STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365823	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Center at the Ridge	3379 Main Street Mineral Ridge, OH 44440

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on observation, medical record review, interview and review of the NSO (Nurses Services Organization) guidelines, the facility failed to ensure Resident #13's bowel and bladder assessment was accurately documented in Resident #13's medical record. This affected one resident (#13) out of three residents reviewed for incontinence care. The facility census was 144. Findings include: Resident #13 was admitted on [DATE] with diagnoses including acute cystitis (urinary bladder infection), encephalopathy, morbid obesity, diabetes mellitus, obstructive sleep apnea, anxiety, cognitive decline, arthritis, scoliosis, diverticulitis, vitamin D deficiency, Raynaud's Syndrome, depression, insomnia, thyrotoxicosis (excessive thyroid hormone) with goiter, fibromyalgia (wide-spread pain), hypothyroidism (underactive thyroid), and meninges (membranes covering the brain) tumor. A review of Resident #13's clinical record revealed a Minimum Data Set (MDS) admission assessment dated [DATE] which indicated Resident #13 had an indwelling urinary catheter. Review of Resident #13's certified nursing assistant (CNA) documentation dated 01/10/25 to 01/30/25 indicated Resident #13 had frequent urinary incontinence with occasional urinary continence. There was no plan of care or interventions implemented to provide care for an indwelling urinary catheter. Further review of Resident #13's clinical record revealed no physician orders to discontinue an indwelling urinary catheter. Resident #13's nursing progress notes dated 01/10/25 to 02/06/25 indicated no documentation of the presence of an indwelling urinary catheter or that the indwelling urinary catheter was discontinued. Resident #13's progress note dated 01/10/25 indicated she had a Brief Interview Mental Status (BIMS) score of 10 which indicated she had moderate cognitive impairment. Resident #13 was alert, oriented, and pleasant. An observation of Resident #13 on 02/03/25 at 9:45 A.M. revealed there was no indwelling urinary catheter tubing or urine drainage bag observed hanging from Resident #13's bed frame. An interview with Resident #13 on 02/05/25 at 12:05 P.M. revealed she had never had an indwelling urinary catheter on admission to the facility. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Director of Nursing (DON) #1241 on 02/05/25 at 10:29 A.M. verified the above findings and agreed there was inconsistent documentation of the presence and/or absence of an indwelling urinary catheter for Resident #13. Interviews with CNA #1294 and CNA #1420 on 02/06/25 between 11:30 A.M. and 12:00 P.M. they had provided care for Resident #13 upon admission to the facility. Both staff indicated Resident #13 did not have an indwelling urinary catheter upon admission to the facility. A review of the NSO (Nurses Services Organization) guidelines dated 2024 for nursing documentation indicated a complete and accurate clinical record presents the strongest defense against any malpractice or licensing board action. While some specialized settings, practice [NAME], regulations and other areas may require additional types or components of documentation, the following principles may lessen nurses' liability exposures: Chart in the correct record. Ensure that key patient identifiers are accurate, including the spelling of the patient's name and their date of birth, to ensure effective linking of patient healthcare information records within and across systems. Chart promptly. As soon as possible after you make an observation or provide care, document your actions for more detailed notes. If you wait until the end of your shift, you could forget to include important information. Be accurate, objective, and complete. Document what you see, hear, and do. Include data relating to all aspects of patient care and the nursing process.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on record review, interview, review of employee corrective action and facility policy review, the facility failed to complete wound treatments as ordered by the physician for Resident #15. This affected one resident (#15) of three residents reviewed for treatments. The facility census was 144. Findings include: Review of the medical record for Resident #15 revealed an admitted [DATE] with diagnoses including disorders of veins, peripheral vascular disease, congestive heart failure and diabetes mellitus type two. The admission Minimum Data Set (MDS) assessment, dated 11/03/24, revealed the resident had no cognitive impairment. The weekly nurse practitioner (NP) wound assessments from 12/05/24 to 01/23/25 indicated Resident #15 had chronic left lower extremity (LLE) vascular ulcers, one medial and one lateral, which required daily wound dressing changes. Review of Resident #15's treatment administration record (TAR) from December 2024 to January 2025 revealed a daily dressing change ordered to begin 12/06/24 for the LLE medial and lateral wounds. On 12/20/24, 01/09/25, 01/11/25, 01/12/25, 01/13/25, 01/19/25 and 01/23/25, the daily dressing changes were not documented as completed. Interview on 02/06/25 at 10:18 A.M. with Wound Nurse (WN) #1217 verified the daily dressing changes for Resident #15's LLE vascular ulcers were not documented as being completed on 12/20/24, 01/09/25, 01/11/25, 01/12/25, 01/13/25, 01/19/25 and 01/23/25. WN #1217 explained on 01/09/25 and 01/23/25 the NP was in the facility and would have completed the dressing changes, and on 01/13/25 and 01/20/25, she remembered being in the facility so the treatments would have been done but just not signed off. WN #1217 continued to explain if any treatments were found not being done then a corrective action form was completed so it was believed the 01/12/25 and 01/19/25 dressings were probably done. However, WN #1217 confirmed there was no documented evidence Resident #15's dressing changes were completed as ordered on 12/20/24 and 01/11/25, and in addition recalled a corrective action form being completed for an additional two times in December 2024 when a nurse had signed off doing Resident #15's treatment but did not. Review of the employee notice of corrective action form signed by Registered Nurse (RN) #1287 on 12/17/24 revealed a verbal warning for not completing treatments on 12/14/24 and 12/15/24 as ordered, yet documenting it was done. Review of the undated facility policy, Dressing Change - Clean revealed to document the completion of treatments in the TAR.

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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** 30809 Based on observation, record review, interview and facility policy review, the facility failed to ensure Resident #56 and Resident #63 were assisted with toileting and/or incontinence care and failed to provide a toileting program for Resident #63. This affected two residents (#56 and #63) out of three residents reviewed for incontinence care. The facility census was 144. Findings include: 1. Resident #56 was admitted on [DATE] with diagnoses including high blood pressure, atherosclerotic heart disease, hyperlipidemia (high cholesterol), [NAME] Syndrome (A syndrome in which the liver of affected individuals processes bilirubin more slowly than the majority.), senile degeneration of the brain, adjustment disorder, diabetes mellitus, and malnutrition. Resident #56's care plan initiated on 04/02/24 indicated Resident #56 had bladder incontinence. The goal of the care plan was Resident #56 would remain clean and odor free through review date. Interventions on the care plan included providing perineal care as needed, assisting with toileting and incontinence care as needed and encouraging Resident #56 to ask for assistance with incontinent care. Resident #56's Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated Resident #56 had moderate cognitive impairment, bowel and bladder incontinence and he needed partial/moderate assistance with toileting/perineal hygiene, adjusting clothes before and after voiding or having a bowel movement. An observation and interview with Resident #56 on 02/03/25 at 9:25 A.M. revealed Resident #56 was lying in bed in his room. There was a strong, foul odor of urine present in the room. An observation of Resident #56's restroom revealed a pair of blue jeans hanging on the towel bar which had a large wet area located on the seat of the pants. The foul odor of urine was stronger in the restroom. Resident #56 stated he was incontinent during the nighttime hours and had removed his blue jeans and hung them on the towel rack. Resident #56 was unable to remember what time it was when he woke up from sleeping and was incontinent, but stated it was still dark outside. Resident #56 stated he was not provided with an incontinence brief and had donned a pair of pajama pants after he removed his blue jeans. Resident #56 stated the staff had not been in his room to check him yet this morning. An interview with Certified Nursing Assistant (CNA) #1234 on 02/03/25 at 9:25 A.M. verified the above findings and stated the CNA assigned to care for Resident #56 was currently on her break. CNA #1234 stated the CNA staff arrived in the morning for the start of their shift at 6:30 A.M. and should have made rounds on all the residents to ensure their care needs were met. CNA #1234 stated she had not seen Resident #56 since she arrived at the facility at 6:30 A.M. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated facility policy titled Incontinence Care indicated the purpose of the policy was to maintain skin integrity, prevent skin breakdown, control odor and provide comfort and self-esteem for the residents. This protocol is to be utilized on residents who are incontinent of bowel and/or bladder. After each episode of incontinence, greet the residents and explain procedure, provide incontinence care, change linens and clothing as needed, and provide an absorbent under pad and/or incontinence brief. 39973 2. Record review for Resident #63 revealed an admitted [DATE] with diagnoses including dementia, altered mental status, aphasia, anxiety disorder, and hypertension. Review of the care plan last revised 05/21/24 revealed Resident #63 was at risk for impaired skin integrity related to fragile skin, incontinence, and he preferred to urinate in various inappropriate places. Interventions included inspecting skin during routine daily care, medications as ordered, and incontinent care after each episode. There were no interventions regarding the prevention of urinating in inappropriate places. Review of the care plan last revised 08/24/24 revealed Resident #63 was on diuretic therapy related to hypertension. Intervention included obtaining and monitoring vital signs as needed. There was nothing in the care plan regarding interventions due to increased urination, especially after administration of medication. Review of the care plan last revised 08/28/24 revealed Resident #63 was at risk for alteration in elimination related to incontinence, decreased mobility and need for staff assist with toileting needs. Interventions including checking and changing the resident every two hours and providing incontinence care as needed. Review of the Continence assessment dated [DATE] revealed Resident #63 was continent as well as incontinent, utilized a toilet, had confusion and memory loss. He was on diuretic therapy which affected his continence. He was frequently incontinent of bowel, and there was not a bowel toileting program in place. He also was frequently incontinent of urine and per the assessment, a trial of a toileting program such as scheduled toileting, prompted toileting, or bladder training had not been attempted since admission. He also was not identified as on a current toileting program and/or trial. There was no documentation explaining why Resident #63 would not be appropriate for a program. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #63 had impaired cognition. He had no behaviors identified and required partial to moderate assistance with toileting. He was able to transfer and ambulate independently. He was frequently incontinent of urine and always incontinent of bowel. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 02/04/25 at 8:18 A.M. revealed Resident #63's room had a large puddle in the upper left corner of his room with brown stained tiles. The closet by the door also had a large puddle, and the inside of the closet had brown, black staining where it appeared the tiles were lifting, and the liquid was seeping underneath the tiles. There were two puddles on the floor by the closet near the window that also contained brown tiles. The baseboards in each of the closets were black covering the length of each closet. There was a strong pervasive urine smell coming from the room that could be smelled from the hallway. Resident #63 was unable to provide any details of the condition of his room. Interview on 02/04/25 at 8:18 A.M. with Registered Nurse (RN) #1273 verified the above findings. She verified all the puddles were urine, and the staining on the baseboards and tiles were also caused by Resident #63 urinating on the floor continuously. She revealed, he just urinates all over his room. She also verified that the tiles were lifting, and the urine was seeping underneath the tiles, and the floor was sticky. She revealed the room had been like that for some time, but housekeeping cleans the room daily and tried to clean the best that they could. She stated all the puddles observed were most likely from the last time housekeeping had cleaned his room yesterday, 02/03/25. She verified that housekeeping or staff do not clean more than once a day because it was an ongoing issue with him continuously urinating on the floor. She stated, yes, it is pretty bad but not sure what else to do for him except his whole room needed to be redone but then he would just continue to urinate on the floor. She was not aware of any toileting program that Resident #63 was on. Observation and interview on 02/04/25 at 8:21 A.M. with Director of Nursing (DON) #1238 and Maintenance Director #1256 of Resident #63 room verified the above findings. They both stated that they had no knowledge of the condition of his room. DON #1238 stated, oh my yes this is unacceptable and not good. They both also verified the multiple puddles of urine throughout the room and strong urine smell that was smelled in the room as well as from the hallway. DON #1238 verified staff should be cleaning after each episode, not waiting for an accumulation of puddles. Maintenance Director #1256 verified the tiles, and the baseboards needed to be replaced. DON #1238 verified there was no urinal present in his room as well as she was not aware if he was on a toileting program and/or what interventions were in place. Observation on 02/04/25 at 11:23 A.M. revealed there was a wet floor sign on the outside of Resident #63's room, but a strong urine smell continued coming from the room into the hallway. The floor was sticky; when this surveyor walked on it, shoes could be heard sticking to the floor, and the stains to the floor and baseboards continued. The puddles of liquid were no longer present. Resident #63 was sitting in the lounge in a recliner. Observation on 02/04/25 at 12:11 P.M. revealed Resident #63 got up from the recliner in the lounge and ambulated down the hallway past RN #1273 and CNA #1403 into his room where he urinated in the closet by the window leaving a puddle of urine. Interview on 02/04/25 at 12:14 P.M. with CNA #1403 revealed she observed Resident #63 get up from the recliner but thought he went into the dining room. She revealed they try to catch him before he urinates in his room, but they get busy with things and do not see when he goes. She verified there was a puddle of urine in the closet by the window and that the floor had not been thoroughly cleaned as it continued to be sticky. She also verified the strong urine smell, and stated, I know, his room is bad; it always was. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/04/25 at 2:40 P.M. with Housekeeping #1244 revealed he usually was assigned to Resident #63's unit and stated when he gets to his room there were multiple puddles of urine everyday as well as the stained black substance on the baseboard and brown stained tiles. He revealed no matter how well he tried to clean; the stains do not come off, and the urine had seeped under the tiles causing most all the tiles to lift. He verified the condition of his room had been like that for a long time. He revealed he usually waited to the end of his shift to clean his room because if he did it at the beginning Resident #63 just messed it up by urinating on the floor so that was why he waited till the end of the shift. He verified he usually only cleaned his room once a shift. Interview on 02/04/25 at 2:54 P.M. with Housekeeping/Laundry Supervisor #1253 revealed Housekeeper #1244 was the housekeeping staff on the unit Resident #63 resided. She verified Housekeeper #1244 should be cleaning Resident #63's room at least twice a day. She revealed, often when she comes in, there were multiple puddles of urine throughout his room. She had been working at the facility for over three years and that the urine was embedded into the floor tiles and baseboards causing the tiles to heave up and pull away from the floor. She revealed she knew Maintenance Director #1256 was aware of the condition of his room for quite a while because she had communicated it to him. She verified no matter how much they cleaned the room; the strong urine smell was still present as the urine had seeped under the stained tiles and baseboards. Interview on 02/05/25 at 7:59 A.M. with CNA #1203 revealed Resident #63 had urinated for years on the floor. She revealed they attempted to take him to the bathroom as often as they could, but Resident #63 was not on a specific toileting schedule and did not have any other interventions that she was aware of. Interview on 02/05/25 at 8:56 A.M. with the DON verified she did not have any documentation regarding where a toileting program had been attempted in the past for Resident #63. She was going to investigate what interventions could be attempted. She verified staff (nursing and housekeeping) should be intervening after each time Resident #63 urinated inappropriately in his room not just leaving the puddles of urine. She also verified she had observed his room and that it needed addressed because the tiles and baseboards were stained, tiles were lifting because urine had accumulated underneath, and there was a strong continuous smell of urine in his room as well as in the hallway. Review of the facility policy labeled, Incontinence Care revealed the purpose of the policy was to maintain skin integrity, prevent skin breakdown, control, odor, and provide comfort and self-esteem for the resident. The policy revealed the facility would assess and document the following regarding the resident: elevation status, pattern tracking when indicated, and urine and bowel elimination. The policy revealed after each episode incontinence care would be provided. There was nothing in the policy regarding toileting programs.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on record review, interview and facility policy review, the facility failed to ensure Resident #36 was reweighed according to facility policy and failed to have documented evidence the physician was notified of after an 8.7% weight loss in 30 days and failed to ensure Resident #37's weekly weights were obtained as ordered. This affected two residents (#36 and #37) of three residents reviewed for nutrition and had the potential to affect all 144 residents in the facility. Findings include: 1. Review of the medical record for Resident #36 revealed an admitted [DATE]. Diagnoses included malnutrition, muscle weakness, prostate disorder, depression and diabetes. Review of Resident #36's weight record revealed on 12/04/24 Resident #36 weighed 322 pounds and on 01/03/2025 Resident #36 weighed 294 pounds which was a 8.70% weight loss in 30 days. There was no documented evidence the physician was notified of the weight loss and no documented evidence a reweight was obtained. Review of the care plan dated 12/30/24 revealed Resident #36 was at risk for alteration in nutritional status. Interventions included assisting with meals as needed, encouraging healthy choices, providing diets as ordered and monitoring weights as ordered. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #36 was cognitively intact. He required set-up help for eating, supervision for oral hygiene, substantial or maximum assistance for personal hygiene and was dependent for toileting and showering. He had weight loss and was not in a prescribed weight loss regimen. Review of the dietary assessment note dated 01/09/25 revealed Resident #36 had a significant weight loss of 8.70% in 30 days. The note indicated a reweight would be requested to verify accuracy. Interview on 02/05/25 at 3:18 P.M. with Registered Dietitian (RD) #1239 confirmed there was no reweigh for Resident #36, based on the progress note dated 01/09/25. 2. Review of the medical record for Resident #37 revealed an admitted [DATE]. Diagnoses included congestive heart failure, diabetes, morbid obesity, kidney disease, dysphagia, anemia and vitamin D deficiency. Review of the care plan dated 12/16/24 revealed Resident #37 was at risk for alterations in nutrition and hydration. Interventions included communicating with the dialysis dietitian, maintaining weight without a significant unplanned weight change, assisting with meals as needed, monitoring intake and output as needed and obtaining weights as ordered. Review of the comprehensive MDS 3.0 assessment dated [DATE] revealed Resident #37 was moderately cognitively impaired. She required supervision for eating and was dependent for toileting, showering, dressing and hygiene. She had weight loss and was not on a prescribed weight loss regimen. (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 physician's orders for January 2025 revealed an order for weekly weights, which began on 12/13/24. Review of Resident #37's weight record revealed she weighed 181 pounds on 12/14/24 and 174 pounds on 01/08/25, a 3.86% weight loss. No other weights were available to review. Interview on 02/05/25 at 3:18 P.M. with RD #1239 confirmed weekly weights for Resident #37 were not obtained as ordered. Review of the undated facility policy titled Weight Policy and Procedure revealed all new admissions would be weighed weekly for the first four weeks after admission and any weight variance of three pounds in one week or three pounds in one month would be reweighed within 24 hours.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on observation, record review, interview and facility policy review, the facility failed to ensure Resident #128's oxygen was administered as ordered by the physician and failed to ensure Resident #128's oxygen tubing was changed as ordered. This affected one resident (#128) of three residents reviewed for oxygen administration and had the potential to affect four additional residents (#36, #60, #95, #128 and #443) identified by the facility as receiving oxygen therapy. The facility census was 144. Findings include: Review of the medical record for Resident #128 revealed an admitted [DATE]. Diagnoses included left rib fracture, chronic obstructive pulmonary disease (COPD), kidney disease, and history of stroke. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #128 was cognitively intact. She required supervision for eating and oral hygiene, partial to moderate assistance for personal hygiene and was dependent on staff for showering and toileting hygiene. Review of the care plan dated 12/20/24 revealed Resident #128 had an alteration in breathing patterns due to COPD. Interventions included assessing lung sounds and providing oxygen per the physician's orders. Review of the physician's orders for January 2025 revealed an order for three liters per minute of oxygen via nasal cannula continuously which began on 09/27/24 and an order to change oxygen tubing, cannula and/or mask every week on Thursday which began on 10/24/24. Observation on 2/04/25 at 9:30 A.M. revealed Resident #128's oxygen tubing was dated 01/23/25 and the oxygen administration was set at four liters per minute. Interview at the time of the observation with Licensed Practical Nurse (LPN) #1231 confirmed oxygen tubing was dated 01/23/25 and should be changed weekly, and Resident #128's oxygen was set at four liters per minute. Review of the undated facility policy titled Oxygen Therapy revealed oxygen would be administered in accordance with the physician's orders and tubing, nasal cannulas and humidifiers would be changed according to the physician's orders.

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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** 45441 Based on record review, interview and facility policy review, the facility failed to ensure pre and post dialysis assessments were accurate and complete. This affected two residents (#37 and #83) of three residents reviewed for dialysis. The facility census was 144. Findings include: 1. Review of the medical record for Resident #37 revealed an admitted [DATE]. Diagnoses included congestive heart failure, diabetes, morbid obesity, kidney disease, dysphagia, anemia, and vitamin D deficiency. Review of the care plan dated 12/16/24 revealed Resident #37 received dialysis three days per week. Interventions included assisting with transfers to dialysis, checking for new orders upon return from dialysis, maintaining communication with dialysis staff and physicians, and monitoring the shunt for signs and symptoms of infection. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #37 was moderately cognitively impaired. She required supervision for eating and was dependent upon staff for toileting, showering, dressing and hygiene. She was receiving dialysis. Review of the physician's orders for February 2024 revealed an order for hemodialysis Tuesday, Thursday and Saturday. The order began 12/19/24. Review of the pre and post dialysis assessment history revealed no pre post assessments were completed on 12/14/24, 12/17/24, 12/21/24, 12/24/24, 12/31/24, 01/04/25, 01/18/25 or 01/28/25. Completed pre and post assessments revealed not all assessments contained all of the necessary relevant information. 2. Review of the medical record for Resident #83 revealed an admitted [DATE]. Diagnoses included diabetes, depression, end stage renal disease, anemia, arthritis, and heart failure. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #83 cognitively intact. She required supervision for eating, set up help for oral hygiene, substantial assistance for personal hygiene and was dependent upon staff for toileting and showering. She was on dialysis. Review of the care plan dated 11/29/24 revealed Resident #38 received dialysis Three days per week. Interventions included receiving treatments as scheduled with monitoring of the disease process, assistance with transfers when going to dialysis, checking for new orders upon return from dialysis and maintaining communication with the dialysis staff and physician. Review of the physician's orders for February 2025 revealed an order for dialysis every Tuesday, Thursday and Saturday. The order began 11/14/24. (continued on next page)

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the pre and post dialysis assessment history revealed no pre or post assessments were completed on 11/21/24, 12/03/24, 12/07/24, 12/12/24, 12/14/24, 12/21/24, 12/24/24, 12/31/24, 01/11/25, 01/14/25, 01/21/25, 01/23/25, 01/25/25, 01/29/25 and 01/30/25. Completed pre and post assessments revealed not all assessments contained all of the necessary relevant information. Interview on 02/05/25 at 10:40 A.M. with Licensed Practical Nurse (LPN) #1240 revealed she was aware of inconsistencies and incomplete pre and post dialysis assessments and was not surprised. Review of the undated facility policy titled Dialysis revealed that for residents receiving hemodialysis, the nurse would obtain vital signs and weight prior to receiving dialysis treatment and upon the resident's return. The nurse would also assess the hemodialysis site for signs and symptoms of infection, monitor for a thrill or bruit.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on interview, record review and review of the facility policy, the facility did not have an individualized care plan with interventions regarding Resident #76's post-traumatic stress disorder (PTSD). This affected one resident (#76) of two residents reviewed for PTSD and had the potential to affect six residents (#15, #21, #38, #76, #194, and #293) that were identified by the facility diagnosed with PTSD. The facility census was 144. Findings include: Review of the medical record for Resident #76 revealed an admitted [DATE] with diagnoses including PTSD, Bipolar disorder, major depression, congestive heart failure, and diabetes. Review of the admission packet dated 12/05/24 and completed by Registered Nurse (RN) #1288 revealed Resident #76 had experienced trauma in his life, but he did not have any triggers identified. Review of the care plan dated 12/10/24 revealed Resident #76 required assistance with activities of daily living (ADL) related to alcoholic cirrhosis of the liver, PTSD, and diabetes. There was nothing in the care plan regarding triggers and/or interventions related to the PTSD. Review of the care plan dated 12/11/24 revealed Resident #76 had an alteration in health maintenance related to alcoholic cirrhosis of the liver, PTSD, and diabetes. There was nothing in the care plan regarding triggers and/or interventions related to the PTSD. There was no other mention of PTSD in the comprehensive care plan. Review of the progress note dated 12/11/24 and completed by Psychiatric Nurse Practitioner (NP) #1240 revealed Resident #76 had a history of abuse as he reported a family friend did some things to young girls and would stare at him inappropriately. He also stated his mother was never happy with anything he did, and she was verbally abusive. The note revealed he had a history of trauma as he stated he had seen people die and he had killed people as he was a veteran of the armed forces. Review of the readmission admission packet dated 12/31/24 and completed by RN #1273 revealed under the area of trauma that Resident #76 had experienced trauma in his life, and he did have triggers that he felt reminded him of his trauma. In the comments section it listed the diagnosis of PTSD but did not list anything regarding specific triggers. Review of Medicare five-day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #76 had impaired cognition as his Brief Interview for Mental Status (BIMS) score was a ten. Interview on 02/05/25 at 11:29 A.M. with Resident #76 revealed he would start a conversation and lose the train of thought and start another conversation as it was difficult to follow. He was unable to provide any information regarding his PTSD and/or any triggers. Interview on 02/05/25 at 7:59 A.M. with Certified Nursing Assistant (CNA) #1411 revealed she frequently worked on the unit that Resident #76 resided and was not aware of what his past trauma was and/or any triggers that he may have that may re-traumatize in relation to his diagnosis of PTSD. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/05/25 at 8:04 A.M. with RN #1273 revealed she frequently worked on the unit Resident #76 resided and was aware that he had a diagnosis of PTSD but was not aware of what his past trauma was as well as any triggers that he may have that may re-traumatize. Interview on 02/05/25 at 8:49 A.M. with MDS/Licensed Practical Nurse (LPN) #1224 verified Resident #76 had a diagnosis of PTSD and that on his re-admission assessment dated [DATE] revealed that he had triggers. She verified there was nothing in his care plan regarding his triggers and interventions to prevent re-traumatization related to his PTSD. Interview on 02/05/25 at 9:09 A.M. with the Director of Nursing (DON) verified Resident #76 had a diagnosis of PTSD and verified on Psychiatric/NP #1240 progress note dated 12/11/24 identified Resident #76 had a history of abuse as well as history of trauma with triggers identified. She also verified on his readmission assessment dated [DATE], under the area of trauma, Resident #76 experienced trauma in his life and that he did have triggers that he felt reminded him of his trauma. She verified Resident #76's care plan did not identify his triggers and/or interventions to prevent re-traumatization related to his PTSD. Review of the facility policy labeled, Trauma Informed Care, dated October 2022, revealed the facility recognizes that residents have had past experiences that have resulted in trauma including veterans, holocaust survivors, crime survivors and victims of sexual, physical and mental abuse. The facility defines trauma: results from an event, series of events, or set of circumstances that was experienced by the individual that had lasting adverse effects. The policy revealed the licensed nurse would assess the resident for potential trauma related to past or current experiences upon admission, quarterly, and with significant changes. Any identified triggers to re-traumatize would be documented and care planned .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on record review, interview and facility policy review, the facility failed to ensure pharmacist recommendations for Resident #36 were addressed by the physician. This affected one resident (#36) of three residents reviewed for unnecessary medication. The facility census was 144. Findings include: Review of the medical record for Resident #36 revealed an admitted [DATE]. Diagnoses included hypertension, anxiety, malnutrition, muscle weakness, prostate disorder, depression, and diabetes. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 was cognitively intact. He required set-up help for eating, supervision for oral hygiene, substantial or maximum assistance for personal hygiene and was dependent for toileting and showering. Review of the physician's orders for February 2025 revealed an order for Lasix 20 milligrams (mg) (diuretic) once per day which began on 09/18/23 and an order for Hydroxyzine 50 mg (antihistamine) three times per day which began on 06/26/22. Review of the medication regime review (MRR) dated 05/28/24 revealed Doctor of Pharmacy #1241 recommended monitoring for signs and symptoms of dehydration, kidney injury, edema, congestion and weight changes due to the use of Lasix. There was no documented evidence the physician addressed this recommendation. Review of the MRR dated 10/15/24 revealed Doctor of Pharmacy #1241 indicated hydroxyzine should be avoided in the elderly and recommended discontinuing the order. The physician responded to the recommendation 11/15/24 and indicated to continue use, but did not provide any rationale for the continued use. Interview on 02/05/25 at 2:29 P.M. with the Director of Nursing (DON) confirmed both MRR's for Resident #36 had not been addressed appropriately by the physician. Review of the facility policy titled Medication Monitoring; Medication Regimen, Review and Reporting, dated January 2024, revealed the consultant pharmacist would review the medication regimen and medical chart of each resident at least monthly to ensure appropriate monitoring of the medication regimen and to ensure medications received were clinically indicated. The findings were communicated to the DON and acted upon by the nursing staff or physician. The physician would act on the report or reject the recommendations, documenting the rationale of why the recommendation was rejected.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on observation, staff interviews and record review, the facility failed to ensure all medications were secured and stored in locked compartments that would limit access only to authorized personnel. This affected three residents (Residents #13, Resident #16 and Resident #95) out of 31 who residents resided on the 200-nursing unit. The facility census was 144. Findings include: 1. Resident #13 admitted on [DATE] with diagnoses including acute cystitis with hematuria, encephalopathy, morbid obesity with status post gastric sleeve, diabetes mellitus, methicillin susceptible staphylococcus aureus infection, and anxiety. Review of Resident #13's medical record dated 01/01/25 to 02/03/25 showed no physician order for self-medication or an assessment of ability to provide self-medication included in the care plan and Minimum Data Set (MDS) 3.0 assessment. Resident #13's clinical record indicated he had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) assessment score of ten, indicating moderate cognitive impairment. An observation on 02/03/25 at 8:17 A.M. revealed multiple oral medications in a medicine cup on the over-the-bed table and unsecured in Resident #13's room. Medications included: Amitriptyline 10 milligrams (mg) (antidepressant), calcium carbonate 500 mg (supplement), Colace 100 mg (stool softener), Levothyroxine 150 micrograms (mcg) (hormone), Mirtazapine 15 mg (antidepressant), multivitamin 1 tablet (supplement), omeprazole 20 mg (proton pump inhibitor to decrease stomach acid), Venlafaxine 300 mg (antidepressant), vitamin B12 100 mcg (supplement), buprenorphine 1.0 mg (schedule III pain medication), Hydroxychloroquine sulfate 200 mg (antirheumatic and antimalarial), and potassium chloride 20 milliequivalent (mEq) (supplement) dissolved in separate cups of water. Interview with Registered Nurse (RN) #1206 on 02/03/24 at 08:25 A.M. confirmed medications were left unattended in Resident #13's room. 2. Resident #16 admitted on [DATE] with diagnoses including muscular dystrophy, above the left knee amputation, type II diabetes mellitus, neurogenic bladder, anemia, congestive heart failure, and major depressive disorder. Review of Resident #16's medical record dated 05/17/24 through 1/31/25 showed no provider order for self-administration of any medications nor does the MDS 3.0 assessment or care plan indicate the ability to self-administer medications. Resident #16's BIMS score was 13, indicating the resident was cognitively intact. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 02/03/25 at 9:17 A.M. revealed unsecured medications in Resident #16's room on the computer desk. Medications observed included: Fluticasone nasal spray (corticosteroid), Timolol ophthalmic solution (treatment for glaucoma), artificial tears ophthalmic solution (eye lubricant), Systane nighttime ophthalmic ointment (eye lubricant), Brimonidine 0.2% ophthalmic solution (lowers eye pressure), and Latanoprost ophthalmic solution (treatment for glaucoma). Interview on 02/05/25 at 8:32 A.M with Licensed Practical Nurse (LPN) #1204 verified Systane ophthalmic ointment, artificial tears, Fluticasone nasal spray, Timolol ophthalmic solution Latanoprost ophthalmic solution and Brimonidine tartrate ophthalmic solution 0.2 % were present and unsecured on the resident's computer desk. 3. Resident #95 was admitted on [DATE] with diagnoses of acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), type II diabetes mellitus, and schizoaffective disorder. An observation on 02/04/25 at 9:26 A.M. in Resident #95's room revealed two unsecured medications on the bedside table. Medications included: Flonase nasal spray (antihistamine) and Azelastine nasal spray (antihistamine). Record review of Resident's #95's medical record dating 01/18/25 to 02/04/25 found no order for self-administration of medication or the assessment of ability for self-administration in the MDS 3.0 assessment or the care plan. Interview at 02/06/25 at 9:20 A.M. with Medication Technician #1415 confirmed both medications Flonase and Azelastine were present and unsecured on Resident #95's over the bed table.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38092 Based on observation, staff interview and facility policy review, the facility failed to ensure food was labeled and dated appropriately. This had the potential to affect 143 of 144 residents who received meals from the facility kitchen. The facility identified one resident (#50) who received no food by mouth. The facility census was 144. Findings include: Observations during of the main initial kitchen tour conducted on 02/03/25 between 8:27 A.M. and 9:10 A.M. with [NAME] #1238 revealed the following concerns: The main walk-in refrigerator contained one pork loin in a metal container that was undated and unlabeled. The reach in refrigerator revealed one undated metal container of 12 quartered hard-boiled eggs which was undated and unlabeled, one metal container of ham which was undated and unlabeled, one Chef salad that was undated, and one metal container of a gelatinous brown-green substance which [NAME] #1238 could not identify, which was unlabeled and undated. Interview on 02/03/25 at 8:50 A.M. with [NAME] #1238 verified all the above items were unlabeled and undated and that she did not know when they were placed in the refrigerators. Review of the undated facility policy titled, Policy and Procedure Manual: Food Storage stated under Refrigerated food storage: All foods shall be covered, labeled, and routinely monitored, to assure that food (including leftovers) will be consumed by their use dates, or frozen (where applicable) or discarded.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on observation, record review, interview, review of the centers for Disease Control and Prevention (CDC) guidelines and facility policy review, the facility failed to ensure staff donned the appropriate personal protective equipment (PPE) when providing direct care to Resident #13, Resident #16, Resident #36, Resident #50 and Resident #119. This affected five residents (#13, #16, #36, #50, and #119) out of five residents reviewed for enhanced barrier precautions (EBP) and/or transmission based precautions (TBP) and had the potential to affect and additional 19 residents (#4, #7, #15, #23, #31, #33, #60, #81, #91, #93, #96, #106, #111, #114, #125, #127, #135, #196, and #444) identified by the facility with orders for EBP. The facility census was 144. Findings include: 1. Resident #50 was admitted on [DATE] with diagnoses including respiratory failure, senile degeneration of the brain, gastronomy and colostomy status, diabetes mellitus, depression, bone density disorder, anxiety, gastroesophageal reflux disease, hemiplegia and hemiparesis, kidney failure, plasma-protein disorder, hyperosmolality, polyneuropathy, vitamin D deficiency, anemia, high blood pressure, and high cholesterol. Resident #50's physician order revised 11/22/24 indicated to implement EBP related to tube feedings. Resident #50's care plan revised on 05/29/24 indicated Resident #50 was at risk for infection related to an ostomy. Interventions on the care plan indicated to maintain EBP with care as indicated and provide education on EBP to family as needed. An observation on 02/05/24 at 7:19 A.M. of Certified Nursing Assistant (CNA) #1261 and CNA #1421 provide incontinence care for Resident #50 revealed a failure to wear the appropriate PPE. A sign outside of Resident #50's doorway indicated implementing EBP when providing care for Resident #50 as needed during direct care tasks. CNA #1261 and CNA #1421 entered Resident #50's room and proceeded to provide incontinence care. Both staff donned a pair of gloves but did not wear a gown while providing the incontinence care for Resident #50. The staff assisted Resident #50 with changing the soiled incontinence brief and linens, cleaned Resident #50's perineal area and repositioned Resident #50 for comfort during the incontinence care. An interview with CNA #1261 and CNA #1421 on 02/05/25 at 7:27 A.M. verified they did not wear the appropriate PPE during Resident #50's incontinence care. Both of the staff stated they thought they were only supposed to wear gloves during the task and stated they didn't know where to find the disposable gowns because there was no supply cart located outside of Resident #50's room with PPE supplies. An interview with Director of Nursing (DON) #1241 on 02/05/25 at 7:27 A.M. verified the staff were supposed to wear the appropriate PPE for EBP during Resident #50's incontinence care and proceeded to provide education to CNA #1261 and CNA #1421 on the policy and procedure for EBP implementation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #16 was readmitted on [DATE] with diagnoses including muscular dystrophy, below the right knee amputation, diabetes mellitus, neuromuscular bladder, polyneuropathy, anemia, high blood pressure, malnutrition, optic atrophy, heart failure, atherosclerotic heart disease and atherosclerotic lower extremity arteries, high cholesterol, encephalopathy, and chronic pain. Resident #16's physician order dated 09/16/24 indicated to implement EBP related to the presence of an indwelling urinary catheter. Resident #16's plan of care initiated on 06/15/20 indicated Resident #16 was at risk for infection related to the presence of an indwelling urinary catheter (Foley), diabetes mellitus, malnutrition, multiple co-morbidities, and communal living. Intervention on the care plan initiated on 12/20/24 indicated to maintain EBP related to Foley catheter. An observation of CNA #1234 on 02/04/25 at 9:35 A.M. assist Resident #16 with bathing and dressing and personal hygiene revealed a failure to wear appropriate PPE during the task. A sign located outside of Resident #16's room revealed EBP during direct care tasks. The sign indicated the staff should don a gown and gloves when providing direct care tasks including bathing, dressing, and personal hygiene. CNA #1234 entered Resident #16's room and donned a pair of gloves but did not wear a gown during the task. On 02/04/25 between 9:30 A.M. and 10:00 A.M. an interview with CNA #1234 stated she forgot to wear the appropriate PPE while assisting Resident #16 with dressing, bathing, and personal hygiene. CNA #1234 stated the PPE was located on the linen cart located in the hallway and she should have worn a gown in addition to the disposable gloves while assisting Resident #16. Review of the undated facility policy and procedure titled Enhanced Barrier Precautions indicated the purpose of the policy was to reduce the transmission of multidrug resistant organism (MDROs) when high contact resident care activities for residents with known to be colonized or infected with MDRO as well as those at increased risk to acquire MDRO. Residents with the following triggers will receive Enhanced Barrier Precautions (EBP) and indicate they should be followed for any resident in the facility with: Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Indwelling medical devices may include central lines, urinary catheters, feeding tubes, and tracheostomies. Chronic wounds include pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous status ulcers. EBP is to be used in conjunction with standard precautions and requires use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Use of eye protection may be necessary when splash or spray may occur but is not necessary in other situations. Examples of high-contact resident care activities requiring gown and glove use among residents that trigger EBP use include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dressing Bathing/Showering Transferring Providing hygiene Changing linens Changing briefs or assisting with toileting Device care or use; central line, urinary catheter, feeding tube, tracheostomy/ventilator 39973 3. Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including acute cystitis (inflammation of the bladder) with hematuria, diabetes, and altered mental status. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #13 had impaired cognition and was on antibiotic therapy. Review of the care plan dated 01/20/25 revealed Resident #13 received intravenous therapy through a peripherally inserted central catheter (PICC) (a thin flexible tube inserted into a vein in the upper arm and threaded into larger vein near the heart). Interventions included administering medications per physician orders, assessing intravenous site daily for signs of infection, assessing intravenous site daily for signs of infection and change dressing to insertion site per facility policy. Review of February 2025 physician orders revealed Resident #13 had a physician order dated 01/10/25 for EBP every shift due to intravenous therapy and wound care and an order dated 01/11/25 for vancomycin (antibiotic) hydrochloride intravenous solution 1000 milligram (mg) intravenously two times a day for 28 days. Review of the care plan dated 02/04/25 revealed Resident #13 was at risk for infection or worsening of related to PICC line. Interventions included administering medications as ordered, encourage frequent hand washing, and maintain EBP with care as indicated. Observation on 02/04/25 at 3:57 P.M. revealed Registered Nurse (RN) #1206 walked into Resident #13's room that had signage on the outside of her door indicating she was on EBP. There was no bin outside of Resident #13's room that contained PPE, including a gown. RN #1206 who already had a mask donned proceeded to wash her hands and donned gloves. RN #1206 then lifted Resident #13's left arm and leaned up against her bed as she administered her intravenous vancomycin. She was not wearing a gown as ordered. RN #1206 then doffed her gloves and washed her hands, exiting the room. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Center at the Ridge	3379 Main Street Mineral Ridge, OH 44440

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/04/25 at 4:09 P.M. with RN #1206 verified she did not don a gown during the administration of Resident #13's intravenous antibiotic. She revealed she had forgotten as there was no PPE sitting on the outside of the door in a bin as she was used to instead of just a sign. She revealed when barriers out of sight then out of mind. She verified Resident #13 had an order for EBP and that she should have had a gown on during the administration. Interview on 02/05/25 at 9:09 A.M. with the DON verified Resident #13 was on EBP, and RN #1206 was to wear a gown during the administration of her intravenous antibiotic. Review of the facility policy labeled, Enhanced Barrier Precautions, last revised March 2024, revealed residents with the following triggers would receive EBP including residents with indwelling medical devices. The policy revealed medical devices may include central lines. EBP was to be used in conjunction with standard precautions and required use of gown and gloves during high- contact resident care activities that provided opportunities for the transfer of MDRO. 41526 4. Observation on 02/04/25 at 8:36 A.M. revealed Resident #119's room had an EBP sign posted at the entrance. There was no PPE including gowns and gloves located nearby. RN #1310 then entered Resident #36's room to administer medications wearing only gloves and no gown. Resident #119 had an enteral tube which RN #1310 used to administer the medications without wearing a gown. Interview at the time of the observation with RN #1310 verified not using the appropriate PPE for EBP which included wearing both gloves and a gown. Review of the medical record for Resident #119 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebrovascular disease affecting the right dominant side, and gastrostomy status. The physician orders effective February 2025 indicated Resident #119 received medications via an enteral tube. Interview on 02/04/25 at 09:17 A.M. with Infection Preventionist (IP) #1240 confirmed staff were to use both gloves and a gown with EBP. The gloves were located inside resident rooms and gowns were located on clean linen carts. Review of facility policy, Enhanced Barrier Precautions, revised March 2024, revealed residents with an indwelling medical device including feeding tubes will receive EBP which required use of a gown and gloves during device care or use. 5. Observation on 02/04/25 at 8:07 A.M. revealed Resident #36's room had a TBP sign posted at the entrance. The sign was a CDC droplet precautions sign which indicated everyone must fully cover their eyes, nose and mouth before room entry and remove face protection before room exit. The sign included a picture which showed the use of a mask and either goggles or a face shield. There was no PPE including masks and goggles or face shields located nearby. CNA #1225 then entered Resident #36's room to deliver a breakfast meal tray wearing only a surgical mask. Afterwards, CNA #1225 exited the room without removing or changing the surgical mask. Interview at the time of the observation with CNA #1225 verified not wearing goggles or a face shield for droplet precautions and not changing or removing the mask upon the room exit. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/04/25 at 8:09 A.M. revealed RN #1310 entered Resident #36's room to administer medications wearing only a surgical mask. Afterwards, RN #1310 exited the room without removing or changing the surgical mask and returned to the medication storage cart to prepare additional medications. RN #1310 then re-entered Resident #36's room to administer the additional medications wearing the same surgical mask and no eye protection. After that, RN #1310 exited the room without removing or changing the surgical mask. Interview at the time of the observation with RN #1310 verified not wearing goggles or a face shield for droplet precautions and not changing or removing the mask upon the room exit. Review of the medical record for Resident #36 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, diabetes mellitus type two and heart failure. The laboratory test dated 01/28/25 indicated Resident #36 was positive for influenza A. Interview on 02/04/25 at 09:17 A.M. with IP #1240 confirmed with droplet precautions the staff were to use masks and eyewear either goggles or a face shield which would be washed or disposed of after use. The masks would be disposed of or changed when staff exited the room, and PPE placed outside the door for staff use. Review of Infection Prevention and Control Strategies for Seasonal Influenza in Healthcare Settings, dated 05/13/21, from the CDC's Influenza (Flu), located at https://www.cdc.gov/flu/hcp/infection-control/healthcare-settings.html revealed droplet precautions were to be used for any residents with suspected or confirmed influenza for seven days after illness onset or 24 hours after the resolution of fever and respiratory symptoms whichever is longer. Review of the facility policy, Transmission-Based Precautions, dated September 2024, revealed droplet precautions included use of a well fitted mask and eyewear in resident care areas at the discretion of the facility. Review of the undated facility policy, Policy Isolation Precautions revealed isolation procedures remained in effect until being discontinued by the physician and the Infection Control Nurse or Designee. Precaution signs were posted on residents' doors to alert staff or visitors.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 Based on record review, interview and facility policy review, the facility failed to administer the pneumonia and Coronavirus-19 (Covid-19) vaccine to Resident #125. This affected one resident (#125) out of five residents reviewed for immunizations. The facility census was 144. Findings include: Resident #125 was admitted on [DATE] with diagnoses of malignant neoplasm of stomach, bipolar disorder, and feeding difficulties with gastrostomy, dysphagia, protein calorie malnutrition, and urinary incontinence. A review of Resident #125's medical record revealed Resident #125's signed request dated 11/11/24 revealed Resident #125 wanted to receive the pneumococcal and Covid-19 vaccinations. Review Resident #125's electronic medical record dated 11/08/24 through 02/04/25 revealed no provider orders for the pneumococcal or Covid-19 vaccination. Review of Minimal Data Set (MDS) 3.0 assessment for Resident #125 completed on 12/19/24 showed the pneumococcal vaccine was not offered, and Resident #125 was not up to date with the vaccine. Additionally, there was no documentation of the status of the Covid-19 vaccination in the MDS assessment. Interview with Resident #125 on 02/04/25 at 11:05 A.M. stated she had not received the Covid-19 vaccine, and she requested the pneumonia vaccine upon admission in the facility. Review of the undated facility policy titled Influenza, Pneumococcal, Shingles, and Covid 19 Immunizations indicated resident will be offered the influenza and pneumococcal vaccine upon admission and the influenza and pneumococcal consent/declination form will be completed at that time. The facility will obtain a physician order for the vaccine at time of consent. Additionally, the policy indicated The nursing facility will offer the vaccine for Covid-19 per the manufacturer guidelines via the authorized provider.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 30809 Based on review of personnel records and interview the facility failed to maintain documentation the COVID-19 vaccine was offered to the staff, and the staff were provided education regarding the benefits and risks associated with COVID-19 vaccine annually. This had the potential to affect all 144 residents in the facility. Findings include: A review of Certified Nursing Assistant (CNA) #1234's, CNA #1274's, CNA #1226's, CNA #1315's and Licensed Practical Nurse (LPN) #1231's personnel records revealed there was no documentation the facility had provided education and/or offered the information/consent regarding the COVID-19 vaccine. An interview with Infection Control Preventionist (ICP) #1240 on 02/06/25 at 10:50 A.M. stated she did not file the employee's consent and/or education regarding the COVID-19 vaccine in the employees' personnel files. ICP #1240 stated the Human Resources Manager (HRM) filed the consents and education in the employees' personnel files. An interview with the HRM #1267 on 02/06/25 at 11:00 A.M. verified the facility failed to maintain documentation the COVID-19 vaccine was offered to the staff, and the staff were provided education regarding the benefits and risks associated with COVID-19 vaccine for staff. Only the newly employed staff with a hire date from 02/06/24 to 02/06/25 had the required documentation in their personnel record. The facility policy titled COVID 19 Vaccination, revised 12/2021, indicated: Prior to offering the COVID-19 immunization to the staff, the nursing facility will provide education regarding the benefits and potential side effects of the immunization. The nursing facility will offer the vaccine for COVID-19 series or booster per the manufacturer guidelines via the authorized provider, unless the immunization is medically contraindicated, the staff refuses the immunization, or if the staff have already been immunized during the time period. The staff would be observed for 15 minutes post vaccination by the authorized administering provider and/or facility licensed nursing staff to monitor for anaphylactic reaction and deliver emergency response care, as needed. The staff had the right to refuse the COVID-19 immunization. The refusal and the reason for the refusal should be documented within the staff member's personnel file. If a staff member refuses to receive the vaccine, they must present evidence from their physician as to why the vaccine would be contraindicated for them. If they cannot do so, they would be removed from the schedule until they provide evidence of vaccination to the facility. Failure to do so may result in disciplinary action to include termination. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The human resource coordinator/designee will document in the staff member's personnel file:That the staff member was provided education regarding the benefits and potential side effects of the COVID-19 immunization. That the staff member either received the COVID-19 Immunization or did not receive the COVID-19 immunization due to medical contraindications or refusal. The facility would record the COVID-19 vaccine receipt, refusal, or contraindications within the staff member's personnel file.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809 39973 Based on observation, interview, record review and facility policy review, the facility failed to adequately clean and maintain Resident #63's room, Resident #23's wheelchair, the laundry room and the resident common areas for [NAME] unit and 200-hall. This affected two residents (#23 and #63) and had the potential to affect all 144 residents residing in the facility. Findings include: 1. Observation on 02/03/25 at 9:38 A.M. of the 200-hall common area revealed a two-person fabric couch located to the right of the television across from room [ROOM NUMBER]. The couch armrests and seats were heavily soiled with the seat fabric torn open from the far-right of the cushion across toward the far-left of the cushion. The large tear was moderately wide which exposed the yellow-colored foam-like material underneath the fabric. Nearby, to the right of the couch was one non-reclining fabric chair with an ottoman placed in front of it which was located across from room [ROOM NUMBER]. Both the chair and the ottoman were heavily soiled with multiple scattered dark colored stains. The fabric of both armrests and the upper rear portion of the chair was worn away which revealed multiple open holes exposing the wood and metal framing beneath. The right armrest had torn fabric which exposed seven large metal nail heads from the wood frame underneath, and the left armrest also had exposed the wood framing from fabric torn away. There were six dining chairs located within the vicinity of the non-reclining chair. Each chair was heavily soiled with dark colored stains on both the seats and upper backs of the chairs. Each wooden chair leg had excessive damage including multiple deep marks, dents and gashes which were unsightly. To the left of the television was a door frame leading from the 200-hall resident care area towards the facility front entrance. There was a large crack in the wall from the right mid to the upper portion of the wall surrounding the door frame. This was adjacent to room [ROOM NUMBER]. There were small areas of missing plaster alongside the cracks and the word crack was written in black onto the lower portion of the cracked wall. The metal framing underneath the damaged wall was visible through the cracked areas on the lower portion of the damage. An interview at the time of the observation with the Director of Nursing (DON) verified the findings. 2. Record review for Resident #63 revealed an admitted [DATE] and diagnoses included dementia, altered mental status, aphasia, anxiety disorder, and hypertension. Review of care plan last revised 05/21/24 revealed Resident #63 was at risk for impaired skin integrity related to fragile skin, incontinence and that he preferred to urinate in various inappropriate places. Interventions included inspecting skin during routine daily care, medications as ordered, and incontinent care after each incontinence episode. There were no interventions regarding the prevention of urinating in inappropriate places. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 02/04/25 at 8:18 A.M. revealed Resident #63's room had a large puddle in the upper left corner of his room with brown stained tiles. The closet by the door also had a large puddle, and the inside of the closet had brown, black staining where it appeared the tiles were lifting, and the liquid was seeping underneath the tiles. There were two puddles on the floor by the closet near the window that also contained brown tiles. The baseboards in each of the closets were black covering the length of each closet. There was a strong pervasive urine smell coming from the room that could be smelled from the hallway. Resident #63 was unable to provide any details of the condition of his room. Interview on 02/04/25 at 8:18 A.M. with Registered Nurse (RN) #1273 verified the above findings. She verified all the puddles were urine, and the staining on the baseboards and tiles were also caused by Resident #63 urinating on the floor continuously. She revealed, he just urinates all over his room. She also verified that the tiles were lifting, and the urine was seeping underneath the tiles, and the floor was sticky. She revealed the room had been like that for some time, but housekeeping cleans the room daily and tried to clean the best that they could. She stated all the puddles observed were most likely from the last time housekeeping had cleaned his room yesterday, 02/03/25. She verified that housekeeping or staff do not clean more than once a day because it was an ongoing issue with him continuously urinating on the floor. She stated, yes, it is pretty bad but not sure what else to do for him except his whole room needed to be redone but then he would just continue to urinate on the floor. She was not aware of any toileting program that Resident #63 was on. Observation and interview on 02/04/25 at 8:21 A.M. with the DON #1238 and Maintenance Director #1256 of Resident #63 room verified the above findings. They both stated that they had no knowledge of the condition of his room. DON #1238 stated, oh my yes this is unacceptable and not good. They both also verified the multiple puddles of urine throughout the room and strong urine smell that was smelled in the room as well as from the hallway. DON #1238 verified staff should be cleaning after each episode, not waiting for an accumulation of puddles. Maintenance Director #1256 verified the tiles, and the baseboards needed to be replaced. DON #1238 verified there was no urinal present in his room as well as she was not aware if he was on a toileting program and/or what interventions were in place. Observation on 02/04/25 at 11:23 A.M. revealed there was a wet floor sign on the outside of Resident #63's room, but a strong urine smell continued coming from the room into the hallway. The floor was sticky; when this surveyor walked on it, shoes could be heard sticking to the floor, and the stains to the floor and baseboards continued. The puddles of liquid were no longer present. Resident #63 was sitting in the lounge in a recliner. Observation on 02/04/25 at 12:11 P.M. revealed Resident #63 got up from the recliner in the lounge and ambulated down the hallway past RN #1273 and CNA #1403 into his room where he urinated in the closet by the window leaving a puddle of urine. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/04/25 at 2:54 P.M. with Housekeeping/Laundry Supervisor #1253 revealed Housekeeper #1244 was the housekeeping staff on the unit Resident #63 resided. She verified Housekeeper #1244 should be cleaning Resident #63's room at least twice a day. She revealed, often when she comes in, there were multiple puddles of urine throughout his room. She had been working at the facility for over three years and that the urine was embedded into the floor tiles and baseboards causing the tiles to heave up and pull away from the floor. She revealed she knew Maintenance Director #1256 was aware of the condition of his room for quite a while because she had communicated it to him. She verified no matter how much they cleaned the room; the strong urine smell was still present as the urine had seeped under the stained tiles and baseboards. 3. Observation on 02/03/25 at 9:04 A.M. on [NAME] unit revealed a couch in the lounge area with multiple brown stains covering the seat cushions and arm rests. The couch seat cushions also contained brownish circular stains appearing to be from urine. Interview on 02/03/25 at 9:04 A.M. with Certified Nursing Assistant (CNA) #1200 verified the couch in the lounge area contained stains. She revealed several of the residents were incontinent on the unit and frequently urinated on the couch causing the brown circular stains, and the couch had been in that condition for quite a while. Observation on 02/04/25 at 7:38 A.M. revealed the couch on [NAME] unit continued to be in the same condition. Interview on 02/04/25 at 7:38 A.M. with the DON verified the couch had multiple brown stains covering the seat cushions and arm rests. She stated, yes it looks like dried urine stains on the seat cushions. 4. Observation on 02/03/25 at 8:27 A.M. revealed Resident #23 was up in her wheelchair and dried food and a white substance was on the side of the chair as well as on her wheelchair seat. There was an accumulation of brown/black substance on her wheelchair seat and brakes. Interview on 02/03/25 at 10:57 A.M. with Licensed Practical Nurse (LPN) #1303 verified the above condition of Resident #23's wheelchair. She revealed that Resident #23's wheelchair needed cleaned as it looks like it had not been cleaned recently. She was not aware of the schedule of how often wheelchairs were cleaned, and who was assigned to clean them. Interview on 02/05/25 at 4:41 P.M. with Administrator revealed the facility did not have a policy in regards to cleaning of wheelchair or a schedule of who or when they were cleaned. She revealed there was nothing formal in place regarding who was assigned to clean the wheelchairs. 5. An observation of the laundry room on 02/04/25 at 8:06 A.M. revealed a thick coating of dust and debris behind the two washing machines. There was a small cardboard box covered in dust and a metal container covered with dust behind the washing machines. An interview with Laundry Aide (LA) #1216 on 02/04/25 between 8:00 A.M. and 8:15 A.M. verified there was an excessive amount of dust and debris behind the washing machines. LA #1216 stated the maintenance department was responsible for cleaning behind the washing machines. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Maintenance Director (MD) #1256 on 02/04/254 at 9:30 A.M. revealed he was responsible for dusting the top of the washing machines, dryers and high areas in the laundry room. MD #1256 stated he was not responsible for cleaning behind the washing machines. 41526