STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365880	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Coshocton	100 South Whitewoman Street Coshocton, OH 43812

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28701 Based on self-reported incident review, medical record review, interview and policy review the facility failed to ensure allegations of abuse were reported to the state survey agency in a timely manner. This affected one (Resident #26) of one residents reviewed for abuse. The facility census was 57. Findings include: Review of Resident #26's medical record revealed an admitted [DATE] with admission diagnoses that included anoxic brain injury, schizoaffective disorder and bipolar disorder. Review of Resident #26's Minimum Data Set (MDS) 3.0 assessment with a reference date of 08/28/24 revealed the resident had an independent and intact cognition level. Review of the facility on-line self reported incidents (SRI) revealed on 09/30/24 the facility created an SRI for Resident #26 for an allegation of physical abuse. Review of the facility investigation revealed the abuse allegation was reported to staff by Resident #26 on 09/27/24. Review of progress notes for Resident #26 revealed on 09/27/24 the resident made an allegation of physical abuse related to her family hitting her in the face. Resident #26 was assessed at that time and no findings of injury or abuse was found. On 10/09/24 at 2:50 P.M. interview with the Director of Nursing and Administrator verified the allegation of abuse was reported on 09/27/24 and the SRI report not created until 09/30/24. Review of the facility policy Abuse, Neglect and Misappropriation of Property with a revision date of 07/06/22 indicated facility reporting guidelines, any abuse allegation must be reported to state (survey agency) within two hours from the time the allegation was received.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on medical record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected medication and pertinent diagnosis. This affected two residents (#6 and #9) of five residents reviewed for unnecessary medications. Findings include: 1. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE]. Diagnoses included schizoaffective disorder, dysphagia, chronic kidney disease, low back pain, and muscle wasting and atrophy. Review of a physician order, dated 07/30/24, revealed the order for Tramadol 50 milligrams (mg), one tablet every six hours, as needed for pain. Review of the August and September 2024 Medication Administration Records (MAR) revealed Resident #6 received Tramadol 50 mg, one tablet, on 08/30/24, 09/02/24, and 09/03/24. Review of the quarterly Minimum Data Set (MDS) assessment, dated 09/05/24, revealed that Resident #6 received an opioid for zero days during the seven day look-back period. Interview on 10/08/24 at 3:24 P.M. with MDS/Registered Nurse (RN) #190 verified the MDS assessment, dated 09/05/24, contained an inaccurate assessment of Resident #6's opioid use. 32801 2. Record review revealed Resident #9 was admitted to the facility on [DATE]. The resident's current diagnoses included schizoaffective disorder, major depressive, general anxiety, intellectual disabilities, and lack of expected normal physiological development disorder. Review of a psychiatry progress note dated 05/23/24 revealed the staff were to monitor anxiety and schizophrenia. Review of Resident #9's physician note dated 05/31/24 revealed the resident's diagnoses included schizophrenia, bipolar disorder, major depression, and anxiety. Review of Minimum Data Set (MDS) 3.0 dated 06/05/24 revealed no evidence of an active diagnosis of anxiety. Interview on 10/09/24 at 9:00 A.M., with Registered Nurse (RN) #190 confirmed the MDS dated [DATE] did not include an active diagnosis of anxiety.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on medical record review and staff interview, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR) document accurately reflected diagnoses. This affected two (Resident #6 and Resident #9) of three residents reviewed for PASRR documents. The census was 57. Findings Include: 1. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE]. Diagnoses included schizoaffective disorder, dysphagia, chronic kidney disease, low back pain, and muscle wasting and atrophy. Review of the quarterly Minimum Data Set (MDS) assessment, dated 09/05/24, revealed the resident had intact cognition and a diagnosis of anxiety disorder. Review of Resident #6's PASRR document, dated 08/24/23, revealed under Section E, there was no check mark selected to indicate the diagnosis of anxiety. Review of the resident's diagnosis list revealed the diagnosis of anxiety on 08/13/20. Review of a physician order, dated 01/03/24, revealed the order for Clonazepam 0.5 milligrams (mg), every night, for anxiety. Interview on 10/08/24 at 11:05 A.M. with Social Services Director #132 confirmed Resident #6's PASRR document was not accurate and did not indicate the diagnosis of anxiety. 32801 2. Record review revealed Resident #9 was admitted to the facility on [DATE]. The resident current diagnoses included schizoaffective disorder (10/12/18), bipolar disorder (10/12/18), major depressive disorder (10/12/18), general anxiety (10/12/18), intellectual disabilities (10/12/18), lack of expected normal physiological developmentof disorder (10/12/18). Review of Resident #9 Preadmission Screening and Resident Review (PASRR) dated 10/08/18 revealed no evidence any type of mental illness or intellectual disability. There was no evidence a PASRR was completed after 10/08/18. Review of Resident #9 Minimum Data Set (MDS) 3.0 dated 06/05/24 revealed the resident was not currently considered by the state level II PASRR process to have serious mental illness/and or intellectual disability or a related condition. The resident's active diagnoses included schizophrenia and intellectual disabilities. There was no evidence of an active diagnoses of bipolar type schizophrenia or general anxiety. Review of Resident #9's physician note dated 05/31/24 revealed the resident's diagnoses included schizophrenia, bipolar disorder, major depression, and anxiety. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of psychiatry progress noted dated 05/23/24 revealed the staff were to monitor anxiety and schizophrenia. Review of Resident #9's current orders dated 10/20/24 revealed the resident was ordered Paliperidone 6 milligrams (mg) daily (anti-psychotic), and Trazodone (anti-depressant) 25 mg at bedtime. Review of Resident #9's plan of care for schizophrenia/schizo-affective bi-polar type dated 12/13/23 and last reviewed 09/18/24 revealed the resident exhibits concerning behaviors, such as reporting hearing voices and seeing individuals in his room. Reports they argue loudly amongst themselves. Reports they do not speak to him but if he tells them to shut up then they do yell at him. Approach included: Psychosis: Observe for/report any signs and symptoms of psychosis: confusion, disorientation, delusions, hallucinations, impulsivity, inappropriate social behavior, obsessions, phobias, suspiciousness, and ritual behavior Depression: Observe for/report any signs and symptoms of depression i.e. sadness, tearfulness, hopelessness, anger, loss of interest in preferred activities, sleep disturbance, overwhelming fatigue, increased/decreased appetite, increased complaints of pain, and isolation Anxiety: Observe / Report signs and symptoms of anxiety: restlessness, pacing, and poor impulse control. Interview on 10/08/24 at 9:32 A.M., with Social Worker (SW) #132 confirmed Resident #9's last PASRR was completed 10/08/18 and did not include his mental or intellectual disability. The SW confirmed the resident would trip for a screening for level II services with his current diagnoses. Review of the facility's policy and procedure tilted PASRR dated 09/15/23 revealed a PASRR was a federal requirement to help ensure that individuals are not inappropriate placed in nursing homes for long term care. The initial pre-screening would be completed prior to admission to the nursing facility. If a significant change in status assessment occurs for an individual condition a referral for a PASRR level evaluation. A referral should be made as soon as the criteria indicating such are evident.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015 Based on record review, and staff interview, the facility failed to ensure there was consistent communication between the facility and the dialysis center regarding a resident's hemodialysis treatments. This affected one (Resident #52) of one resident reviewed for dialysis. Resident #52 was the only resident in the facility receiving dialysis treatments. The facility census was 57. Findings include: Review of the medical record for Resident #52 revealed an admitted [DATE]. Diagnoses included end stage renal disease, essential hypertension, and type two diabetes mellitus with diabetic nephropathy. Review of Resident #52's October 2024 Physician orders revealed orders for the resident to receive outpatient dialysis on Monday, Wednesday and Friday every weekly. The resident has been receiving dialysis three times a week since his admission to the facility. Review of Resident #52's Care Plan dated 08/30/24 revealed the resident has a diagnosis of chronic renal failure and has the potential for complications from hemodialysis. Interventions included outpatient dialysis on Monday, Wednesday, and Friday, and communicate with dialysis center regarding medication, diet, and lab results. Review of Resident # 52 dialysis communication log from August, September, and October 2024 revealed missing communication logs from 09/04/24, 09/09/24, 09/13/24, 09/27/24, and 09/30/24. The logs contain information such as the residents code status, transfer time, allergies, mental status, medications, skin issues, bruit and thrill (bruit is the sound of bloodflow that is heard with a stethoscope and caused by the sound of blood flowing through a vessel and thrill is the vibration caused by blood flowing through the fistula and can be felt by placing your fingers just above the incision line. The indicate a dialysis fistula is working), infection, vitals and pre and post dialysis weights. Interview on 10/09/24 on 2:18 P.M. the Administrator confirmed the facility could not locate Resident #52's dialysis communication logs from 09/04/24, 09/09/24, 09/13/24, 09/27/24, and 09/30/24.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015 Based on interview, record review, and pharmacy recommendations the facility failed to timely address pharmacy recommendation related to Resident #3's pain medication and lab work. This affected one (#3) of five residents reviewed for unnecessary medications. The facility census was 57. Findings include: Review of the medical record for Resident #3 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, pain in left hip, and non-pressure chronic ulcer of other part of left foot. Review of Resident #3's Pharmacy Recommendation dated 01/05/24 stated to please evaluate the following as needed medications and assess proper parameters (i.e. pain scale 1-10) to identify which medication to administer or consider discontinuation of one of the agents. The agents listed were acetaminophen 325 mg take two every six hours as needed for pain and tramadol 50 mg as need for pain. Review of Resident #3's Pharmacy Recommendation dated 08/04/24 stated to please be sure the following lab results are posted in the chart as they were unavailable during the of review. The lab listed was for a Hemoglobin A1C (HbA1c) (blood test that measures a person's average blood sugar) every three months. Review of Resident #3's October 2024 physician orders revealed orders for tramadol 50 milligrams (mg) every six hours as needed for pain, acetaminophen 1000 mg as needed three times a day and insulin glargine solution eight units subcutaneous daily before bedtime. The resident's tramadol and acetaminophen did not have pain parameters listed. Review of Resident #3's lab work revealed the facility had not obtained a HbA1c. Interview on 10/10/24 at 8:55 A.M. Regional Care Consultant # 189 verified Resident #3's tramadol and acetaminophen did not have pain parameters in place as requested in the pharmacy recommendation. Interview on 10/10/24 at 1:07 P.M. the facility's DON confirmed the facility missed the pharmacy recommendation stating to obtain a HbA1c every three months. She verified the lab was not completed.

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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** 32801 Based on medical record review, interview and policy review the facility failed to ensure residents were free of significant medication errors. This affected one resident (Resident #13) of five residents reviewed for unnecessary medication use. The facility census was 57. Findings included: Medical record review revealed Resident #13 was admitted to the facility on [DATE] with diagnoses including infection and inflammatory reaction due to other internal orthopedic prosthetic devices, implants and grafts, subsequent encounter, acute Infection, infection following a procedure, other surgical site, subsequent encounter, and pain. 1. Review of Resident #13's admission orders dated 08/21/24 revealed the resident was ordered vancomycin 2,000 milligrams (mg) intravenous (IV) twice daily for a spinal surgical wound infection. The wound culture grew Enterococcus Faecalis, Candida Albicans, and Staph Haemolyticus . Additional orders for the central line (special access to administer intravenous medication) included to change dressing weekly and as needed, may obtain blood draws from central line, change IV tubing daily, flush with 10 milliliters of normal saline before and after medication administration and blood draws, and to monitor site for signs and symptoms of infection every shift. Review of Resident #13's medication administration record (MAR) dated 08/2024 revealed the resident didn't receive the second dose of vancomycin 2,000 mg on 08/21/24 (first scheduled dose after admission to the facility) or the first scheduled dose of the day on 08/22/24. The resident also did not receive the first scheduled dose of the day on 08/27/24 due to it was not available. Review of Resident #13's progress note dated 08/22/2024 revealed the resident had not received IV antibiotics due to not being available in the emergency medication kit. The medication was requested to be drop shipped this morning around 7:00 A.M. This nurse called again as medication was still not here by 12:00 P.M. Pharmacy stated medication were just going out the door when the writer called around 1:00 P. M. There was no documented evidence the infectious disease physician or the facility's physician was notified. Review of Resident #13's progress note dated 08/27/24 revealed the nurse went in to to administer the morning dose of vancomycin and there were no doses left (for administration). The nurse called pharmacy to get the doses drop shipped. Medications came around 3:00 P.M., so the morning dose was not given. Nurse Practitioner was in house and aware. There was no documented evidence the infectious disease doctor was notified until 08/28/24. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #13's progress note dated 09/05/24 revealed the infectious disease pharmacist called regarding Resident #13's laboratory results (to monitor the antibiotic levels in the resident's blood). The pharmacist was advised the facility's pharmacy had re-dosed the vancomycin from 2 grams (gram) to 1.7 grams (documentation error the vancomycin was decreased to 1.75 grams on 09/03/24 by the facility's pharmacist). The infectious disease pharmacist advised (the nurse) to hold the night (dose on 09/05/24) and morning dose (on 09/06/24) of vancomycin and re-draw trough level (vancomycin level). Review of Resident #13's MAR dated 09/2024 revealed no evidence the vancomycin was held on 09/05/26 for the P.M. dose or the A.M. dose on 09/06/24 perthe infectious disease pharmacist recommendation on 09/05/24. Review of Resident #13's progress note dated 09/06/24 revealed the infectious disease pharmacist returned the nurse's call regarding laboratory results. The pharmacist asked if the doses were held as previously ordered. Upon investigation the vancomycin was not held and no orders were written to hold. New orders were received to hold tonight's vancomycin dose and to start 1.25 mg every 12 hours and re-draw labs on Monday (09/07/24). The pharmacist continued to state the infectious disease pharmacist would like to take care of the vancomycin dosing because they do it a little differently than the facility's pharmacist. The nurse voiced understanding, and the pharmacist gave the nurse his contact information and fax number to send the laboratory results to. Interview on 10/10/24 at 12:03 P.M., with the Director of Nursing (DON) verified the infectious disease pharmacist was not notified the resident didn't receive the vancomycin on the night of 08/21/24 or the morning of 08/22/24. The DON confirmed the resident didn't receive the morning dose on 08/27/24 and the P. M. dose was not held on 09/05/24 or the morning dose on 09/06/24 per verbal orders from the infection preventionist pharmacist. Review of the facility's policy titled Medication Administration dated 09/2018 revealed to administer medication in accordance to written orders per the prescriber.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 32801 Based on medical record review, observation, interview, and policy review revealed the facility failed to ensure medications were stored appropriately. This had the potential to affect all 57 residing in facility. Findings included: 1. Observation on 10/07/24 at 2:04 P.M. revealed the Sycamore Valley medication cart was left unlocked and unattended. The nurse (Licensed Practical Nurse (LPN) #158) was observed in a room with a resident, which was at the other end of the hall. Interview on 10/07/24 at 2:04 P.M., with State tested Nurse's Aide (STNA) #162 confirmed the medication cart was unlocked and unattended. Review of the facility's policy tilted Medication Administration dated 09/2018 revealed the medication cart is kept closed and locked when out of sight of the medication nurse. 42015 2. Observation 10/08/24 at 7:40 A.M. revealed the facility's Director of Nursing (DON) administered medication to Resident #7. While in the room, whom she shares with Resident #35, a pill cup with several pills on Resident #35's bedside table. The DON asked the resident what the pills were doing there, and the resident responded that the nurse gave them to her earlier, but she liked to take them with her breakfast, so they were left on her bedside table. The DON removed the cup of pills and stated she would bring them back when she was ready for them. Review of Resident #35's morning medication revealed she was to receive aspirin 81 milligrams (mg), budesonide 3 mg, cholecalciferol 125 micrograms (mcg), clopidogrel 75 mg, cyclobenzaprine 5 mg, folic acid 1 mg, furosemide 20 mg, losartan 25 mg, metoprolol succinate 25 mg, omeprazole 20 mg, oystershell calcium 500 mg, potassium chloride 10 mcg, preservation 250-90-40-1mg, ropinirole 0.25 mg, and metoclopramide HCL 5 mg. Interview on 10/08/24 at 7:40 A.M. with the DON revealed the night shift nurse got Resident #35's medication ready and left them on her nightstand to take. She confirmed medication is not supposed to be left unattended and the nurse should have verified the resident #35 took all her medications at the time of administration. Review of the facility policy Medication Administration General Guidelines dated 09/18 revealed medications must be administered at the time they are prepared.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, observation, interview, and policy review the facility failed to ensure a resident received dental services timely. This affected one (Resident #11) of one reviewed for dental services. Findings included: Record review revealed Resident #11 was admitted to the facility on [DATE] with hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, gastro-esophageal reflux disease without esophagitis, and need for assistance with personal care. Review of Resident #11's face sheet revealed the resident's primary insurance was Medicaid. Review of Resident #11's progress notes revealed on 09/04/24 the Social Worker (SW) #132 was notified Resident #11 needed to see a dentist related to losing a bottom right filling. Review of Resident #11's progress note dated 09/05/24 revealed the resident had voiced complaints of right-sided mouth pain due to a filling lost from a tooth. The resident requested as needed Tylenol. The medication was administered and effective. Review of Resident #11's progress note dated 09/14/24 revealed the resident had voiced complaints of right-sided mouth pain. As needed Tylenol was administered. The resident stated it was his tooth on the bottom right side of his mouth due to the filling came out. Review of Resident #11's progress note dated 09/17/24 revealed the nurse entered the resident's room and the resident requested Tylenol and stated his mouth was hurting. As needed Tylenol administered. The resident asked when this was going to get taken care of. The nurse told resident to ask the day team in the morning. Review of Resident #11's progress note dated 09/18/24 revealed the resident had complaints of tooth pain this morning. Tylenol given for pain relief, left message with the SW #132 for update on getting the resident into a dentist. Review of Resident #11's progress note dated 09/22/24 revealed the resident had voiced complaints of right bottom tooth pain, the resident had requested as needed Tylenol at night stating it helps to take the edge off so he could sleep. Tylenol administered and effective. Review of Resident #11's progress note dated 09/29/24 revealed the resident complained of tooth pain rated a five out of ten (on a 0-10 pain scale with 0 being no pain and 10 being the worst pain). Tylenol given per order and pain decreased to 3/10. Review of Resident #11's medical record revealed no evidence a dental appointment was made. Review of Resident #11's care plan revealed no evidence of a dental plan of care. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/07/24 at 9:54 A.M., with Resident #11 revealed he was having mouth pain due to a filling had fallen out of his right back tooth. The resident reported he requested to see a dentist but was told he would have to wait until the facility dentist visited again. The resident reported he has been taking Tylenol for the pain. Interview on 10/09/24 at 8:32 A.M., interview with SW #132 revealed he was aware the resident had dental issues, but he had spoken to the resident and explained to the resident he would have to wait longer to get into a local dentist because he was not an established patient anywhere local, and it would be faster to see the facility's dentist on 12/17/24. The SW reported he didn't complete an emergency referral form with the facility's dentist because he didn't think the resident would have meet criteria to have an emergency visit due to, he did not have an infection, fever, nor was on antibiotics. The SW confirmed he didn't attempt to get the resident an appointment without an outside dentist either. Interview on 10/09/24 at 8:58 A.M., with Resident #11 confirmed it hurt to chew on the right back side of his tooth due to the pain. The resident reported he must chew on his front teeth. The resident wanted the surveyor to see the tooth, but it was hard to visualize. The gums around the back three teeth on the right were white and the other surrounding gums were pink. The resident reported he doesn't think the gums were swollen. Interview on 10/09/24 at 10:10 A.M., with SW #132 reported he called a local dental office today and they would see the resident today. The SW reported he was unaware until today the local dentist office would see Medicaid resident and they told him they would see any resident as soon as possible. Review of dental policy and procedure dated 03/28/24 revealed the facility would assist residents in obtaining routine and emergency dental care as needed. The facility would assist in getting emergency dental services for each resident as needed.

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	365880	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Coshocton	100 South Whitewoman Street Coshocton, OH 43812

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on review of invoices, review of alternative menu, review of the contract, observation, and interviews the facility failed to ensure alternate menu items were available. This had the potential to affect all 57 residents residing in the facility. Findings included 1. Interview on 10/07/24 at 9:45 A.M., with Resident #24 revealed the facility doesn't honor food alternatives ordered. Interview on 10/07/24 at 1:17 P.M., with Resident #46 revealed the facility was always out of menu and alternative food items. The other day the facility was out of lettuce and orange juice. The facility quit providing cottage cheese as well, which was on the alternative menu. Interview and observation on 10/08/24 at 8:48 A.M., with Resident #20 revealed he was told the facility was no longer providing residents with cottage cheese and he would have to buy his own. The resident reported he loved cottage cheese and had been purchasing his own. Interview on 10/08/24 at 8:48 A.M. with State tested Nurse's Aide (STNA) #176 revealed he was told the facility was out of cottage cheese last week, but he was unaware the facility was no longer providing cottage cheese. Review of the alternative menu undated revealed tossed salad and cottage cheese were listed on the menu. Review of the last three months of food invoices revealed the last time cottage cheese was ordered was 09/17/24. Interview on 10/09/24 at 12:12 P.M., with District Manager #129 revealed the dietary department was contracted out with her company. Per the contract her company only provided items based on the approved menu. She was not aware cottage cheese was on the alternative menu, and she would have the dietary manger order it. She doesn't recommend the facility to purchase food from the local stores when they run out and encourage the staff to ask residents if they would like an alternative. She recommended staff to ask residents if they were at home and didn't have what they wanted to eat, what would they eat instead of what they wanted. Review of the food service contract dated 04/25/21 revealed all food and supplies would be prepared and served by the contracted company four-week menu and alternative menu. Resident choice meals are included and should be items in line with normal menu offering. Items that exceed normal meal budget such as prime rib and steak are not available as choice of meal and would be consider and exclusion. The always available menu includes side salad and fruit and cottage cheese plate. 28701 (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Interview with Resident #56 on 10/07/24 at 2:07 P.M. revealed alternate food items are not always available, including cottage cheese. Review of Resident #56's medical record revealed an admitted [DATE] with diagnoses that included endocarditis, diabetes mellitus, and sepsis. Further review of the medical record including Minimum Data Set (MDS) 3.0 admission assessment with a reference date of 09/16/24 indicated the resident had an intact and independent cognition level. Review of the facility food delivery invoices revealed that cottage cheese was last delivered on 09/17/24. Review of the facility alternate food item list revealed cottage cheese was available per resident request. Interview with the facility certified dietary manager (DM) #121 on 10/09/24 at 10:25 A.M., verifies last cottage cheese ordered and received was on 09/17/24, facility does not have any cottage cheese at this time and it is on the alternate item menu.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on observation, record review, and interview, the facility failed to provide an appropriate assistive device to maintain/improve the ability to eat independently. This affected one (Resident #5) of two residents reviewed for mobility/restorative. Findings include: Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left nondominant side, muscle wasting and atrophy, lack of coordination, and cognitive communication deficit. Review of the Minimum Data Set (MDS) assessment, dated 08/21/24, revealed Resident #5 was cognitively intact. There were no behaviors or rejection of care. The resident was receiving hospice services. Review of the Care Plan, dated 01/30/24, revealed Resident #5 was limited in ability to eat and drink related to weakness, cerebral infarction with left-sided hemiplegia, and dysphagia with interventions including to provide diet as ordered and eating assistance. Review of physician order, dated 07/25/24, revealed the diet order with instructions for a small maroon spoon with meals. Observation on 10/08/24 at 8:16 A.M. revealed Resident #5 sitting in bed eating breakfast, which included oatmeal. Resident #5 was observed using a regular spoon and not a small maroon spoon (assistive device) as ordered by the physician. Interview on 10/08/24 at 8:22 A.M. with Regional Registered Nurse (RN) Consultant #189 confirmed Resident #5 did not have a small maroon spoon (assistive device) available as ordered by the physician. Interview on 10/08/24 at 8:40 A.M. with Dietary Manager #121 confirmed Resident #5's current diet order included a small maroon spoon to be provided with meals.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32801 Based on observation and interview the facility failed to ensure the ice machine was maintained and cold air-vents were cleaned. This had the potential to affect all 57-resident residing in the facility. Findings included Observation on 10/09/24 at 12:12 P.M., of the kitchen with revealed the three cold air ducts and one duct no longer used were visibly dusty. Additional observations revealed the bottom drainpipe for the ice machine was running into the floor drainpipe. There was no gap between the ice machine drainpipe and floor drainpipe. The floor drainpipe was clogged and filled with stagnant water filling, backing into the ice machine drainpipe. Findings confirmed during observation with District Manager #129. Review of the food service contract 04/25/21 revealed the contracted company was responsible for providing labor to perform menu and recipes development, procuring, handling, inventorying and storing food and related supplies, preparing, staging, and transporting meals to resident dining areas, and cleaning and sanitizing.

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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** 42015 Based on observation, interview, record review, and policy review the facility failed to ensure Enhanced Barrier Precautions (EBP) were in place for Resident #261 who was admitted with a chronic venous ulcer. This affected one (Resident #261) of one residents reviewed for wounds. The facility census was 57. Finding include: Review of the medical record for Resident #261 revealed an admitted [DATE]. Diagnoses included unspecified venous ulcer, cellulitis, morbid obesity, and peripheral vascular disease. Review of Resident #261 wound assessment dated [DATE] revealed the resident had a right ankle unspecified venous ulcer measuring three centimeters (cm) length by three cm width and 0.1 cm deep. The wound was noted to have light exudate of serosanguineous (pale red to pink, thin and watery) drainage. Review of Resident #261 October 2024 physician orders revealed the resident did not have an order in place for EBP. Observations on 10/07/24 at 9:29 A.M. and 03:43 P.M. revealed the Resident #261 did not have a EBP sign on the door or available Personal Protective Equipment (PPE) close to the resident's door. Interview on 10/07/24 at 3:43 P.M. the facility's Director of Nursing verified Resident #261 was admitted with a venous ulcer and EBP should be in place. Review of the facility policy, Enhanced Barrier Precaution Policy dated 03/25/24 revealed the policy is intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help and manage transmission of diseases and infection. EBP are indicated for residents who have chronic wounds and or indwelling medical devices regardless of MDRO status.