STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365865	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Main Street Care Center	500 Community Drive Avon Lake, OH 44012

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - 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** 42013 Based on observation, interview, record review and review of the facility policy the facility failed to ensure Resident #56 received care and services to prevent prolonged pressure to her bilateral buttocks resulting in pressure injury. Actual Harm occurred on 06/24/24 at 10:00 A.M. when Resident #56, who was at risk for developing pressure ulcers and required assistance on staff for incontinence care, was left on a bed pan for a unknown length of time resulting in a deep tissue pressure injury (a serious type of pressure injury that occurred when prolonged pressure and shear forces damage the tissues beneath the skin) to her bilateral buttocks. This affected one resident (Resident #56) out of three residents reviewed for pressure injuries. The facility census was 110. Findings include: Review of Resident #56's medical record revealed an admitted [DATE] and diagnoses included atherosclerotic heart disease of native coronary artery with unstable angina pectoris, type two diabetes, wedge compression fracture of T5-T6 vertebra, and moderate protein calorie malnutrition. Review of Resident #56's Braden Scale for Predicting Pressure Sore Risk dated 06/21/24 revealed Resident #56's risk was very high. (continued on next page)

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

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #56's Pressure Injury Investigation dated 06/24/24 at 6:53 P.M. included Resident #56's Pressure Ulcer was discovered on 06/24/24, was a new area and in house acquired, the location of the wound was her bilateral buttocks and measurements were length 23.2 cm, width 30.0 cm, and depth was UTD (unable to be determined). The new wound was unstageable related to suspected Deep Tissue Injury (DTI). Area to bilateral buttocks, full thickness, 10 percent pink, 40 percent purple, maroon discoloration, 50 percent epithelial tissue, no drainage, peri wound moist, macerated, no signs and symptoms of infection. Unable to determine progress related to new area. Treatment ordered was cleanse with normal saline, pat dry, apply zinc oxide, leave open to air, apply every shift and as needed. Resident #56 had chronic bowel incontinence and continuous urinary incontinence or voiding dysfunction. Resident #56's HOB (head of bed) was elevated most days due to medical necessity. Resident #56 was receiving routine prevention daily (turning and repositioning, pressure relief, skin care, kept clean and dry), her care plan was appropriate and implemented consistently, and Resident #56 was compliant with her care. The section under Summary Statement of Wound was not completed. Resident #56's risk was very high for Braden Scale for Predicting Pressure Sore Risk. Resident #56's physician and family were notified. Initial evaluation with Wound Nurse Practitioner (WNP) #209 was completed, follow up in one week. Review of Resident #56's late entry progress notes dated 06/25/24 at 9:56 P.M. for 06/24/24 at 9:48 A.M. revealed Resident #56's Admission skin assessment was completed with WNP #209. During assessment it was noted that Resident #56 had an area to her bilateral buttocks caused by the bed pan. Treatment orders and interventions were put in place. Nurse Practitioner (NP) #210, the care team, and Resident #56's son were notified. Resident #56's Braden Scale was 9 (very high risk for developing a pressure ulcer, injury). Review of Resident #56's Wound Care Notes dated 06/24/24 at 10:00 A.M. and completed by WNP #209 included Resident #56 was being seen today for an initial consultation for wound care services in the setting of a Skilled Nursing Facility (SNF). Resident #56 was a [AGE] year-old female, and was a new admit from the hospital. Resident #56 had a fall and broke her T6. Resident #56 had urinary retention and a Foley (indwelling) catheter. Resident #56 was pleasantly confused, resting in bed and agreeable to care. Further review revealed Resident #56 had a DTPI (Deep Tissue Pressure Injury) to her bilateral buttocks. Depth Exposure was full thickness. Wound size measurements were length 23.2 cm (centimeters), width 30.0 cm, depth was UTD, clustered wound with intact skin bridge present. Wound base was 10 percent pink, 40 percent purple or maroon discoloration, 50 percent epithelial. There was no exudate, the peri wound was moist, macerated. The wound status was initial evaluation, linear purple discoloration from left to right buttock. Skin had a moist and macerated appearance with a small area of exposed pink tissue to the left buttock. Skin was dry in between with no exposed tissue to right buttock. Treatment was cleanse area with normal saline, apply zinc oxide to protect skin and keep dry, and leave open to air every shift and as needed. The treatment was chosen to help promote autolytic (breakdown of cells or tissues by enzymes produced by the cells themselves) debridement of the wound. Review of Resident #56's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #56 was unable to complete the interview for Brief Interview for Mental Status. Resident #56 was dependent for toileting hygiene, bathing, and lower body dressing. Resident #56 was dependent to roll left and right, sit to lying, lying to sitting on side of bed, chair, bed-to-chair transfers and toilet transfers. Resident #56 had an indwelling catheter and was occasionally incontinent of bowel. Resident #56 had a pressure ulcer, injury and was at risk of developing pressure ulcer, injuries. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #56's care plan dated 06/28/24 included Resident #56 had impairment of skin integrity related to weakness, impaired mobility, DTI of her bilateral buttocks. Resident #56's skin interventions, preventative measures were maintained. Resident #56 would have no avoidable skin breakdown. Interventions included turn and reposition every two hours while in bed (initiated 06/25/24); minimize pressure on bony prominences, pressure reducing mattress to bed (initiated 06/25/24). Further review did not reveal a care plan related to noncompliance with interventions related to DTPI of her bilateral buttocks. Review of Resident #56's Wound Report dated 07/01/24 at 12:30 P.M. revealed Resident #56 had an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed), originated as DTPI, was full thickness, measurements were length 20.1 cm, width 18.7 cm, and UTD depth, it was a clustered wound, with intact skin bridge present. Wound base was 20 percent granulation, 20 percent slough, 20 percent purple or maroon discoloration, 40 percent epithelial, with moderate serosanguinous drainage, peri wound was moist, macerated. The wound status had declined, Resident #56 was poorly compliant with offloading, poor nutritional intake, dementia, confusion, incontinence, and overall poor medical condition making the presence of the wound unavoidable (although the resident was identified to be on a bedpan contributing to the wound). Left buttock with dark purple discoloration as well as granulation tissue exposed. There was an area of slough to the upper left buttock which was debrided today. The wound was now more accurately identified as unstageable. Apply alginate silver to decrease bacterial colonization and manage drainage and apply zinc oxide to peri wound to protect skin and keep dry. Review of Resident #56's progress notes Wound Track documentation dated 08/26/24 at 8:52 A.M. included Resident #56's unstageable pressure ulcer related to suspected DTI had a length of 1.6 cm, width 0.5 cm, depth 0.2 cm, was in house acquired on 06/24/24, was unavoidable and Resident #56 was not compliant with interventions, had a red, yellow wound bed with scant amount of serous drainage, slough 30 percent, 70 percent granulation. Review of Resident #56's progress notes dated 07/28/24 through 08/27/24 revealed no evidence in the nursing progress notes or care plan Resident #56 was not compliant with interventions. Review of Resident #56's aide charting in the electronic record dated 08/26/24 at 6:41 P.M. through 08/28/24 at 4:15 P.M. did not reveal evidence Resident #56 was turned and repositioned. Review of Resident #56's Treatment Administration Record (TAR) dated 08/27/24 revealed it was documented on day shift by Licensed Practical Nurse (LPN) #214 that Resident #56 was turned and repositioned. Observation on 08/27/24 from 10:00 A.M. through 1:00 P.M. revealed Resident #56 was in bed, lying on her back with her eyes closed. There was no observation of any staff entering Resident #56's room and offering to turn and reposition her. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 08/27/24 at 1:04 P.M. with State tested Nurse Aide (STNA) #212 revealed she worked in the facility Assisted Living area and sometimes helped out in the Nursing Home. STNA #212 stated on 08/27/24, day shift, she was assigned to work in the Assisted Living area, but went to the Nursing Home nursing unit Resident #56 resided on to help from 8:00 A.M. until 10:00 A.M. STNA #212 stated while she was assigned to the nursing unit Resident #56 resided on, she did not check or change Resident #56's incontinence brief or turn and reposition her. Observation on 08/27/24 from 1:07 P.M. until 1:57 P.M. of Resident #56 revealed Resident #56 was lying on her back, the head of her bed was elevated, and her eyes were closed. No staff entered Resident #56's room and offered to turn and reposition her. Observation on 08/27/24 from 2:11 P.M. through 2:58 P.M. of Resident #56 revealed she was lying on her back, the head of her bed elevated, eyes closed. No staff entered Resident #56's room and offered to turn and reposition her. Observation on 08/27/24 at 2:58 P.M. revealed STNA #213 gathered incontinence care supplies and entered Resident #56's room to provide care. STNA #213 stated she arrived for work at 10:00 A.M. today, and this was the first time she entered Resident #56's room to provide care including turning and repositioning. STNA #213 stated she was too busy until now to assist Resident #56 with turning and repositioning and incontinence care. STNA #213 proceeded to provide Resident #56's incontinence care, and during the observation a long curving line on Resident #56's left buttock could be seen. The line was a purplish red in color and along the line about midway a small opening about a half inch by three quarters of an inch could be seen, and the wound bed was dark red. Resident #56's right buttock was reddened with no open area. Resident #56 did not resist or refuse to have STNA #213 provide incontinence care. Interview on 08/28/24 at 9:08 P.M. with Nurse #215 revealed on 06/24/24 Resident #56 was found lying on a bedpan when WNP #209 entered her room with Nurse #215 to evaluate Resident #56's pressure injuries which were present on admission to the facility. Nurse #215 stated the length of time Resident #56 was on the bedpan was unknown because it was first thing in the morning and when they entered Resident #56's room to assess her they found her with the bedpan underneath her. Nurse #215 stated the bedpan was left underneath Resident #56 from the night shift, and with the amount of agency staff in the building it could not be determined how the situation happened, or who caused the situation. Nurse #215 stated Resident #56 was treated for the injury caused by the bedpan. Nurse #215 stated we were both pretty mortified that something like that could happen, and the marks on her left buttock had the impression from the bedpan. Nurse #215 stated the injury was a DTI which progressed. Interview on 08/28/24 at 9:23 A.M. with NP #210 confirmed Resident #56 was found on a bedpan which caused a pressure injury. NP #210 stated she did not know the details, and did not look at the wound because WNP #209 was taking care of it and ordered treatments. Interview on 08/28/24 at 10:46 A.M. with STNA #216 revealed she was assigned to care for Resident #56 today and had taken care of her previously. STNA #216 stated Resident #56 was compliant with her care and she lets us do what we need to do. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 08/28/24 at 2:06 P.M. with WNP #209 revealed on 06/24/24 she was at the facility in the morning to evaluate Resident #56's wound. WNP #209 stated she was told about the bedpan and her job was to evaluate the wound. WNP #209 stated Resident #56 had a DTI on her buttocks which was caused by prolonged pressure for an extended period of time. WNP #209 stated anything that pushes could cause a DTI. WNP #209 stated Resident #56 had issues with declining health, something could have happened with the bedpan, and she heard Resident #56 was on the bedpan for a prolonged period of time, and I am sure it contributed. Review of the facility policy titled Wound Prevention and Management Policy dated 10/2022 included a Wound Track Assessment would be documented at the time of discovery of the skin breakdown and then weekly thereafter. A care plan would be initiated and updated as necessary until the area was resolved. A preventative plan of care and intervention would be initiated for any residents determined to be at risk, to reduce the possibility of further breakdown. This deficiency represents non-compliance investigated under Complaint Number OH00156926.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on interview, record review and review of facility policy the facility failed to ensure care planned interventions were implemented to treat Resident #75's substance abuse. This affected one resident (Resident #75) out of three residents reviewed for substance abuse. The facility census was 110. Findings include: Review of Resident #75's medical record revealed an admitted [DATE] and diagnoses included congestive heart failure (CHF), alcohol dependence with alcohol-induced mood disorder, and bipolar disorder. Review of Resident #75's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #75 was cognitively intact. Resident #75 required substantial to maximal assistance with toileting hygiene, bathing, lower body dressing, and putting on and taking off footwear. Resident #75 required partial to moderate assistance to walk 10 feet, walking further and car transfer was not attempted due to medical condition or safety concerns. Review of Resident #75's physician orders dated 07/08/24 revealed no LOA (leave of absence) except for Dr. appointments until further notice per MD #216. The order was discontinued on 08/16/24. Review of Resident #75's progress notes dated 07/30/24 at 6:50 P.M. included after Resident #75's girlfriend was at the facility for a visit Resident #75 was sleeping in his room. After dinner Resident #75 woke up and appeared to be inebriated. Resident #75 stated his girlfriend gave him a bottle. There was an empty water bottle in Resident #75's trash that smelled of liquor. Information passed on to the nightshift nurse and Physician made aware. Review of Resident #75's progress notes dated 07/30/24 at 10:00 P.M. included the nightshift nurse was informed Resident #75 was intoxicated, went to happy hour and may have had one drink. Resident #75 told the nurse he had one drink. The nurse told Resident #75 she needed an honest answer for his safety. Resident #75 stated his girlfriend came to visit, and asked him to go to her car because she had a gift. Resident #75's caretaker gave him a bottle with vodka in it when he went with her to the car. Resident #75 pointed to the empty water bottle in his trash when asked where the bottle was. The nurse removed the water bottle which smelled like alcohol. Resident #75's nurse practitioner was made aware and he was being watched for safety. Call light within reach. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #75's care plan with a target date of 10/03/24 included Resident #75 had a risk for harm, injury to self, non compliance. Resident #75 drinks ETOH (alcohol) to excess and had a physician order to only have one to two beers at happy hour, which was discontinued on 08/19/24. Resident #75's resident rights would be respected, Resident #75 would accept reason why to be compliant, Resident #75 would have decreased episodes of non compliance and his safety would be maintained. Interventions included one to one visit as needed, involve family and make referrals as needed; acknowledge Resident #75's right to not comply, provide positive feedback for compliance; identify reasons for noncompliance such as lack of understanding, cultural differences and emphasize positives. The care plan was revised and included Resident #75 remained non compliant with ETOH use despite education on negative effects, continued to go on LOA where ETOH was potentially involved, MD prefers LOA be only for medical appointment. The Goal and Interventions were unchanged. Review of Resident #75's medical record including orders and progress notes dated 07/30/24 through 08/15/24 did not reveal evidence of care planned interventions being implemented after Resident #75 used alcohol on 07/30/24. Review of Resident #75's progress notes dated 08/16/24 at 5:16 P.M. revealed a call was placed to MD #217's office regarding Resident #75's request to have LOA and to fishing this weekend. Return call received and orders noted that resident may resume LOA's. Resident #75 was educated on safety on LOA and dangers of consuming alcohol excessively. Resident #75 verbalized understanding. Review of Resident #75's physician orders dated 08/16/24 through 08/28/24 did not reveal further orders related to Resident #75's LOA's, including MD prefers Resident #75 to only go on medical appointments. Interview on 08/28/24 at 2:41 P.M. with Director of Nursing (DON) revealed she only knew about one episode of Resident #75 drinking, was not aware Resident #75 had another episode of inebriation, and did not know about Resident #75's girlfriend bringing him vodka in a water bottle on 07/30/24. The DON stated she spoke with Resident #75 today, and he stated he had no problem, saw an outside psych counselor, and did not want to see anyone else. Interview on 08/28/24 at 3:19 P.M. with Licensed Practical Nurse (LPN) #220 revealed she worked night shift on 07/30/24 and was told by the day shift nurse Resident #75 went to happy hour, seemed like he had more than one drink, was very intoxicated and not able to stand. Resident #75 stated the nurse told her there was an empty water bottle in his room that smelled like alcohol. LPN #220 stated Resident #75's caretaker brought the water bottle with vodka when she came to visit, and Resident #75's physician was notified of the situation and did not give further instructions or orders. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/28/24 at 3:57 P.M. with Social Services Designee (SSD) #221 revealed Resident #75 had a drinking problem in the past, and he said he was an alcoholic. SSD #221 stated she was aware of one situation where Resident #75 became drunk, and she had to follow up with him, but did not know he had another episode of drinking on 07/30/24. SSD #221 stated when she talked to MD #217 she was told MD #217 was restricting LOA's until further notice, but Resident #75 could participate in happy hour at the facility because alcohol consumption was limited. SSD #221 indicated she did not offer Resident #75 psych services because she only knew of one time when Resident #75 became drunk, thought it was a one time issue, and if she knew about the second episode she would have offered services including a psychology consult. Resident #75 received psych services from an outside hospital and SSD #221 would have contacted his outside provider social worker so the appropriate services could be provided. SSD #221 stated she was not notified the second drinking situation happened, and usually nursing reviewed progress notes and the DON would bring it to her attention. Interview on 08/28/24 at 4:19 P.M. with MD #217 revealed she was notified about Resident #75's caretaker bringing him vodka on 07/30/24. MD #217 stated Resident #75's LOA should have been revoked, and he should not have been allowed to go on LOA for a fishing trip due to safety reasons. MD #217 stated she did not know who called from her office and told the facility Resident #75 could go on a LOA for a fishing trip. A request was made for the facility substance abuse treatment policy and an illegal substance policy was provided. A substance abuse treatment policy was not provided for review. This deficiency represents non-compliance investigated under Complaint Number OH00156926.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of the manufacturers instructions and facility policy the facility failed to ensure appropriate incontinence care was provided for Resident's #43, #48 and #56. This affected three residents (#43, #48, and #56) and had the potential to affect resident residing in the facility who were incontinent. The facility census was 110. Findings include: 1. Review of Resident #48's medical record revealed an admitted [DATE] and diagnoses included type two diabetes mellitus, major depressive disorder, anxiety disorder, and alcohol abuse. Review of Resident #48's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #48 had moderate cognitive impairment. Resident #48 was dependent for toileting hygiene and was frequently incontinent of urine and bowel. Observation on 08/27/24 at 1:26 P.M. of State tested Nursing Assistant (STNA) #213 revealed she gathered supplies and entered Resident #48's room to provide incontinence care. Resident #48 stated she was getting really frustrated because she needed incontinence care and wanted to go to the activity with animals, and she was afraid she was going to miss the activity, and she really loved animals. STNA #213 asked Resident #48 how much help she needed and Resident #48 stated she could not lift her bottom, she had not been changed today, and was wearing a liner and a pull up for incontinence. STNA #213 proceeded to provide Resident #48 incontinence care, and observation of her bottom revealed a small open abrasion area on her right lower buttocks. Resident #48 stated she did not get changed timely and that was why she wanted two liners in her pull up before she went to see the animals. Resident #48 stated she often had to wait a long time before her call light was answered and her incontinence pull up and liners were changed, and if she only had one liner her leggings would be soaked by the time someone came to change her. Resident #48 stated she did not want her leggings to get wet and that was why she requested two liners. Resident #48 stated by the time she peed three times the urine gets on her leggings. Resident #48 indicated the two liners in her pull up made it look like she had a penis, but that was okay because she would be dry. Review of the facility incontinence liners manufacturers instructions included two incontinence liners should not be worn at the same time, and you should not wear more than one liner at a time. Wearing multiple pads could cause hard edges that could damage skin and be uncomfortable. Using more than one pad did not provide extra absorbency. Leakage from the first product would overflow into the second product, causing both products to leak more quickly. The first product would leak onto the second and both would become less absorbent. Wearing more than one pad was considered bad practice. Review of the facility policy titled Protocol Related to Assessment of Bowel and Bladder Incontinence revised 10/2014 included the policy was a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. If continence assessment identified a resident as incontinent of bowel, bladder, the facility would initiate appropriate interventions to help maintain dryness and the resident's right to dignity. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #56's medical record revealed an admitted [DATE] and diagnoses included atherosclerotic heart disease of native coronary artery with unstable angina pectoris, type two diabetes, wedge compression fracture of T5-T6 vertebra, and moderate protein calorie malnutrition. Review of Resident #56's Admission MDS 3.0 assessment dated [DATE] revealed Resident #56 was unable to complete the interview for mental status. Resident #56 was dependent for toileting hygiene. Review of Resident #56's aide charting in the electronic record from 08/26/24 at 6:42 P.M. through 08/28/24 at 4:15 P.M. revealed there was no evidence Resident #56 was provided incontinence care and her incontinence brief and liners were changed. Observation on 08/27/24 at 2:58 P.M. of STNA #213 revealed she gathered incontinence supplies and entered Resident #56's room to provide incontinence care. STNA #213 proceeded to provide incontinence care and Resident #56 was observed to have one incontinence brief and two liners on inside her brief. The incontinence liners and incontinence brief were wet with urine. Resident #56's perineal area and buttocks were red and irritated looking. STNA #213 stated she arrived to work at 10:00 A.M. and this was the first time she checked and changed Resident #56's incontinence brief and liners. STNA #213 was unable to complete Resident #56's incontinence care without help because Resident #56 was afraid of falling on the floor. STNA #213 made Resident #56 comfortable and left the room to find someone to assist her. Observation on 08/27/24 at 3:33 P.M. STNA #213 arrived back to Resident #56's room with the Director of Nursing (DON) to help her complete Resident #56's incontinence care. STNA #213 placed two incontinence liners on Resident #56, and did not use panties. The Director of Nursing confirmed Resident #56 was wearing two incontinence liners. Interview on 08/27/24 at 4:24 P.M. with the DON and Wound Nurse (WN) #222 revealed Resident #56 preferred an incontinence liner over a brief. When asked if two incontinence liners was appropriate the DON did not answer the question directly. Review of the facility incontinence liners manufacturers instructions included two incontinence liners should not be worn at the same time, and you should not wear more than one liner at a time. Wearing multiple pads could cause hard edges that could damage skin and be uncomfortable. Using more than one pad did not provide extra absorbency. Leakage from the first product would overflow into the second product, causing both products to leak more quickly. The first product would leak onto the second and both would become less absorbent. Wearing more than one pad was considered bad practice. Review of the facility policy titled Protocol Related to Assessment of Bowel and Bladder Incontinence revised 10/2014 included the policy was a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. If continence assessment identified a resident as incontinent of bowel, bladder, the facility would initiate appropriate interventions to help maintain dryness and the resident's right to dignity. 3. Review of Resident #43's medical record revealed an admitted [DATE] and diagnoses included Alzheimer's Disease, rheumatoid arthritis, and retention of urine. (continued on next page)

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	365865	A. Building B. Wing	09/03/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #43's Quarterly MDS 3.0 assessment dated [DATE] revealed Resident #43 had severe cognitive impairment. Resident #43 was dependent for bathing, personal hygiene and toileting hygiene. Resident #43 was frequently incontinent of urine and always incontinent of bowel. Observation on 08/27/24 at 3:43 P.M. of STNA's #213 and #223 revealed they entered Resident #43's room to provide incontinence care. STNA #213 stated this was the first time since she arrived to work at 10:00 A. M. that she checked Resident for incontinence and changed her incontinence brief. STNA's #213 and #223 proceeded to provide Resident #43's incontinence care, and when the soiled incontinence brief was removed a soiled incontinence liner was observed. Resident #43's bottom was reddened over most of her perineum and buttocks, and she had a moderate bowel movement and it looked like feces was dried on her skin, and STNA #223 had to scrub back and forth on Resident #43's skin to remove the feces. STNA #223 stated the bowel movement looked fresh to her. STNA's #213 and #223 finished with Resident #43's care and placed a clean incontinence brief and incontinence liner on her. Review of the facility incontinence liners manufacturers instructions included two incontinence liners should not be worn at the same time, and you should not wear more than one liner at a time. Wearing multiple pads could cause hard edges that could damage skin and be uncomfortable. Using more than one pad did not provide extra absorbency. Leakage from the first product would overflow into the second product, causing both products to leak more quickly. The first product would leak onto the second and both would become less absorbent. Wearing more than one pad was considered bad practice. Review of the facility policy titled Protocol Related to Assessment of Bowel and Bladder Incontinence revised 10/2014 included the policy was a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. If continence assessment identified a resident as incontinent of bowel, bladder, the facility would initiate appropriate interventions to help maintain dryness and the resident's right to dignity. This deficiency represents non-compliance investigated under Complaint Number OH00156926.

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F 0743 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a resident does not develop patterns of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless unavoidable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on interview, record review and review of facility policy the facility failed to ensure appropriate placement and interventions were in place to ensure Resident #111's choice and safety were maximized. This affected one resident (Resident #111) out of three residents reviewed for behavioral health services. The facility census was 110. Findings include: Review of Resident #111's medical record revealed an admitted [DATE] and diagnoses included Parkinson's Disease without dyskinesia, without mention of fluctuations, dementia with agitation, hallucinations, and wedge compression fracture of third lumbar vertebra. Resident #111 was discharged from the facility on 08/09/24. Review of Resident #111's hospital notes for his admission from 07/17/24 through 07/24/24 included Resident #111 was brought to the ED for wandering away from his home. Resident #111 had Parkinson's disease and dementia, and his ton stated Resident #111 was not very compliant with his medications. EMS stated they were called to the home because Resident #111 was found wandering. On arrival to the ED Resident #111 was awake, alert, oriented, he knew where he was. Resident #111's son stated Resident #111 cooked, cleaned and seemed to take care of himself very well, but did have an occasional instance where he had hallucinations and wandered away from home. Resident #111's son stated at this time he felt Resident #111 was safe to reside in his home by himself, they checked on him periodically. Resident #111's son was given information for services that could provide additional assistance with the home. Resident #111's son stated he felt there were no acute findings today and Resident #111 could be discharged and return to his home. Resident #111 was referred to follow up with his family physician for reevaluation or placement if desired in the future. Review of Resident #111's After Visit Summary for hospital stay 07/16/24 through 07/24/24 included Resident #111 was unable to ambulate. Resident #111's mental status was disoriented, alert, and wax and wane. Resident #111 used a walker and needed assistance with walking. Safety concerns were sundowners syndrome, history of falls in past 30 days and was at risk for falls. Resident #111 was discharged to the facility due to he required a Skilled Nursing Facility for less than 30 days. There were no orders for Resident #111 to be placed in a secured nursing unit. Review of Resident #111's physician orders dated 07/24/24 revealed MD (Medical Doctor) #217 approved placement, continued placement in secured unit. Review of Resident #111's Elopement Risk assessment dated [DATE] revealed Resident #111 was not at risk for elopement. Review of Resident #111's progress notes Admission assessment dated [DATE] at 6:16 P.M. included Resident #111 was alert and oriented times three (time, place, person), MD #217 notified of admission and orders verified. Resident #111 was able to explain his current diagnosis of Parkinson's disease and he was at the facility to receive therapy and get his strength back up. (continued on next page)

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F 0743 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #111's care plan dated 07/25/24 included Resident #111 had the potential for impaired adjustment. Resident #111 identified inability to adequately adjust and cope. Resident #111 would adjust to new environment with minimal frustration. Interventions included to assess Resident #111's interests and strengths and encourage activity particiation; to encourage expression of feelings; one on one visits as needed, allow to vent feelings related to placement, involve family in care and update as needed. Review of Resident #111's progress notes dated 07/27/24 at 11:03 P.M. included Resident #111 was alert and oriented times two (person, place), and at times seemed to be oriented times two to three. Resident #111 voiced being able to leave and go home. Resident #111 was reminded he needed to be at the facility to get stronger. Review of Resident #111's progress notes dated 07/28/24 at 10:20 A.M. revealed Resident #111 was alert and oriented times one to two. Resident #111 insisted he needed to call his bank to check on his account. It was explained to Resident #111 that his son would be handling all his financial needs while he was in the facility. Resident #111 was very upset and stated he had to get out of here,and continuously paced throughout the secured unit. Review of Resident #111's progress notes dated 07/28/24 at 4:18 P.M. revealed at approximately 3:15 P.M. Resident #111 was alert and oriented times four (person, place, time, situation) went to walk outside the facility for air and did not notify the nurse or staff. Resident #111 returned and the leave of absence policy was reviewed by the nurse and Resident #111 was educated on courtyard adherence. Resident #111 was last seen at the nurse's station at around 2:30 P.M., was asking to use the telephone and call the bank. Resident #111's sons and MD #217 were notified. Review of Resident #111's progress notes dated 07/28/24 at 6:03 P.M. revealed Resident #111 was not confused and family aware Resident #111 calling bank was normal behavior for financial concerns. Family and MD #217 noted Resident #111 did not need to be on a dementia unit at this time and at no risk at present. Review of Resident #111's Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #111 was cognitively intact. Resident #111 used a walker, and required supervision or touching assistance for toileting and personal hygiene, and lower body dressing. Resident #111 was independent for putting on and taking off footwear, and upper body dressing. Resident #111 required supervision with assistance for walking 10 feet to 150 feet. Resident #111's ability to walk 10 feet on uneven surfaces was not attempted due to medical condition or safety concerns. Observation on 08/27/24 at 10:17 A.M. of Resident #111's former room with Assistant Director of Nursing (ADON) #202 revealed there were two metal brackets secured to the window frame on both sides of the window, and above the metal brackets on both sides of the window revealed two black brackets attached above the metal brackets. ADON #202 stated the metal brackets and the black brackets were to prevent the window from being opened. ADON #202 stated we thought Resident #111 was an elopement risk and needed the secured unit. ADON #202 indicated Resident #111 could do things on his own, could manage his money and after a lengthy conversation it was noticed Resident #111 was a bit confused. ADON #202 stated Resident #111 was adamant about moving, got out and said he was not like these people. ADON #202 stated Resident #111 was found wandering at home and taken to the hospital. (continued on next page)

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F 0743 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/27/24 at 10:43 A.M. of Maintenance Assistant (MA) #208 revealed the Maintenance Supervisor was on vacation and she was called into the facility when Resident #111 left via his window. MA #208 stated he was not sure how Resident #111 opened his window and exited the facility, but he put a second set of black brackets on the window. MA #208 stated the Maintenance Supervisor put new metal brackets on the window until the black brackets could be installed. Interview on 08/27/24 at 12:23 P.M. of Licensed Practical Nurse (LPN) #206 revealed she was working the day Resident #111 left the secured unit via his window. LPN #206 stated the metal brackets on the window were very loose and Resident #111 was able to move them and push the window up. LPN #206 stated she saw Resident #111 when he was coming back in the window and she saw his foot come in through the window. LPN #206 indicated Resident #111 told her he was only gone a short time, only went to the parking lot and back, and just needed some air. LPN #206 stated Resident #111 was not exit concerned, he was more tired of other residents, and said he was not like these people and why am I here on this unit. LPN #206 indicated Resident #111 was upset and stated he had to get out of here. LPN #206 stated the Director of Nursing (DON) told her to move Resident #111 out of the secured unit because he should not be on the unit due to a BIMS (Brief Interview for Mental Status) of 14. LPN #206 stated Resident #111 did not have an order to be on the unit and MD #217 told her it was okay to move him. LPN #206 indicated Resident #111 told her they were restraining me and had to let me go. Interview on 08/27/24 at 4:45 P.M. of MD #217 revealed Resident #111 was placed in a secured unit and he was transferred out of the unit to have the ability to have more freedom and would be less restless. MD #217 stated Resident #111 had a BIMS of 14 and was automatically placed on admission in the secured unit. MD #217 stated wherever he came from must have requested a secured unit, it must have been requested by the hospital, and she did not order him to be on a secured unit. Interview on 08/27/24 at 4:58 P.M. of Registered Nurse (RN) #218 revealed Resident #111 was placed on a secured unit because he was wandering at home, and admissions made the decision to place him on the unit. RN #218 stated she verified Resident #111's medication orders with MD #217, but not the secured unit order. RN #218 stated she did not take an order from MD #217 to place Resident #111 on the secured unit. RN #218 indicated she might have sent MD #217 a message stating Resident #111 was on the secured unit. RN #218 stated she did not know if the secured unit admission form was signed, and was not responsible to make sure the form was signed. RN #218 stated the secured unit order was a standard batch order, Resident #111 was admitted to the secured unit and batch orders were placed. RN #218 indicated an order for the secured unit was automatically placed under Resident #111's primary care providers name (MD #217). Interview on 08/27/24 at 5:06 P.M. of Admissions Director (AD) #205 revealed the hospital staff told Hospital Liason (HL) #219 that Resident #111 needed a secured unit, and HL #219 told her he needed the secured unit. AD #205 stated she had no written documentation Resident #111 needed a secured unit, and it was all done verbally. Interview on 08/27/24 at 5:10 P.M. of HL #219 revealed revealed Resident #111 was in the hospital for altered mental status. HL #219 stated there was some back and forth communication with the facility regarding the high cost of a medication, but she did not tell the facility Resident #111 needed to be in a secured unit, and the hospital did not say Resident #111 needed a secured unit. HL #219 stated Resident Rights were important and she would have requested psych notes, but the hospital did not think psych needed to be involved so she did not request them. (continued on next page)

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F 0743 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/28/24 at 9:47 A.M. of the DON revealed Resident #111 was alert and oriented most of the time he was in the facility, and was independent. The DON stated she was called when Resident #111 left his room via the window, and when he returned she spoke to him and he told her he wanted to go outside for a breath of fresh air, walked up and down the sidewalk then came back in his window. Resident #111 stated he wanted to call the bank and pay his bills, and the DON spoke to his son who told her Resident #111 took care of his business at home and was fine to do it while he resided in the facility. Resident #111's son told the DON the only reason he was in the facility was because he needed therapy to get stronger, then he was going home. The DON stated Resident #111 was moved off the secured unit. The DON stated the hospital said he was noted walking around the community, he was confused, his labs were off, and the hospital treated him. The DON stated Resident #111's son felt he needed therapy, he was admitted to the facility for therapy, and the facility wanted to keep him safe and felt the secured unit was appropriate. The DON stated the family gave verbal consent for Resident #111 to be placed in the secured unit. The DON confirmed Resident #111 was placed in the secured nursing unit for four days. Interview on 08/28/24 at 3:10 P.M. of the Administrator revealed AD #205 forgot she had a signed form for Resident #111 to be in the secured unit and just found it. The Administrator handed a signed Secured Unit form to the surveyor which was dated 07/24/24 and electronically signed by Resident #111. Review of Resident #111's medical record dated 07/24/24 through 08/09/24 revealed although Resident #111 electronically signed the Secured Unit form there was no evidence it was clinically indicated he needed a secured unit. Review of the policy titled Secured Unit Placement assessment dated ,d+[DATE] included Residents with a diagnosis of dementia, behaviors, memory impairment and, or those resident that were exit seeking would be considered for placement on the secured unit. The resident representative, responsible party, POA, would sign the secured unit consent prior to placement on the unit, unless placement was needed in an emergency situation. This deficiency represents non-compliance investigated under Complaint Number OH00156926.