STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365839	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbus Alzheimer's Care Ctr	700 Jasonway Avenue Columbus, OH 43214

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47059 Based on record review, family interview, staff interviews, and policy review the facility failed to make a life insurance policy payment from a facility managed account for one resident (Resident #9) out of five residents reviewed for personal funds. The facility census was 99. Findings include: Review of Resident #9's record revealed the resident was admitted on [DATE] with diagnoses that included dementia, age-related osteoporosis, psoriasis, dysphagia, aphasia, Alzheimer's disease, history of other mental and behavioral disorders. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #9 was not interviewed for cognition because she was rarely or never understood. Resident #9 had poor short term and long-term memory and was unable to make daily care decisions on her own. Resident #9 displayed physical behaviors four to six days during the look back period. Resident #9 was unable to be interviewed for the resident screening process. Interview on 08/19/24 at 1:03 P.M. via telephone with Resident #9's daughter revealed Resident #9 had a life insurance policy established prior to admission to the facility. The policy premiums were recently set up to be paid out of the resident's account. The previous business office manager didn't make a payment, and the policy was canceled. The current business office manager staff #700 is working with Resident #9's daughter to get the policy reinstated, and a payment has been made however th policy has not been reinstated. Review of Resident #9's monthly funds account statements for 2023 and 2024 revealed insurance premium payments were made 05/12/23, 07/11/23, 10/16/23 and 01/19/24. There was not another payment made until 06/20/24 and this payment was twice the amount of the previous payments. Interview 08/22/24 at 11:55 A.M. with Staff #700 confirmed, Resident #9's family had been managing payments for Resident #9's life insurance since 2002. The facility's business office manager took over making the life insurance payments as of 05/12/23 and the payments were to be made quarterly starting 07/11/23. Quarterly payments were made on 07/11/23, 10/16/23 and 01/19/24. Staff #700 confirmed the facility did not make the April 2024 quarterly payment and the policy was canceled by the insurance company. Staff #700 stated they had worked with Resident #9's daughter and called the insurance company in an effort to reinstate the life insurance policy and a double payment was made on 06/20/24 as directed by the life insurance company, but the policy has not been reinstated. (continued on next page)

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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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property last reviewed 10/2023 revealed the facility's policy to educate all staff to prevent any abuse, neglect exploitation or misappropriation and for all staff to recognize and report any concerns.

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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** 47059 Based on medical record review, staff interview, and review of the facility policy, the failed to ensure staff notified resident physicians of abnormal lab results in a timely manner. This affected one (Resident #72) of 25 residents sampled. The facility census was 99 residents. Findings include: Review of the medical record for Resident #72 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, venous insufficiency, open wound of the left lower leg, generalized anxiety disorder and major depressive disorder. Review of the MDS assessment for Resident #72 dated 07/18/24 revealed the resident was cognitively intact. Review of the physician's orders for Resident #72 revealed an order dated 08/21/24 to obtain a culture to the wound on the resident's left lower extremity. Review of the wound culture results for Resident #72 revealed the wound culture was obtained on 08/21/24 and the results were received on 08/24/24 at 2:06 P.M. indicating the wound was infected with a heavy growth of streptococcus pyogenes (bacteria) which was susceptible to penicillin and first generation cephalosporins (antibiotic medications.) Review of the nurse progress notes for Resident #72 dated 08/24/24 to 08/26/24 revealed the notes did not include documentation of physician notification of the abnormal wound culture obtained on 08/21/24. Interview on 08/26/24 at 4:05 P.M. with Licensed Practical Nurse (LPN) #215 confirmed she notified the physician of Resident #72's the abnormal wound culture results on 08/26/24, but she had not heard back from the physician. LPN #215 further confirmed the results were available on 08/24/24 and the physician was not notified in a timely manner. Review of the facility policy titled Notification of Change undated revealed the facility must immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or an interested family member when there was a need to alter treatment significantly or to commence a new form of treatment.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 48568 Based on observation, interviews, and record review, the facility failed to maintain a clean and homelike environment for seven (#18, #26, #35, #44, #78, #90, and #92) residents, all residents were screened during the annual survey. The facility census was 99. Findings include: 1. Review of Resident #44's medical record identified admission to the facility occurred on 07/18/17 with medical diagnosis including aphasia, Alzheimer's disease, and dementia. Observation on 08/19/24 at 3:47 P.M. of Resident #44's room revealed the room was filthy, the floor was sticky causing feet to stick to the floor. The bedspread was visibly soiled and the wall behind the bed was stained with residue. Observation on 08/22/24 at 10:31 A.M. with Maintenance Director #801 and Housekeeping Supervisor #615 of Resident #44's room revealed the floor was very sticky and there were brown and yellow stains on the wall next to Resident #44's bed. Interview on 08/22/24 at 10:31 A.M. with Maintenance Director #801 verified the floor was sticky. Interview on 08/22/24 at 10:31 A.M. with Housekeeping Supervisor #615 verified the stains on the wall next to the resident's bed. 2. Review of Resident #78's medical record identified admission to the facility occurred on 05/14/22 with medical diagnosis including depression, generalized anxiety disorder, and dementia. Observation on 08/19/24 11:19 at A.M. revealed Resident #78's room includes one pink wall with patches of white where it has been repaired. There was not one single picture or photo on any wall. The floor was very sticky. There was dried residue on the bathroom floor to left side of toilet and commode. Observation on 08/22/24 at 10:42 A.M. with Maintenance Director #801 and Housekeeping Supervisor #615 of Resident #78's room revealed the floor was very sticky and there were little black balls all over the floor. Interview on 08/22/24 at 10:42 A.M. with Housekeeping Supervisor #615 confirmed the room floor was sticky and the bathroom floor was soiled. Interview on 08/22/24 at 10:46 A.M. with Maintenance Director #801 confirmed there were shredded rubber pellets on the room floor. Review of the undated Routine Cleaning and Disinfection Policy stated This facility's policy is to ensure routine cleaning and disinfection to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #26's medical record identified admission to the facility occurred on 12/29/21 with medical diagnosis including depression, epilepsy, and dementia. Observation on 08/20/24 at 8:51 A.M. of Resident #26's room revealed the walls were scuffed there were drywall patches by the bed. Observation on 08/22/24 at 10:56 A.M. with Maintenance Director #801 and Housekeeping Supervisor #615 of Resident #26's room revealed there was nothing on the walls in room and the room was not in a homelike condition. Interview on 08/22/24 at 10:57 A.M. with Housekeeping Supervisor #615, Maintenance Director #801, and Activity Supervisor #608 all confirmed there was nothing in the room. 4. Review of Resident #90's medical record identified admission to the facility occurred on 12/12/23 with medical diagnosis including traumatic hemorrhage of cerebrum, depression, and dementia. Observation on 08/19/24 at 10:10 A.M. revealed Resident #90's walls were scuffed and had dry wall patches showing throughout the room. Observation on 08/20/24 at 9:22 A.M. of Resident #90's room revealed the room was not homelike. There was nothing on the walls. Observation on 08/22/24 at 11:13 A.M. with Maintenance Director #801 and Housekeeping Supervisor #615 of Resident #90's room revealed there was nothing on walls of the room and it was not in a homelike condition. Interview on 08/22/24 at 11:13 A.M. with Housekeeping Supervisor #615 confirmed there was nothing on the walls. 5. Review of Resident #35's medical record identified admission to the facility occurred on 03/01/24 with medical diagnosis including depression, aphasia, and dementia. Observation on 08/20/24 at 9:15 A.M. revealed Resident #35's wall and ceiling are patched with drywall and scuffed. Observation on 08/22/24 at 10:59 A.M. with Maintenance Director #801 and Housekeeping Supervisor #615 of Resident #35's room revealed there is nothing on Resident #35's side of the room and it is not in a homelike condition. Also observed was a piece of coving missing which exposed valves and there was broken flooring in front of the room. Interview on 08/22/24 at 10:59 A.M. with Housekeeping Supervisor #615 confirmed there was nothing in Resident #35's room. Interview on 08/22/24 at 11:00 A.M. with Maintenance Director #801 confirmed there was missing coving with exposed valves and there is broken flooring in front of the room. 6. Review of Resident #92's medical record identified admission to the facility occurred on 03/14/24 with medical diagnosis including dementia, depression, and bipolar disorder. (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 08/20/24 at 9:00 A.M. of Resident #92's room revealed the room was not homelike. Observation on 08/22/24 at 10:33 A.M. with Maintenance Director #801 and Housekeeping Supervisor #615 of Resident #92's room revealed there was nothing in the room to look at. It was not in a homelike condition. Interview on 08/22/24 at 10:33 A.M. with Housekeeping Supervisor #615 confirmed nothing was in the room. Housekeeping Supervisor #615 said there are supposed to be clocks and dressers in the room. 7. Review of Resident #18's medical record identified admission to the facility occurred on 01/10/19 with medical diagnosis including insomnia, Alzheimer's disease, and dementia. Observation on 08/22/24 at 11:13 A.M. of Resident #18's room with Maintenance Director #801 and Housekeeping Supervisor #615 revealed there is nothing on the walls in the room and it was not in a homelike condition. Interview on 08/22/24 at 11:13 A.M. with Housekeeping Supervisor #615 confirmed there is nothing on the walls. Review of the Quality of Life-Homelike Environment policy dated May 2017 stated Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on observation, record review, staff interview, policy review, and review of the facility assessment, the facility failed to effectively communicate with Resident #34. This affected one (Resident #34) of two residents reviewed for communication. The facility identified four residents who spoke an alternate language. The facility also failed to provide necessary assistance to maintain personal hygiene for one (Resident #35) of 25 reviewed. The facility census was 99. Findings include: Review of Resident #34's medical record revealed an admitted [DATE]. Medical diagnoses included dementia, depression, aphasia (difficulty forming words or speaking) and cerebrovascular accident (stroke). Review of Resident #34's minimum data set (MDS) 3.0 annual assessment, dated 07/01/24 revealed the resident's preferred language was French Creole. The resident was identified to not want the use of an interpreter. Resident #34 was recorded as rarely/never understanding others, and rarely/never was able to make herself understood. Resident #34's breif interview of mental status (BIMS) was not assessed as she was rarely/never able to be understood. Review of Resident #34's care plan, revised on 07/03/24, revealed the resident had impaired communication due to expressive aphasia, dementia, and Alzheimer's disease. The resident was recorded as sometimes understands others and is sometimes able to make herself understood. Resident #34 spoke French Creole and spoke a few words in English. The listed goal was for Resident #34 to be able to communicate her basic care needs clearly through simple responses and gestures daily. Listed interventions included to provide an interpreter who speaks French, as needed, speak clearly and slowly during daily care opportunities, use a communication board when trying to have a conversation, and use questions that can be answered with non-verbal signals or simple cues. Review of Resident #34's progress notes from 01/01/22 to 08/26/24 revealed no evidence staff had attempted to use alternative means, (such as a communication board or an interpreter) to communicate with Resident #34. The progress notes contained no notation that the resident had misused any alternative means of communication. Review of Resident #34's physician progress note, dated 08/12/24, revealed the resident was seen for an expert evaluation by a physician. The note indicated Resident #34 had a language barrier that further complicated the assessment. Resident #34 was noted to have baseline confusion and was unable to state her name at this time. The patient was deemed to be disoriented to person, place, time and situation, and was recorded as dependent on staff for activities of daily living (ADLs) and for medication management. The note did not indicate that any alternative means to communicate were attempted. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #34's psychiatric progress note, dated 08/13/24, revealed the Resident #34 was seen at the facility. The note indicated Resident #34 engaged with the provider, but it was difficult to understand her speech due to a language barrier. Resident #34 appeared tearful and it was unclear whether the tearfulness was related to internal stimuli or the resident attempting to tell the provider about something sad. Supplemental screenings, such as the mini mental status examination and the BIMS test was noted as unable to be completed due to a language barrier. Review of the facility assessment, dated as updated between 08/15/24 and 08/19/24, revealed the assessment was completed using a facility assessment tool which provided guidelines and prompts for completing a comprehensive assessment. The section prompting the facility to describe ethnic, cultural, or religious factors or personal resident preferences that could affect the care provided to the residents was blank. An attempted interview on 08/20/24 at 9:01 A.M. revealed Resident #34 speaking in another language. Resident #34 did not appear to understand any questions and the interview was unsuccessful. A communication board was not readily seen in Resident #34's room. An observation on 08/20/24 at 3:13 P.M. revealed Resident #34 seated in a lounge area in the pink hallway of the skilled unit. Resident #34 attempted to gesture at both the surveyor and staff while speaking in Creole and was unable to be understood. An interview on 08/20/24 at 3:17 P.M. with Registered Nurse (RN) #202 revealed she does not speak the same language that Resident #34 speaks. RN #202 stated she had never used an interpreter to communicate with Resident #34, rather she primarily guessed and estimated what Resident #34 needed. RN #202 additionally stated she had never used, nor seen any other staff member use, a communication board or picture board to communicate with Resident #34. RN #202 stated Resident #34 had lived at the facility for years and staff just knew her. An observation on 08/21/24 at 12:59 P.M. revealed Resident #34 seated in the lounge area eating lunch, with television on playing the news in English. Resident #34 was not observed to have any communication or interaction with any other staff or residents. An interview on 08/21/24 at 5:16 P.M. with Licensed Practical Nurse (LPN) #222 revealed Resident #34 speaks Creole, and she does not. When asked how she communicated with Resident #34, LPN #222 stated she knew the resident's baseline and recognize her change in behavior as indicative of what the resident needed. LPN #222 stated Resident #34 was unable to communicate her needs to staff verbally due to the language barrier. LPN #222 stated Resident #34 was incontinent, and they would know when she needs changed based on odor or if Resident #34 exhibited an increase in negative behaviors. LPN #222 stated there were a few staff members employed at the facility who speak Creole, but if not on shift, English-speaking staff members are unable to verbally assess the resident's needs. LPN #222 stated she had never used an interpreter or translator to communicate with Resident #34 and did not believe the facility had one. LPN #222 indicated approximately three years ago the resident's daughter had created a picture board that the resident previously used while her room was in another unit of the facility but believed it had been lost when Resident #34 moved rooms. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 08/22/24 at 11:59 A.M. with State tested Nurse Aide (STNA) #245 revealed Resident #34 did not utilize an interpreter, translator, picture board, or any alternative means of communication. STNA #245 stated Resident #34 used to have a picture board that worked well but she probably threw it away. STNA #245 stated she could not understand or communicate with Resident #34. An interview on 08/22/24 at 3:20 P.M. with Activity Director (AD) #608 revealed Resident #34 only received one-on-one visits. When asked how she communicated with residents with different language or cultural preferences or interests, AD #608 indicated those residents primarily only did 1:1 activities which consisted of music, swatches of textures, or hand rubs. AD #608 stated she had never used a picture or communication board and denied ever seeing staff use a translator or interpreter to communicate with residents. AD #608 stated she did not believe the facility had an interpreter or translation service. An interview on 08/26/24 at 11:46 A.M. with LPN Unit Manager (UM) #215 revealed some staff members speak Resident #34's language and are the primary ones who communicate with Resident #34. LPN UM #215 confirmed Resident #34 used to have a picture board that staff used to assist the resident in expressing her needs. She believed the picture board got lost or thrown away and had not been replaced or recreated. LPN UM #215 stated she had never attempted to use an interpreter or heard of staff who had with Resident #34, but the facility had a contracted phone interpreter service, with the contact information available near the front desk. LPN UM #215 confirmed it was difficult to accurately assess Resident #34 as she was unable to verbally respond to questions or instructions. An interview on 08/26/24 at 4:10 P.M. with the Director of Nursing (DON) revealed Resident #34 used to speak French Creole, but from what she heard from staff who do speak the language, Resident #34 just speaks aphasic. The DON clarified she heard from staff the resident's spoken language was not discernable and more so illogical sounds and/or phrases. The DON confirmed she did not speak French Creole. She indicated multiple staff members at the facility spoke French Creole, and she hired them based on their ability to communicate verbally and non-verbally. The DON stated Resident #34 previously had a communication board a few years ago that therapy staff had made her, but the resident no longer had one as she had thrown it at a staff member. The DON indicated there was not always a French Creole speaking staff person on-site, but the facility had an interpreter service's information posted at the front desk and staff members had translation applications on their phones to aid in communication with residents. The DON indicated the interpreter/translator and communication board, as listed on Resident #34's care plan, were not current interventions the facility utilized as part of Resident #34's care. The DON stated the facility did not have a policy regarding alternative means of communication. 19571 2. Review of Resident #35's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included dementia, chronic obstructive pulmonary disease (COPD), depression, Rheumatoid arthritis, PVD (peripheral vascular disease), osteoarthritis (OA) and Congestive Heart Failure (CHF). Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed her cognition was not intact. No impairment on either side for functional range of motion. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care dated 06/27/23 revealed she had the potential to have activity of daily living self care performance deficit due to dementia, chronic obstructive pulmonary disease (COPD), rheumatoid arthritis, PVD, osteoporosis, idiopathic progressive neuropathy, CHF. She is very independent with need of assistance at times. Observation on 08/22/24 8:13 A.M. revealed her hair appears unkept. At 10:35 A.M., 12:00 P.M., and 2:10 P. M. She still has not had her hair care completed. On 08/26/24 at 10:33 A.M. Remains up in common area with walker, her hair remains unkept and greasy. Interview with RN #276 at 10:39 A.M. verified Resident #35's hair was unkept and when staff asked her to go to her room so they could fix her hair, she complied and went with them. Review of the policy Supporting Activities of Daily Living (ADLs), reviewed 08/2021, revealed residents will be provided with appropriate care and services will be provided for residents who are unable to carry out ADLs independently in accordance with the plan of care, including appropriate support and assistance with communication. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals, and recognized standards of practice.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on medical record review, observation, and staff interview, the facility failed to provide activities to meet the needs and preferences of the residents. This affected three (Resident #27, #45, and #72) of 32 residents observed for activities. The Census was 99 Findings Include: 1. Review of Resident #27's medical record revealed an admitted [DATE]. Medical diagnoses included dementia, depression, osteoarthritis, and hypertension. Review of Resident #27's MDS Medicare/5-day assessment, dated 07/02/24, revealed the resident had a BIMS score of 11, indicating moderately impaired cognition. Review of Resident #27's Activity Assessment, dated 02/06/2, revealed the resident's former occupation was a carpenter and he had current interests in reading, music, spiritual/religious activities, and watching television and movies. The assessment indicated it was somewhat important to Resident #27 to listen to music he liked, be around animals such as pets, to do his favorite activities, to go outside to get fresh air when the weather is good, and to participate in religious services or practices. Review of Resident #27's care plan, revised 05/22/24, revealed the resident was at risk for alteration in activity participation related to a cognitive impairment and a diagnosis of dementia. Resident #27 was recorded to enjoy watching television, reading, working with his hand, enjoyed the outdoors and walking, and was of Methodist faith. Interventions included to familiarize the resident with the nursing home environment and activity programs on a regular basis, provide 1 on 1 activities as needed, and to provide the resident with a calendar of scheduled activities. Review of Resident #27's activity participation log for June 2024, July 2024, and August 2024 revealed the resident received two pet visits in August 2024, but none in June 2024 or July 2024. The logs revealed no evidence of participation in any outdoor activities in June 2024, July 2024, or August 2024, and reflected Resident #27 received only one religious activity on 07/07/24. An interview on 08/20/24 at 9:16 A.M. revealed Resident #27 seated up in his chair. Resident #27 stated there was nothing to do here other than listen to his radio. Resident #27 explained he used to enjoy being outdoors and enjoyed rabbit hunting, sports such as football, and motorcycle. Resident #27 stated he enjoys watching television, but sometimes his remote comes up missing and he cannot change the channel or adjust the volume. Resident #27 denied being invited to any group activities. Observations made on 08/20/24 at 3:26 P.M., 08/21/24 at 9:40 A.M., 08/21/24 at 5:28 P.M., and 08/22/24 at 8:32 A.M. revealed the resident sitting upright in his chair listening to the radio or watching television. (continued on next page)

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	365839	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbus Alzheimer's Care Ctr	700 Jasonway Avenue Columbus, OH 43214

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 08/22/24 at 8:36 A.M. with Licensed Practical Nurse (LPN) Unit Manager (UM) #215 revealed Resident #27 broke his hip a month or two ago and only comes out now for therapy. LPN UM #215 stated the resident used to be a lot happier and used to come out to group activities. LPN UM #215 stated she was unsure if activities staff routinely rounded to invite residents to activities. An interview on 08/22/24 at 3:20 P.M. with Activity Director (AD) #608 revealed the facility has a regular activity calendar and a special one for low-functioning residents. Most activities are held in the larger 300-hall program unit. AD #608 stated Resident #27 never comes to activities and prefers to stay in his room. AD #608 stated the facility rarely used their secured courtyard for outdoor activities and stated the only residents who go outside are the residents who smoke. For residents who do not come to activities, one on one visits are completed which include music and instruments, rubbing swatches of textures against hands and faces, and religious services. AD #608 denied providing Resident #27 with any religious material or services in the last three months. Activity Director #608 revealed Resident #27 never comes to activities and was unsure if any staff person had ever invited him to any activities. AD #608 was unaware of Resident #27's activity preferences or interests. An interview on 08/26/24 at 8:13 A.M. revealed Resident #27 seated upright in his chair eating breakfast. Resident #27 reported there was not a lot going on at the facility and that he had not been invited to activities. Resident #27 stated there was an activity calendar on the wall next to the door to the bathroom but the print was too small to read. Resident #27 stated he wished he could go outside while the weather was still nice. Resident #27 stated he was not happy at the facility and did not get to participate in his preferred activities. 2. Review of Resident #72's medical record revealed an admitted [DATE]. Medical diagnoses included Alzheimer's disease with early onset, depression, anxiety, and morbid obesity. Review of Resident #72's MDS 3.0 annual assessment, dated 07/17/24, revealed the resident had a BIMS score of 15, indicating intact cognition. Resident #72 had listed activity preferences which included listening to music he enjoyed, being around animals such as pets, and doing his favorite activities as being somewhat important. Review of Resident #72's care plan, revised on 09/15/21, revealed Resident #72 is dependent on staff for activities. Resident #72 is a younger gentleman who previously worked in maintenance. Resident #72 enjoys reading, music, exercise, shopping, television and movies. Listed interventions included for staff to converse with Resident #72 while providing care, assist and escort the resident to activity functions, and to invite the resident to scheduled activities. The care plan indicated Resident #72 was able to go off the unit unsupervised and preferred activities included reading, gardening, bingo, music, arts and crafts, cards, religious activities, shopping, and exercise. Review of Resident #72's activity participation log for June 2024, July 2024, and August 2024 revealed no evidence the resident participated in exercise or games, outdoor activities, arts and crafts, games or puzzles, or religious or church services during the three months. Resident #72 was primarily recorded as using the television or radio in his room and reminiscing. An interview on 08/19/24 at 11:41 A.M. with Resident #72 revealed the resident enjoyed activities, but there were not enough activities to do. Resident #72 stated he liked exercise, but if he even tried to exercise on his own, as soon as he walked into the hallway staff would tell him to get back to his room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 08/20/24 at 9:18 A.M. revealed Resident #72 stood in the doorway to his room. He was speaking to staff in a friendly manner who were in the hallway outside of his room. Subsequent observations on 08/20/24 at 4:30 P.M. 08/21/24 at 3:27 P.M., and 08/22/24 at 8:25 A.M., and 08/26/24 at 8:13 A.M. revealed the Resident #72 his room with his television on. An interview on 08/22/24 at 3:20 P.M. with Activity Director #608 revealed Resident #72 never comes to activities and was unsure if any staff person had ever invited him to any activities. AD #608 was unaware of Resident #72's activity preferences or interests. An interview on 08/26/24 at 11:39 A.M. with Resident #72 revealed he loved to be outside, but he is never able to go outside to do anything. He would enjoy going for a walk, but if he walked into the hall, staff would instruct him to get back to his room. Resident #72 stated he felt trapped and not able to leave the room. Resident #72 additionally discussed his interest in any kind of sports and enjoyed visiting with other residents and staff members. Resident #72 stated he chatted with the regular staff members and enjoyed when they would come into his room to visit. Resident #72 stated he tried to stay in his room to stay out of trouble. Resident #72 stated he at times felt lonely and confirmed there were not enough activities that met his interest at the facility that he had been invited to participate in. An interview on 08/26/24 at 2:51 P.M. with AA #275 revealed activity staff members are all scheduled to work daytime hours. In the last three months, the only evening activity scheduled was an evening dinner and a movie, scheduled for the first time for 08/26/24 at 5:00 P.M. AA #275 stated she does not routinely go around and invite residents or transport residents to the location where the activity is happening, and neither do direct care staff as they are too busy. AA #275 stated she was unaware of Resident #72's activity preferences or interests. 48568 3. Record review for Resident #45 revealed an admitted [DATE]. Diagnoses included dementia, other specified disorders of bone density and structure, hemiplegia and contracture of muscle right hand and left hand. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #45 was severely cognitively impaired and dependent for activities of daily living. Review of the care plan with the focus area of activity dated 04/08/24 revealed Resident #45 is dependent on staff for activities. Interventions included Resident #45's preferences for activities including: music, spiritual activities, and watching movies. Observation made on 08/20/24 at 04:52 P.M. revealed Resident #45 sitting in her wheelchair by the window in the room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/21/24 at 09:57 AM with Activity Supervisor #608 revealed she has worked with Resident #45. When asked what activities Activity Supervisor #608 had done with Resident #45 she said everything. Activity Supervisor #608 said Resident #45 does more sensory activities because she can't see well. Activity Supervisor #608 said she is given busy boards, has books read to her, specifically religious books. Activity Supervisor #608 also revealed Resident #45 likes to go outside and the loves the dog. Activity Supervisor #608 said Resident #45 is with the low functioning group. When asked if Resident #45 likes one on one or group activities, Activity Supervisor #608 said group activities. Record Review for Resident #45 monthly activity sheets shows there is a blank week in May, June, and July from the 20 to the 27. Interview on 08/21/24 at 10:45 A.M. with Activity Supervisor #608 revealed she was asked by the surveyor why are there blank weeks on Resident #45 activity sheets from May 20 to May 27, 2024, June 20 to June 27, 2024, and July 20 to July 27, 2024 each month. Activity Supervisor #608 responded that she does not have much staff at the end of the month like she does at the beginning of the month. Activity Supervisor #608 revealed that aides fill out the forms. Interview on 08/21/24 at 2:39 P.M. with STNA #180 revealed she has worked with Resident #45. STNA #180 said Resident #45 likes to sing and she really likes strawberry ice cream. STNA #180 said Resident #45 will kick you out of any activity but she likes when we play music. Interview on 08/21/24 at 02:51 P.M. with STNA #485 revealed sometimes physical activities are done with Resident #45 like exercises with arms, hands, and legs. Interview on 08/21/24 at 05:48 P.M. with RN #190 revealed she works with Resident #45 and she has not seen activities with Resident #45. Review of the August 2024 Activity Calendar for August 22 at 11:30 A.M. revealed a Nature walk is to take place. Interview on 08/22/24 at 11:29 A.M. with Activity Supervisor #608 revealed Activity Supervisor #608 was asked when your activity and what activity is it. Activity Supervisor #608 said they are going outside right now. When asked if everyone is going, Activity Supervisor said no, just a few at a time. Observation on 08/22/24 at 11:30 A.M. revealed Resident #45 was sitting in wheelchair in room towards window. Interview on 08/22/24 at 11:30 A.M. with Resident #45 revealed the surveyor asked if Resident #45 would like to go outside. Resident #45 responded if she had a jacket she would. Observation on 08/22/24 at 11:47 A.M. revealed Activity Supervisor #608 was passing out soup in the dining room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/22/24 at 11:47 A.M. with Activity Supervisor #608 revealed they only did a 15 minute walk. Activity Supervisor said they go to all rooms to see ask everyone, however since there are only two activity staff they have no more than 6 people for ratio purposes. When asked how did you get everyone in 15 minutes, Activity Supervisor #608 revealed that cafe ended at 11:00 A.M. and the next event started at 11:30 A.M. so she had buffer room. Activity Director #608 said Resident #45 would tell us if she wanted to go out, only 10 residents wouldn't. Activity Director #608 said they get separate activities. When asked if Resident #45 went out, Activity Supervisor #608 said STNA #245 would have asked her. Interview on 08/22/24 at 11:58 A.M. with Resident #45 revealed she was not asked to go outside. Interview on 08/22/24 at 3:24 P.M. with Activity Supervisor #608 revealed poetry and reading is not taking place because that event is for lower functioning residents and they are all sleeping. Observation on 08/22/24 at 3:31 P.M. revealed Resident #45 was in her room in her wheelchair singing to the radio. Observation on 08/26/24 at 8:32 A.M. revealed Resident #45 was listening to music in her room. Observation on 08/26/24 at 10:23 A.M. revealed Resident #45 was in her room listening to music with the door open. There was different music playing outside her room in the open area. Observation on 08/26/24 at 11:31 A.M. revealed Resident #45 was sitting in her wheelchair listening to music. Interview on 08/26/24 at 2:50 P.M. with STNA #245 revealed most of the time we don't have enough staff to have activities in all the areas. When asked if events are offered after three o ' clock in the afternoon, STNA #245 responded with I don't know what else they do. STNA #245 revealed that Resident #45 has not been at any event they held in the past week. Review of the undated Activities Guidelines policy stated This facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well being of each resident.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. 47059 Based on personnel file review, staff interview and review of a job description, the facility failed to ensure a qualified Activity Director (AD) was in place to oversee the facility's overall activity services. This had the potential to affect all 99 resident residing in the facility. The census was 99. Findings include: Review of personnel files on 08/21/24 at 1:20 P.M. revealed Activities Director (AD) #608 was hired as activities aid 10/30/22 part-time. Staff #608 had a high school diploma and had attended some collage studying social work but did not graduate. Staff #608 resigned her part-time position 01/19/23 and became employed on an as needed or PRN basis. A new application to be activities aid full-time was submitted on 09/26/23 and human resources documents indicate this is when Staff #608 became a full-time activities assistant. Staff #608 was promoted to Activities Manager 04/05/2024. Interview on 08/20/24 at 03:26 P.M. with AD #608 confirmed she is not certified yet. AD #608 stated she has worked here for three years as activity assistant; 5 months as director. AD #608 confirmed she not certified as an activities director but believes facility is going to pay for her education but they had not done that yet. AD #608 confirmed there are 9-10 activity staff members here at the facility; AD #608 confirmed so staff at the facility are certified to be an Activities Director. AD #608 stated there is no regional or corporate activity person/oversight. When asked how she decides what activities are needed; AD #608 stated she uses online resources and online groups for ideas in planning activities. Interview on 08/21/24 at 1:35 P.M. with Human Resources Director (HRD) #775 confirmed AD #608 was hired as activities aid 10/30/22 part-time, and resigned her part-time position 01/19/23 and became employed on an as needed or PRN basis. A new application to be activities aid full-time was submitted on 09/26/23 and human resources documents indicate this is when AD #608 became a full-time activities assistant. HRD #775 stated AD #608 was promoted to Activities Manager 04/05/2024. HRD #775 confirmed AD #608 did not meet the criteria to be an activities director as she did not have an associates degree or certification and did not have two years full-time experience as an activities aid. HRD #775 stated AD #608 had just over six months experience full-time as an activities aid. Review of the Position Description for Activities Director (created on 06/01/05) signed by AD #608 on 04/05/24 revealed the facility requirements for an Activities Director state: 1. Associates degree in recreation is required. 2. Must have two years experience in long-term care as a supervisor 3. In lieu of college degree will consider an applicant with two years experience in recreation department plus the required two years supervisory experience. 4. Certification in accordance with regulatory agencies is required. (continued on next page)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 08/27/24 at 2:20 P.M. with HRD #775 confirmed AD #608 did not have two years experience in activities; she had one year six months experience and only six months of that was full-time. AD #608 had no supervisory experience and has no degree or certification.

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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** 19571 Based on medical record review and staff interview, the facility failed to follow physicians orders in obtaining daily weights. This affected one (Resident #4) of 25 residents records reviewed. The census was 99. Findings include: Review of Resident #4's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease with agitation, congestive heart failure (CHF), Psychotic disorder with delusions and paranoid schizophrenia. Review of the significant change minimum data set assessment dated [DATE] revealed her cognition was not intact. Review of the physicians orders revealed an order on 07/18/24 weigh daily at 6:00 A.M. notify if weight gain is three pounds in a day or five pounds in a week. This weight must be done every morning and charted at 6:00 A.M. by the night shift nurse. Review of the plan of care dated 07/17/24 revealed Resident #4 has need for cardiac assessment/potential for alteration in cardiac output Complete cardiac assessment, as clinically indicated, and notify the physician of findings which significantly vary from her baseline, as needed. Provide follow up, as indicated, per physician order. Monitor weights as ordered notify the doctor if weight gain is three pounds in a day or five pounds in one week. Review of Resident #4's medical record revealed there were no weights documented on 07/28/24, 08/09/24, and 08/12/24. On 08/22/24 at 2:58 P.M. interview with Unit Manager #227 verified the weights were not obtained and documented everyday as ordered.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on observation, record review, resident and staff interview, the facility failed to assist Resident #78 with applying his corrective lenses. This affected one (Resident #78) of two residents reviewed for communication-sensory. The facility census was 99. Findings include: Review of Resident #78's medical record revealed an admitted [DATE]. Medical diagnoses included dementia, polyneuropathy, and hemiplegia and hemiparesis (weakness and paralysis) following a cerebrovascular accident (stroke). Review of Resident #78's Minimum Data Set 3.0 quarterly assessment, dated 07/01/24 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 03, indicating severely impaired cognition. The assessment noted the resident's vision was adequate with no corrective lenses. Resident #78 was identified as usually able to make himself understood and usually able to understand others. Review of Resident #78's care plan, initiated on 05/24/22 and revised 06/27/24, revealed the resident had a visual acuity deficit due to the aging process, he wears glasses some of the time to correct this issue. A listed goal stated the resident will be free from signs and symptoms of a visual acuity deficit through wearing corrective eyewear daily, as recommended, over the course of the review period. Listed interventions included to adapt his environment to meet his individual needs, and to assist him in keeping his eyeglasses clean and stored appropriately. Review of Resident #78's optometry note, dated 07/02/24, revealed the resident was assessed to have myopic astigmatism (a refractive change that can result in blurry vision) and presbyopia (gradual loss of the eye's ability to focus on nearby objects). The plan noted the resident needed new bifocals. New glasses were recommended and noted to be delivered upon approval. The note indicated Resident #78 required glasses and encouraged full-time use for distance and reading. Review of Resident #78's interdisciplinary progress notes revealed a note dated 08/14/24 at 1:36 P.M. which stated the resident received his new glasses today, and stated they worked good. An observation on 08/19/24 at 11:25 A.M. revealed Resident #78 was seated up in his wheelchair in his room. He was not wearing glasses. Resident #78's glasses were observed on top of a wardrobe against the wall and next to his bed which was approximately five foot tall. An observation on 08/20/24 at 4:44 P.M. of Resident #78's room revealed the resident was not in his room, but his glasses were observed on top of the wardrobe next to his bed. An observation on 08/20/24 at 4:47 P.M. revealed Resident #78 was seated in the dining room table with his evening meal in front of him. He was not wearing his eyeglasses. Subsequent observations on 08/21/24 at 9:40 A.M., 10:29 A.M., and 12:55 P.M. revealed Resident #78 was observed seated in his wheelchair and was not wearing his eyeglasses. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 08/21/24 at 12:55 P.M. with Resident #78 revealed him seated in his wheelchair in the 100 hallway near the nurse's station. The resident stated he had glasses and was supposed to wear them all the time. An observation at 12:57 P.M. of Resident #78's room revealed the glasses were again observed on top of the wardrobe next to the bed. An observation and interview on 08/21/24 at 12:58 P.M. with Stated tested Nurse Aide (STNA) #345 revealed she was unsure if Resident #78 wore glasses or not. STNA #345 stated she would check the resident's room and proceeded to walk down to Resident #78's room where she retrieved his glasses off the top of his wardrobe. STNA #345 returned to where Resident #78 was seated and applied his glasses. Resident #78 thanked STNA #345 and stated now he can see great. An observation on 08/22/24 at 10:38 A.M. revealed Resident #78 seated in his wheelchair propelling himself down the long hallway towards the 300 hallway. The resident stated he was looking for his room but was having trouble finding it. When asked where his glasses were, he stated he did not know. An interview on 08/22/24 at 10:39 A.M. with Activity Director (AD) #608 revealed she had never seen Resident #78 wear glasses but would assist him back to his room on the other side of the building and would ask someone. An observation on 08/22/24 at 11:57 A.M. of Resident #78 revealed him seated up in the dining room awaiting lunch. The resident was not wearing his eyeglasses. An observation and interview on 08/22/24 at 11:57 A.M. with STNA #350 confirmed Resident #78 was not wearing his eyeglasses. STNA #350 asked Resident #78 if he wanted her to retrieve his eyeglasses, to which he responded yes while nodding his head. STNA #350 exited the dining room, walked towards the 100 hallway, and retrieved Resident #78's glasses from on top of the wardrobe in his room. STNA #350 confirmed the glasses were on top of the tall wardrobe in the resident's room, but she was able to find them. STNA #350 applied the glasses to Resident #78's face. Resident #78 thanked STNA #350 and stated he could see much better with his glasses on. An observation and interview on 08/26/24 at 4:01 P.M. revealed Resident #78 propelling himself down the 100 hallway towards his room. Resident #78 was not wearing his eyeglasses. Licensed Practical Nurse (LPN) Unit Manager (UM) #215 was present in the hall and verified the resident did not have on his glasses. LPN UM #215 confirmed staff should be providing and assisting the resident to apply his eyeglasses when he is up. Review of the policy Supporting Activities of Daily Living (ADLs), reviewed 08/2021, revealed residents will be provided with appropriate care and services will be provided for residents who are unable to carry out ADLs independently in accordance with the plan of care, including appropriate support and assistance with communication. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals, and recognized standards of practice.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19571 Based on medical record review, observation and staff interview, the facility failed to maintain interventions to promote healing of pressure ulcers. This had the potential to affect three (Resident #1, #18 and #90) of four residents reviewed for pressure ulcers. The Census was 99. Findings include: Review of Resident #18's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included protein calorie malnutrition, pressure ulcer of the right ankle, open wound of the left lower leg, Alzheimer's disease, aphasia, anxiety and major depression. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed her cognition was not intact. Resident #18 had no limitation in range of motion. Resident #18 had a Stage II pressure ulcer and an open lesion other than an ulcer coded on the assessment. Resident #18 was coded as having a pressure reducing device for her chair and the bed. Review of the physician's orders revealed an order for a pressure reducing cushion to her chair dated 03/13/24 . Review of the plan of care dated 03/13/24 revealed Resident #18 had the potential for skin breakdown and needs extensive assistance with care and mobility, can be resistive to care, and has a history of pressure ulcers. Observations on 08/20/24 at 8:15 A.M., 10:20 A.M., 11:19 A.M. and 12:08 P.M. revealed Resident #18 was up in her chair without the pressure reduction cushion in place. Interview on 08/20/24 at 2:20 P.M. with Unit Manager #227 verified Resident #18 did not have her pressure reducing cushion in place in her chair as ordered. 2. Review of Resident #90's medical record revealed he was admitted to the facility on [DATE]. Diagnoses included traumatic hemorrhage of cerebrum, aphasia, hemiplegia and hemiparesis, hypertension, convulsions, dysphagia, vascular dementia with agitation, anxiety, depression, and insomnia. Review of the quarterly MDS assessment dated [DATE] revealed his cognition was not intact. It identified no functional limitation in range of motion. No pressure ulcers were coded on the assessment. Review of the physicians orders dated 08/09/24 revealed heel elevators to bilateral heels, off for hygiene only. Review of the plan of care date 12/15/23 revealed the resident is at risk for impaired skin integrity due hemiparesis, hemiplegia, tube feeding, dementia, hemorrhage of cerebrum,and chronic kidney disease. Observations on 08/22/24 at 11:42 A.M. revealed no heel elevators were observed on while the resident was in bed. On 08/26/24 at 8:40 A.M. and 10:00 A.M. no heel elevators were observed on while he was in bed. On 08/26/24 at 10:17 A.M. interview with Unit Manager #227 verified during interview the resident did not have the heel elevators on. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbus Alzheimer's Care Ctr	700 Jasonway Avenue Columbus, OH 43214

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47990 3. Review of Resident #01's medical record revealed an admitted [DATE]. Medical diagnoses included Alzheimer's disease, aphasia (difficulty speaking), hemiplegia (paralysis) affecting the left dominant side following cerebrovascular disease. Resident #01 received hospice services at the facility. Review of Resident #01's MDS 3.0 quarterly assessment, dated 07/23/24, revealed the resident had impairment on his bilateral upper and bilateral lower extremities. Resident #01 was recorded as dependent for all activities of daily living (ADLs) and mobility. Resident #01 was noted to have one unstageable pressure ulcer not present on admission. Review of Resident #01's care plan, revised on 06/20/24, revealed the resident had a wound to his right ischium caused by pressure. The resident's wound was noted to be unavoidable due to multiple risk factors including end stage disease processes for which he received hospice services, bilateral lower extremity contractures, incontinence, and a history of poor meal intakes. Listed interventions included to measure wounds weekly, provide treatment to the wounds daily per physician's orders, and utilize an alternating pressure mattress. Review of Resident #01's physician's orders included an order dated 02/11/24 for an alternating pressure mattress to bed with bolster overlay. The order specified to check the settings of the mattress every shift. Review of Resident #01's Treatment Administration Record (TAR) dated 08/01/24 through 08/26/24 revealed the alternating pressure mattress setting was signed off as checked twice daily, once on day shift and once on night shift, by the nursing staff. Review of Resident #01's interdisciplinary progress notes revealed a note dated 08/21/24 from the Wound Care Nurse Practitioner which indicated the resident was seen for his recurrent wounds. The note indicated Resident #01 had wounds to his right and left hips and coccyx (sacral) area. The note indicated the resident utilized interventions which included a low air loss alternating pressure bed. The wounds were evaluated on 08/21/24 and were identified to have stalled under the current treatment plan. An observation on 08/20/24 at 4:38 P.M. revealed Resident #01 in bed. He was positioned using multiple pillows and appeared in no pain or distress. His mattress setting was set on static. An observation and interview with Registered Nurse (RN) #190 confirmed Resident #01's air mattress was set on static. RN #190 stated Resident #01's mattress was not an alternating pressure type mattress. RN #190's attention was drawn to the option on the mattress control box which indicated two other options which included pulsate and alternate. RN #190 stated she was unaware of Resident #01's mattress settings and made no adjustments to the settings. An observation on 08/21/24 at 2:21 P.M. revealed Resident #01 in bed. The mattress control box setting was set on pulsate. A subsequent observation on 08/21/24 at 5:26 P.M. and 08/22/24 at 8:28 A.M. additionally revealed the resident's mattress remained on the pulsate setting. An interview on 08/22/24 at 8:39 A.M. with Licensed Practical Nurse (LPN) Unit Manager (UM) #215 revealed she was unsure of what type of mattress Resident #01 had or what the settings should be. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview on 08/22/24 at 12:24 P.M. revealed LPN UM #215 seated in Resident #01's room feeding him lunch. Resident #01 was in bed with the head of bed elevated. LPN UM #215 verified the air mattress setting remained on the pulsate setting. LPN UM #215 stated she had no idea what the mattress setting was supposed to be on, just thought it was a plain air mattress, and it was a mattress that Resident #01's hospice company provided. LPN UM #215 stated she had checked and Resident #01 order did specify for an alternating pressure mattress. LPN UM #215 did not adjust the settings and stated she was unsure how to operate Resident #01's mattress. A follow up interview on 08/26/24 at 8:16 A.M. with LPN UM #215 revealed she had talked to hospice, and Resident #01's air mattress should be set on the alternate setting. LPN UM #215 stated sometimes staff move the resident's bed out to provide care and must have bumped into the mattress control box and changed the settings. LPN UM #215 stated she just checked Resident #01's air mattress and it was appropriately set to alternate. Review of the Rhythm Multi Alternating and Low Air Loss Pressure Relief System User Manual, dated 09/30/22, revealed the mattress system utilized low air loss technology at a high flow rate that provided pressure management for the treatment of pressure ulcers. The advanced 3:1 alternating function also provided active prevention for pressure relief, especially for those in long term care settings. The cells in the mattress inflate and deflate in a 3:1 cycle, meaning 2/3rd's of the body is always supported at one time. The manual noted the pulsation function can be used for pressure redistribution, and the static function stops the alternation function and would provide only low air loss therapy. Review of the policy Pressure Injury Treatment, dated as reviewed 08/2022, revealed residents with pressure injuries will be treated with an individualized treatment program that provides the appropriate treatment to facilitate healing and that assesses and addresses comorbid conditions in a systematic manner Orders for treatment are obtained from or approved by the attending physician or nurse practitioner (NP).

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19571 Based on medical record review, observation, and staff interview, the facility failed to ensure tube feedings were administered at the rate ordered by the physician. This affected one (Resident #26) of two facility-identified residents with orders for tube feeding. The facility census was 99 residents. Findings include: Review of the medical record for Resident #26 revealed an admitted [DATE] with diagnoses including dementia with agitation, dysphagia, contracture of muscles, severe protein calorie malnutrition, paranoid schizophrenia, and diabetes. Review of the Minimum Data Set assessment for Resident #26 dated 05/22/24 revealed the resident was cognitively impaired. Review of the physician's orders for Resident #26 revealed an order dated 05/09/24 to administer Isosource 1.5 per gastrostomy tube via pump at 55 cubic centimeters (cc) per hour continuously. Review of the plan of care for Resident #26 dated 03/31/24 revealed the required a tube feeding related to having severe protein calorie malnutrition and dysphagia with interventions which included staff should administer the tube feeding as ordered. Observation on 08/19/24 at 9:54 A.M. revealed Resident #26 was receiving Jevity 1.5 tube feeding via pump at 50 cc per hour. Observation on 08/20/24 at 4:18 P.M. revealed Resident #26 was receiving Jevity 1.5 tube feeding via pump at 50 cc per hour. Interview on 08/20/24 at 4:23 P.M. with Unit Manager (UM) #227 confirmed Resident #26 was receiving Jevity 1.5 tube feeding via pump at 50 cc per hour, but the physician's order was for Isosource 1.5 at 55 cc per hour.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on medical record review, observation, staff interview, policy review, and review of manufacturer's guidelines, the facility failed to ensure the medication error rate did not exceed five percent (%). The facility had four medication errors of 31 opportunities for an error rate of 12.9 %. This affected four (Residents #64, #27, #08, and #49) of five residents reviewed for medication administration. The facility census was 99 residents. Findings include: 1. Review of the medical record for Resident #64 revealed an admitted [DATE] with diagnoses including dementia, type two diabetes mellitus, paranoid schizophrenia, and hypertension. Review of the Minimum Data Set (MDS) assessment for Resident #64 dated 07/23/24 revealed the resident had intact cognition. Review of the physician's orders for Resident #64 revealed an order dated 09/01/23 for Namenda 10 milligram (mg) one tablet by mouth twice daily. Observation on 08/21/24 at 8:38 A.M. revealed Licensed Practical Nurse (LPN) #470 prepared Resident #64's morning medications for administration. Namenda was not available for administration. Interview on 08/21/24 at 8:38 A.M. with LPN #470 confirmed Namenda for Resident #64 was not available for administration. LPN #470 confirmed she would order the medication from the pharmacy, and it should arrive later in the day. Observation on 08/21/24 at 9:30 A.M. with LPN #120 revealed the skilled hallway medication room contained the facility's emergency supply of commonly ordered and/or used medication. The supply included six Namenda 5 mg tablets. Interview on 08/21/24 at 11:10 A.M. with the Director of Nursing (DON) confirmed she was not notified that Resident #64 did not receive his morning dose of Namenda 10 mg, and LPN #470 should have retrieved Namenda from the facility's emergency supply so he did not miss his dose of medication. 2. Review of the medical record for Resident #27 revealed an admitted [DATE] with diagnoses including dementia, depression, osteoarthritis, and hypertension. Review of the MDS assessment for Resident #27 dated 07/02/24 revealed the resident had moderately impaired cognition. Review of the physician's orders for Resident #27 revealed an order dated 08/07/24 for Zoloft 150 mg every morning. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/21/24 at 9:18 A.M. revealed Registered Nurse (RN) #120 prepared Resident #27's morning medications. RN #120 checked the cards of medications and stated she only had Zoloft 100 mg tablets present in the medication cart and was missing a 50 mg tablet of Zoloft to make up the total dose of 150 mg. Observation on 08/21/24 at 9:30 A.M. with RN #120 revealed the emergency supply of medications included six 125 mg Zoloft tablets. Interview on 08/21/24 at 9:30 A.M. with RN #120 confirmed the doses of Zoloft in the emergency supply were 125 mg per dose and would not work to make up Resident #27's dose of Zoloft 150 mg. RN #120 confirmed she would not be able to administer Resident #27's full dose of Zoloft and would give him a partial dose of 100 mg. Observation on 08/21/24 at 9:36 A.M. revealed RN #120 administered Zoloft 100 mg to Resident #27. Interview on 08/21/24 at 9:52 A.M. with Unit Manager (UM), LPN #215 confirmed Zoloft 50 mg for Resident #27 had been ordered from the pharmacy and would not arrive till later in the afternoon. 3. Review of the medical record for Resident #08 revealed an admitted [DATE] with medical diagnoses included glaucoma, Alzheimer's disease, depression, and aphasia. Review of the MDS assessment for Resident #08 dated 03/14/23 revealed the resident was cognitively impaired. Review of the physician's orders for Resident #08 revealed an order dated 07/26/22 for Senna-S 8.6-50 mg 1 tablet by mouth twice daily. Review of the Medication Administration Record (MAR) for Resident #08 dated August 2024 revealed Senna S had been signed as given twice daily from 08/01/24 to 08/21/24's morning dose. Observation on 08/21/24 at 9:43 A.M. revealed RN #160 administered a Senna 8.6 mg tablet to Resident #08 with his morning medications. Interview on 08/21/24 at 10:09 A.M. with RN #160 confirmed she gave Resident #08 the wrong laxative. RN #160 confirmed she gave the resident a dose of senna 8.6 mg, because she did not have a bottle of Senna-S in the medication cart. RN #160 stated she could have checked the medication room or central supply as it was an over-the-counter medication, but the Senna 8.6 mg was close enough to the ordered Senna-S tablets. 4. Review of the medical record for Resident #49 revealed an admitted [DATE] with diagnoses including type two diabetes and hemiplegia and hemiparesis following a cerebrovascular accident. Review of the MDS assessment for Resident #49 dated 06/29/24 revealed the resident was cognitively impaired and received insulin injections. Review of the physician's orders for Resident #49 revealed an order dated 02/23/24 for Humalog insulin two units by subcutaneous injection three times daily before meals. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/21/24 at 11:55 A.M. revealed Registered Nurse (RN) #190 applied a clean needle to the Humalog insulin pen, dialed the pen to 2 units, cleansed a site on Resident #49's left upper arm, and administered the Humalog to the resident. RN #190 did not prime the needle prior to administering the resident's medication. Interview on 08/21/24 at 12:00 P.M. with RN #190 confirmed she did not prime the insulin pen for Resident #49 after applying the new clean needle. Interview on 08/21/24 at 12:22 P.M. with the Director of Nursing (DON) confirmed the expectation of the nurse was to prime the new needle applied to an insulin pen prior to each use. Review of the manufacturer's instructions for the Humalog insulin pen revised 07/2023 revealed the nurse should prime the insulin pen prior to each injection. Priming the pen meant removing air from the needle and cartridge that might collect during normal use and ensured that the pen was working correctly. If the nurse did not prime the pen before each injection there could be too much, or too little insulin administered. Review of the facility policy titled Medication Dispensing System undated revealed prior to medication administration the nurse should verify each medication to ensure that the medication is the right drug, at the right dose, the right route, at the right rate, at the right time, for the right customer, and to verify that the MAR reflects the most recent medication order. Nurses should follow appropriate medication administration guidelines. Review of the policy titled Medication Errors Reporting - Pharmacy Related undated revealed errors included medications not administered within the allowed time frame, failing to administer an ordered dose, and administration of medication which was greater/lesser than what was ordered. Medication errors should be documented on an occurrence report. All medication incident reports would be reviewed by appropriate pharmacy and long-term care facility management to ensure the appropriate action was being consistently implemented. Review of the facility policy titled Emergency Pharmacy Service and Emergency Kits dated 03/28/18 revealed medications were only administered with a valid provider's order. A list of all medications and supplies were posted on the kit and system and should include medication, quantity, expiration date and the pharmacy name and phone number. A method of recording use of items from the emergency kit should be in place. Medications used from the emergency kit/system or entire kit shall be replaced.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on medical record review, observation, staff interview, and policy review, the facility failed to ensure residents were free from significant medication errors related to insulin administration. This affected one (Resident #49) of five residents reviewed for medication administration. The facility identified eight residents whose medication regimens required insulin injections. The facility census was 99 residents. Findings include: Review of the medical record for Resident #49 revealed an admitted [DATE] with diagnoses including type two diabetes and hemiplegia and hemiparesis following a cerebrovascular accident. Review of the Minimum Data Set (MDS) assessment for Resident #49 dated 06/29/24 revealed the resident was cognitively impaired and received insulin injections. Review of the physician's orders for Resident #49 revealed an order dated 02/23/24 for Humalog insulin two units by subcutaneous injection three times daily before meals. The order specified to hold the medication if the blood glucose level was less than 140 milligram (mg)/deciliter (dl). Review of the Medication Administration Record (MAR) for Resident #49 dated August 2024 revealed the resident's morning dose of Humalog was administered on the following dates when the blood glucose level was less than 140 mg/dl which was outside of the parameters specified in the physician's order. Resident #49 received 2 units of insulin on the following dates when her blood glucose was too low for administration per the physician ordered parameter: 08/02/24-84, 08/03/24-67, 08/04/24-112, 08/06/24-126, 08/08/24- 77, 08/11/24-97, 08/15/24-105, 08/22/24-115. Interview on 08/26/24 at 9:36 A.M. with the DON confirmed Resident #49's morning dose of insulin had been given outside of the parameters on 08/02/24, 08/03/24, 08/04/24, 08/06/24, 08/08/24, 08/11/24, 08/15/24, and 08/22/24. Review of the facility policy titled Medication Dispensing System undated revealed prior to medication administration the nurse should verify each medication to ensure that the medication is the right drug, at the right dose, the right route, at the right rate, at the right time, for the right customer, and to verify that the MAR reflects the most recent medication order. Nurses should follow appropriate medication administration guidelines.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 47990 Based on observation, staff interview, medical record review, policy review, and review of manufacturer's guidelines, the facility failed to ensure medications were labeled and stored appropriately per manufacturer's guidelines and failed to ensure medication carts were secured when not in use. This had the potential to affect all residents residing in the facility. The facility census was 99 residents. Findings include: 1.Observation on 08/21/24 at 8:52 A.M. revealed Registered Nurse (RN) #190 was at her medication cart preparing medications on the 300 unit. RN #190 had a cup of crushed medications mixed with applesauce in her hand. RN #190 turned her back to the medication cart and walked approximately 30 feet to the center of the dining room and did not lock her medication cart. RN #190 returned to the cart approximately one minute later. Interview on 08/21/23 at 8:54 A.M. with RN #190 confirmed she had left her medication unlocked and unattended. Observation on 08/21/24 at 2:19 P.M. revealed RN #120 at her medication cart in the Pink hall of the skilled unit. RN #120 had a cup of pills in her hand, turned her back to the medication cart and walked into a resident's room without locking her medication cart. Four residents were observed in the pink hallway of the skilled unit near the nurse's station/lounge area within 15 feet of RN #120's medication cart. RN #120 returned to her medication cart at 2:23 P.M. Interview on 08/21/24 at 2:24 P.M. with RN #120 confirmed she left her cart unlocked and unattended and should not have done so. Review of the policy titled Medication Dispensing System undated revealed medication carts were always to be locked when out of sight or unattended. 2. Review of the medical record for Resident #8 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, glaucoma, and osteoarthritis. Review of the Minimum Date Set (MDS) assessment for Resident #8 dated 03/14/23 revealed the resident was cognitively impaired. Review of the August 2024 physician's orders for Resident #8 revealed an order for Cosopt ophthalmic solution (eye drops used to treat glaucoma) one drop in each eye twice daily. Review of the Medication Administration Record (MAR) for Resident #8 dated August 2024 revealed the resident's eye drops had been recorded as administered twice daily from 08/01/24 through 08/21/24. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 08/21/24 at 9:43 A.M. revealed RN #120 administered Resident #8's Cosopt ophthalmic solution. Neither the Cosopt eye drop box nor the vial contained a date the medication was opened. The vial did list 03/09/24 as the date the medication was delivered by the pharmacy. Interview on 08/21/24 at 10:09 A.M. with RN #120 confirmed there was no date opened listed on the Cosopt eye drop vial or box. RN #120 confirmed the printed fill date from the pharmacy listed on label of the vial and box read 03/09/24. RN #120 was unsure when eye drops should be discarded after opening. Interview on 08/21/24 at 10:18 A.M. with Licensed Practical Nurse (LPN) #215 confirmed she was unsure when eye drops should be discarded after opening. Review of the facility policy titled Medications with Shortened Expiration Dates undated revealed medications in multiple dose-containers should be discarded 28 days after opening unless otherwise specified by the manufacturer. Review of the manufacturer's information for Cosopt eye drops/solution dated 12/12/16 revealed Cosopt can be used for 28 days after first opening the container and then should be discarded. 3. Observation on 08/21/24 at 2:53 P.M. with LPN #227 revealed the medication room refrigerator on the 300 unit contained a box which contained an open undated vial of tuberculin testing solution and a vial of influenza vaccine which was being stored in a tuberculin testing solution box. Interview on 08/21/24 at 2:53 P.M. with LPN #227 confirmed the tuberculin testing solution should be dated when opened and should be discarded within 30 days. LPN #227 further confirmed the influenza vial should not be stored inside a tuberculin testing solution box as a staff member could easily grab the wrong vial. Review of the manufacturer's package insert for tuberculin testing solution dated November 2013 revealed vials in use more than 30 days should be discarded due to possible oxidation and degradation which might affect potency.

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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. 48568 Based on observation, staff interview, and review of the facility policy, the facility failed to prevent clean equipment and utensils from contamination, failed to maintain kitchen equipment in operating condition, and failed to follow proper datemarking procedures. This had the potential to affect all residents with the exception of Residents #26 and #90 who receive nothing by mouth. The facility census was 99 residents. Findings include: 1. Observation on 08/19/24 at 04:18 P.M. revealed there was a rectangular door on the ceiling above a storage rack for clean pots and pans with chipped paint on the door and all around the door frame. Interview on 08/19/24 at 04:18 P.M. with Dietary Director (DD) #570 confirmed the clean pots and pans were stored underneath the ceiling door to the attic access and the chipping paint could fall on the clean pots and pans. Review of the facility policy titled Cross Contamination Overview dated August 2008 revealed physical contaminants included foreign objects that might inadvertently enter the food. 2. Observation on 08/19/24 at 04:33 P.M. in the dish room with DD#570 revealed there was a pink pool of liquid near the drain. Interview on 08/19/24 04:34 P.M. with DD#570 confirmed that the garbage disposal had a leak for approximately two months prior to the survey and the leak allowed fluid to pool on the floor of the dish room. DD #570 further confirmed the facility had a new garbage disposal, but the facility staff had not installed it yet. Observation on 08/21/24 at 10:18 A.M. revealed the garbage disposal was leaking with water pooling on the floor underneath. There was red fluid dripping from the disposal. Interview on 08/21/24 at 10:18 A.M. with DD#570 confirmed the red fluid leaking from the garbage disposal was cranberry juice. Interview on 08/26/24 at 08:49 A.M. with DD #570 confirmed the kitchen staff performed general monitoring of the kitchen equipment every day. Review of the facility policy titled Floor Cleaning dated August 2008 revealed all kitchen floors should be cleaned as needed or at a minimum after each meal. Review of the work orders from the last six months revealed there were no work orders regarding the garbage disposal leaking on the floor. (continued on next page)

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	365839	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled Maintenance Records dated August 2008 revealed a work order request should be completed for all equipment in need of repair. 3. Observation on 08/19/24 at 04:52 P.M. of the walk-in cooler revealed there was a bag of sliced yellow and white cheese that was dated 08/07/24 and a bag of shredded cheese dated 08/08/24. Interview on 08/19/24 at 04:54 P.M. with DD #570 confirmed the hold time for cheese was seven days and the bags of cheese should have been discarded. Observation on 08/19/24 at 04:56 P.M. with DD #570 revealed the walk-in cooler contained a large half sliced log of undated bologna. Interview on 08/19/24 at 04:56 P.M. with DD #570 confirmed there was no date on the open log of bologna, and it should be discarded. Observation on 08/21/24 at 12:54 P.M with DD #570 revealed the walk-in cooler contained a bin of mushrooms dated 08/12/24. Interview on 08/21/24 at 12:54 P.M. with DD#570 confirmed the mushrooms were out of date and should be discarded. Interview on 08/26/24 at 08:49 A.M. with DD #570 confirmed the facility datemarking policy was the date opened plus 6 days out. DD #570 further confirmed the date of disposal was to be marked on the product. Review of the facility policy titled Datemarking dated August 2008 revealed food maintained at a temperature of 41 degrees Fahrenheit (F) or less, should be marked to be used in seven calendar days. 4. Observation on 08/19/24 at 04:58 P.M. revealed the noncommercial microwave had peeling metal around the interior edge and on the inside of the microwave. Interview on 08/19/24 at 04:59 P.M. with DD#570 revealed the microwave was not commercial grade and there was peeling metal on the edge and inside the microwave. Interview on 08/20/24 at 03:00 P.M. with Maintenance Director (MD) #801 confirmed the microwave in the facility kitchen was not commercial grade. Interview on 08/21/24 at 12:48 P.M. with DD #570 confirmed the microwave was not commercial grade and had peeling metal on the edge and inside the microwave. DD #570 further confirmed the local health department told the facility to get a commercial grade microwave. Interview on 08/26/24 at 08:49 A.M. with Dietary Director #570 confirmed the kitchen staff performed general monitoring of kitchen equipment every day. Review of the facility policy titled Microwave Cleaning dated August 2008 revealed the microwave should be cleaned and sanitized as needed or at a minimum daily. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the work orders from the last six months revealed there were no work orders for the microwave. Review of the facility policy titled Maintenance Records dated August 2008 revealed a work order request should be completed for all equipment in need of repair. 5. Observation on 08/19/24 at 05:00 P.M. of the reach-in cooler revealed there was a large amount of water pooling in the bottom. Interview on 08/19/24 at 05:00 P.M. with DD #570 confirmed water was pooling at the bottom of the cooler. DD #570 confirmed the cooler did that every couple of weeks. Observation on 08/21/24 at 12:04 P.M. revealed water was pooling in the bottom of the reach-in cooler. Interview on 08/21/24 at 12:05 P.M. with the DD #570 confirmed water was pooling in the bottom of the unit again. Review of the policy titled Refrigerator, Reach-in Cleaning dated August 2008 revealed all refrigerators should be cleaned and sanitized as needed or at a minimum monthly. Review of the work orders from the last six months revealed there were no work orders for water pooling at the bottom of the reach in cooler.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on facility document review and staff interview, the facility failed to ensure the facility assessment contained all required information. This had the potential to affect all residents residing in the facility. The facility census was 99. Findings include: Review of the facility assessment updated 08/19/24 revealed the assessment was completed using a facility assessment tool which provided guidelines and prompts for completing a comprehensive assessment. The section prompting the facility to describe ethnic, cultural, or religious factors or personal resident preferences that could affect the care provided to the residents was blank. The section prompting the facility to list contracts, memoranda of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies, such as transfer agreements, was blank. The section prompting the facility to list their health information technology resources for electronically managing patient records and electronically sharing information with other organizations, was blank. The section prompting the facility to provide the facility-based and community-based risk assessment, utilizing an all-hazards approach, was blank. There were no attachments or addendums. The assessment listed the updated facility assessment was to be reviewed at the Quality Assurance/Performance Improvement (QAPI) meeting scheduled for 08/26/24. Interview on 08/26/24 at 8:48 A.M. with the Administrator confirmed the facility assessment was updated 08/19/24. Interview on 08/26/24 at 4:10 P.M. with the Director of Nursing (DON) confirmed the facility had four residents whose primary language was not English. The DON confirmed two residents spoke French Creole, one resident spoke [NAME], and one resident spoke Vietnamese. The DON shared the facility held their scheduled QAPI meeting early in the day of 08/26/24, but none of the QAPI members in attendance had time to read the multiple pages of the facility assessment. The DON confirmed the facility assessment sections regarding ethnic, cultural, or religious factors, contracts and agreements with third parties, health information technology resources, and the facility-based and community-based risk assessments were blank.

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F 0843 Level of Harm - Potential for minimal harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. 48568 Based on review of facility documents and staff interview, the facility failed to ensure transfer agreements were in place. This had the potential to affect all residents who reside in the facility. The facility census was 99 resident. Findings include: Review of the facility document titled 2024 Tabletop Disaster Drill dated 05/24/24 revealed the facility had two sister facilities within their geographical region. Review of the transfer agreement dated 08/26/24 revealed the facility made an agreement to transfer residents to the two sister facilities in the event of an emergency. Interview on 08/26/24 at 04:55 P.M. with the Director of Nursing (DON) confirmed the facility did not execute a written transfer agreement until 08/26/24. Interview on 08/27/24 at 2:38 P.M. with the Administrator confirmed the facility did not have a transfer agreement in place prior to 08/26/24.

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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** 47059 Based on medical record review, observation, staff interview and review of the facility policy review, the facility failed ensure residents with physician's orders for enhanced barrier precautions (EBP) had appropriate signage outside the room indicating the precautions and failed to ensure containers of appropriate personal protective equipment (PPE) was available outside the residents' rooms. This affected three (Residents #1, #38, and #72) of 10 facility-identified residents with physician's orders for EBP. The facility also failed to ensure staff performed proper hand hygiene and followed appropriate infection control practices during wound care. This affected one (Resident #72) of six residents reviewed for wounds. The facility failed to ensure staff discarded gloves and performed hand hygiene after providing care. This affected two (Residents #1 and #34) of 25 residents sampled. The facility also failed to ensure staff donned gloves prior to insulin administration. This affected one (Resident #49) of eight facility-identified residents with orders for insulin. The facility census was 99 residents. Findings include: 1.Review of the medical record for Residents #1 revealed an admitted [DATE] with diagnoses including included Alzheimer's Disease, hemiplegia affecting left dominant side, aphasia, dysarthria, dysphagia, and depression. Review of the August 2024 physician's orders for Resident #1 revealed an order for the resident be on enhanced barrier precautions for open wounds. Review of the Minimum Data Set (MDS) assessment for Resident #1 dated 07/23/24 revealed the resident was cognitively impaired and was dependent on staff for all activities of daily living (ADLs) and mobility and had an unstageable pressure ulcer that was not present on admission. Review of the medical record for Resident #38 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, history of malignant neoplasm of the large intestine, aphasia, dementia, and major depressive disorder. Review of the August 2024 physician's orders for Resident #38 revealed an order for the resident be on EBP for open an open wound to the left buttock. Review of the MDS assessment for Resident #38 dated 07/03/24 revealed the resident was cognitively impaired. Review of the medical record for Resident #72 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, venous insufficiency, open wound of the left lower leg, generalized anxiety disorder and major depressive disorder. Review of the MDS assessment for Resident #72 dated 07/18/24 revealed the resident was cognitively intact. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the August 2024 physician's orders for Resident #72 revealed an order for the resident be on EBP for venous and stasis ulcers. Observations on 08/22/24 from 4:55 P.M. to 5:10 P.M. revealed Residents #1, #38, and #72 did not have signage visible from the hallway on their doors to indicate they were in EBP nor were there containers of personal protective equipment (PPE) container outside the rooms. Interview on 08/22/24 at 5:10 P.M. with Registered Nurse (RN) #125 confirmed Residents #1, #38, and #72 had physician orders to be in EBP. RN #125 confirmed Residents #1, #38, and #72 did not have signs outside their doors indicating they were in PPE, nor did residents have PPE containers located outside the room. Interview on 08/26/24 at 10:00 AM with the Director of Nursing (DON) confirmed residents on EBP should have signs on the outside of the door to indicate the precautions and there should be a container of PPE outside the resident's room. Review of the facility policy titled Standard Precautions revised August 2022 revealed supplies necessary for adherence to proper PPE should be readily accessible in resident care areas and equipment supply carts should not be brought into the residents' room. 2. Observation on 08/26/24 at 3:30 P.M. of wound care for Resident #72 per Licensed Practical Nurse (LPN) #315 revealed the nurse cut off the soiled dressing on the resident's leg and then used the same scissors to cut the calcium alginate dressing for the open wound without cleaning the scissors. LPN #315 applied the Santyl cream to the open wound and touched the container to the open wound. LPN #315 also changed her gloves multiple times between stages of the dressing change but only washed her hands once. Interview on 08/26/24 at 4:00 PM with LPN #215 confirmed she used same scissors to cut off the old dressing and to cut the calcium alginate dressing Resident #72's open wound. LPN #215 further confirmed she touched the tip of the Santyl cream container directly to the resident's open wound and confirmed she did not wash her hands or perform hand hygiene between glove changes. Review of policy titled Standard Precautions revised August 2022 revealed staff must perform hand hygiene even if gloves are worn before and after contact with the resident, before performing an aseptic task, and after removing PPE (e.g. gloves, gown, facemask.) Review of the facility policy titled Wound Care reviewed August 2024 revealed the following steps for wound care: nurse should don gloves, remove the old dressing and discard, doff gloves and wash hands, don new gloves and cleanse wound, apply treatments as ordered and dress wound, discard disposable items in appropriate container, doff gloves and wash and dry hands thoroughly. Further review of the policy revealed staff should wash and dry hands each time gloves were changed. 3. Observation on 08/26/24 at 3:20 P.M. revealed State tested Nursing Assistant (STNA) # 460 exited Resident #34's room wearing gloves. STNA #460 touched her hair, touched her face and then pulled her phone out of her pocket and typed into it. STNA #460 then entered Resident #1's room, exited the room, and entered the nurses' station wearing the same gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/26/24 at 3:22 P.M. confirmed with LPN #215 confirmed STNA #460 had exited Resident #34's room with gloves on and then entered and exited Resident #1's room wearing the same gloves. LPN #215 confirmed staff should remove gloves and perform hand hygiene after providing resident care. Review of policy titled Standard Precautions revised August 2022 revealed PPE should be appropriately discarded after resident care prior to leaving the room followed by hand hygiene. 47990 4. Review of the medical record for Resident #49 revealed an admitted [DATE] with diagnoses including type two diabetes. Review of the Minimum Data Set (MDS) assessment for Resident #49 dated 06/29/24 revealed the resident was cognitively impaired and received insulin injections. Review of the physician's orders for Resident #49 revealed an order dated 02/23/24 for resident to receive Humalog insulin 2 units by subcutaneous injection three times daily before meals. Observation on 08/21/24 at 11:55 A.M. revealed Registered Nurse (RN) #190 administered Resident #49's pre-lunch dose of insulin injection to the resident's left upper arm and was not wearing gloves during administration. Interview on 08/21/24 at 12:00 P.M. with RN #190 confirmed she did not wear gloves while administering Resident #49's insulin. RN #190 confirmed she should have applied clean gloves prior to insulin administration. Interview on 08/21/24 at 12:22 P.M. with the DON confirmed nurses should don clean gloves prior to administration of insulin injections. Review of the facility policy titled Standard Precautions revised August 2022 revealed gloves should be worn before and removed after contact with blood or body fluid, mucous membranes, or non-intact skin.