/26/25, revealed Resident #29 was at risk for compromised nutritional status secondary to impaired skin integrity, would make choices which were not always in the best interest of the resident, and was obese and on a fluid restriction. Interventions included providing medical nutritional therapy as ordered, monitor, document, and evaluate meal and fluid intakes, fluid restriction per order, and providing nutrition education, counseling, and nutritional discharge planning as needed. Review of the physician orders revealed an order, dated 02/11/25, for a No Added Salt diet (NAS), regular texture, regular/thin liquids and an order, dated 02/11/25, for a 1500 milliliter (ml) fluid restriction with the order revised on 02/18/25 to reflect dietary would provide 1080 ml per day and nursing would provide 420 ml per day for the 2,000 ml fluid restriction. Review of the facility document titled Medical Nutrition Therapy Review, dated 02/12/25, revealed Resident #29 was on a NAS diet and 1500 ml per day fluid restriction. The fluid restriction was new from readmission, and the resident was not receptive to the fluid restriction. Education was provided, and the resident was not agreeable to remove the large tumbler (that he used for water pitcher) from the room. It was indicated in the medical nutrition therapy review that the resident may not be compliant despite education, and the facility would honor the resident's informed decision and encourage and educate when appropriate. Review of the February 2025 MAR for Resident #29 revealed the 1500 ml fluid restriction with a start date of 02/12/25 was documented on the MAR, however, there was only a check mark to indicate the nurse had signed it off each shift without accurately documenting how much fluid had been consumed by Resident #29 on each shift. This was discontinued on 12/17/25 and on 12/18/25 the order for 1500 ml per day, dietary 1080 ml per day, nursing 420 ml per day was added, but again only a check mark by the nurse was marked and not an accurate amount of how much fluid was consumed. (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 the February 2025 TAR revealed no documentation of the 1500 ml per day fluid restriction. An interview on 02/25/25 at 12:12 P.M with Resident #29 revealed he was not aware of being on fluid restriction. An interview on 02/27/25 at 10:18 A.M. with LPN #466 revealed Resident #29 was on a fluid restriction and nursing was allowed 420 ml fluids in a 24-hour period which meant each 12-hour nursing shift was allowed 210 ml each shift. She stated Resident #29 received medications at 9:00 A.M, 11:00 A.M., 2:00 P.M., and at 4:00 P.M. and each time she gave the resident his medications she would give the medications along with a half-full four-ounce cup of water (60ml) for a total of approximately 240ml being given with his medications. After looking at Resident #29's MAR, LPN #466 confirmed that the MAR indicated that nursing was allotted 420 ml in a 24 period, but there was no place to document how many ml of fluid had been provided each shift. LPN #466 indicated without nursing documenting the amount of fluids they provided during each 12-hour shift for Resident #29, there was no way to monitor how much fluids had been provided by nursing in a 24-hour period. Review of undated facility policy titled Fluid Restriction, revealed the total fluid restriction amount would be divided between nursing and dietary. The dietary allotment was provided to the resident according to their beverage preferences and was noted specifically by the amount on their meal card, and the nursing allotment would be found on MAR.

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F 0697 Level of Harm - 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** 51525 Based on observation, record review, facility policy review, and interview, the facility failed to develop and implement a comprehensive, individualized and effective pain management program for Resident #273 and Resident #66. This affected two residents (#273 and #66) of two residents reviewed for pain. The facility census was 67. Actual harm occurred beginning on 02/20/25 when the facility failed to ensure narcotic (pain) medication (that Resident #273 had been receiving prior to admission) was ordered and provided at the time of and timely following admission to manage the resident's pain. On 02/21/25 and 02/22/25 the resident reported constant pain, all over that limited his functional abilities during therapy evaluations. On 02/23/25 the resident refused therapy due to pain and was teary-eyed. On 02/24/25 at 10:01 A.M., Resident #273 stated he was in constant pain all over. The resident was tearful and covered his face with his hands and was lying in bed with his knees bent and stated he couldn't straighten his legs because it hurt too bad. The resident reported staff told him they were unable to give him anything stronger than Tylenol for pain until he was evaluated by a physician, and the resident had not yet been seen by the physician. Findings include: 1. Review of the medical record for Resident #273 revealed an admitted [DATE] with diagnoses of osteoarthritis (OA), chronic gout, major depressive disorder, chronic pain, pain in right and left ankles and feet. Review of medical record revealed Resident #273 was admitted from another nursing facility with active order for Norco Oral tablet 5/325 mg (opioid pain medication) every six hours as needed for pain. In review of the admission orders, there was no order for Norco on admission. Review of Resident #273's admission assessment dated [DATE] revealed Resident #273 was alert and oriented to person, place, time and situation and that he was verbally appropriate. The admission assessment also revealed Resident #273 relayed no pain upon admission. An admission falls assessment dated [DATE] stated Resident #273 required assistance with activities of daily living (ADL) self-performance, had an unsteady gait and used an assistive device for mobility. Review of Resident #273's Physical Therapy (PT) Evaluation dated 02/21/25 revealed Resident #273 rated his pain at rest at seven on a pain scale of zero to ten, ten being the worst, and pain with movement at nine, frequency and duration of the pain as constant and location of the pain as all over, all my joints, everywhere. The PT eval also revealed that Resident #273 verbalized pain and that the pain limits his functional abilities. Clinical Impressions in the PT assessment summary reveal severe pain limiting activity tolerance and functional mobility. Review of Resident #273's Occupational Therapy (OT) Evaluation dated 02/22/25 reveals Resident #273 rated his pain at rest at six and pain with movement at nine, frequency and duration of the pain as constant and location of the pain as all over. The OT eval also revealed that Resident #273 verbalized pain and that the pain limited his functional abilities. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the PT notes dated 02/23/25 reveal Resident #273 was teary-eyed throughout the therapy session and reported frustration with pain and Resident #273 declined further therapeutic exercises on that date. Review of the medical record revealed Resident #273 was ordered Tylenol 325 mg (analgesic) two tablets by mouth every four hours as needed for pain beginning on 02/24/2025 at 6:30 P.M. Review of the Medication Administration Record (MAR), he was given his first dose of Tylenol on 02/24/25 at 8:38 P.M. Interview with Resident #273 on 02/25/25 at 12:17 P.M. revealed Resident #273 was awake and lying in bed. He rated his pain at five, and he was tearful. The resident was hiding his face in his hands and stated he was in pain overnight but was offered nothing for pain. He also stated he had not yet seen a doctor. Observation of Resident #273 on 02/26/25 at 8:23 A.M. revealed he was awake and lying in bed. The surveyor observed Certified Nursing Assistant (CNA) #462 check on Resident #273 who stated he was in a lot of pain; CNA #462 stated that he would tell the nurse. Interview with Licensed Practical Nurse (LPN) #497 on 02/26/25 at 10:43 A.M. revealed Resident #273 expressed pain a lot but would not take Tylenol because he stated it doesn't help. LPN #497 was on her way to help the CNAs weigh the resident and stated she would assess his pain at that time. LPN #497 also stated Resident #273 was last medicated for pain with Tylenol on 2/24/25 at 8:38 P.M. which Resident #273 stated was effective; this was verified by record review. Interview with LPN #497 on 02/26/25 at 11:08 A.M. revealed Resident #273 refused to take Tylenol that morning and said, I tried it before and it doesn't work. LPN #497 stated she planned to reach out to the physician for further intervention. Interview with Nurse Practitioner (NP) #506 on 02/26/25 at 2:43 P.M. revealed she saw Resident #273 that afternoon and when she entered his room, he was lying in bed on his phone and was not expressing any non-verbal signs of pain. She stated that during her examination, Resident #273 stated he had burning pain in his feet and could not straighten out his legs due to pain. She prescribed Tramadol 50 mg (opioid analgesic) every six hours as needed since Resident #273 said the Tylenol does not help him. Review of Resident #273's medical record on 02/26/25 at 4:32 P.M. and review of pain assessment in Treatment Administration Record (TAR) show no pain identified for Resident #273 during all but two shifts since admission. Interview with LPN #497 confirmed this at the time of the review and stated the resident expressed pain a lot and could not account for why there were so many zeroes marked in the TAR regarding Resident #273's pain. Review of the care plan dated 02/27/25 revealed Resident #273 was at risk for pain and the goals were that the pain and discomfort would be controlled as evidenced by no signs or symptoms of pain and no complaints of pain. The care plan interventions included staff should note if pain medications were effective and notify medical doctor (MD) as indicated. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Observation of Resident #273 on 02/27/25 9:28 A.M. revealed the resident was awake and alert in bed. The resident stated his pain was not too bad this morning and expressed his feeling that the new medication that was ordered had helped. He stated he hoped to participate in therapy later that day. Observation of Resident #273 on 03/03/25 at 9:05 A.M. revealed complaints of pain in both feet and stated his pain was at seven. Resident #273 stated he had been taking pain medication but did not feel any different. He was lying in bed moaning with pained facial expression. He stated the nurse was aware of his pain that morning, and she had just left his room after medicating him with Tramadol. Interview with the Director of Nursing (DON) on 03/03/25 at 12:19 P.M. revealed when residents were admitted from another facility, the admission orders were taken from the other facility's order summary and verified with the physician. A follow-up interview with DON on 03/03/25 at 3:36 P.M. confirmed Norco orders did not transfer to admission orders because this facility's doctors do things differently than other facility's doctors, and there was no chronic condition indicated for the use of Norco. The DON was unable to state where in the chart that would be documented. Interview with LPN #510 on 03/03/25 at 3:48 P.M. confirmed Resident #273's pain inhibited his ability to walk to the bathroom and his willingness to get up to use the commode. Observation of Resident #273 on 03/03/25 at 3:50 P.M. revealed the resident was lying in bed on his back, knees bent. He was awake and alert and stated he was in some pain. He stated he took a pain pill earlier. Interview with CNA #401 on 03/03/25 3:54 P.M. revealed Resident #273 doesn't allow her to touch him due to pain. He resists getting dressed or bathed because he is in too much pain. Interview with Resident #273 on 03/04/25 10:48 A.M. revealed he was about the same and rated his pain at six. He was lying on his bed with a pained facial expression and his knees were bent. Review of the undated facility pain policy revealed if the presence of pain was identified or the resident has an order for pain medication, an assessment would be completed to determine the intensity, location and interventions required. The pain policy also stated ineffective pain control, or the onset of new pain would trigger a further assessment of the pain and interventions used. 42013 2. Review of Resident #66's medical record revealed an admitted [DATE] with diagnoses including hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction affecting the left non-dominant side, aphasia (language disorder that affects the ability to communicate effectively) following cerebral infarction, dysphagia (difficulty swallowing), dysarthria (slurred speech) following cerebral infarction and vascular dementia. Review of Resident #66's care plan dated 01/12/25 included Resident #66 was at risk for pain related to cerebral vascular accident (CVA) with left sided weakness. Resident #66 would display signs of comfort and would have no signs and symptoms or complaints of pain or discomfort. Resident #66 would report pain was resolved with medication and other interventions. Interventions included assessing symptoms of pain on occurrence and documenting location and pain scale as reported by the resident; notifying the physician as indicated; providing pain medication as prescribed. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #66's physician orders dated 01/23/25 revealed acetaminophen tablet 325 mg, give two tablets by mouth every four hours as needed for general discomfort. Review of Resident #66's progress notes dated 01/31/25 at 6:42 A.M. included the nurse entered Resident #66's room to help transfer him into his wheelchair so he could be assisted to the dining room for breakfast. Resident #66 stated he did not want to get up in the chair or go to the dining room due to his left knee hurting. Review of Resident #66's Medication Administration Record (MAR) dated 01/31/25 did not reveal pain medication including acetaminophen was administered. Resident #66's MAR on 01/31/25 from 6:42 A.M. through 7:00 P.M. did not reveal evidence his pain was rated on a scale of zero to ten, zero being no pain and ten being the worst pain. Review of Resident #66's MAR dated 02/01/25 through 02/26/25 revealed there was no evidence Resident #66's pain was evaluated on 02/07/25 day shift, 02/08/25 day shift and 02/14/25, 02/15/25, 02/23/25 day shift. On 02/26/25 during day shift, Resident #66's pain was rated at a zero on a pain scale with zero being no pain and ten being the worst pain. Review of Resident #66's PT evaluation and plan of treatment dated 02/08/25 included Resident #66's pain at rest was rated as a five out of a ten, zero being no pain and ten being the worst pain. Resident #66's pain was intermittent, he had left sided hypersensitivity, and the pain was described as shooting pain. Resident #66's pain with movement was rated as a ten out of ten on a zero to ten pain scale. Resident #66's pain was intermittent, he had left sided hypersensitivity, and the pain was described as shooting. Resident #66 communicated pain using the faces pain rating scale. Pain limited Resident #66's functional activities. Resident #66 received pain medications on a scheduled program, and Resident #66 received pain medications as needed. Upon evaluation, Resident #66 presented with impaired bilateral lower extremity (BLE) strength the left greater than the right, left sided hemiparesis, hypersensitivity and neglect, impaired functional mobility compared to baseline, impaired balance, impaired activity tolerance and pain. Due to documented physical impairments and associated functional deficits, Resident #66 was at risk for increased tone, limiting functional movement and increased pain. Review of Resident #66's OT evaluation and plan of treatment dated 02/09/25 included Resident #66's pain at rest was a four out of a ten, on a zero to ten pain scale, the pain was located in the left knee, was constant and described as sharp. Resident #66's pain with movement was a seven out of ten on a zero to ten pain scale, the pain was in the left knee, was constant and described as sharp pain. Resident #66 verbalized his pain level and the pain limited Resident 366's functional activities. Resident #66's pain interventions were unknown. Review of Resident #66's MAR dated 02/08/25 and 02/09/25 did not reveal pain medication including acetaminophen was administered. Further review of the MAR dated 02/09/25 revealed Resident #66's pain was rated as zero. Review of Resident #66's progress notes dated 02/08/25 and 02/09/25 did not reveal documentation related to pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the 5-day Medicare Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #66 was cognitively intact. Resident #66 was dependent on staff for toileting hygiene and lower body dressing. Resident #66 required substantial to maximal assistance with bathing. Resident #66 had an indwelling catheter and was always incontinent of bowel. Resident #66 did not reject care during the seven-day assessment look-back period. Resident #66 was not on a scheduled pain regimen. He received as needed (PRN) pain medications and did not receive non-medication pain regimen. The MDS states a pain assessment interview should not be conducted because the resident was rarely/never understood. The staff assessment for pain stated Resident #66 had indicators of pain in the last five days including facial expressions (grimaces, winces, wrinkled forehead, furrowed brows, clenched teeth or jaw) observed one to two days. Review of Resident #66's physician orders dated 02/21/25 revealed Baclofen oral tablet 10 mg (muscle relaxant), give one tablet by mouth every eight hours as needed for spasms. Review of Resident #66's MAR dated 02/21/25 through 02/26/25 did not reveal Resident #66 was administered Baclofen 10 mg. Interview on 02/25/25 at 2:42 P.M. of Director of Rehab (DOR) #509 revealed Resident #66 received PT, OT, and Speech Therapy (ST). DOR #509 stated Resident #66 had difficulty with expressive and receptive communication and they were working on things like word retrieval, following commands, auditory processing and yes and no accuracy. PT and OT were working on lower and upper extremity strengthening. DOR #509 stated Resident #66 used a mechanical lift for transfers. Observation on 02/26/25 at 9:58 A.M. of Resident #66 revealed CNA #462 and CNA #491 were preparing Resident #66 to be transferred to his wheelchair using a mechanical lift. LPN #402 was standing at Resident #66's bedside along with CNA's #462 and #491. Observation of Resident #66 revealed he had facial grimacing, grunted, and cried out in pain when the mechanical lift started to lift him out of the bed. Resident #66's left leg was pulled up towards his upper body and when CNA #491 attempted to straighten it during the transfer Resident #66 cried out in pain and he had a worried look on his face. CNA #491 did not continue attempting to strengthen his leg. CNA #462 stated Resident #66 used to want to come out of his room much more when he first arrived at the facility than he did now. LPN #402 instructed the aides that when Resident #66 was uncomfortable and in pain during mechanical lifts they should get a staff person from therapy to assist them with Resident #66's positioning during transfers. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Interview on 02/26/25 at 12:12 P.M. of Occupational Therapy Assistant (OTA) #508 and PT #507 revealed they worked with Resident #66 on things like simple grooming and hygiene, unsupported sitting, passive stretching, gentle range of motion. OTA #508 stated Resident #66 was having quite a bit of pain in his left arm and left leg. PT #507 stated Resident #66's left leg had a lot of tone and was drawn in, and he babied his left arm because it hurt. PT #507 stated she thought Resident #66 was receiving a muscle relaxant. PT #507 stated pain was a dominant thing that was limiting Resident #66's participation in therapy, and his tolerance for therapy was limited. PT #507 stated Resident #66 used to be up a lot but was now spending more time in bed. PT #507 and OTA #508 stated they had been in communication with the nursing staff regarding Resident #66's pain, but they could not remember which nurses they told about Resident #66's pain. PT #507 stated Resident #66 laid on his left side, he favored it, and it was hard to get him positioned so he does not lay like that. OTA #508 stated Resident #66 was cooperative with his therapy and wanted to do well, but his pain interfered with therapy. OTA #508 and PT #507 stated they did not document Resident #66's pain every day when he had therapy because his pain was constant and chronic and everyone knows he had a lot of pain including the nurses. PT #507 stated Resident #66 could not verbalize the type of pain he was having, but had facial grimacing, and you could tell he was in pain. PT #507 stated Resident #66's pain could be the reason he did not want to come out of his room. Interview on 02/26/25 at 3:23 P.M. of NP #506 revealed she evaluated Resident #66's pain and stated when someone moved him he was in pain and when he was laying still he did not have pain. NP #506 stated Resident #66 was ordered Baclofen 10 mg tablet as needed but the nurses were not giving it to him. NP #506 stated she ordered Baclofen 5 mg tablet to be given on a schedule three times a day. Review of Resident #66's MAR dated 02/26/25 did not reveal pain medication including acetaminophen was administered. Review of Resident #66's physician orders dated 02/26/25 revealed Baclofen oral tablet 5 mg, give one tablet by mouth three times a day for spasms. Interview on 02/27/25 at 8:37 A.M. of CNA's #420 and #444 revealed Resident #66's left leg was bent and pulled up towards his chest and CNA #420 stated he could not straighten his leg because it caused pain when they tried to straighten it. CNA #420 stated on 02/24/25 and 02/25/25 Resident #66 was in pain and not tolerating much in the way of care, but today his pain seemed better. Review of Resident #66's MAR dated 02/24/25 and 02/25/25 revealed Resident #66's pain for day and night shift was rated as a zero on a scale of zero to ten, zero being no pain and ten being the worst pain. Interview on 03/03/25 at 9:35 A.M. of LPN #402 revealed Resident #66 was uncomfortable and in pain when she was in his room on 02/26/25 assisting with his transfer using a mechanical lift. LPN #402 stated she was not the nurse assigned to Resident #66 on 02/26/25 and she did not remember if she told the nurse assigned to him if he was having pain. Interview on 03/03/25 at 12:05 P.M. of LPN #497 revealed she did not know why on 02/26/25 she put a zero for Resident #66's pain rating and could not remember details. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Interview on 03/04/25 at 11:06 A.M. of PT #507 revealed Resident #66 was still in pain and she could just see it in his face when he received therapy. PT #507 stated she wished the facility would at least try a pain medication to see if it was effective. Interview on 03/04/25 at 11:30 A.M. of the DON revealed after the surveyor told her PT #507 stated Resident #66 was still in pain when he received therapy, the DON indicated she would reach out to NP #506 for pain medication and maybe they could try Botox. Review of the facility policy which was untitled and undated included the purpose of the policy was to safely control a resident's prolonged pain and maintain a pain free existence in achieving an optimal level of comfort. It was the policy of the facility to assess residents for the presence of pain and provide pain relief measures. All residents would be assessed for pain on admission and on an on-going basis. If the presence of pain was identified or the resident had an order for pain medication an assessment would be completed to determine the intensity, location and interventions required.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on record review, interviews, review of the long term care facility compliance agreement, and review of communication sheets from dialysis, the facility failed to ensure communication between the facility and the dialysis center was being received after every dialysis treatment as required for Resident #31. This affected one resident (#31) out of one resident reviewed for dialysis. The facility identified Resident #31 as the only resident receiving dialysis. The facility census was 67. Findings include: Review of the medical record for Resident #31 revealed an admitted [DATE]. Diagnoses included end stage renal disease, diabetes mellitus with hyperglycemia (high blood sugar), dependence on renal dialysis, anemia in chronic kidney disease, and renovascular hypertension (a condition in which high blood pressure is caused by the kidneys' hormonal response to the narrowing of arteries in the kidneys). Review of Resident #31's physician orders revealed an order dated 10/24/24 for dialysis Monday, Wednesday, and Friday at a dialysis center with a chair time of 10:45 A.M. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #31 was cognitively intact, was mostly dependent on staff for mobility and for activity of daily living and received dialysis. Review of the care plan initiated on 08/03/20 revealed Resident #31 was at risk for complications from dialysis. Interventions included: hemodialysis as outpatient at an outside facility on Monday, Wednesday, and Friday; be alert to signs of fluid retention; check access site every shift and after each dialysis; lab work per physician order; monitor mental status change every shift and after each dialysis; monitor shunt for presence of bruit (swishing sound caused by turbulent blood flow through an artery) /thrill (palpable vibration on the skin over the area of turbulent blood flow), redness, bleeding or swelling at site; and monitor vital signs per physician order and as needed. Interview on 02/26/25 at 4:33 P.M. with License Practical Nurse (LPN) #451 revealed the facility would send a face sheet and a list of Resident #31's medications with the resident when she went to dialysis; however, the dialysis center didn't always send back a communication sheet with the resident. She stated when there was no communication sheet sent back from the dialysis center with Resident #31, she would call the dialysis center to see if there had been any changes and the only time she would document the call in Resident #31's medical record was if there had been changes. Interview on 02/27/25 at 10:26 A.M. with LPN #466 stated she always sent a face sheet and a list of medications with the resident when she went to dialysis; however, Resident #31 didn't always come back with a communication sheet from the dialysis center. When she noticed the resident hadn't been sent back with a communication sheet, she would call the dialysis center to have the form faxed to the facility and would give the faxed form to Medical Records #482 so it could be uploaded into the resident's electronic medical record. She went on to state she felt the communication between the facility and the dialysis center could be better. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/27/25 at 11:00 A.M. with Medical Records #482 revealed all the information which had been sent back from the dialysis center had been uploaded into Resident #31's medical record. She went on to state there were days when Resident #31 didn't come back with a communication form from the dialysis center and confirmed there were missing communication forms in Resident #31's electronic medical record from the dialysis center. Interview on 02/27/25 at 11:10 A.M. with the Administrator revealed the normal procedure would be for the dialysis center to send back communication with Resident #31. If no communication had been sent from the dialysis center, the facility should call the dialysis center to have the communication paper faxed to the facility, so it could be uploaded into Resident #31's electronic medical record. Interview with Representative #511 from the dialysis center on 03/03/24 at 11:09 A.M. confirmed the Resident #31's chair time was on Monday, Wednesday, and Fridays; however, during the weeks of Christmas and New Year's Day, the resident went to dialysis on Sunday, Tuesday, and Friday. Review of the uploaded items in Resident #31's medical record revealed from the time frame between 12/01/24 and 2/27/25 there were uploaded communication sheets from the dialysis center for treatments on 12/02/24, 01/08/25, 01/15/25, 01/22/25, and 02/12/25. There were no communication sheets from the dialysis center for treatments on 12/04/24, 12/06/24, 12/09/24, 12/11/24, 12/13/24, 12/16/24, 12/18/24, 12/20/24, 12/22/24, 12/24/24, 12/27/24, 12/29/24, 12/31/24, 01/02/25, 01/06/25, 01/10/25, 01/13/25, 01/17/25, 01/20/25, 01/24/25, 01/27/25, 01/29/25, 01/31/25, 02/03/25, 02/05/25, 02/07/25, 02/10/25, 02/14/25, 02/17/25, 02/19/25, 02/21/25, 02/24/25, and 02/26/25. Further review of Resident #31's medical record revealed there was nothing documented in the progress notes between 12/01/24 and 02/27/25 indicating the facility had reached out to the dialysis center when the facility had not received a communication sheet from the dialysis center to see if there had been any changes with the resident. Review of the LTCF (long term care facility) Compliance Agreement, dated 07/01/23, between the facility and the dialysis center, revealed the parties agreed to coordination of care which included information transmitted to the dialysis center by the LTCF prior to dialysis and information transmitted to the LTCF by the dialysis center after dialysis.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	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** 46195 Based on observations, interviews, record review, and review of the facility menu spreadsheets and facility policy, the facility failed to follow the menu for dinner on 02/25/25 for all residents on a regular texture and mechanical soft diet. This affected all residents receiving meals from the kitchen excluding 11 residents (#10, #11, #13, #21, #28, #40, #43, #57, #59, #61, and #225) the facility identified as receiving a pureed diet, one resident (#52) who received nothing by mouth (NPO) and Resident #22 who the facility identified as having a special preference noted to receive bread and margarine at the dinner meal. The facility census was 67. Findings include: Review of the facility spreadsheet for Tuesday week three dinner (02/25/25) revealed residents on a regular texture or a mechanical soft diet were to receive one number six scoop (five and one third ounces) of cheese tortellini with marinara sauce, one four ounce spoodle (a type of serving utensil which was a combination between a spoon and a ladle) of steamed Brussel sprouts, one slice of bread with one teaspoon of margarine, and one two-inch by two-inch piece of chocolate cream cake. Observation on 02/25/25 from 3:35 P.M. to 5:00 P.M. revealed there was no bread or margarine near the tray line for the meal. No residents on a regular texture or mechanical soft diet received a slice of bread with margarine, except Resident #22 who had a slice of bread and margarine listed as a preference for the meal. Review of the medical record for Resident #18 revealed an admitted [DATE]. Diagnoses included diabetes mellitus, hypertension (high blood pressure), and dysphagia (difficulty swallowing). The resident was severely impaired cognitively, was on a No Concentrated Sweets (NCS) diet, regular texture and regular/thin liquids, and was able to feed himself after meal set up. The resident was at nutritional risk related to being morbidly obese and by not making choices in the best interest of his nutrition. Interview on 02/25/25 at 5:02 P.M. with Resident #18 revealed he would have liked bread with his meal. Review of the medical record for Resident #122 revealed an admitted [DATE]. Diagnoses included diabetes mellitus, intestinal obstruction, congestive heart failure (CHF), and gastrointestinal reflux disease (GERD). The resident was moderately impaired cognitively, was on a No Concentrated Sweets (NCS) diet, regular texture and regular/thin liquids; received a house supplement twice a day and received assistance and cueing for meals as needed. Interview on 02/25/25 at 5:03 P.M. with Resident #122 revealed he would have liked a piece of bread with dinner (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of medical record for Resident #29 revealed an admitted [DATE]. Pertinent diagnoses included incomplete paraplegia, pressure ulcer of sacral region, chronic obstructive pulmonary disease, major depressive disorder, and generalized anxiety disorder. The resident was cognitively intact, was on a No Added Salt (NAS) diet, regular texture, regular/thin liquids, received super cereal (fortified oatmeal) once a day and Juven two times a day, and was able to feed self after meal set up. Resident #29 was at nutritional risk related to impaired skin integrity, being obese, and by making choices which were not always in the best interest of the resident. Interview on 02/25/25 at 5:05 P.M. with Resident #29 revealed he would have loved a nice piece of bread with margarine to soak up the sauce. Review of the medical record for Resident #47 revealed an admitted [DATE]. Pertinent diagnoses included gastroesophageal reflux disease (GERD), hypokalemia (low potassium in the blood), and dysphagia (difficulty swallowing). The resident was cognitively intact, was on a regular diet, regular texture, regular/thin liquids, was able to feed self after meal set up. Resident #47 was at nutritional risk secondary impaired medical status. Interview on 02/25/25 at 5:07 P.M. with Resident #47 revealed he would have liked a piece of bread with the meal. Interview on 02/27/25 at 12:18 P.M. with Food and Nutrition Services Manager (FNSM) #473 confirmed bread and margarine had not been served for dinner on 02/25/25 and stated she had missed that bread and margarine had been on the menu so there was none offered as indicated on the planned menu. Review of facility policy Food and Nutrition History, revised 04/01/22, revealed menus were planned and choices were offered and available.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365822	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarfield Manor	461 South Canfield Niles Road Youngstown, OH 44515

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 46195 Based on observation, interviews, record review, review of the facility Fall and Winter menus, and review of the facility policy, the facility failed to ensure there was a nutritionally equivalent alternate for residents who disliked Brussel sprouts. This affected nine residents (#2, #8, #15, #32, #45, #59, #272, #276, and #278) the facility identified as having a dislike of Brussel Sprouts out of 66 residents receiving meals from the kitchen. The facility identified one resident (#52) as receiving nothing by mouth (NPO). The facility census was 67. Findings include: Review of the facility spreadsheet for Tuesday week three dinner (02/25/25) revealed residents on a regular and mechanical soft diet were to receive one number six scoop (five and one third ounces) of cheese tortellini with marinara sauce, one four ounce spoodle (a type of serving utensil which was a combination between a spoon and a ladle) of steamed Brussel sprouts, one slice of bread with one teaspoon of margarine, and one two-inch by two-inch piece of chocolate cream cake. Observations on 02/25/25 from 3:45 P.M. to 5:00 P.M. of the dinner meal service revealed on the steam table were Brussel Sprouts and pureed Brussel Sprouts. There were no alternative cooked vegetables prepared for the meal. Observation of the facility's dinner tray line revealed residents who had Brussel sprouts listed as a dislike on their tray ticket didn't receive the Brussel sprouts or another comparable alternate vegetable. Interview during the observation with Food and Nutrition Services Manager (FNSM) #473 confirmed for the nine residents who were identified to dislike Brussel sprouts for the meal, the facility did not replace it with another vegetable. Interview on 02/26/25 at 4:16 P.M. with Resident #8 revealed for dinner the previous night, she had received no vegetable, she disliked Brussel sprouts and she had been hungry after the meal. Interview on 02/26/25 at 4:21 P.M. with Resident #15 revealed for dinner the previous night she received no vegetable, she disliked Brussel Sprouts and would have liked to have received another vegetable instead of no vegetable. Interview on 02/26/25 at 4:49 P.M. with Resident #45 revealed for dinner the previous night he had not received a vegetable and he disliked Brussel sprouts. He went on to state that the previous night's dinner was not enough for him, and he had been hungry after the meal. Review of the facility four-week cycle Fall and Winter 2024 to 2025 menu revealed a wide of variety of meal items were offered and for each week of the cycle there were three additional entrees listed as being available if a resident didn't like the menu entree, however, there was no alternate vegetables listed as being available if a resident didn't like the main vegetable. Review of facility policy Food and Nutrition History, revised 04/01/22, revealed menus were planned and choices were offered and available.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	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** 46195 Based on observation, record review, interview, and review of the facility Fall and Winter menu, the facility did not ensure residents were offered a substantial snack in the evening when the time between dinner and breakfast exceeded 14 hours. This had the potential to affect all residents who received meals from the kitchen excluding eight residents (#5, #7, #15, #24, #33, #35, #50 and #223) the facility identified as receiving routine evening snacks and Resident #52 who received nothing by mouth (NPO). The facility census was 67. Findings include: Review of the facility four week Fall and Winter menu for 2024 to 2025 revealed there was no evening snack listed on the menu. Review of the resident council meeting minutes dated 04/25/24, 05/30/24, 06/27/24, 07/30/24, 08/09/24, 09/25/24, 10/14/24, 11/11/24, 12/16/24, 01/14/25, and 02/11/25 revealed Food and Nutrition Services Manager (FNSM) #473 had attended every resident council meeting, and there was no documentation in the minutes indicating the residents had agreed to having a greater than 14 hour meal span between dinner and breakfast. Observation of dinner tray line on 02/26/25 revealed the first meal tray was plated at 4:00 PM. and the last resident meal was plated at 5:00 P.M., placed on a food cart, and then delivered to the floor. Observation of the breakfast cart delivery times on 02/26/25 revealed the first cart had been delivered at 7:11 A.M. and the last cart had been delivered to the dining room at 8:06 A.M. The time difference from the first cart for dinner to the first cart at breakfast was approximately 15 hours and 11 minutes and the last cart for dinner and last cart for breakfast was approximately 15 hours and six minutes. Interview on 02/26/25 at 4:05 P.M. with Resident #55 revealed the facility staff didn't come around at night to offer snacks, and she indicated there were times when she was hungry and would be receptive to receiving an evening snack. Interview on 02/26/25 at 4:06 P.M. with Resident #276 revealed staff didn't come around at night to offer snacks, and he would like a snack. Interview on 02/26/25 at 4:10 P.M. with Certified Nursing Assistant (CNA) #455 confirmed the facility did not go around in the evening to ask residents if they wanted a snack. She stated the only residents who received snacks were residents who had labeled snacks from the kitchen. Interview on 02/26/25 at 4:21 P.M. with Resident #15 revealed no staff went around in the evening to offer snacks, and she had her own stock of snacks in her room since she got hungry. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Interview on 02/26/25 at 4:49 P.M. with Resident #45 revealed staff didn't come around in the evening to offer snacks, and he would have liked a snack on the nights when he was hungry. Interview on 02/26/25 at 6:25 P.M. with Resident #49 revealed she had heard staff tell other residents about their snacks, but she had never been asked routinely if she wanted a snack. She stated she had her own supply of snacks in her room. Observations on 02/26/25 at 6:50 P.M. of the clear storage container of snacks being delivered by Dietary Aide (DA) #512 to the nurses' stations revealed in the container were labeled Styrofoam bowls of pudding with lids for each of the nurses' stations, one labeled milk and one labeled styrofoam bowl with a lid of dry cereal for Resident #50, three labeled peanut butter sandwiches in a sandwich bag for Residents #24, #33, and #223, one labeled package of peanut butter crackers for Residents #7 and #15, one labeled individual package of [NAME] Doones for Resident #35, and one individual labeled package of graham crackers for Resident #5. DA #512 at the time of observation revealed the only snacks in the container were labeled snacks, and there were no extra unlabeled snacks in the container. Interview on 02/27/25 at 12:18 P.M. with FNSM #473 confirmed the time between dinner and breakfast was greater than 14 hours, and the only snacks sent from dietary were the labeled snacks for select residents. She stated she attended resident council meetings, and the residents had not agreed to having the meal span between dinner and breakfast greater than 14 hours. Review of the facility document Meal Times, revised 06/27/23, revealed scheduled time spans between dinner and breakfast was 14 hours and 45 minutes for each section.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, interview, record review, review of the Centers for Disease control and Prevention (CDC) guidelines and facility policy review, the facility failed to ensure infection control logs were accurate and appropriate isolation precautions were in place for Resident #57. This affected one resident (#57) of three residents reviewed for infection control. The facility census was 67. Findings include: Review of Resident #57's medical records revealed an admitted [DATE]. Diagnosis included Methicillin-resistant Staphylococcus aureus (MRSA) (bacterial infection). Review of the care plan dated 12/24/24 (revised 02/25/25) revealed Resident #57 had received intravenous (IV) therapy related to an acute infection. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #57 had impaired cognition. Resident #57 was dependent on staff for toileting and required maximum assistance with personal hygiene. Review of the physician orders for February 2025 revealed Resident #57 was ordered Vancomycin (IV antibiotic) every 48 hours for MRSA infection and enhanced barrier precautions (EBP) (due to the central line IV catheter in her upper right chest). Review of Resident #57's hospital paperwork with an encounter date of 02/07/25 revealed Resident #57 had MRSA detected in blood work. Review of infection control logs for February 2025 revealed Resident #57 was on EBP related to osteomyelitis (bone infection). Observation on 02/24/25 at 9:30 A.M. revealed no signs posted to the entrance of Resident #57's room related to isolation precautions. Further observation revealed an IV pump and pole in Resident #57's room. Observation on 02/25/25 at 12:09 P.M. revealed no signs posted to the entrance of Resident #57's room related to isolation precautions, and the IV pump and pole remained in Resident #57's room. Observation of Resident #57 on 02/25/25 at 12:12 P.M. with Licensed Practical Nurse (LPN) #510 revealed Resident #57 had a central line IV catheter in her upper right chest. LPN #510 stated Resident #57 had received IV antibiotics for pneumonia treatment. LPN #510 stated she was unaware of Resident #57 on any type of isolation precautions. Interview on 03/03/25 at 12:05 P.M. with Director of Nursing (DON)/infection preventionist confirmed the infection control log for February 2025 indicated Resident #57 had an osteomyelitis infection; however, it had been inaccurate due to Resident #57 having an MRSA infection. The DON stated Resident #57 should have been placed on contact precautions related to the MRSA infection and EBP for the central line IV catheter in her upper right chest. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the CDC guidance for Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 04/02/24, revealed EBP should be in place for a resident with an indwelling medical device. An indwelling medical device provides a direct pathway for pathogens in the environment to enter the body and cause infection. Examples of indwelling medical devices include, but are not limited to, central vascular catheters (including hemodialysis catheters, peripherally-inserted central catheters (PICCs)), indwelling urinary catheters, feeding tubes, and tracheostomy tubes. Review of the facility policy titled Isolation Precautions, revised 01/21, revealed residents with an MRSA infection required contact isolation precautions.