STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365875	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestmont North Nursing Home	13330 Detroit Ave Lakewood, OH 44107

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. Based on record review and resident and staff interviews, the facility failed to ensure the residents were provided routine and timely notices when their resident's funds exceeded the Supplement Security Income (SSI) resource limit for one person. This affected four (Resident #17, #29, #31 and #47) of seven residents reviewed for personal funds. The facility census was 68. Findings Include: 1. Review of the Authorization to Manage Resident Funds dated 01/20/21 revealed Resident #47 authorized the facility to manage her money. Review of the spend-down notice dated 04/05/25 revealed Resident #47 had $9,060.24 in her account that needed to be spent down some of the money, so she did not exceed the limit, or it would have to be submitted to Medicaid. The spend down notice was signed by Resident #47 on 04/05/25. Review of the current account balance on 05/29/25 revealed Resident #47 had $10,987.24. Interview on 05/27/25 at 10:00 A.M. with Resident #47 stated she could not remember how much money she had in her account but was given a spend down notice by the facility. She stated she has not spent any of her money because she did not know what she needed. 2. Review of the Authorization to Manage Resident Funds revealed Resident #17 authorized the facility to manage his money on 05/11/18. Review of the spend-down notice dated 04/05/25 revealed Resident #17 had $3,140.88 in his account and he needed to spend down his money, to ensure his money would not have to be sent back to Medicaid. Review of the current balance on 05/29/25 revealed Resident #17 had #3,140.88 still in his account. Interview on 05/27/25 at 3:31 P.M. with Resident #17 stated the facility does manage his account and he has received notice that he need to spend some of the money or it would have to be given to Medicaid. 3. Review of Resident #29's medical record revealed Resident #29 had a legal guardian. (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

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Authorization to Manage Resident Funds revealed Resident #29 signed for the facility to manage her funds on 02/14/18. Review of the quarterly statement from January 2025 through March 2025 revealed Resident #29 had $5, 154.98 in her account. Review of the spend-down notice dated 04/05/25 revealed it was given to Resident #20 and not her legal guardian. Resident #29 had $5,154.98 in her account and needed to spend down her money, to ensure it would not have to be sent to Medicaid for being over the limit of funds allowed. Review of the current balance on 05/29/25 revealed $5,655.98 in her account at that time. 4. Review of the Authorization to Manage Resident Funds revealed Resident #31 signed for the facility to manage funds on 06/06/23. Review of the quarterly statement from January 2025 through March 2025 revealed Resident #31 had $8, 471.69 in her account. Review of the spend-down notice dated 04/05/25 revealed Resident #31 had $8,830.69 in his account and needed to spend-down his money or it would have to be sent to Medicaid for being over the limit of money allowed in his account. Interview on 05/27/25 at 11:45 A.M. with Resident #31 stated he had an account with the facility and he did receive a letter stating he needed to spend down his money or it would have to be sent back. Interview on 5/29/25 at 11:03 A.M. with the Administrator confirmed Resident #17, #29, #31, and #47 had fund exceeding the SSI resource limit for one resident. The Administrator stated residents on Medicaid have a liability that they have to pay the facility which generally leaves the residents with $50 a month but the county was not taking the liability out of resident funds. The county office needs to fix the problem so the money can be distributed.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. Review of the medical record for Resident #1 revealed an admission dated [DATE]. Diagnoses included schizoaffective disorder, dementia and severe morbid obesity. Review of the physician orders dated [DATE] revealed Resident #1's advance directive was Do Not Resuscitate Comfort Care - Arrest (DNRCC-Arrest) (would receive standard medical care until experiencing a cardiac or respiratory arrest). The comprehensive care plan for Resident #1 dated [DATE] did not address Resident #1's advance directives. Review of the DNR Identification Form for Resident #1 revealed the top portion was filled out with Resident #1's name, address, birthday and signature of legal guardian. At the bottom of the form, the check box for Do-Not-Resuscitate Order (DNR) was checked stating my signature below constitutes and confirms a formal order to emergency medical series and other health care personnel that the person identified above is to be treated under the State of Ohio DNR protocol. At the bottom of the form revealed the physician did not sign or date this documentation. Interview on [DATE] at 8:35 A.M. with Licensed Practical Nurse (LPN) #323 stated Resident #1 was a DNRCC-Arrest and verified the DNR form was not signed by the physician or dated. LPN #323 stated if the DNR form was not signed by the physician, then cardiopulmonary resuscitation (CPR) would be performed if the resident was unresponsive. Review of the facility policy titled Advance Directives dated [DATE] revealed advance directives would be respected in accordance with state law. Information about if the resident executed an advance directive, the advance directive would be displayed prominently in the medical record. The care plan for each resident would be consistent with the resident's documented advance directive preference. There was nothing in the policy regarding ensuring the advance directives matched including the order in the electronic medical record and what was on the DNRCC form. Based on staff interview, record review and review of facility policy, the facility failed to ensure residents had accurate advance directives orders and information in place throughout the medical record and failed to ensure the resident's advance directive form was signed and dated by the physician. This affected three residents (#1, #6, and #12) of three residents reviewed for advance directives. The facility census was 68. Findings include: 1. Review of medical record for Resident #12 revealed an admission date of [DATE] and his diagnoses included chronic obstructive pulmonary disease and paraplegia. Review of Do Not Resuscitate Comfort Care (DNRCC) form dated [DATE] (located in his hard medical record) and completed by Nurse Practitioner (NP) #900 revealed Resident #12 was a DNRCC-Arrest (would receive standard medical care until experiencing a cardiac or respiratory arrest). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan for Resident #12 dated [DATE] did not address Resident #12's advance directives. Review of [DATE] physician orders in the electronic medical record revealed on [DATE], Resident #12 had an advance directive order for DNRCC (comfort measures effective at the time the form is signed). Interview on [DATE] at 1:48 P.M. with Licensed Practical Nurse (LPN) #316 verified the advance directives did not match in Resident #12's medical record. LPN #316 verified the electronic medical record for Resident #12 indicated Resident #12 was a DNRCC but in his hard medical record the DNRCC-Arrest was elected on the DNRCC from signed by the NP. LPN #316 took the discrepancy to the Director of Nursing (DON) for review. Interview on [DATE] at 1:49 P.M. with the DON verified Resident #12's advance directives were not accurate in the medical record. 2. Review of the medical record for Resident #6 revealed an admission date of [DATE] and her diagnoses included chronic obstructive pulmonary disease, dementia, and schizoaffective disorder. Review of undated care plan revealed Resident #6's preferred code status was a Do Not Resuscitate Comfort Care (DNRCC). Review of undated DNRCC form (located in Resident #6's hard medical record) revealed the form was blank. Review of [DATE] physician orders per Resident #6's electronic medical record revealed she had an order dated [DATE] indicating she was a DNRCC. There was no advance directive form signed by the physician in Resident #6's electronic medical record. Interview on [DATE] at 1:48 P.M. with Licensed Practical Nurse (LPN) #316 verified Resident #6 did not have an advance directive form signed by the physician. LPN #315 verified Resident #6 had a physician order for DNRCC. LPN #315 verified he looked through the entire medical record and was unable to find a signed DNRCC form. LPN #312 stated he was unsure what he would do in case of an emergency. Interview on [DATE] at 1:49 P.M. with the Director of Nursing (DON) verified Resident #6's DNRCC form in her hard medical record was blank and did not have a signed advance directive form. Interview on [DATE] at 10:37 A.M. with LPN #346 revealed if a resident was found to be unresponsive, she would first check the physician order in the electronic medical record and then she would go to the hard medical record to verify the DNRCC form that was located in the front of the chart. LPN #346 would not know what to do in case of an emergency.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff and resident interview, the facility failed to ensure care plans were completed accurately to include fall interventions and behaviors exhibited by the resident. This affected two (Residents #9 and #58) of 21 residents reviewed for care plans. The facility census was 68. Findings include: 1. Review of the medical record for Resident #9 revealed an admission date of 07/10/19. Diagnoses included viral hepatitis, anxiety and arthritis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 was cognitively intact. Review of the fall investigation dated 02/12/25 revealed Resident #9 was lying on the floor by his bed and said he rolled off the bed and fell. A mattress was placed beside the bed to prevent future falls and was reported to have already been on 15 minute checks. Review of the care plan dated 05/20/25 revealed Resident #9 was at risk for falls. Interventions included ensuring his pathway was clear of clutter, 15 minute checks, keeping his call bell within reach at all times, a perimeter mattress on the bed, and non skid socks or shoes on at all times. The fall intervention for placing a mattress beside the bed was not listed in the care plan. Interview on 05/29/25 at 9:01 A.M. with the Director of Nursing (DON) verified Resident #9's care plan did not include the fall intervention for placing a mattress beside the bed. The DON stated the mattress beside the bed and 15 minute checks were only temporary interventions and were no longer in place. The DON confirmed the mattress next to the bed was never listed as a fall intervention in Resident #9's care plan. 2. Review of the medical record for Resident #58 revealed an admission date of 10/09/23. Diagnoses included anxiety and viral hepatitis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #58 was cognitively intact. Resident #58 had behavioral symptoms including confusion, forgetfulness and difficulty remember anything shortly after discussed. Review of the care plan dated 04/30/25 revealed Resident #58 was at risk for behavioral symptoms due to confusion and forgetfulness. Interventions included diverting her attention when she became agitated or combative, refraining from arguing with the resident and discussing behaviors if reasonable, explaining and reinforcing why the behavior was inappropriate. Interview on 05/27/25 at 10:40 A.M. with Resident #58 reviewed there was a certified nursing aide who called her derogatory names and yelled at her. Interview 05/27/25 at 10:50 A.M. with the Director of Nursing (DON) revealed Resident #58 had behaviors of accusing staff of false accusations and not listening to her which had been occurring for at least the past year with an increase in the past six months. She confirmed this information was not in Resident #58's care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled Care Plans, Comprehensive Person-Centered dated December 2016 revealed care plans should be revised as information about the residence condition changed and would identify problem areas and risk factors.

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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** Based on observation, record review, policy review, and staff interview, the facility failed to ensure falls were investigated thoroughly. This affected one (Resident #9) of three residents reviewed for falls. The facility census was 68. Findings include: Review of the medical record for Resident #9 revealed an admission date of 07/10/19. Diagnoses included viral hepatitis, anxiety and arthritis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 was cognitively intact and required partial to moderate assistance for toileting. Review of the care plan dated 01/01/25 revealed Resident #9 was at risk for falls due to muscle weakness and difficulty walking. Interventions included ensuring his pathway was clear of clutter, keeping his call bell within reach at all times, a perimeter mattress on the bed and non skid socks or shoes on at all times. A revision to the care plan on 03/13/25 revealed the resident was placed on 15 minute checks. There was no fall intervention to include a mattress next to his bed, which was a fall intervention implemented on 02/12/25. Review of the fall risk assessment dated [DATE] revealed Resident #9 was not at risk for falls. Review of the fall investigation dated 02/12/25 at 11:30 A.M. revealed Resident #9 was in the dining room when he slipped and fell. The resident did not hit his head, but reported pain in his right knee and right elbow. Resident #9 said he didn't really know what happened he just found himself on the floor. 15 minute checks were initiated. X-rays were obtained of Resident #9's right knee and right wrist with negative findings. The fall investigation did not address if he was wearing shoes or non skid socks at the time of the fall. Review of the fall investigation dated 02/12/25 at 4:50 P.M. revealed Resident #9 was lying on the floor by his bed and said he rolled off the bed and fell. His range of motion was within normal limits. A mattress was placed beside the bed to prevent future falls. No injuries were noted. The fall investigation did not address if a perimeter mattress was on the bed, or if Resident #9 was wearing non skid socks or shoes. Observation on 05/29/25 at 8:00 A.M. revealed a perimeter mattress was in place on Resident #9's bed. There was no evidence on a mattress to the floor. (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 05/29/25 at 9:01 A.M. with the Director of Nursing (DON) revealed Resident #9 had an acute change in condition at the time of the falls on 02/12/25 and shortly after was diagnosed with the flu. The facility was of the belief this may have contributed to both falls. The DON confirmed the investigation for the first fall on 02/12/25 did not include evidence if non skid socks or shoes were in place at the time. She stated 15 minute checks were only temporary until Resident #9 felt better. The DON confirmed the investigation into the second fall on 02/12/25 did not include if the fall interventions were place at the time of the fall, which included if a perimeter mattress was on the bed or if he was wearing non skid socks or shoes. The DON also stated the mattress to the floor was only a temporary intervention. Review of the facility policy titled Falls and Fall Risk, Managing dated December 2007 revealed the facility would monitor and document a resident's response to interventions which were in place to attempt to reduce falls or the risk of falls. Interventions that were not successful would be reevaluated and reconsidered to determine if interventions were still required or if the problem that require the intervention, such as dizziness or weakness, had been resolved.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of medical record for Resident #23 revealed an admission date of 04/22/25. Diagnoses included malignant neoplasm of oropharynx (middle section of the pharynx/ throat) and hypotension. Review of undated care plan revealed Resident #23 was at risk for impaired gas exchange related to malignant neoplasm of the oropharynx requiring a tracheostomy. Intervention included ensure trach ties were always secured, give humidified oxygen as prescribed, observe for changes in level of consciousness, observe respiratory rate, depth, and quality, and suction as needed. The undated care plan revealed Resident #23 had alteration in cardiac status. Interventions included administer oxygen as ordered and monitor vitals as indicated. Review of admission Minimum Data Set (MDS) dated [DATE] revealed Resident #23 had impaired cognition. He had a tracheostomy and had oxygen. Review of May 2025 physician orders for Resident #23 revealed his oxygen was to be at 35 percent with a two liter oxygen bleed per his trach collar. Observation on 05/27/25 at 9:23 A.M. revealed Resident #23's oxygen setting was at seven liters, and his trach collar mask was lying on his bed next to him. He displayed no signs of respiratory distress. Observation on 05/27/25 at 9:23 A.M. revealed Registered Nurse (RN) #367 entered Resident #23's room to obtain his blood pressure and oxygen saturation rate. She proceeded to reapply his tracheostomy mask collar over his tracheostomy and verified the oxygen rate was seven liters. She then exited the room to prepare Resident #23's medications. Observation on 05/27/25 at 9:32 A.M. revealed RN #367 re-entered Resident #23's room to administer his medications through his feeding tube and provide his aerosol treatment. She proceeded to remove her gloves, perform hand hygiene and leave the room without adjusting his oxygen setting as ordered. Interview on 05/27/25 at 9:54 A.M. with RN #367 revealed she was unsure what Resident #23's physician order was regarding his oxygen setting. She reviewed Resident #23's physician orders and then verified Resident #23 had an order for oxygen at two liters, not seven liters. She verified she had not looked at the order after reapplying his trach collar while preparing his medications as she revealed she did not know it was at the wrong setting. Interview on 05/27/25 at 10:33 A.M. with Director of Nursing (DON) verified Resident #23 had an order for two liters of oxygen and not seven liters. The facility identified Residents #6, #16, #21, #22, #23, #46, #52, #54, #58 and #222 who resided in the facility and utilized oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Oxygen Administration dated October 2010 revealed the purpose of the guidelines was for safe oxygen administration. The nurse was to verify there was a physician order and review the order for oxygen administration. Based on observation, record review, policy review, and staff interview, the facility failed to ensure oxygen was administered according to physician orders and ensure there was sign on the resident's door to address oxygen was in use. This affected two (Residents #23 and #58) of three residents reviewed for oxygen. The facility identified 10 current residents (Residents #6, #16, #21, #22, #23, #46, #52, #54, #58 and #222) who utilized oxygen. The facility census was 68. Findings include: 1. Review of the medical record for Resident #58 revealed an admission date of 10/09/23. Diagnosis included chronic obstructive pulmonary disease (COPD). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #58 was cognitively intact. She required supervision for showering and was independent in eating, oral hygiene, toileting and personal hygiene. She had a diagnosis of COPD and was not on oxygen. Review of the physicians order stated 05/28/25 revealed Resident #58 was on two liters of oxygen as needed and the tubing and nasal cannula should be changed weekly. Review of the care plan revision dated 05/28/25 revealed Resident #58 was on oxygen therapy due to respiratory illness. Interventions included giving medications as ordered, serving and documenting for side effects and effectiveness, observing for signs and symptoms of respiratory distress and providing reassurance to alleviate anxiety. Observation on 05/27/25 at 9:13 A.M. revealed an oxygen tank and oxygen tubing in Resident #58's room. No sign indicating the use of oxygen was observed on Resident #58's door. Interview on 05/27/25 with Licensed Practical Nurse (LPN) #316 confirmed Resident #58 used oxygen as needed and did not have the appropriate signage on her bedroom door. Review of the facility policy titled Oxygen Administration dated October 2010 revealed a no smoking or oxygen in use sign would be in place for any resident who used oxygen.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. Record review of Resident #26 revealed she was admitted to the facility 03/21/25. Diagnoses included PTSD. Her care plan identified potential for behaviors related to PTSD including accusatory behaviors, but did not clarify what caused the PTSD or potential triggers or situations to avoid. Review of her progress notes, care plan, assessments, and psychiatry service notes revealed no documentation of the cause, triggers, or ongoing effects of the PTSD. Interview with the Director of Nursing (DON) on 05/29/25 at 9:35 A.M. confirmed Resident #26's medical record did not contain an assessment for trauma informed care related to the resident's of PTSD and did not address the needs of the trauma survivor by minimizing triggers and/or re-traumatization. The DON said PTSD was managed with an outside counseling service who only provided their information on request alongside the facility psychiatric service. She said the surveyor would have to speak with Resident #26 to find out the source of her PTSD. Interview with Resident #26 on 05/29/25 at 9:55 A.M. revealed she was diagnosed with PTSD roughly five years ago when a man entered the woman's bathroom with her, grabbed her throat, and broke her nose. She denied having specific triggers but said the PTSD was the reason she currently took anxiety medications. The facility identified Residents #12, #19, #22, #26, #58, #61 and #63 with PTSD. Review of the facility policy titled Trauma- Informed and Culturally Competent Care dated August 2022 revealed the purpose of the policy was to guide staff in providing care that was culturally competent, and trauma informed in accordance with professional standards of practice and to address the needs of trauma survivors by minimizing triggers and/or re-traumatization. All staff were to receive training about trauma and trauma informed care, and nursing staff were to be trained on trauma screening and assessment tools. The facility was to select a screening and assessment tool to be utilized to identify the need for further assessment and care. The assessment was to be an in-depth process of evaluating the presence of symptoms, their relationship to trauma and identification of triggers. The policy revealed that they should develop individualized care plans that identified and decreased the exposure to triggers that may re-traumatize. 2. Review of medical record for Resident #12 revealed an admission date of 12/05/24. Diagnoses included PTSD. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had impaired cognition. Review of Psychiatric Evaluations dated 03/26/25 and 04/20/25 and completed by Psych Nurse Practitioner (NP) #901 revealed Resident #12 had a history of heroin withdrawal, anxiety, PTSD, insomnia and depression. The note revealed Resident #12 reported the problems began after being shot years ago and reported current stressors were his living situation and being shot. The note revealed alleviating factors including stretching. NP #901 recommended his diagnosis of PTSD required ongoing monitoring. There was no other information regarding his PTSD including other triggers and/or interventions. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of undated care plan revealed Resident #12 had the potential for behaviors related to PTSD, visual/ audio hallucinations, and accusing staff members. Interventions included administering medications, document behaviors, informing the physician of worsening behaviors, and intervene as needed to protect the rights and safety of others. There was nothing in the care plan in regard to triggers and/or personalized interventions to prevent re-traumatization related to his PTSD. Interview on 05/28/25 at 9:16 A.M. with Registered Nurse (RN) #355 verified Resident #12 had a diagnosis of PTSD and she was unsure regarding any triggers Resident #12 had. She verified there was nothing in Resident #12's care plan regarding any specific triggers and/ or interventions related to his PTSD. Interview on 05/28/25 at 10:13 A.M. and on 05/29/25 at 9:35 A.M. with Director of Nursing verified she was unsure what psych had regarding his PTSD and verified nothing was in his care plan regarding triggers and/or interventions to eliminate or mitigate triggers that may cause re-traumatization of the resident. She also verified the facility had no training/ education to staff regarding trauma- informed care. Based on record review, facility policy review, and resident and staff interview, the facility failed to comprehensively assess and develop a comprehensively plan of care for residents with Post Traumatic Stress Disorder (PTSD). This affected three (Residents #12, #26, and #61) of three residents reviewed for PTSD. The facility identified seven residents (Residents #12, #19, #22, #26, #58, #61 and #63) with PTSD. The facility census was 68. Findings include: 1. Review of the medical record for Resident #61 revealed an admission date of 04/28/25. Diagnoses included PTSD. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #61 was cognitively intact. Resident #61's medical record did not have an assessment for trauma informed care related to the resident's of PTSD and did not address the needs of the trauma survivor by minimizing triggers and/or re-traumatization. Interview on 05/29/25 at 9:35 AM with the Director of Nursing (DON) confirmed the facility did not assess Resident #61 for triggers or symptoms of PTSD. She confirmed Resident #61 was a good historian and would accurately and willingly share information if asked.

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	365875	A. Building B. Wing	05/29/2025

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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** Based observation, staff interview, record review, and review of facility policy, the facility failed to ensure Resident #23 was free of significant medication errors. This affected one (#23) of five residents observed for medication administration. The facility census was 68. Findings include: Review of the medical record for Resident #23 revealed an admission date of 04/22/25. Diagnoses included malignant neoplasm of oropharynx (middle section of the pharynx/ throat), rheumatoid arthritis, hypotension, and convulsions. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 had impaired cognition and had a PEG tube. Review of undated care plan revealed Resident #23 was at risk for aspiration related to tube feeding as he had a malignant neoplasm of the oropharynx. Interventions included check placement of percutaneous endoscopic gastrostomy (PEG) tube prior to tube feedings, assess tube site daily for infection, flush PEG tube as ordered and notify physician of any changes. There was nothing in the care plan regarding crushing his medications and mixing together (cocktailing) all at once. Review of May 2025 physician orders revealed Resident #23 had the following orders to be given every day at 9:00 A.M.: Primidone 50 milligram (mg) tablet per PEG tube for seizures, Hydroxychorolonequine sulfate 200 mg tablet per PEG tube for arthritis, and Midodrine 5.0 mg tablet per PEG tube for hypotension. There was no order to crush the medications and mix together (cocktailing). Observation on 05/27/25 at 9:32 A.M. revealed Registered Nurse (RN) #367 prepared Resident #23's medications: Primidone 50 mg tablet, Hydroxychorolonequine sulfate 200 mg tablet, and Midodrine 5.0 mg tablet and then proceeded to take all the medications and crushed them together. RN #367 then mixed the combined crushed medications with water in a medication cup. RN #367 proceeded to administer a water flush and then the combined crushed medications followed by a water flush per Resident #23's PEG tube. Interview on 05/27/25 at 9:54 A.M. with RN #367 verified she crushed the Primidone, Hydroxychorolonequine sulfate, and Midodrine and administered the combined medications all at once. She verified there was no order to cocktail or mix all the medications together and administer at the same time. She verified she was unaware if it was reviewed with the physician regarding potential side effects/interactions if the medications were administered together. Interview on 05/27/25 at 10:33 A.M. with the Director of Nursing verified Resident #23 did not have an order to mix the medications together and administer all at the same time (cocktailing). She verified if there was no order the medications should not have been crushed and given all at one time. Review of undated facility procedure titled Administering Medications Through an Enteral Tube revealed the purpose of the procedure was to provide guidelines for the safe administration of medications through an enteral tube. The procedure revealed to dilute the crushed medication with 30 milliliter (ml) or more of water and administer each medication separately.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, facility policy review, and review of the Center for Disease Control and Prevention (CDC) guidance, the facility failed to initiate and use enhanced barrier precautions (EBP) for residents with indwelling medical devices during high contact resident care activities. The facility also failed to ensure staff followed infection control procedures during catheter care. This affected two (#12 and #23) of two residents reviewed for EBP and one (#12) of one resident reviewed for catheter care. The facility identified nine residents on EBP and two residents with catheters. The facility census was 68. Findings include: 1. Review of the medical record for Resident #23 revealed an admission date of 04/22/25. Diagnoses included malignant neoplasm of oropharynx (middle section of the pharynx/ throat), rheumatoid arthritis, hypotension and convulsions. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 had impaired cognition and had a percutaneous endoscopic gastrostomy (PEG) tube and a tracheostomy. Review of the care plan dated 05/27/25 revealed Resident #23 was on EBP due to his tracheostomy. Intervention included EBP would be used for the duration of his stay at the facility or until no longer meeting criteria and educate resident/ family on EBP. Observation on 05/27/25 at 9:23 A.M. revealed on the outside of Resident #23's door frame upon entrance to his room, there was a sign indicating Resident #23 was on EBP and everyone was to wear gloves and a gown for the following high contact resident care activities: dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs, and device care including feeding tube and tracheostomy. There was a bag hanging on Resident #23's door with personal protective equipment (PPE) including gloves and gowns. Observation on 05/27/25 at 9:23 A.M. revealed Registered Nurse (RN) #367 entered Resident #23's room to obtain his blood pressure and oxygen saturation rate. She donned gloves but no gown. She proceeded to take his blood pressure, but the automatic blood pressure was low, so she proceeded to retake his blood pressure utilizing a manual cuff. She then proceeded to reapply his tracheostomy mask collar over his tracheostomy. RN #367 then removed her gloves, performed hand hygiene and left Resident #23's room to prepare his morning medications. Observation on 05/27/25 at 9:32 A.M. revealed RN #367 re-entered Resident #23's room to administer his medications through his PEG tube and provide his aerosol treatment. RN #367 proceeded to perform hand hygiene, apply gloves but did not apply a gown. RN #367 administered Resident #23's morning medications, water flushes, and enteral tube feeding through his PEG tube. RN #367 then administered his albuterol sulfate inhalation nebulizer solution (breathing treatment) .083 percent three ml per his tracheostomy. Then, she proceeded to remove her gloves, perform hand hygiene and leave the room. During both encounters 05/27/25 at 9:23 A.M. and 05/27/25 at 9:32 A.M. RN #367's nursing uniform was noted to come into direct contact with Resident #23. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/27/25 at 9:54 A.M. with RN #367 verified there was a sign on Resident #23's entrance to his room indicating he was on EBP. RN #367 verified she should have worn a gown for Resident #23's care including during his care of his PEG tube and tracheostomy. Interview on 05/27/25 at 10:33 A.M. with Director of Nursing (DON) verified Resident #23 was on EBP and RN #367 should have worn a gown while administering medications and feeding through his PEG tube as well as when providing care to his tracheostomy including reapplying trach collar and administering his aerosol treatment. 2. Review of the medical record review for Resident #12 revealed an admission date of 12/05/24. Diagnoses included chronic obstructive pulmonary disease (COPD), paraplegia, neuromuscular dysfunction of the bladder, and pressure ulcer to sacral region. Review of undated care plan revealed Resident #12 was to be on EBP due to chronic wounds and suprapubic catheter. Interventions included EBP would be used for the duration of his stay or until qualifying criteria no longer met, educate resident/ family on EBP, and staff would wear appropriate PPE for high contact resident activities. The undated care plan revealed Resident #12 had an alteration in voiding pattern related to indwelling catheter due to neuromuscular dysfunction of the bladder. Interventions included change catheter bag per policy, check tubing for kinks, monitor for infection, and position catheter bag and tubing below level of bladder. There was nothing in the care plan regarding catheter care and how to empty the catheter bag. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had impaired cognition and he had an indwelling catheter and pressure ulcers. Review of May 2025 physician orders revealed Resident #12 was on EBP due to chronic wounds. He also had the following orders: suprapubic catheter to continuous drainage due to neuromuscular dysfunction of the bladder, catheter care every shift and monitor, and document output every shift. Observation on 05/27/25 at 8:52 A.M. revealed Resident #12 had a suprapubic catheter and wound care dressing to his bilateral feet but there was no signage on the outside of his doorway that indicated he was on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/28/25 at 6:36 A.M. revealed Certified Nursing Assistant (CNA) #393 entered Resident #12's room to provide catheter care. CNA #393 proceeded to perform hand hygiene, applied gloves but no gown. CNA #393 then retrieved two wet washcloths (one to use as rinse washcloth and one with soap on it) and one dry washcloth. CNA #393 placed the dry washcloth on his nightstand next to his bed over unknown brown dried substances. CNA #393 then placed the two wet washcloths on top of the dry washcloth. CNA #393 took the washcloth with the soap and proceeded to wash around his suprapubic catheter and then placed the washcloth on the nightstand (that contained brown dried substances). CNA #393 then took the other wet washcloth and rinsed around the suprapubic catheter and then laid this washcloth over the other wet washcloth on the nightstand. Then, CNA #393 took the dry washcloth (that had come in contact with the nightstand with the dried brown substances) to dry around the suprapubic catheter. During the care, CNA #393's uniform had come in direct contact with Resident #12 as she did not wear a gown. CNA #393 then proceeded to empty his catheter drainage bag into a graduate by unclipping the drainage bag port. After the bag had emptied into the graduate, CNA #393 took the (used) rinse washcloth that she had used to clean around his suprapubic catheter to then wipe off the port to the drainage bag. CNA #393 then proceeded to empty the graduate, remove her gloves, wash her hands and leave the room as she stated she needed to get the resident's socks. Interview on 05/28/25 at 6:45 A.M. with CNA #393 verified there was no signage on the outside of Resident #12's doorway that indicated Resident #12 was on EBP. CNA #393 verified she did not wear a gown while completing catheter care as she stated she gets Resident #12 up almost everyday, and nobody had ever told her Resident #12 was on EBP and CNA #393 needed to wear a gown during his care including catheter care and other high contact care activities. CNA #393 also verified the nightstand that she placed the dry and wet wash clothes on had brown substances as she stated, yes it probably was not clean. CNA #393 verified she had taken the used washcloth that she had cleaned around his suprapubic catheter site and cleaned the drainage bag port with the same cloth. CNA #393 stated, yeah I can see how that is cross contamination I never considered that. Interview on 05/28/25 at 8:34 A.M. with Infection Control Coordinator (ICC) #355 stated residents who should be on EBP were the residents who had wounds and PEG tubes. ICC #355 was unsure if residents including Resident #12 who had a suprapubic catheter should be on EBP. ICC #355 stated she was not 100 percent sure but did not feel Resident #12 needed EBP precautions when staff completed his catheter care. ICC #355 stated do not need to wear EBP for all high contact care activities and only need to wear it when providing wound care. She verified CNA #393 should not have placed the wash clothes on a nightstand that contained brown substances as well as clean the catheter drainage bag port with the same used washcloth that she used to clean his suprapubic catheter site. Subsequent interview on 05/28/25 at 9:16 A.M. with ICC #355 revealed she misspoke as she had reviewed further, and staff should wear EBP for all high contact care activities for Resident #12 including catheter care. Review of facility policy titled Suprapubic Catheter Care dated October 2010 revealed the purpose of the policy was to prevent skin irritation and prevent infection of the resident's urinary tract. The policy revealed to place the clean equipment on the bedside stand or over the bed table. There was nothing in the policy ensuring the bedside stand was clean. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility titled Emptying a Urinary Drainage Bag dated October 2010 revealed the purpose of the policy was to prevent the drainage bag from becoming full, to measure the output and obtain a specimen. After the drainage bag was emptied, staff were to close the drain and wipe the drain with an alcohol sponge or swab. The facility policy titled Enhanced Barrier Precautions dated 04/24/24 revealed EBP was to be utilized to prevent the spread of multi-drug-resistant organisms to residents. EBP was indicated for any resident with wounds and/or indwelling medical device. Gloves and gowns were to be applied prior to performing high contact resident care activities. High contact care activities that required the use of gown and gloves included dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assistance with toileting, device care (central line, urinary catheter, feeding tube, tracheostomy) and wound care. Signs were to be posted in the door or wall outside the resident's room indicating the type of precaution and PPE required. Review of CDC guidance titled Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) found at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html and dated 04/02/24 revealed MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status.