STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365897	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Lebanon Rehabilitation and Healthcare Center	101 Mills Place New Lebanon, OH 45345

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on observation, record review, interview and policy review, the facility failed to ensure resident privacy. This affected one (Resident #5) of two residents reviewed for dignity and respect. The facility census was 105. Findings include: Review of the medical record for Resident #5 revealed an admitted [DATE]. Diagnoses included cervical disc disorder with myelopathy, mid-cervical region, contracture, right hip, contracture, left hip, contracture, right knee, and contracture, left knee. Review of the Discharge Return Anticipated Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. She was dependent on staff assistance with toileting hygiene, bathing, dressing, personal hygiene, bed mobility, and wheelchair mobility. Review of the Care Plan dated 01/17/24 revealed Resident #5 has an Activities of Daily Living (ADL) self-care performance deficit with interventions of assist with activities of daily living (i.e.: dressing, grooming, personal hygiene, locomotion, oral care, etc.) as needed. Two person assist with bed mobility. During an observation on 08/19/24 at 1:07 P.M., 1:40 P.M., and 1:55 P.M., Resident #5 was lying in bed with her buttocks exposed to the hallway. Flies were in the room landing on the resident. During an observation on 08/19/24 at 2:03 P.M., Resident #5 was still in bed exposed. She had a fly swatter in the bed with her. During an interview on 08/19/24 at 2:04 P.M., Activities Manager #20 confirmed resident was lying in bed with her buttocks exposed to the hallway and that the curtain was not pulled to keep anyone in the hall from seeing the resident. The resident was not able to reach the curtain to pull it closed or open it. Activities Manager #20 stated, The flies like her because she won't take a shower. She confirmed Resident #5 had the fly swatter to use to keep flies away. During an observation on 08/20/24 at 8:27 A.M., Resident #5 was lying in bed asleep with gnats around her. Licensed Practical Nurse (LPN) #50 confirmed the presence of the gnats at the time of the observation. sleep with the presence of gnats around her. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled Dignity, undated, revealed each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents are always treated with dignity and respect. Demeaning practices and standards of care that compromise dignity if prohibited. Staff are expected to promote dignity.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on record review, observation, interview and policy review, the facility failed to ensure call lights were within reach. This affected one (Resident #15) of four residents reviewed for accommodations of needs. The facility census was 105. Findings include: 1. Medical record review for Resident #15 revealed an admission on 05/06/24, with diagnoses including chronic obstructive pulmonary disease, asthma, type 2 diabetes with polyneuropathy, hypertension, anxiety, and depression. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #15 had impaired cognition. Resident #15 had no impairments for bilateral upper extremities. Resident #15 required supervision for eating, total staff dependence for toileting and transfers, maximal assistance for bed mobility. Review of the plan of care for Resident #15 dated 05/15/24 revealed the resident had an activities of daily living self-care performance deficit. Interventions include assist with activities of daily living (dressing, grooming, personal hygiene, locomotion and oral care) as needed and encourage resident to use call light when assistance is needed. During an observation on 08/21/24 at 5:40 P.M., Resident #15 was lying in bed and verbally calling out for assistance. The head of bed was positioned away from the center of the room. Resident #15 did not have the call light within reach. The call light was a plastic-coated soft cable wire attached to a plastic switch in the center of the bedroom wall. During an interview on 08/21/24 at 5:45 P.M.,State tested Nurse Aide (STNA) #216 verified the call light was not within reach of the resident and that Resident #15 was capable of activating the call light if needed. During an interview on 08/21/24 at 5:50 P.M., the Maintenance Director #72 verified the call light was not long enough for the resident to reach and was a plastic-coated soft wire. Review of the policy titled Call Light, dated September 2021, stated nursing staff shall check call lights daily and report any defective call light to maintenance for repair and ensure call lights are placed within reach of the residents who are able to use them.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on record review, interview, and policy review, the facility failed to notify a resident representative of a change in condition. This affected one (Resident #87) one resident reviewed for notification. The facility census was 105. Findings include: Review of the medical record for Resident #87 revealed an admitted [DATE]. Diagnoses included acute transverse myelitis in demyelinating disease of central nervous system and major depressive disorder. Review of the Discharge Return Anticipated Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #87 was cognitively intact. Resident was independent for eating, oral hygiene, personal hygiene, and bed mobility. Resident required partial assistance with toileting hygiene, transfers, and ambulating 10 feet. Resident required substantial assistance with bathing and dressing. Review of progress notes revealed no documentation of Resident #87 leaving the facility and being transferred to the hospital on 07/06/24. There was no documentation that Resident #87's physician or resident representative was made aware of resident being sent to the hospital on 07/06/24. On 07/10/24 at 12:47 P.M., Resident #87's representative called to check on the resident and it was at that time the representative was informed the resident had been sent to the hospital on 07/06/24. During an interview on 08/19/24 at 1:44 P.M., Resident #87's representative stated Resident #87 was sent to the hospital on 07/06/24 and she was not made aware of the transfer. During an interview on 08/29/24 at 12:10 P.M., Regional Clinical Nurse #222 confirmed there was no documentation showing the physician or Resident #97's representative was notified the resident was transferred to the hospital on 07/06/24. Review of the policy titled Change in Condition or Status, undated, revealed the facility notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical / mental condition and / or status (e.g. changes in level of care, billing / payments, resident rights, etc.). Unless otherwise instructed by the resident, a nurse will notify the resident's representative when e. it is necessary to transfer the resident to a hospital / treatment center. This deficiency represents non-compliance investigated under Complaint Number OH00157310.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069 Based on record review, review of facility Self-Reported Incidents (SRI), staff interview, and policy review, the facility failed to thoroughly investigate resident-to-resident altercations. This affected six (Residents #69, #72, #74, #79, #91, and #152) of six residents reviewed for abuse. The facility census was 105. Findings include: 1. Review of the medical record for Resident #69 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus without complications, acute kidney failure, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, insomnia, neurocognitive disorder with Lewy bodies, and hyperlipidemia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #69 was rarely/never understood and had impaired cognitive skills. Resident #69 was assessed to require set-up assistance for eating, substantial/maximal assistance for oral hygiene, toileting, bathing, dressing, personal hygiene, bed mobility, and transfer. 2. Review of the medical record for Resident #91 revealed an admitted [DATE]. Diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, obstructive sleep apnea, benign prostatic hyperplasia without lower urinary tract symptoms. Review of the admission MDS assessment dated [DATE] revealed Resident #91 had severely impaired cognition. Resident #91 was assessed to require set-up assistance for eating, oral hygiene, upper body dressing, personal hygiene, bed mobility, and transfer, and supervision for bathing, and lower body dressing. Review of the SRI dated 07/12/24 revealed there was an allegation of bruising to Resident #69's side from a possible resident-to-resident altercation. The SRI indicated the other resident involved was Resident #91. The SRI concluded there was no bruising. Review of the facility investigation for the alleged resident-to-residents incidents revealed the folder lacked documentation regarding the investigations, including any statements from staff or follow-up with any residents. 3. Review of the medical record for Resident #72 revealed an admitted [DATE]. Diagnoses included metabolic encephalopathy, hypertension, obstructive sleep apnea, chronic obstructive pulmonary disease, congestive heart failure, schizophrenia, anxiety disorder, hyperlipidemia, and major depressive disorder. Review of the quarterly (MDS assessment dated [DATE] revealed Resident #72 had moderately impaired cognition. Resident #72 was assessed to require set-up assistance for eating, oral hygiene, toileting, personal hygiene, bathing, dressing, transfer, and bed mobility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of the medical record for Resident #74 revealed an admitted [DATE]. Diagnoses included schizoaffective disorder, adult failure to thrive, depression, syncope and collapse, and delusional disorders. Review of the quarterly MDS assessment dated [DATE] revealed Resident #74 had severely impaired cognition. Resident #74 was assessed to require set-up assistance for eating, and supervision for toileting, transfers, and bed mobility. Review of the SRI dated 07/12/24 revealed a nurse observed Resident #74 pulling Resident #72 by her coat. Resident #72 reported Resident #74 pulled her coat and gummed her finger. The residents were separated, and the families and nurse practitioner were notified with no new orders given. Review of the facility investigation for the alleged resident-to-residents incidents revealed the folder lacked documentation regarding the investigations, including any statements from staff or follow-up with any residents. 5. Review of the medical record for Resident #79 revealed an admitted [DATE]. Diagnoses included schizophrenia, paranoid schizophrenia, shortness of breath, and emphysema. Review of the discharge MDS assessment dated [DATE] revealed Resident #79 was cognitively intact. Resident #79 was assessed to require set-up assistance for eating, oral hygiene, toileting, dressing, personal hygiene, bed mobility, and transfers, and supervision for bathing. 6. Review of the medical record for Resident #152 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included metabolic encephalopathy, moderate protein-calorie malnutrition, dementia in other diseases classified elsewhere, severe, with agitation, hyperlipidemia, hypothyroidism, anxiety disorder, schizophrenia, and type two diabetes mellitus without complications. Review of the admission MDS assessment dated [DATE] revealed Resident #152 was rarely/never understood and had impaired cognitive skills. Resident #152 was assessed to require set-up assistance for eating, partial/moderate assistance for oral hygiene, upper body dressing, and personal hygiene, and substantial/maximal assistance for toileting, bathing, lower body dressing, bed mobility, and transfer. Review of the SRI dated 07/19/24 revealed a nurse witnessed Resident #152 hit Resident #79. The SRI indicated the residents were separated and Resident #152 was placed on one-to-one supervision until being transferred to the hospital for evaluation. The SRI stated the families were contacted and no major injuries were noted. Review of the facility investigation for the alleged resident-to-residents incidents revealed the folder lacked documentation regarding the investigations, including any statements from staff or follow-up with any residents. Interview on 08/29/24 at 4:05 P.M., with Regional Director of Operations (RDO) #224 verified the investigation folders for the SRIs, lacked documentation related to the investigations conducted, including interviews or follow up with the residents. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy titled Abuse Investigation and Reporting, dated September 2021, revealed upon conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms and provide the completed documentation to the Administrator.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on interview and record review, the facility failed to permit a resident to remain in the facility and not transfer or discharge a resident from the facility without the proper documentation. This affected one (Resident #100) of three residents reviewed for transfer or discharge. The facility census was 105. Findings include: Review of the Resident #100's chart revealed Resident #100 admitted to the facility on [DATE] with diagnoses including spinal stenosis, polyneuropathy, paresthesia of skin, radiculopathy, major depressive disorder and other specified arthritis. Resident #100 was discharged from the facility on 05/22/24. Review of Resident #100's discharge Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and Resident #100 required set up with eating, oral hygiene, toileting, and personal hygiene. Resident #100 required supervision with showering, upper body dressing, and moderate assistance with lower body dressing, putting on and taking off footwear, sitting to standing, chair transfers, toilet transfers and walking ten feet. Resident #100 was independent with rolling left and right, sitting to lying, and lying to sitting. Review of Resident #100's progress notes from 03/20/24 to 05/20/24 revealed no information related to Resident #100 receiving a formal discharge notice from the facility. Review of Resident #100's progress note dated 03/20/24 revealed Resident #100 was admitted to the facility on [DATE]. Review of Resident #100's progress note dated 05/21/24 written by Social Services Director (SSD) #36 revealed Resident #100 presented with her termination letter from her insurance company. At first Resident #100 stated she would be amenable to going to a homeless shelter then she came to the office and began berating SSD #36 and Social Services Aide (SSA) #206 about how they were not helping her, they should have told her this was going to happen when she first came to the facility and that they were all lying. SSD #36 and SSA #206 tried to explain how the process works and that she must leave tomorrow. Resident #100 stated she had nowhere to go and that SSD #36 and SSA #206 must find her a place. SSD #36 and SSA #206 explained that they don't find places for residents to go and we will help her get in the homeless shelter. At that point, Resident #100 became very verbally aggressive and started yelling at both SSD #36 and SSA #206 and stated they were lying to her. SSD #36 presented the determination letter to her, and she was escorted out of our office by the DON. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #100's progress note dated 05/22/24 written by SSD #36 revealed SSD #36 went to Resident #100 to ask who her pharmacist was so it could be entered on her discharge paperwork. Resident #100 refused to provide that information. Resident #100 was then asked to sign the discharge paperwork, but she refused to sign. Resident #100 stated were that SSD #36 had done nothing for her the whole time she was at the facility and SSD #36 did not help her mother who resided on the secured unit. Resident #100 went so far as to say the social worker 'manufactured' the termination letter from her insurance company in an effort to get rid of her. Resident #100 was picked up by a friend who then took her away from the building for the discharge. Review of Resident #100's physician order from 03/20/24 to 05/22/24 revealed no discharge order was listed in the chart. Review of Resident #100's insurance notice of adverse determination dated 05/21/24 revealed Resident #100's continued stay in a skilled nursing facility could not be approved. The dates of service from 05/20/24 to 05/21/24 were approved but starting on 05/22/24 the stay would be denied. Resident #100's records did not show a need for skilled nursing daily. Resident #100 had no therapy notes and there was no records showing that Resident #100 needed hands on help with at least two daily needs. There was no record showing Resident #100 needed help with medications or 24 hour care for her memory. Resident #100 did not meet the rules to stay, and her needs could be managed at a lower level. Discharge plans were being worked on per the determination letter. Review of Resident #100's discharge assessment initiated on 05/21/24 and locked on 05/22/24 revealed Resident #100 was discharged to a homeless shelter on 05/21/24. No follow up doctor's appointments were made, and the discharge assessment stated resident will arrange follow up appointments. Interview with the Administrator, SSD #36 and SSA #206 on 08/22/24 at 1:27 P.M. verified Resident #100 received an insurance denial letter around 05/21/24. SSD #36 verified he told Resident #100 that she must leave tomorrow and that the facility does not find places for residents. SSD #36 stated that Resident #100 discharged on [DATE] and her friend picked her up, but SSD #36 did not know where Resident #100 went to live. SSD #36 verified Resident #100's discharge location was listed as a homeless shelter on the discharge assessment. The Administrator and SSD #36 verified Resident #100 did not want to discharge from the facility and she was not given a 30 day or other type of formal discharge notice. Review of the facility assessment dated [DATE] revealed the facility provides for discharge planning for residents per individualized care plans that meet current regulations. Review of the facility's policy titled Transfer and Discharge Notice, dated September 2021, revealed the facility shall provide a resident and/or the resident's representative with a thirty day written notice of an impending transfer or discharge.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on interview and record review, the facility failed to provide notification to a resident of the transfer or discharge and the reasons for the move to a resident that was discharged to a homeless shelter. This affected one (Resident #100) out of three residents reviewed for transfer or discharge. The facility census was 105. Findings include: Review of the Resident #100's chart revealed Resident #100 admitted to the facility on [DATE] with diagnoses including spinal stenosis, polyneuropathy, paresthesia of skin, radiculopathy, major depressive disorder and other specified arthritis. Resident #100 was discharged from the facility on 05/22/24. Review of Resident #100's discharge Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and Resident #100 required set up with eating, oral hygiene, toileting, and personal hygiene. Resident #100 required supervision with showering, upper body dressing, and moderate assistance with lower body dressing, putting on and taking off footwear, sitting to standing, chair transfers, toilet transfers and walking ten feet. Resident #100 was independent with rolling left and right, sitting to lying, and lying to sitting. Review of Resident #100's progress notes from 03/20/24 to 05/20/24 revealed no information related to Resident #100 receiving a formal discharge notice from the facility. Review of Resident #100's progress note dated 03/20/24 revealed Resident #100 was admitted to the facility on [DATE]. Review of Resident #100's progress note dated 05/21/24 written by Social Services Director (SSD) #36 revealed Resident #100 presented with her termination letter from her insurance company. At first Resident #100 stated she would be amenable to going to a homeless shelter then she came to the office and began berating SSD #36 and Social Services Aide (SSA) #206 about how they were not helping her, they should have told her this was going to happen when she first came to the facility and that they were all lying. SSD #36 and SSA #206 tried to explain how the process works and that she must leave tomorrow. Resident #100 stated she had nowhere to go and that SSD #36 and SSA #206 must find her a place. SSD #36 and SSA #206 explained that they don't find places for residents to go and we will help her get in the homeless shelter. At that point, Resident #100 became very verbally aggressive and started yelling at both SSD #36 and SSA #206 and stated they were lying to her. SSD #36 presented the determination letter to her, and she was escorted out of our office by the DON. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #100's progress note dated 05/22/24 written by SSD #36 revealed SSD #36 went to Resident #100 to ask who her pharmacist was so it could be entered on her discharge paperwork. Resident #100 refused to provide that information. Resident #100 was then asked to sign the discharge paperwork, but she refused to sign. Resident #100 stated were that SSD #36 had done nothing for her the whole time she was at the facility and SSD #36 did not help her mother who resided on the secured unit. Resident #100 went so far as to say the social worker 'manufactured' the termination letter from her insurance company in an effort to get rid of her. Resident #100 was picked up by a friend who then took her away from the building for the discharge. Review of Resident #100's physician order from 03/20/24 to 05/22/24 revealed no discharge order was listed in the chart. Review of Resident #100's insurance notice of adverse determination dated 05/21/24 revealed Resident #100's continued stay in a skilled nursing facility could not be approved. The dates of service from 05/20/24 to 05/21/24 were approved but starting on 05/22/24 the stay would be denied. Resident #100's records did not show a need for skilled nursing daily. Resident #100 had no therapy notes and there was no records showing that Resident #100 needed hands on help with at least two daily needs. There was no record showing Resident #100 needed help with medications or 24 hour care for her memory. Resident #100 did not meet the rules to stay, and her needs could be managed at a lower level. Discharge plans were being worked on per the determination letter. Review of Resident #100's discharge assessment initiated on 05/21/24 and locked on 05/22/24 revealed Resident #100 was discharged to a homeless shelter on 05/21/24. No follow up doctor's appointments were made, and the discharge assessment stated resident will arrange follow up appointments. Interview with the Administrator, SSD #36 and SSA #206 on 08/22/24 at 1:27 P.M. verified Resident #100 received an insurance denial letter around 05/21/24. SSD #36 verified he told Resident #100 that she must leave tomorrow and that the facility does not find places for residents. SSD #36 stated that Resident #100 discharged on [DATE] and her friend picked her up, but SSD #36 did not know where Resident #100 went to live. SSD #36 verified Resident #100's discharge location was listed as a homeless shelter on the discharge assessment. The Administrator and SSD #36 verified Resident #100 did not want to discharge from the facility and she was not given a 30 day or other type of formal discharge notice. Review of the facility's facility assessment dated [DATE] revealed the facility provides for discharge planning for residents per individualized care plans that meet current regulations. Review of the facility's policy titled Transfer and Discharge Notice, dated September 2021. revealed the facility shall provide a resident and/or the resident's representative with a thirty day written notice of an impending transfer or discharge.

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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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on interview and record review, the facility failed sufficiently prepare and orient a resident to ensure a safe and orderly discharge from the facility. This affected one (Resident #100) out of three residents reviewed for transfer or discharge. The facility census was 105. Findings include: Review of the Resident #100's chart revealed Resident #100 admitted to the facility on [DATE] with diagnoses including spinal stenosis, polyneuropathy, paresthesia of skin, radiculopathy, major depressive disorder and other specified arthritis. Resident #100 was discharged from the facility on 05/22/24. Review of Resident #100's discharge Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and Resident #100 required set up with eating, oral hygiene, toileting, and personal hygiene. Resident #100 required supervision with showering, upper body dressing, and moderate assistance with lower body dressing, putting on and taking off footwear, sitting to standing, chair transfers, toilet transfers and walking ten feet. Resident #100 was independent with rolling left and right, sitting to lying, and lying to sitting. Review of Resident #100's progress notes from 03/20/24 to 05/20/24 revealed no information related to Resident #100 receiving a formal discharge notice from the facility. Review of Resident #100's progress note dated 03/20/24 revealed Resident #100 was admitted to the facility on [DATE]. Review of Resident #100's progress note dated 05/21/24 written by Social Services Director (SSD) #36 revealed Resident #100 presented with her termination letter from her insurance company. At first Resident #100 stated she would be amenable to going to a homeless shelter then she came to the office and began berating SSD #36 and Social Services Aide (SSA) #206 about how they were not helping her, they should have told her this was going to happen when she first came to the facility and that they were all lying. SSD #36 and SSA #206 tried to explain how the process works and that she must leave tomorrow. Resident #100 stated she had nowhere to go and that SSD #36 and SSA #206 must find her a place. SSD #36 and SSA #206 explained that they don't find places for residents to go and we will help her get in the homeless shelter. At that point, Resident #100 became very verbally aggressive and started yelling at both SSD #36 and SSA #206 and stated they were lying to her. SSD #36 presented the determination letter to her, and she was escorted out of our office by the DON. Review of Resident #100's progress note dated 05/22/24 written by SSD #36 revealed SSD #36 went to Resident #100 to ask who her pharmacist was so it could be entered on her discharge paperwork. Resident #100 refused to provide that information. Resident #100 was then asked to sign the discharge paperwork, but she refused to sign. Resident #100 stated were that SSD #36 had done nothing for her the whole time she was at the facility and SSD #36 did not help her mother who resided on the secured unit. Resident #100 went so far as to say the social worker 'manufactured' the termination letter from her insurance company in an effort to get rid of her. Resident #100 was picked up by a friend who then took her away from the building for the discharge. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #100's physician order from 03/20/24 to 05/22/24 revealed no discharge order was listed in the chart. Review of Resident #100's insurance notice of adverse determination dated 05/21/24 revealed Resident #100's continued stay in a skilled nursing facility could not be approved. The dates of service from 05/20/24 to 05/21/24 were approved but starting on 05/22/24 the stay would be denied. Resident #100's records did not show a need for skilled nursing daily. Resident #100 had no therapy notes and there was no records showing that Resident #100 needed hands on help with at least two daily needs. There was no record showing Resident #100 needed help with medications or 24 hour care for her memory. Resident #100 did not meet the rules to stay, and her needs could be managed at a lower level. Discharge plans were being worked on per the determination letter. Review of Resident #100's discharge assessment initiated on 05/21/24 and locked on 05/22/24 revealed Resident #100 was discharged to a homeless shelter on 05/21/24. No follow up doctor's appointments were made, and the discharge assessment stated resident will arrange follow up appointments. Interview with the Administrator, SSD #36 and SSA #206 on 08/22/24 at 1:27 P.M. verified Resident #100 received an insurance denial letter around 05/21/24. SSD #36 verified he told Resident #100 that she must leave tomorrow and that the facility does not find places for residents. SSD #36 stated that Resident #100 discharged on [DATE] and her friend picked her up, but SSD #36 did not know where Resident #100 went to live. SSD #36 verified Resident #100's discharge location was listed as a homeless shelter on the discharge assessment. The Administrator and SSD #36 verified Resident #100 did not want to discharge from the facility and she was not given a 30 day or other type of formal discharge notice. Review of the facility's facility assessment dated [DATE] revealed the facility provides for discharge planning for residents per individualized care plans that meet current regulations. Review of the facility's policy titled Transfer and Discharge Notice, dated dated September 2021, revealed the facility shall provide a resident and/or the resident's representative with a thirty day written notice of an impending transfer or discharge.

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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** 39702 Based on record review, observation, interview, and policy review, the facility failed to ensure the Minimum Data Set (MDS) assessments were completed accurately. This affected three (Residents #41, #62, and #77) of twelve residents reviewed for MDS accuracy. The facility census was 105. Findings include: 1. Record review revealed Resident #41 was admitted on [DATE]. Diagnoses included traumatic hemorrhage of cerebrum, hemiplegia or right and left sides, epilepsy, respiratory failure, systemic inflammatory response syndrome, persistent vegetative state, acute cystitis without hematuria, hypertension, anxiety disorder, tracheostomy status, encephalopathy, and gastrostomy. Review of the active physician orders for Resident #41 revealed an ordered dated 03/20/24 for nothing by mouth (NPO), an order dated 03/21/24 for tube feeding, Jevity 1.5- 60 milliliters/hour (ml/hr) until 1320 ml has infused, allow two hours off for nursing care. Review of the annual MDS assessment for Resident #41 dated 08/15/24 revealed resident is in a persistent coma state. Resident #41 has physical impairments on both sides. Resident #41 is dependent for all care. Resident #41 has loss of liquids when eating or drinking, holding food in mouth, choking during meals and when swallowing, and complaints of difficulty of pain when swallowing. Resident #41 has a feeding tube and receives 51 percent of calories thru parenteral feedings. During an observation on 08/22/24 at 9:50 A.M., Resident #41 revealed the resident lying in bed on her back with feeding pump in place providing resident with Jevity 1.5, at 60 ml/hr via gastrostomy tube (g-tube). Resident #41 had tracheostomy in place. During an interview on 08/22/24 at 10:10 A.M., MDS Registered Nurse (RN) #166 verified the MDS was not coded correctly, because Resident #41 was NPO and did not consume any food by mouth during the assessment period. 44412 2. Review of the medical record for Resident #77 revealed an admitted [DATE]. Diagnoses included dementia, major depressive disorder, and type two diabetes mellitus (DM II). Review of the Admission Evaluation dated 03/20/24 revealed Resident #77 had a history of wandering or wandered within the facility. Review of the Admission MDS assessment, dated 03/26/24, revealed Resident #77 had moderate cognitive impairment. The MDS assessment revealed Resident #77 did not have wandering behaviors. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan dated 06/11/24 revealed Resident #77 was at risk for elopement related to exit seeking behavior, verbalized wants to leave the facility. Interventions included calmly redirect and divert resident's attention. Staff to distract resident when wandering/insistent on leaving facility by offering pleasant diversions, structured activities, food, conversation, or books. Staff evaluate for need of Wanderguard use. Staff to refer to psychiatrist, psychologist, or behavior specialist as needed. Staff to complete behavior monitoring and interventions. During an interview on 08/28/24, MDS Coordinator #166 verified the MDS was not coded correctly related to Resident #77's wandering behaviors. 3. Review of the medical record for Resident #62 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, type 2 diabetes mellitus with other specified complication, and bipolar disorder. Review of the care Plan dated 03/10/24 revealed resident is at risk for altered nutrition and hydration status related to a history of mouth sores with interventions of refer to ancillary services i.e. dental, vision etc. as needed. Review of the quarterly MDS, dated [DATE], revealed Resident #62 was cognitively intact. The resident required set-up assistance with eating, Resident #62 with no broken or loosely fitting full or partial denture and no chipped, cracked, uncleanable, or loose teeth present. No mouth or facial pain, discomfort or difficulty with chewing present. During an interview on 08/19/24 at 2:20 P.M., Resident #62 stated a referral to oral surgeon was to be done quite a while ago and has not been done. Resident #62 complained of tooth pain. During an observation on 08/21/24 at 1:53 P.M., Resident #62 had multiple cavities in the left upper back teeth and two teeth were broken. During an interview on 08/21/24 at 2:10 P.M., Licensed Practical Nurse (LPN) #50 confirmed resident has multiple cavities and broken teeth. LPN #50 stated the resident by the visiting dentist on 07/24/24 and was referred to see an oral surgeon. During an interview on 08/21/24 at 2:20 P.M., MDS Coordinator #166 confirmed the MDS completed on 08/16/24 was not accurate and did not contain the information on the resident's cavities on his left side of his teeth. Review of the policy titled, MDS Completion and Submission Timeframes, dated September 2021, revealed the facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. The Assessment Coordinator or designee was responsible for ensuring a resident assessment was submitted accurately. This deficiency represents non-compliance investigated under Complaint Number OH00156885.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on record review and interview, the facility failed notify the state mental health authority with a significant change pre-admission screening and resident review (PASARR) for residents with a change in their mental health or physical condition. This affected two (Residents #04 and #79) of five resident reviewed for PASARR. The facility census was 105. Findings include: 1. Review of the Resident #04's medical record revealed an admitted [DATE]. Diagnoses included unspecified psychosis not due to a substance or known physiological condition, dementia in other diseases classified elsewhere severe with other behavioral disturbance, major depressive disorder, other seizures, adult failure to thrive, anorexia, cerebral palsy, schizoaffective disorder, depression, insomnia, age related osteoporosis without current pathological fracture and cerebral infarction. Review of Resident #04's PASARR dated 08/31/22 revealed Resident #04 had no indications of serious mental illness. There were no diagnoses of mental disorders listed on the PASARR and Resident #04's diagnoses of unspecified psychosis not due to a substance or known physiological condition, major depressive disorder, schizoaffective disorder, anxiety disorder, depression, and insomnia were not listed on the PASARR. Review of Resident #04's physician order dated 02/17/24 revealed Resident #04 was admitted to hospice on 02/17/24 for senile degeneration of the brain. Review of Resident #04's medical record revealed Resident #04 did not have a significant change PASARR or notification to the state mental health authority of Resident #04's admission to hospice services on 02/17/24. Review of Resident #04's quarterly Minimum Data Set (MDS) assessment, dated 08/17/24, revealed the resident had severely cognitive impairment. During an interview on 08/22/24 at 1:27 P.M., with the Administrator, Social Service Designee (SSD) #36 and Social Service Assistant (SSA) #206, verified Resident #04 did not have a significant change PASARR or notification to the state mental health authority of Resident #04's admission to hospice services on 02/17/24. It was also verified the PASARR did not include Resident #04's diagnoses of unspecified psychosis not due to a substance or known physiological condition, major depressive disorder, schizoaffective disorder, anxiety disorder, depression, and insomnia. 2. Review of Resident #79's PASARR dated 07/20/23 revealed Resident #79 had schizoaffective disorder but did not have any indications of serious mental illness. Review of the Resident #79's medical record revealed a admitted [DATE]. Diagnoses included schizophrenia, paranoid schizophrenia, shortness of breath and emphysema. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #79's discharge MDS assessment, dated 06/20/24, revealed the resident was cognitively intact. Review of Resident #79's progress note dated 06/21/24 revealed Resident #79 was transferred to the psychiatric hospital on 06/21/24 for behaviors and refusing medications. Review of Resident #79's progress note dated 07/05/24 revealed Resident #79 returned from the psychiatric hospital on 07/05/24. Review of Resident #79's medical record revealed Resident #79 did not have a significant change PASARR or notification to the state mental health authority of Resident #79's admission to psychiatric hospital on 06/21/24 until 08/21/24. During an interview on 08/22/24 at 1:27 P.M., with the Administrator, SSD #36 and SSA #206, verified Resident #79 did not have a significant change PASARR or notification to the state mental health authority of Resident #79's admission to psychiatric hospital on 06/21/24.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on observation, record review, interview, and policy review, the facility failed to develop comprehensive care plans for residents. This affected three (Residents #04, #62, #77) of twelve residents reviewed for care plans. The facility census was 105. Findings include: 1. Review of the medical record for Resident #62 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, type 2 diabetes mellitus with other specified complication, and bipolar disorder. Review of the care plan dated 03/10/24 revealed resident is at risk for altered nutritional / hydration status related to history of mouth sores with interventions of refer to ancillary services i.e. dental, vision etc. as needed. Further review of the care plan revealed no documentation related to resident has multiple dental cavities. During an interview on 08/19/24 at 2:20 P.M., Resident #62 stated he was to be referred to an oral surgeon quite a while agodue to cavities to left posterior teeth. The resident complaint of tooth pain. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #62 was cognitively intact. The resident required set-up assistance with eating, oral eating, and wheelchair mobility. The resident had no broken or loosely fitting full or partial denture and no chipped, cracked, uncleanable, or loose teeth present. No mouth or facial pain, discomfort or difficulty with chewing present. During an observation on 08/21/24 at 1:53 P.M., Resident #62 had multiple cavities in the left upper back teeth. Two teeth were broken. During an interview on 08/21/24 at 2:10 P.M., Licensed Practical Nurse (LPN) #50 confirmed the resident has multiple cavities and broken teeth. During an interview on 08/21/24 at 2:20 P.M., Registered Nurse (RN) Minimum Data Set (MDS) Coordinator #166 confirmed the resident's care plan was not updated to include dental concerns. 39967 2. Record review revealed Resident #04 was admitted to the facility on [DATE]. Diagnoses included unspecified psychosis not due to a substance or known physiological condition, dementia in other diseases classified elsewhere severe with other behavioral disturbance, major depressive disorder, other seizures, adult failure to thrive, anorexia, cerebral palsy, schizoaffective disorder, depression, insomnia, age related osteoporosis without current pathological fracture and cerebral infarction. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #04's quarterly MDS assessment, dated 08/17/24, revealed the resident had severely cognitive impairment. Resident #04 was dependent for all activities of daily living and had limited mobility on both upper and lower extremities. Review of Resident #04's skin integrity care plan revised 08/21/24 revealed Resident #04 had contractures to the bilateral hands and knees. There were no interventions addressing the contractures to the resident's hands until 08/21/24, when an intervention was added to have wash cloths placed in the hands and to clean the hands between cloth replacements. During an observation on 08/20/24 at 9:16 A.M., Resident #04 had a contracture to her left hand with no device in place. During an observation of Resident #04 on 08/21/24 at 4:15 P.M., Resident #04 did not have any towels rolled up in her hands. During an interview on 08/21/24 at 4:15 P.M., LPN #18 verified Resident #04 did not have towels rolled up in hands, but LPN #18 stated the towels were in her hands earlier. LPN #18 stated Resident #04 did not tolerate and kept pulling them out. LPN #18 reported that the towels were implemented as an intervention on 08/21/24 but Resident #04 did not have that intervention prior to 08/21/24. LPN #18 stated she was told that morning to place towels in her hands related to contractures. During an interview on 08/22/24 at 1:27 P.M., the Administrator verified Resident #04's care plan did not have any interventions such as towels to Resident #04's hands prior to 08/21/24 and the Administrator was not aware of why the intervention was added to the care plan. 44412 3. Record review revealed Resident #77 was admitted on [DATE]. Diagnoses included dementia, major depressive disorder, and type two diabetes mellitus. Review of the admission MDS, dated [DATE], revealed Resident #77 had moderate cognitive impairment. The resident required setup with eating, toileting, dressing, supervision with bathing, and independent with transfers. Review of the Admission MDS care assessment summary dated 03/26/24 revealed Resident #77 triggered a care plan for psychotropic drug use. Review of the medical record revealed Resident #77 did not have a psychotropic care plan initiated until 08/05/24. During an interview on 08/28/24 at 4:13 P.M., Regional Clinical Nurse (RCN) #222 verified Resident #77's psychotropic drug use care plan was not timely completed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Care Plans, Comprehensive Person-Centered, dated September 2021 revealed a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs was developed and implemented for each resident. The comprehensive, person-centered care plan will include identified problem areas, measurable objectives and timeframes, and desired outcomes. Assessments of residents are ongoing, and care plans are revised as information about the resident and residents' conditions change. This deficiency represents non-compliance investigated under Complaint Number OH00156885.

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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** 44412 Based on record review, interview, and policy review, the facility failed to revise the plans of care timely and failed to conduct care conferences as required. This affected three (Residents #46, #77, and #92) of three residents reviewed for care planning. The facility census was 105. Findings include: 1a. Review of the medical record for Resident #46 revealed an admitted [DATE]. Diagnoses included Parkinson's disease, type two diabetes mellitus (DM II), epilepsy, and paraplegia. Review of the five-day Medicare Minimum Data Set (MDS) assessment, dated 08/02/24, revealed Resident #46 was not able to complete a Brief Interview for Mental Status (BIMS) because he was rarely/never understood. The resident required supervision with eating, dependent with toileting, bathing, dressing, and transfers. Resident #46 had an indwelling catheter and was always incontinent of bowel. Review of the care plan dated 08/25/23 revealed Resident #46 had a need for suprapubic catheter related to neurogenic bladder. Interventions included enhanced barrier precautions for indwelling catheter. Staff monitor for signs and symptoms of urinary tract infections including blood in urine, cloudiness, foul smell, fever, and change in mental status. Staff to document output every shift and as needed. Review of the progress note dated 04/11/24 at 8:43 A.M. revealed labs were sent to physician with a new order to start Macrobid 100 milligrams (mg), twice a day for seven days related to urinary tract infection (UTI). Review of the progress note dated 07/27/24 at 4:14 P.M. revealed new orders for Ciprofloxacin 250 mg, twice a day for seven days related to UTI. Review of the care plan dated 08/25/23 revealed Resident #46 had no revisions related to urinary tract infections. During an interview on 08/28/24 at 4:47 P.M., MDS Coordinator #166 verified Resident #46's care plan had not been updated after his urinary tract infections. MDS Coordinator #166 reported all care plans should be updated after a resident had an infection. 1b. Review of the medical record for revealed Resident #46 only had two care conferences in the last 12 months. Review of the progress notes revealed a care conference was held on 04/18/24 and 08/21/24. There were no other care conferences documented. During an interview on 08/27/24 at 1:16 P.M., Social Services Designee (SSD) #206 verified Resident #46 had a care conference on 07/19/23, 04/18/24, and 08/21/24. SSD #206 verified care conferences should be every three months. (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 September 2021 revealed a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs was developed and implemented for each resident. The comprehensive, person-centered care plan will include identified problem areas, measurable objectives and timeframes, and desired outcomes. Assessments of residents were ongoing and care plans were revised as information about the residents and the residents' conditions change. 2. Review of the medical record for Resident #77 revealed an admitted [DATE]. Diagnoses included dementia, major depressive disorder, and type two diabetes mellitus. Review of the admission MDS assessment, dated 03/26/24, revealed Resident #77 had moderate cognitive impairment. Review of the medical record revealed Resident #77 eloped on 05/24/24. The elopement care plan was not initiated until 06/11/24. During an interview on 08/28/24 at 4:13 P.M., Regional Clinical Nurse (RCN) #222 verified Resident #77's elopement care plan was not completed timely. 44069 3. Review of the medical record for Resident #92 revealed an admitted [DATE]. Diagnoses included schizophrenic disorder, bipolar disorder, borderline personality disorder, other psychoactive substance abuse, nicotine dependence, cannabis use, other amnesia, bradycardia, suicidal ideations, post-traumatic stress disorder, catatonic disorder due to known physiological condition, major depressive disorder, and chronic motor or vocal tic disorder. Review of the admission assessment dated [DATE] revealed Resident #92 was at risk for elopement. Review of the plan of care initiated on 07/11/24, with no revisions since admission, revealed Resident #92 was at risk for elopement related to exit seeking behavior. Interventions included calmly redirect and divert the resident's attention, distract resident when wandering/insistent on leaving facility by offering pleasant diversions, structured activities, food, conversation, television, books, promptly check when alarm system goes off to ensure resident is safe and remains in facility, refer to psychiatrist/psychologist/behavior specialist as needed, and set up meting with family/guardian to determine if resident may need a more appropriate facility if elopement attempts continue. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #92 was cognitively intact. Resident #92 was assessed to require set-up assistance for eating, oral hygiene, upper body dressing, personal hygiene, bed mobility, and supervision for toileting, lower body dressing, and transfer. Review of the progress note dated 08/11/24 revealed the nurse observed Resident #92 run out a back door before being escorted back to the secured unit by staff. Review of the progress note dated 08/12/24 revealed Resident #92 pushed on the door until the alarm sounded and was brought back into the facility by staff. (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 progress note dated 08/21/24 revealed Resident #92 was pacing the hallway and pushing on the door to set off the alarm. The note indicated Resident #92 went out the door and was found by staff sitting on the side of the building before being escorted back into the facility. During an interview on 08/29/24 at 12:05 P.M., RCN #222 verified no new interventions were implemented after the elopement attempts.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on record review, observation, interview and policy review, the facility failed to ensure residents dependent on staff for activities of daily living (ADL) received care and services in a timely manner. This affected four (Residents #4, #6, #41 and #50) of four residents reviewed for care and services. The facility census was 105. Findings include: 1. Record review revealed Resident #41 was admitted on [DATE]. Diagnoses included traumatic hemorrhage of cerebrum, hemiplegia on right and left side, epilepsy, respiratory failure, coma, persistent vegetative state, acute cystitis without hematuria, hypertension, anxiety disorder, tracheostomy status and gastrostomy status. Review of the annual Minimum Data Set (MDS) assessment for Resident #41 revealed resident was in a persistent coma state and was dependent for all care. The resident had a gastrostomy tube and received 51 percent of calories through parenteral feedings, had a tracheostomy in place and received oxygen via compressor at 20 pounds per square inch (PSI) and was incontinent of bowel and bladder. Review of the plan of care for Resident #41 dated 03/19/22 revealed resident had an ADL self-care performance deficit related to motor vehicle accident (MVA) with brain injury resulting in comatose state. Interventions include assisting with activities of daily living requiring two staff members for the completion of bed mobility, transfers with a mechanical lift, and toileting. Rview of the physician orders for Resident #41 revealed an order for nothing by mouth, head support cushion under head as tolerated, Hoyer lift for all transfers, incontinence care every two hours and as needed, with house barrier cream after each incontinent episode and keep head of bed elevated as tolerated. During an observation on 08/22/24 at 9:50 A.M., Resident #41 was lying in bed on her back with the head of the bed elevated to approximately 30 degrees. On 08/22/24 at 11:30 A.M. State tested Nurse Aide (STNA) #12 entered the room and shut the door and came out of the room at 11:51 A.M. During an interview on 08/22/24 at 11:53 A.M., STNA #12 stated she provided incontinent care to Resident #41 and repositiooned her. STNA #12 stated she had not had the time to provide care for Resident #41 since she arrived at the facility and clocked in at 7:00 A.M. STNA #12 stated she has 20 residents on her assignment at that time. STNA #12 received report and then started passing breakfast trays. STNA #12 stated she has had three total bed changes due to incontinence and changed eight resident incontinent garments before providing care for Resident #41. STNA #12 stated sometimes the nurses were able to help but the other STNA's were in the same situation that she was in and were not able to help at times either. During an interview on 08/28/24 at 10:40 A.M., the Director of Nursing (DON) stated staff should be checking and changing incontinent residents every two hours. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44412 2. Review of the medical record for Resident #4 revealed an admitted [DATE]. Diagnoses included psychosis, dementia, major depressive disorder, and schizoaffective disorder. Review of the care plan, dated 08/31/22, revealed Resident #4 had an activity of daily living (ADL) self-care performance deficit related to dementia, cerebral palsy, and seizures. Interventions included assist with bed mobility for two-person assist, place call light within reach, transfers with two-person assist, and assist with dressing, grooming, personal hygiene, and oral care as needed. Review of the task log for transfers dated June 2024 revealed Resident #4 was transferred out of bed one time. Review of the task log for transfers dated July 2024 revealed Resident #4 was transferred out of bed two times. Review of the task log for transfers dated August 2024 revealed Resident #4 was not transferred out of bed. Review of the quarterly MDS assessment dated [DATE] revealed Resident #4 was not able to complete a brief interview for mental status because she was rarely or never understood. Resident #4 was dependent with eating, toileting, bathing, dressing, and transfers. During an observation on 08/22/24 at 12:05 P.M., Resident #4 was asleep in bed with her eyes closed. Her lunch tray was on her bedside table. During an interview on 08/22/24 at 12:24 P.M., STNA #46 stated there were five residents on the memory care unit that needed fed their meal, including Resident #4. There is typically one STNA assigned for 18 residents. During an observation on 08/22/24 at 12:54 P.M., STNA #172 entered Resident #4's room to feed her. During an interview on 08/22/24 at 12:55 P.M., STNA #172 stated meal trays arrived at noon to the memory care unit, but she had other residents to feed and supervise in the dining room. She then had three other residents to feed after residents in the dining room were fed and cleaned up. STNA #172 also reported Resident #4 required a Hoyer lift to get out of bed, but due to staffing, she had not gotten out of bed in months. 3. Record review revealed Resident #6 was admitted on [DATE]. Diagnoses included neurocognitive disorder with Lewy bodies, dementia, anxiety disorder, and panic disorder. Review of the care plan dated 04/28/22 revealed Resident #6 had an ADL self-care performance deficit related to dementia. Interventions included to assist with ADLs, two-person assist for bed mobility, toileting, and transfers, call light within reach, and report any changes in ADL ability to nurse, physician, and/or therapy. Review of the annual MDS assessment, dated 06/21/24, revealed Resident #6 was not able to complete a brief interview for mental status because she was rarely or never understood. Resident #6 was dependent with eating, toileting, bathing, dressing, and transfers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the task log for transfers dated June 2024 revealed Resident #6 was transferred out of bed one time. Review of the task log for transfers dated July 2024 revealed Resident #6 was transferred out of bed three times. Review of the task log for transfers dated August 2024 revealed Resident #6 was not transferred out of bed. During an observation on 08/22/24 at 12:05 P.M., Resident #6 was lying in bed with oxygen on and eyes closed. Resident #6's lunch tray was sitting on the bedside table. During an interview on 08/22/24 at 12:10 P.M., Licensed Practical Nurse (LPN) #162 stated Resident #6 needed fed meals. During an interview on 08/22/24 at 12:24 P.M., STNA #46 stated there were five residents that needed fed on the memory care unit and typically one STNA was assigned to 18 residents. During an observation on 08/22/24 at 12:44 P.M., STNA #46 was feeding Resident #6 in bed in her room. During an interview on 08/22/24 at 12:45 P.M., STNA #46 stated due to staffing, she was not able to feed Resident #6 until residents in the dining room were fed first. STNA #6 stated Resident #6's tray was in her room for 39 minutes before she was able to feed her. During an interview on 08/22/24 at 12:49 P.M. STNA #172 stated Resident #6 required a Hoyer lift for transfers, and it took two staff members to transfer her out of bed. STNA #172 stated Resident #6 had gotten out of bed approximately three times in the last three months due to staffing. 48570 4. Medical record review for Resident #50 revealed an admitted [DATE] with diagnoses including but not limited to vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of the comprehensive MDS assessment dated [DATE] for Resident #50 revealed staff assessment for memory indicated severe cognitive impairment. Resident #50 was not coded with any behaviors during the assessment period. Resident #50 requires set up for eating. Resident #50 was coded as dependent on staff for toileting, bed mobility and transfers. Resident #50 is incontinent for both bladder and bowel. Review of the plan of care for Resident #50 dated 03/18/22 and revised on 06/29/22 revealed resident has an ADL self-care performance deficit related to schizoaffective disorder and hemiparesis. Interventions include assist with ADL as needed, eating requires one staff member assistance, transfers with Hoyer lift with two staff members, toileting and bed mobility requires two staff members. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 08/26/24 at 9:48 A.M., Resident #50 was in bed with dried food on his upper chest area. Resident #50 had a soaked incontinent brief, and the bed linen had a yellow wet circular area around the resident. During an observation on 08/26/24 at 9:48 A.M., there were two STNAs present working the floor at the current time. STNA #148 was covering all of 200 and 300 halls except the memory care unit and one covering the mental health unit. There were 40 residents on 200 hall, 10 residents on the 300 hall, and 25 residents on the mental health unit. During an interview on 08/26/24 at 9:55 A.M., STNA #148 stated she had not been in Resident #50 ' s room since 7:00 A.M., the start of the shift due to not enough staff this morning. There were only two STNA in the whole building at that time and since the start of the shift, one STNA covering mental health and one covering the rest of the building. STNA #148 confirmed Resident #50 had old, dried food on his chest, not the same food as breakfast that was served. She also confirmed Resident #50 was wet with urine and the bed linens were wet with a yellow ring surrounding the resident. This deficiency represents non-compliance investigated under Complaint Number OH00155787.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on record review, interview and policy review, the facility failed to ensure a resident had an order for a dressing change and failed to change the dressing as ordered; failed to ensure transportation was provided to appointments; and failed to timely address a change in condition. This affected three (Residents #86, #87 and #303) residents. Seven residents were reviewed for wound care, and two residents were reviewed for transportation and changes in condition. The facility census was 105. Findings include: 1a. Record review revealed Resident #86 was admitted on [DATE] with diagnoses including fracture of tibia or fibula following insertion of orthopedic implant, joint prosthesis, or bone plate, right leg and paraplegia. Review of the Discharge Return Anticipated Minimum Data Set (MDS) assessment, dated, 05/24/24 revealed Resident #86 was cognitively intact. Resident #86 had an order for a follow up appointment on 08/15/24 at 9:30 A.M. at [NAME] Health [NAME] Wound Care. Review of the nursing note dated 08/19/24 at 12:32 P.M. revealed the nurse rescheduled the appointment for 08/29/24 at 1:30 PM because the facility had no transportation. During an interview on 08/28/24 at 12:43 P.M., Licensed Practical Nurse (LPN) #50 stated Resident #86 missed a follow up appointment on 08/15/24 due to facility van being broke down. The appointment scheduled for 08/28/24 to the wound center was also rescheduled due to the van being broken down. 1b. Review of the medical record for Resident #87 revealed an admitted [DATE] with diagnoses including adjustment disorder with mixed anxiety and depressed mood, acute traverse myelitis in demyelinating disease of central nervous system, major depressive disorder, suicidal ideations, and alcohol dependence. Review of the Discharge Return Anticipated MDS assessment, dated 07/06/24, revealed the resident was cognitively intact. Review of the physcian orders revealed Resident #87 had an appointments scheduled on 07/30/24 at 2:20 P. M. and 08/17/24 at 1:00 P.M. with a neurologist with the facility to transport. Review of progress notes revealed on 08/05/24 at 1:48 P.M. a message left at the neurologist's office to reschedule the appointment that was missed today due to transport. During an interview on 08/28/24 at 2:10 P.M., Regional Maintenance Director #226 stated the facility van was still out of service and can be fixed, but they borrowed one and it arrived yesterday. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/28/24 at 2:16 P.M., State tested Nurse Aide (STNA) #56 stated the ramp in the transportation van quit working the last week of July and appointments had to be canceled and rescheduled until yesterday, when the facility borrowed a van from another facility. During an interview on 08/28/24 at 10:03 A.M., Regional Clinical Nurse #222 stated the facility does not have a policy on transportation for appointments. 2. Record review revealed Resident #303 was admitted on [DATE] with diagnoses including displaced bicondylar fracture of left tibia, subsequent encounter for closed fracture with routine healing and intervertebral disc disorders with radiculopathy, lumbosacral region. Review of the discharge instructions from the hospital, dated 08/14/24, stated OK for dressing change post operative day #3 with daily dressing change with xeroform, 4 x 4 [gauze pad], and Kerlix. Review of the Admission Evaluation dated 08/14/24 revealed Resident #303 was alert to person, place and time. The resident had no current skin impairments and had a low risk for pressure. Review of the care plan dated 08/15/24 revealed the resident had an Activities of Daily Living (ADL) self-care performance deficit related to displaced bicondylar fracture of left tibia, subsequent encounter for closed fracture with routine healing, unspecified osteoarthritis, and chronic pain syndrome. Review of the Establishment and Stabilization note by Certified Nurse Practitioner (CNP) #218 dated 08/15/24 revealed the visible areas of skin were warm, dry, no rashes. Unable to assess left lower extremity wound, immobilizer in place. During an observation on 08/19/24 at 10:56 A.M., Resident #303 had a dressing to the left lower leg dated 08/12/24. During an interview at the time of the observation, Resident #303 stated her left leg has been a concern since admission. She stated the dressing should be changed daily and hasn't been changed. Resident #303 stated she was admitted on [DATE] and the dressing had not been changed since admission. During an interview on 08/19/24 at 11:06 A.M. CNP #218 stated Resident #303 was seen on admission and the wound was reviewed. CNP #218 stated there were no new orders issued and Resident #303 had not been seen again since admission. During an interview on 08/19/24 at 11:08 A.M., LPN #38 confirmed the dressing on Resident #303's left lower leg was dated as 08/12/24. LPN #38 removed the dressing. The wound was clean, the edges were well approximated and ten stitches were intact. LPN #38 confirmed the Admission Assessment that was completed on 08/14/24 stated Resident #303 had no skin impairments. LPN #38 also confirmed the discharge instructions from the hospital had an order for a dressing change. LPN #38 stated the order was not transcribed on admission and has not been implemented. Review of the policy titled Admission Assessment, dated September 2022, revealed to conduct a physical assessment, of the skin and to conduct supplemental assessments (following facility forms and protocol) including a skin assessment. 44069 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the plan of care for Resident #87 initiated on 05/13/24 and revised on 05/29/24 revealed Resident #87 had impaired psychiatric/mood status related to adjustment disorder with mixed anxiety and depressed mood, major depressive disorder, and suicidal ideations. Interventions included administer medications as ordered, behavioral health consults as needed, monitor for and report to physician any signs/symptoms of acute psychosis or changes from resident's baseline, monitor for signs of mood changes or distress, offer encouragement/assistance/support to maintain as much independence and control as possible, offer resident choices whenever possible to promote a feeling of self-worth and control over the environment, provide a calm, safe environment when resident is frustrated, and refer to social worker as needed if resident communicates need to speak with someone. Review of an electronic mail (email) communication from the counselor to the Director of Social Services (DSS) #36 dated 07/16/24 revealed Resident #87 had a self-harm thought the previous week. Review of the psychiatric progress note dated 08/16/24 revealed the counselor informed the psychiatric nurse practitioner via email that Resident #87 had recent self-harm thoughts. The note also indicated under medical history that Resident #87 had a previous failed suicide attempt. Further review of the medical record revealed no follow-up by facility staff regarding recent self-harm thoughts. During an interview on 08/29/24 at 12:45 P.M., Director of Social Services (DSS) #36 revealed Resident #87 never mentioned self-harm thoughts directly to him. DSS #36 confirmed he had not implemented any new interventions to address Resident #87's recent expressions of self-harm thoughts. This deficiency represents non-compliance investigated under Master Complaint Number OH00157310, and Complaint Numbers OH00156885, and OH00155787.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069 Based on record review, observation, interview, review of the National Pressure Ulcer Advisory Panel (NPUAP) information, and policy review, the facility failed to provide adequate care and services to prevent and timely identify pressure ulcers and injuries for Residents #37, #86, and #4. This resulted in Immediate Jeopardy and serious life-threatening harm, injuries, and/or negative health outcomes, when Resident #37 developed six facility acquired deep tissue pressure injuries and was hospitalized for osteomyelitis. Additionally, Resident #86 developed facility acquired unstageable (the base of the wound is covered by dead tissue) pressure ulcers to the coccyx, left heel, and left lateral ankle, and was hospitalized for osteomyelitis. Furthermore, Resident #4 developed facility acquired moisture associated skin damage (MASD), which healed, and was then found to have an unstageable pressure ulcer to the coccyx. This affected three (#86, #37, and #4) of six residents reviewed for pressure ulcers. The facility census was 105. On 08/27/24 at 2:55 P.M., Regional Director of Operations (RDO) #224, Regional Clinical Nurse (RCN) #222, and the Administrator were notified Immediate Jeopardy began on 04/05/24 when Resident #37 was identified with six facility acquired deep tissue pressure injuries and was subsequently hospitalized for osteomyelitis. In addition, Resident #86 was then identified to have unstageable pressure ulcers to the coccyx, left heel, and left lateral ankle, which required hospitalization that included surgical debridement and intravenous (IV) antibiotics due to osteomyelitis, and Resident #4 developed an unstageable pressure ulcer to the coccyx that was facility acquired. The Immediate Jeopardy was removed on 08/28/24, when the facility implemented the following corrective actions: On 08/27/24, Wound Nurse Practitioner (WNP) #228 assessed Resident #86 ' s wounds and ordered new treatments as indicated. On 08/27/24, the Director of Nursing (DON) reviewed Resident #86 ' s record and Resident #86 had the following interventions in place: Foley Catheter. Air mattress. Apply protective barrier cream after incontinent episodes and as needed. Assist with turning and repositioning as needed. Encourage Resident #86 to reposition self if able. Encourage/assist as needed to elevate heels off the mattress as tolerated. Pressure redistribution device in chair. Pressure reducing boots to bilateral feet as tolerated. May remove for care. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #86 uses half side rail for repositioning and bed mobility. By 08/28/24, the DON or designee implemented the following interventions for Resident #86: Limit time in chair to three hours, then back to bed for two hours before getting up again. ROHO (specialized seating cushion for pressure relief) cushion to wheelchair. Side to side turns only every two to three hours, which will be signed off in the treatment administration record when completed. On 08/27/24, WNP #228 assessed Resident #4 ' s wounds with no new orders given. On 08/27/24, the DON reviewed Resident #4 ' s record and Resident #4 had the following interventions in place: Assist with turning and repositioning as needed. Pressure reduction mattress. Provide incontinence care as needed. Place washcloths in bilateral hands, clean hands between washcloth replacements. Assist with toileting needs. Provide perineal care after each incontinent episode; apply house barrier cream. Pressure relieving boots to be worn for prevention as tolerated. By 08/27/24, the DON or designee implemented the following interventions for Resident #4: Air mattress. ROHO cushion to wheelchair. Turn and reposition side to side every two to three hours, which will be signed off in the treatment administration record when completed. Pressure relieving boots to both heels. On 08/27/24, WNP #228 assessed Resident #37 ' s wounds and ordered new treatments as indicated. On 08/27/24, the DON reviewed Resident #37 ' s record and Resident #37 had the following interventions in place: Apply protective barrier cream after incontinent episodes and as needed. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Assist with turning and repositioning every two hours and as needed. Encourage/assist as needed to elevate heels off the mattress as tolerated. Provide a non-irritating surface to reduce friction or shearing forces. Provide incontinence care every two hours and as needed. Air mattress. Encourage Resident #37 to reposition self if able. Resident #37 uses half side rail for repositioning and bed mobility. Wheelchair with standard cushion with Dycem under cushion when out of bed for comfort and positioning. By 08/28/24, the DON or designee implemented the following interventions for Resident #37: No shoes until healed. Pressure reducing boots to bilateral feet. By 08/28/24, residents with turn and reposition interventions had a physician order, and it would be signed off in the treatment administration record when completed. By 08/28/24, the DON or designee completed a skin assessment on all residents to ensure all pressure areas had been identified and treatment initiated. By 08/28/24, the DON or designee audited all residents with orders for splints to ensure the skin around it is checked on the daily basis for signs of pressure. By 08/28/24, the DON or designee audited all residents to ensure each resident had a shower sheet completed in the last seven days. By 08/28/24, the DON or designee audited all residents to ensure all residents had an updated quarterly Braden Assessment (an assessment used to evaluate a resident ' s risk of developing pressure ulcers). By 08/28/24, the DON or designee audited all residents with moderate, high risk, and very high-risk Braden scores to ensure appropriate interventions are in place to prevent new pressure ulcers or worsening of present pressure ulcers. On 08/27/24, [NAME] President of Clinical (VPC) #230 developed a Skin/Wound Clinical Program Best Practice that included the following: A shower sheet addressing the resident ' s skin condition must be completed with each shower to timely identify new areas. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A skin assessment must be accurately completed by the floor nurse weekly, to timely identify new areas. Any time a resident is at risk for skin breakdown, appropriate interventions must be implemented immediately to prevent new development or worsening of pressure ulcers. Any time there is a new pressure area identified; a wound care treatment must be immediately initiated. By 08/28/24, the nursing staff were educated by the DON or designee on the facility Skin/Wound Clinical Program Best Practice. By 08/28/24, an ad hoc Quality Assurance (QA) Committee Meeting was held to review the plan. Weekly for four weeks, the DON or designee will review four residents to ensure shower sheets were completed with each shower. Weekly for four weeks, the DON or designee will review four skin assessments to ensure that the assessments were completed accurately. Weekly for four weeks, the DON or designee will review four residents at risk for skin breakdown to ensure appropriate interventions were implemented. Weekly for four weeks, the DON or designee will review all new pressure ulcers to ensure a treatment was initiated immediately. Weekly for four weeks, the DON or designee will review the residents with splints to ensure that the skin around it is checked daily for signs of pressure. The audits will be submitted weekly to the QA Committee for tracking, trending, and recommendations. Although the Immediate Jeopardy was removed on 08/28/24, the facility remains out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: 1. Review of the medical record for Resident #86 revealed an admitted [DATE] with diagnoses of fracture of tibia or fibula following insertion of orthopedic implant, joint prosthesis, or bone plate, right leg and paraplegia. Review of the 5-Day Minimum Data Set (MDS) assessment, dated 03/21/24, revealed Resident #86 was cognitively intact, required set-up assistance with eating, required substantial assistance with oral hygiene, toileting hygiene, bed mobility, transfers, and wheelchair mobility up to 50 feet. Resident was dependent on staff assistance with bathing, dressing, and wheelchair mobility greater than 150 feet. Resident had no pressure ulcers and was at risk for developing pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Care Plan dated 03/16/24 revealed resident has impaired skin integrity with interventions for assist resident with turning and repositioning as needed, complete Braden Scale as needed, complete skin inspection every 7-10 days and as needed, complete wound evaluation to monitor the progress of the resident's skin condition, and consult dietitian as needed. Resident has an Activities of Daily Living (ADL) self-care deficit with an intervention of assistance of one person with bed mobility. Review of the discontinued physician orders revealed an order dated 03/19/24 for multi-podus boots on as tolerated. There was no physician order to remove the multi-podus boots and inspect the skin. Review of the task documentation completed by the state tested nurse aides (STNA) for Resident #86 from 04/01/24 to 04/30/24 revealed no new skin issues were observed from 04/16/24 to 04/19/24. The documentation lacked any information related to turning and repositioning of Resident #86. Review of the facility documentation revealed no shower sheets for Resident #86 from 04/15/24 to 05/01/24. Review of the facility assessment for Resident #86 titled Skin Inspection, dated 04/18/24, revealed no new skin issues were observed. Review of the Care Plan dated 04/18/24 revealed a new intervention for impaired skin integrity of pressure redistribution device in chair. Review of the Wound Evaluation Assessment completed on 04/19/24 revealed a pressure wound to Resident #86 ' s buttocks as in-house acquired measuring 4.7 centimeters (cm) by 4.3 cm. The depth was unable to be determined. Review of the Wound Evaluation Assessment completed on 04/25/24 revealed a pressure wound to Resident #86 ' s left heel as in-house acquired measuring 5 cm by 2 cm. The depth was unable to be determined. Review of an incident report dated 04/25/24 revealed the nurse discovered Resident #86 had a pressure area to the left heel when his boot was removed. The incident report indicated the root cause was related to immobility and bilateral boots to feet. Review of the Care Plan dated 04/25/24 revealed a new intervention for impaired skin integrity of encourage/assist as needed to elevate heels off the mattress as tolerated. Review of the Care Plan dated 04/25/24 revealed a new intervention for impaired skin integrity of encourage resident to reposition self if able. Review of the Wound Evaluation Assessment completed on 04/30/24 revealed a pressure wound to Resident #86 ' s left lateral ankle as in-house acquired measuring 1.6 cm by 1 cm. The depth was unable to be determined. Review of the April 2024 Treatment Administration Record (TAR) revealed an order dated 04/30/24 for Low Air loss Mattress for Wound Management when authorization approved. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Care Plan dated 05/01/24 revealed a new intervention for impaired skin integrity of pressure reducing boots to bilateral feet as tolerated, may remove for care and an air mattress. Review of the Discharge Return Anticipated MDS assessment, dated 05/24/24, revealed Resident #86 was cognitively intact, required set-up assistance with eating, required substantial assistance with oral hygiene, toileting hygiene, bathing, bed mobility, transfers, dressing, and wheelchair mobility. Resident #86 was at risk for developing pressure areas and had five unstageable pressure areas. Review of the hospital referral for Resident #86, dated 05/28/24, revealed on 05/24/24, Resident #86 was admitted to the hospital for a wound check after the resident was noted with chills, sweats, nausea, and increased fatigue during wound care rounds at the facility. A decline of wounds was also noted. WNP #228 ordered the resident to be sent to the hospital. Resident #86 was seen by an emergency room physician and admitted to the hospital with diagnoses including sepsis, with sacrum wound being source of sepsis, requiring surgical debridement, and IV antibiotic treatment for osteomyelitis to the sacral wound. Review of the hospital paperwork dated 06/19/24 revealed Resident #86 was transferred from the hospital to a long-term acute care hospital on 06/06/24 for further care related to acute sacral osteomyelitis, left ankle osteomyelitis, and a stage four sacral decubitus ulcer. Resident #86 had an excisional debridement of sacrum with bone biopsy on 05/25/24 at the previous hospital, which was positive for multi drug-resistant Acinetobacter baumannii, Klebsiella pneumonia, E coli, and Proteus mirabilis. Resident #86 received IV antibiotics and treatment with a wound vacuum (uses suction to help heal wounds) while admitted to the long-term acute care hospital before being admitted to the facility again on 07/03/24. Review of physician orders revealed Resident #86 had a physician order dated 07/16/24 for wound care to the left heel, cleanse with Vashe wound cleanser and pat dry, apply Gentell Blue Foam (a dressing for full thickness wounds) to the wound bed and cover with bordered gauze dressing. Change three times weekly and as needed. During an observation on 08/19/24 at 4:00 P.M., Resident #86 was lying on his back in bed. During an observation on 08/20/24 at 2:30 P.M., Resident #86 was lying on his back in bed. Review of physician orders revealed an order dated 08/22/24 for wound care to the right lateral calf to cleanse with Vashe wound cleanser and pat dry, apply Xeroform (a non-adherent gauze occlusive dressing) to the wound bed and cover with bordered gauze dressing. Change three times weekly and as needed. Review of physician orders revealed an order dated 08/22/24 for wound care to the distal right lateral lower leg to cleanse with Vashe wound cleanser and pat dry, apply Betadine to wound bed and cover with bordered gauze. Change three times weekly and as needed. Review of physician orders revealed an order dated 08/22/24 for wound care to the sacrum to cleanse with Vashe wound cleanser and pat dry, apply skin prep to wound perimeter, lightly pack wound with Vashe-moistened gauze and cover with Composite (a multi layered dressing product) dressing. Change daily and as needed. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of physician orders revealed an order dated 08/22/24 for wound care to the right lateral ankle, cleanse with Vashe wound cleanser and pat dry. Apply Xeroform to wound bed and cover with bordered gauze dressing. Change three times weekly and as needed. Review of physician orders revealed an order dated 08/22/24 for wound care to the left lateral ankle, cleanse with Vashe wound cleanser and pat dry. Apply Silver Alginate to wound bed. Cover with bordered foam dressing. Change three times weekly and as needed. Review of physician orders revealed an order dated 08/23/24 for wound care to right shin, cleanse with Vashe wound cleanser, pat dry, apply Xeroform to surgical incision. Cover with ABD pad and wrap with Kerlix. Change daily and as needed. During an observation on 08/22/24 at 11:07 A.M., Resident #86 had seven wounds, with three wounds currently classified as pressure ulcers. Bilateral heel lift boots were in place along with a low air loss mattress. Resident #86 had an indwelling urinary catheter in place. Licensed Practical Nurse (LPN) #50 completed wound care at this time. The left lateral ankle had an open wound with scant amount of serous drainage present, wound color pale pink in color, stage 3, cleansed with Vashe, patted dry, silver alginate and bordered foam. The left heel was an open wound with small amount of bloody drainage present, wound color pink in color, stage 4, cleansed with Vashe, patted dry, Gentell Blue and bordered foam. The sacrum was a large open wound with edges rolled under with bone exposed to the lower part of wound, moderate amount of serosanguinous drainage present, stage 4. Wound cleansed with Vashe, patted dry, skin prep applied around peri wound, wound lightly packed with Vashe soaked gauze, covered with composite dressing. During an interview on 08/26/24 at 11:10 A.M., STNA #12 stated it required two staff to turn and reposition Resident #86. There were not always two staff available, and Resident #86 was not being turned as he should be. During an observation on 08/26/24 at 11:15 A.M. of Resident #86 revealed he was lying on his back and sleeping. During an interview on 08/26/24 at 12:57 P.M., RCN #222 confirmed there were no shower sheets for Resident #86 from 04/15/24 to 05/01/24. During an interview on 08/26/24 at 1:01 P.M., Certified Nurse Practitioner (CNP) #218 stated staffing is an issue in the facility, and it is possible that the wounds occurred and worsened due to the facility staffing levels, the facility has always had a staffing concern which affects the care. Just like today, there is staffing concerns. During an interview on 08/26/24 at 1:20 P.M., RCN #222 verified there was no documentation related to Resident #86 ' s refusals of care. During an interview on 08/26/24 at 1:44 P.M., WNP #228 confirmed Resident #86 had an unstageable wound to his sacrum on 04/30/24, the first time the resident was seen for the sacrum wound. Resident #86 did not have an air mattress prior to the sacrum wound being found. The wound could have been prevented if the facility had put an air mattress on his bed and if the facility had not had the resident sitting up all day in the chair. The facility did not implement the air mattress due to payor type. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 08/26/24 at 4:08 P.M., RCN #222 confirmed there was no documentation related to turning and repositioning of Resident #86. During an observation on 08/26/24 at 4:36 P.M., Resident #86 revealed he was lying on his back in the same position. During an interview at that time, Resident #86 stated staff had not been in to reposition him, and he would like to get up into his wheelchair. During an interview on 08/26/24 at 6:15 P.M., RCN #222 confirmed there was no documentation that the multi-podus boots were removed to inspect Resident #86 ' s skin. RCN #222 stated the STNA should be assessing the skin when taking the boots on and off, and the nurses should be doing the same when completing their skin assessments. RCN #222 verified the incident report indicated the root cause of the pressure ulcer to the left heel was from the boots. RCN #222 confirmed the skin assessment on 04/18/24 indicated there were no skin issues, and the task documentation by the STNA under the area of skin observation also indicated there were no skin issues for Resident #86. During interview on 08/28/24 at 5:00 P.M., RCN #222 confirmed the facility has a Pressure Ulcers/Skin Breakdown - Clinical Protocol, but not a pressure ulcer prevention policy. 2. Review of the medical record for Resident #37 revealed an admitted [DATE] with diagnoses including peripheral vascular angioplasty status with implants and grafts, Type 2 diabetes mellitus without complications, and contractures of both knees. Review of the Care Plan dated 11/21/21 revealed resident was at risk for impaired skin integrity related to confined to a chair all or most of the time, Decreased sensation: PVD, DM, Neuropathy, Impaired mobility, Incontinence. Picks and scratches at her skin at times. Review of the Braden Scale assessment on admitted d 05/31/21 revealed resident was at risk for pressure wounds. Review of the annual MDS assessment, dated 02/02/24, revealed resident with severe cognitive impairment. Resident #37 was dependent on staff assistance with all ADLs except requires set-up assistance with eating and oral hygiene. No pressure ulcers present and was at risk for developing pressure ulcers. The care plan had interventions to assist resident with turning and repositioning and as needed and complete skin inspection every seven to ten days and as needed dated 04/05/24. The Braden Scale completed on 04/06/24 revealed resident was at high-risk for pressure wounds. There was no documentation of a Braden scale completed from May 2021 to 04/06/24. Review of physician orders revealed Resident #37 had an order dated 04/13/24 for a health shake (a nutritional supplement) with meals for suboptimal intakes, an order dated 05/07/24 for Pro-Stat supplement two times a day for increased protein needs, and an order dated 06/04/24 for Arginaid supplement two times a day for wound healing. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Significant Change MDS assessment, dated 05/06/24, revealed resident with severe cognitive impairment. Resident was dependent on staff assistance with all ADLs except required set-up assistance with eating and required substantial assistance with oral hygiene. Resident had two Stage 3 pressure ulcers present. The care plan had interventions dated 05/08/24 to add an air mattress, consult dietitian as needed, encourage resident to reposition self, and encourage/assist as needed to elevate the heels off mattress as tolerated. Review of physician orders revealed treatment orders dated 06/04/24 for the right lateral ankle, left lateral ankle, right fifth toe, left fifth toe and right heel, cleanse with wound cleanser and pat dry. Paint with Betadine and cover with ABD/Kerlix. Change three times a week and as needed; left fourth toe, cleanse with wound cleanser and pat dry. Apply Adaptic to wound bed followed by Silver Alginate. Cover with ABD/Kerlix. Change three times a week and as needed. Review of physician orders revealed treatment orders dated 08/06/24 for wound care to the left heel, cleanse with wound cleanser and pat dry. Paint with Betadine and cover with ABD/Kerlix, secure with tape. Change three times a week and as needed. Review of physician orders revealed treatment orders dated 08/07/24 for wound care to the left great toe, cleanse with wound cleanser and pat dry. Apply Medi Honey to wound bed followed by Calcium Alginate. Cover with ABD/Kerlix, secure with tape. Change three times a week and as needed. During an observation on 08/22/24 at 11:56 A.M., Resident #37 had eight wounds present. She was laying on a low air loss mattress, on her right side, with one pillow under her right lateral ankle and one pillow between her knees. LPN #50, present during the observation, confirmed a pillow was under right lateral ankle against the air mattress, and it should not be between the wound and the air mattress. LPN #50 completed wound care. One wound to right lateral ankle revealed wound with 100 percent necrotic scab present, cleansed with wound cleanser, patted dry, betadine applied, covered with abdominal pad, and wrapped with Kerlix. One wound to right heel revealed wound with 100 percent necrotic scab present, cleansed with wound cleanser, patted dry, betadine applied, covered with abdominal pad, and wrapped with Kerlix. One wound to right 5th toe revealed wound with 100% granulated pink tissue present, cleansed with wound cleanser, patted dry, betadine applied, covered with abdominal pad, and wrapped with Kerlix. One wound to left great toe area (medial area) revealed open wound with moderate about of serosanguinous drainage with tendon exposed, peri-wound white, cleansed with wound cleanser, patted dry, applied Medi honey to wound bed, applied alginate over wound, covered with abdominal pad, and wrapped with Kerlix. One wound to left later ankle revealed wound with 100% brown necrotic tissue present, no drainage present, cleansed with wound cleanser, betadine applied, covered with abdominal pad, and wrapped with Kerlix. One wound to left heel revealed 100% brown necrotic tissue present, cleansed with wound cleanser, patted dry, betadine applied, covered with abdominal pad, and wrapped with Kerlix. One wound to left 4th toe revealed pink wound bed with granulation tissue present, cleansed with wound cleanser, applied Adaptic then sliver alginate, covered with abdominal pad, and wrapped with Kerlix. One wound to left 5th toe revealed pink wound bed with granulation tissue present, cleansed with wound cleanser, patted dry, betadine applied, apply abdominal pad, and wrapped with Kerlix. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 08/26/24 at 1:01 P.M., CNP #218 confirmed staffing is an issue in the facility, and it is possible that the wounds occurred and worsened due to the facility staffing levels, the facility has always had a staffing concern which affects the care. Just like today, there is staffing concerns. During an interview on 08/26/24 at 1:44 P.M., WNP #228 confirmed all the pressure wounds could have been prevented if the facility had implemented the intervention of an air mattress when the risk was there, instead of delaying the application of the air mattress. Interview also confirmed the facility did not implement the air mattress due to payor type. During an interview on 08/26/24 at 4:10 P.M., RCN #222 confirmed the resident ' s body assessment on 04/04/24 revealed no skin issues. Interview also confirmed on 04/05/24 the resident was found with six new skin concerns to her bilateral feet, with a new intervention to encourage/assist as needed to elevate heels off the mattress as tolerated. Interview also confirmed the care plan did not have any interventions to prevent a pressure ulcer until 05/08/24 when an air mattress was ordered and put on the care plan. Interview also confirmed on the point of care documentation, there was no documentation showing any skin areas present on 04/04/24 or 04/05/24. Interview also confirmed a Braden Scale was completed on 05/31/21 on admission assessment and the next Braden Scale wasn ' t completed until 04/06/24. During an interview on 08/26/24 at 4:21 P.M., LPN #186 confirmed she notified the in-house wound nurse and Wound Nurse Practitioner #228 on 04/05/24 to see the resident for new skin concerns. Interview also confirmed there wasn ' t documentation present in the medical record of Resident #37 having the skin issues prior to the Wound Nurse Practitioner #228 seeing the resident on 04/05/24 and that she did not open a wound assessment until after the Wound NP had seen the wounds and initiated treatments. 3. Review of the medical record for Resident #4 revealed an admitted [DATE]. Diagnoses included psychosis, dementia, major depressive disorder, and schizoaffective disorder. Review of the quarterly MDS assessment, dated 08/17/24 revealed Resident #4 was not able to complete a Brief Interview for Mental Status (BIMS) because she was rarely/never understood. This resident was assessed to require dependence with eating, toileting, bathing, dressing, and transfers. Review of the Braden scale dated 05/08/24 revealed Resident #4 was at high risk. Review of the skin inspection dated 06/17/24 revealed Resident #4 had no skin issues. Review of the wound evaluation dated 06/18/24 revealed Resident #4 had moisture associated skin damage (MASD) to her coccyx, which was in-house acquired, that measured 0.6 cm in length by 0.6 cm in width by 0. 1 cm in depth. Tissue was 100 percent pink. Recommendations were pressure reduction mattress, reposition, and nutritional consult. Review of the physician order dated 06/18/24 revealed Resident #4 was ordered a treatment to cleanse coccyx with wound cleanser and pat dry. Apply thin layer of Triad paste (a hydrophilic wound dressing) to wound bed and cover with bordered gauze, and to change daily and as needed. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the wound progress note dated 06/25/24 revealed Resident #4 ' s MASD to the coccyx measured one cm in length by 0.6 cm in width by 0.1 cm in depth. Partial thickness noted with 100 percent pink tissue to the wound bed. Wound was unchanged. Review of the physician order dated 06/26/24 revealed Resident #4 was ordered a health shake (a nutritional supplement) two times a day. Review of the wound progress note dated 07/02/24 revealed Resident #4 ' s MASD to the coccyx had healed. Review of the wound progress note dated 07/09/24 revealed Resident #4 had MASD to coccyx with partial thickness that measured one cm in length by one cm in width by 0.1 cm in depth. Wound bed tissue was 100 percent pink. Review of the physician order dated 07/09/24 revealed Resident #4 was ordered a treatment to cleanse coccyx with wound cleanser and pat dry, apply thin layer of Triad paste to wound bed and cover with bordered gauze. Change three times a week (Monday, Wednesday, and Friday) and as needed. Review of the wound progress note dated 07/16/24 revealed Resident #4 had MASD to coccyx with partial thickness that measured one cm in length by one cm in width by 0.1 cm in depth. Wound bed tissue was 100% pink. Wound was unchanged. Review of the wound progress note dated 07/23/24 revealed Resident #4 ' s coccyx was now an unstageable pressure ulcer that measured 2.1 cm in length by 1.1 cm in width and unable to determine (UTD) the depth. Wound bed was 20 percent granulation tissue and 80 percent slough. The wound had declined. Review of the physician order dated 07/23/24 revealed to cleanse coccyx with wound cleanser and apply MediHoney to wound bed and cover with bordered foam dressing and change three times a week and as needed. Review of the care plan dated 07/26/24 revealed Resident #4 had impaired skin integrity as evidenced by an unstageable wound to the coccyx. Interventions included to assist resident with turning and repositioning as needed. Staff to complete skin inspection every seven to ten days and as needed. Staff to complete wound evaluation to monitor the progress of the resident's skin condition. Staff to consult dietitian. Staff to follow enhanced barrier precautions (EBP). Staff to complete treatment per physician orders. Review of the wound progress note dated 07/30/24 revealed Resident #4 had an unstageable pressure ulcer to the coccyx that measured 2.6 cm in length by 2.6 cm in width and UTD the depth. Wound bed was 20 percent granulation tissue and 80 percent slough. The wound had declined. Review of the physician order dated 07/30/24 revealed to cleanse coccyx with wound cleanser, pat dry, apply MediHoney to wound bed and cover with bordered gauze dressing, change daily and as needed. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the wound progress note dated 08/06/24 revealed Resident #4 had an unstageable pressure ulcer to the coccyx that measured 2.6 cm in length by 2.6 cm in width and UTD the depth. Wound bed was 10 percent granulation, 40 percent slough, and 50 percent necrotic tissue. The wound was unchanged. Review of the physician order dated 08/06/24 revealed Arginaid (a nutritional supplement for wounds) two times a day for wound healing for 60 days, mix with beverage of choice. Review of the wound progress note dated 08/13/24 revealed Resident #4 had an unstageable pressure ulcer to the coccyx that measured 2.6 cm in length by 4 cm in width and depth was unable to be determined. The wound bed was 60 percent necrotic and 40 percent purple or maroon discoloration. The wound had declined. Review of the physician order dated 08/13/24 revealed to cleanse the wound with 0.25% Dakins solution (an antise [TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48570 Based on observation, record review, interview and policy review, the facility to ensure residents did not have their smoking equipment in their rooms. This affected three (Residents #51, #68 and #77) residents. The facility identified 47 residents who used tobacco products. The facility census was 105. Findings include: 1. Review of the medical record for Resident #51 revealed an admitted [DATE] with diagnoses of emphysema, unspecified and vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #51 with moderate cognitive impairment. Review of physician orders revealed an order dated 07/24/24 for oxygen two liters via nasal cannula as needed to maintain oxygen saturations greater than 90 percent. Review of Other Smoking Evaluation dated 08/19/24 revealed Resident #51 is able to be an unsupervised smoker. Review of the care plan for smoking, revised 08/19/24, revealed Resident #51 is an unsupervised smoker, will smoke safely at the designated area(s) at scheduled times through the next review. Resident will follow and verbalize understanding regarding the facility rules for designated smoking areas and smoking material through next review. Resident will smoke safely with the appropriate smoking gear (e.g. smoking vest, smoking apron, smoking blanket) through the next review with interventions to inform resident or /family/responsible if applicable, regarding the center's smoking rules, designated smoking areas, and storage of smoking materials. Keep oxygen away from smoking materials. Ensure removal prior to resident smoking. Monitor the resident's safety during smoking. During an observation on 08/20/24 at 10:09 A.M., Resident #51 was in his wheelchair in his room with cigarettes and lighter in hand. Resident #51 stated he keeps his own cigarettes and lighter in his room. During an interview on 08/20/24 at 10:10 AM, Licensed Practical Nurse (LPN) #202 stated all residents keep their cigarettes, lighters and anything else they smoke in their rooms and they are not supervised when they smoke. LPN #202 confirmed Resident #51 did have his cigarettes and lighter in his room. 39702 2. Medical record review for Resident #68 revealed an admission on 07/25/22. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #68 revealed the resident was cognitively intact. Review of the plan of care for Resident #68 revealed resident was a smoker. Interventions include resident will follow and verbalize understanding of the facility rules for designated smoking areas and smoking material, resident will smoke safely with the appropriate smoking gear as indicated, inform resident and family of the smoking rules, designated smoking areas and storage of smoking material, keep oxygen array from smoking material and monitor resident safety during smoking. Review of the facility smoking assessment for Resident #68 completed on 08/19/24 documented the resident was able to smoke independently without supervision. During an observation on 08/20/24 at 6:05 P.M., Resident #68 was sitting on the edge of her bed in her room facing the hallway exhaling large white smoke into the air. Resident #68 had a vaping device in her hand. During an interview on 08/20/24 at 6:05 P.M., Resident #68 admitted to smoking in her room. Resident #68 stated she is not supposed to be smoking in her room. During an interview on 08/20/24 at 6:05 P.M., LPN #212 verified Resident #68 was vaping in her room. LPN #212 stated the residents are allowed to keep smoking supplies with them but are not allowed to smoke in the rooms. Review of the polity titled Smoking Policy, dated September 2022, stated The facility established smoking areas that considers non-smoking residents and complies with applicable federal, state, and local laws and regulation regarding smoking, smoking area and smoking safety. Policy Interpretations and Implementation: For those deemed unsafe to smoke independently, per smoking assessment, there will be specific times for smoking and will be supervised while smoking in the designated areas. For those deemed safe to smoke independently, per smoking assessment, they may smoke at any time resident chooses in the designated areas. Resident smoking materials will be retained and distributed by facility to residents during the designated smoking times and/or when independent resident chooses to smoke. 44412 3. Review of the medical record for Resident #77 revealed an admitted [DATE]. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #77 was moderately cognitively impaired. Review of the admission evaluation assessment dated [DATE] revealed Resident #77 was not a smoker. During an observation on 08/21/24 at 4:12 P.M., Resident #77, who resided on the memory care unit, had three cans of tobacco in his room on bedside table. During an observation on 08/22/24 at 11:24 A.M., Resident #77 was actively chewing tobacco in his room and spitting into a water bottle. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/22/24 at 11:27 A.M., LPN #162 verified Resident #77 had multiple cans of tobacco in his room and was actively chewing tobacco. During an interview on 08/22/24 at 11:37 A.M. with the Administrator verified residents should not have tobacco devices on hand. The Administrator stated she was unaware Resident #77 used tobacco. This deficiency represents non-compliance investigated under Complaint Number OH00156885.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on observation, record review, interview, and policy review, the facility failed to ensure catheter care was provided appropriately. This affected one (Resident #46) of two residents reviewed for urinary concerns. The facility census was 105. Findings include: Review of the medical record for Resident #46 revealed an admitted [DATE]. Diagnoses included Parkinson's disease, type two diabetes mellitus (DM II), epilepsy, and paraplegia. Review of the Five-day Medicare Minimum Data Set (MDS) assessment, dated 08/02/24, revealed Resident #46 was not able to complete a Brief Interview for Mental Status (BIMS) because he was rarely/never understood. Resident #46 was dependent with toileting. Resident #46 had an indwelling catheter and was always incontinent of bowel. Review of the care plan, dated 08/25/23, revealed Resident #46 had a need for a catheter related to neurogenic bladder. Interventions included enhanced barrier precautions for indwelling catheter. Staff monitor for signs and symptoms of urinary tract infections including blood in urine, cloudiness, foul smell, fever, and change in mental status. Staff to document output every shift and as needed. Review of the progress note dated 04/11/24 at 8:43 A.M. revealed labs were sent to physician with a new order to start Macrobid, an antibiotic, 100 milligrams (mg), twice a day for seven days related to urinary tract infection (UTI). Review of the progress note dated 07/27/24 at 4:14 P.M. revealed new orders for Ciprofloxacin, an antibiotic, 250 mg, twice a day for seven days related to UTI. During an observation on 08/28/24 at 10:39 A.M., State tested Nurse Aide (STNA) #144 performed catheter care for Resident #46. STNA #144 applied a gown prior to entering the room, performed hand hygiene and applied gloves. STNA #144 cleaned the catheter tubing away from the urethra and back up. After providing care, STNA #144 did not remove her gloves, and touched the bed controller with soiled gloves. During an interview on 08/28/24 at the time of the observation, with STNA #144 verified she cleaned the catheter tubing going down and back up the tubing of the catheter. She also verified she did not change her gloves during care or after care while touching the bed controller with soiled gloves. Review of the facility policy titled, Catheter Care, Urinary, dated September 2023 revealed standard precautions should be used when handling or manipulating the drainage system. Staff to maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag. For a male resident, use a washcloth with warm water and soap to cleanse around the meatus. Cleanse the glans using circular strokes from the meatus outward. Use a clean washcloth with warm water and soap and rinse the catheter from insertion site to approximately four inches outward.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069 Based on record review and interview, the facility failed to ensure the physician approved admission to the facility in writing. This affected three (Residents #58, #85, and #92) out of five residents reviewed for physician services. The facility census was 105. Findings include: 1. Record review revealed Resident #58 was admitted on [DATE]. Diagnoses included schizophrenia, severe intellectual disabilities, morbid (severe) obesity due to excess calories, autistic disorder, type two diabetes mellitus without complications, constipation, hypothyroidism, vitamin d deficiency, drug induced akathisia, insomnia, attention-deficit hyperactivity disorder, generalized anxiety disorder, and restlessness and agitation. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #58 had severely impaired cognition. Resident #58 was assessed to require set-up assistance for eating, oral hygiene, dressing, personal hygiene, supervision for bathing, and was independent for toileting, bed mobility, and transfer. Further review of the medical record revealed no documentation the physician had approved Resident #58's admission to the facility in writing. 2. Review of the medical record for Resident #85 revealed an admitted [DATE]. Diagnoses included schizoaffective disorder, hallucinations, delusional disorders, and personal history of traumatic brain injury. Review of the quarterly MDS assessment dated [DATE] revealed Resident #85 was cognitively intact. Resident #85 was assessed to require set-up assistance for eating and bathing, and was independent for oral hygiene, toileting, dressing, personal hygiene, bed mobility, and transfer. Further review of the medical record revealed no documentation the physician had approved Resident #85's admission to the facility in writing. 3. Review of the medical record for Resident #92 revealed an admitted [DATE]. Diagnoses included schizophreniform disorder, bipolar disorder, borderline personality disorder, other psychoactive substance abuse, nicotine dependence, cannabis use, other amnesia, bradycardia, suicidal ideations, post-traumatic stress disorder, catatonic disorder due to known physiological condition, major depressive disorder, and chronic motor or vocal tic disorder. Review of the admission MDS assessment dated [DATE] revealed Resident #92 was cognitively intact. Resident #92 was assessed to require set-up assistance for eating, oral hygiene, upper body dressing, personal hygiene, bed mobility, and supervision for toileting, lower body dressing, and transfer. Further review of the medical record revealed no documentation the physician had approved Resident #92's admission to the facility in writing. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/28/24 at 4:16 P.M., Regional Clinical Nurse (RCN) #222 verified the facility had no documentation the physician had approved the admissions to the facility in writing.

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F 0712 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on record review and interview, the facility failed to ensure residents were seen by the physician upon admission. This affected three (Resident #58, #87 and #92) of three reviewed for physician visits. The facility census was 105. Findings include: 1. Record review revealed Resident #87 was admitted on [DATE]. Diagnoses included acute transverse myelitis in demyelinating disease of central nervous system and major depressive disorder. Review of the Establishment and Stabilization note, dated 05/14/24, revealed Resident #87 was seen by Certified Nurse Practitioner (CNP) #218 on 05/14/24. Review of the the physician progress notes revealed Resident #87 had not been seen by a physician or the medical director since admission on 05/13/24. During an interview 08/29/24 at 2:29 P.M. with Licensed Practical Nurse (LPN) #50 confirmed there was no documentation present in Resident #87's medical record that he was seen by the physician since admission to the facility on [DATE]. 44069 2. Review of the medical record for Resident #58 revealed an admitted [DATE]. Diagnoses included schizophrenia, severe intellectual disabilities, morbid (severe) obesity due to excess calories, autistic disorder, type two diabetes mellitus without complications, constipation, hypothyroidism, vitamin d deficiency, drug induced akathisia, insomnia, attention-deficit hyperactivity disorder, generalized anxiety disorder, and restlessness and agitation. Review of the nurse practitioner note dated 07/26/24 revealed Resident #58 was seen only by the nurse practitioner for establishment of care since being admitted to the facility. 3. Review of the medical record for Resident #92 revealed an admitted [DATE]. Diagnoses included schizophreniform disorder, bipolar disorder, borderline personality disorder, other psychoactive substance abuse, nicotine dependence, cannabis use, other amnesia, bradycardia, suicidal ideations, post-traumatic stress disorder, catatonic disorder due to known physiological condition, major depressive disorder, and chronic motor or vocal tic disorder. Review of the nurse practitioner note dated 07/11/24 revealed Resident #92 was seen only by the nurse practitioner for establishment since being admitted to the facility. During an interview on 08/28/24 at 10:03 A.M., Regional Clinical Nurse (RCN) #222 confirmed the facility does not have a policy on physician visits. During an interview on 08/29/24 at 11:25 A.M., Physician #232 stated the nurse practitioner sees residents to establish care upon admission and then he sees the residents after.

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on record review, interview, observation, nursing staff schedule review, facility assessment review, and policy review, the facility failed to maintain sufficient levels of state tested nursing staff and licensed nursing staff to meet the total care needs of all facility residents. This resulted in Immediate Jeopardy when on 08/26/24 at 7:00 A.M., there were three licensed practical nurses (LPN) and two state tested nurse aides (STNA) on duty to provide for the routine care, monitoring, medication administration, assessments, response to urgent resident needs and/or treatments for all 105 residents residing in the facility. The lack of nursing staff in the facility to provide nursing care and services resulted in actual and/or the potential for serious harm, injuries and/or negative health outcomes for residents related to the lack of care and services, activities of daily living (ADL), supervision of common areas, smoking areas and assistance with meal intake. This had the potential to affect all 105 residents. On 08/27/24 at 2:55 P.M. Regional Director of Operations (RDO) #224, Regional Clinical Nurse (RCN) #222, and the Administrator were notified that the Immediate Jeopardy began on 08/26/24 at 7:00 A.M. when the facility failed to ensure an sufficient nursing staff was on duty and present in the facility to provide for the routine care, monitoring, response to urgent resident needs and meal assistance for all 105 residents residing in the facility. The Immediate Jeopardy was removed on 08/28/24 when the facility implemented the following corrective actions: By 08/28/24, staffing levels will be increased to five nurses on day shift and four nurses on night shift, STNA ' s staffing levels will be increased to eight STNA ' s on first shift and six nursing assistants on night shift. Staffing levels will be increased by increasing hours for current staff, reassigning staff from sister facilities and signing contracts with two temporary staffing agencies. The shift charge nurse will authorize the use of the agency staff. By 08/28/24, the charge nurses will be provided with the agencies phone numbers and will be educated to call agency when there are call offs and our staff will not pick up open shifts. By 08/28/24, RDO #224 will develop a bonus structure for new hires. By 08/28/24, the RDO #224 will develop a bonus structure for staff that will pick up extra shifts. By 08/28/24, RDO #224 will develop a bonus structure for staff who refer new candidates. By 08/28/24, Human Resource (HR) Director #6 will call all applicants for the last 60 days to re-offer interviews. By 08/28/24, the Director of Nursing (DON) or designee will conduct resident assessments to identify those with pressure ulcers and extensive assist from two staff members with ADL to prioritize their care and ensure immediate needs are addressed. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	By 08/28/24, RDO #224 or designee will notify residents and their representatives about the staffing situation, the steps that are being taken to address the issue and what they can expect in terms of care. By 08/28/24, an ad hoc quality assurance (QA) committee meeting will be held to review the plan. By 08/28/24, [NAME] President of Human Resources (VPHR) #800 or designee will develop and implement a long-term plan to recruit and retain qualified staff including offering competitive wages, benefits and professional development opportunities. Beginning 08/28/24, RDO #224 or designee will review staffing levels daily and adjust as necessary depending on new admissions/discharges and significant changes. This may involve hiring additional permanent staff or adjusting the staff to resident ratio based on acuity levels. By 08/28/24, RDO #224 will educate the administrator, the DON and HR Director #6 on the appropriate staffing levels to meet the residents needs and to adjust the staffing levels depending on new admissions/discharges and significant changes. Weekly for four weeks, RDO #224 or designee will interview four residents and four direct care members to ensure appropriate staffing levels and quality of care. The data collected from the above audits and feedback will be used to make ongoing adjustments to the staffing plan and care protocols, ensuring compliance and that residents receive high-quality care. The audits will be submitted weekly to the QA committee for trending, tracking and recommendations. Although the Immediate Jeopardy was removed on 08/28/24, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. 1. Medical record review for Resident #41 revealed an admission on 03/15/17 with diagnoses including but not limited to traumatic hemorrhage of cerebrum, hemiplegia on right and left side, epilepsy, respiratory failure, coma, persistent vegetative state, acute cystitis without hematuria, hypertension, anxiety disorder, tracheostomy status and gastrostomy status. Review of the annual Minimum Data Set (MDS) assessment for Resident #41 revealed resident was in a persistent coma state. Resident #41 has physical impairments on both sides affecting arms and legs. Resident #41 is dependent for all care. Resident #41 has a gastrostomy (feeding tube) and receives 51 percent of calories through parenteral feedings. Resident #41 has a tracheostomy in place and receives oxygen via compressor at 20 pounds per square inch (PSI). Review of the plan of care for Resident #41 dated 03/19/22 revealed resident has an ADL self-care performance deficit related to motor vehicle accident (MVA) with brain injury resulting in comatose state. Interventions include assisting with activities of daily living requiring two staff members for the completion of bed mobility, transfers with a mechanical lift, and toileting. Resident #41 was dependent for eating with one staff member required for task involving enteral feedings. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the active physician orders for Resident #41 revealed an order for nothing by mouth dated 03/20/24, head support cushion under head as tolerated dated 03/20/24, Hoyer lift for all transfers dated 03/20/24, incontinence care every two hours and as needed, with house barrier cream after each incontinent episode dated 03/20/24 and keep head of bed elevated as tolerated dated 07/24/24. During an observation on 08/22/24 at 9:50 A.M., Resident #41 was lying in bed on her back, head of bed elevated to approximately 30 degrees, neck appeared to be in a contracted state leaning to the resident ' s right shoulder, tracheostomy in anterior neck and secured appropriately, linens clean and resident without odor. On 08/22/24 at 11:30 A.M., STNA #12 was observed to enter the room of Resident #41 and shut the door. At 11:51 A.M. STNA #12 was observed to exit the room. During an interview on 08/22/24 at 11:53 A.M. with STNA #12 verified Resident #41 was checked for incontinence and repositioned. STNA #12 stated she completed ADL and incontinent care for Resident #41. STNA #12 stated she had not had the time to provide care for Resident #41 since she arrived at the facility and clocked in at 7:00 A.M. STNA #12 stated she has 20 residents on her assignment at that time. STNA #12 received report and then started passing breakfast trays. STNA #12 stated she has had three total bed changes due to incontinence and changed eight resident incontinent garments before providing care for Resident #41. STNA #12 stated sometimes the nurses were able to help but the other STNA ' s were in the same situation that she was in and were not able to help at times either. 2. Medical record review for Resident #4 revealed an admitted [DATE] with diagnoses including but not limited to psychosis, dementia, major depressive disorder, and schizoaffective disorder. Resident #4 resided on the memory care unit. Review of the quarterly MDS assessment dated [DATE] revealed Resident #4 was not able to complete a Brief Interview for Mental Status (BIMS) because she was rarely/never understood. Resident #4 was dependent with eating, toileting, bathing, dressing, and transfers. Resident #4 required two staff members for toileting, transfers and bed mobility. Review of the plan of care for Resident #4 revealed resident has an ADL self-care performance deficit related to dementia with behaviors, cerebral palsy, seizures, schizophrenia, psychosis, major depressive disorder, cerebrovascular accident with right hemiparesis and hemiplegia. Interventions include assist with activities of daily living, two-staff member assistance is required with bed mobility, toileting and transfers. Resident #4 resides on a secured unit. Review of the care plan dated 07/26/24 revealed Resident #4 had impaired skin integrity as evidenced by pressure to coccyx. Interventions included assist with turning and repositioning as needed, complete skin inspection every seven to 10 days and as needed, complete wound evaluation to monitor the progress of skin condition, enhanced barrier precautions, medications per orders, and good nutrition and hydration. Review of the task log for Resident #4 revealed the resident has not gotten out of bed in the last three months. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation on 08/22/24 at 12:05 P.M., Resident #4 was sleeping in bed. Her lunch tray was in the room, but there were no staff available to feed her. Resident #4 was lying on her right side. At 12:22 P.M., no one had been in the room to feed Resident #4 her lunch. During an interview on 08/22/24 at 12:24 P.M., STNA #46 stated there are at least five residents that require assistance with meals and typically only one STNA assigned to the memory care unit. One STNA cannot feed five residents at the same time. STNA #46 stated at 12:30 P.M. Resident #4 ' s lunch tray was still sitting unattended due to not having staff available. STNA #46 stated there was no wound dressing on Resident #4 ' s coccyx, but dried gauze from a previous time. STNA #46 stated there has not been a dressing on the wound since she started training on this unit on 08/12/24. Resident #4 had a foul-smelling odor with two flies near the coccyx wound. During an observation on 08/22/24 at 12:42 P.M., Resident #4 was sleeping in bed and the lunch tray was still in the room. Resident #4 had not been fed her lunch meal. During an interview on 08/22/24 at 12:49 P.M., STNA #172 stated the wound dressing for Resident #4 was not in place this morning. STNA #172 stated they used to get residents up with the Hoyer lift because they had two staff members on this unit. STNA #172 stated now it's just one STNA on the memory care unit and the unit does not have Hoyer lift pads to get residents up with. STNA #172 stated the last time Resident #4 was out of bed was at least a month ago. STNA #172 stated she had six residents to feed on the memory care unit, and she was the only staff back there at the time of meal tray delivery. STNA #172 stated she fed the residents in the dining room first, and then she assisted with the residents in their room after the dining room residents were finished. On 08/22/24 at 12:55 P.M., STNA #172 entered Resident #4 ' s room to assist her with eating her lunch, which was 50 minutes after the lunch tray was observed in the resident ' s room at 12:05 P.M. 3. Medical record review for Resident #50 revealed an admitted [DATE] with diagnoses including but not limited to vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of the comprehensive MDS assessment dated [DATE] for Resident #50 revealed staff assessment for memory indicated severe cognitive impairment. Resident #50 was not coded with any behaviors during the assessment period. Resident #50 requires set up for eating. Resident #50 was coded as dependent on staff for toileting, bed mobility and transfers. Resident #50 is incontinent for both bladder and bowel. Review of the plan of care for Resident #50 dated 03/18/22 and revised on 06/29/22 revealed resident has an ADL self-care performance deficit related to schizoaffective disorder and hemiparesis. Interventions include assist with ADL as needed, eating requires one staff member assistance, transfers with Hoyer lift with two staff members, toileting and bed mobility requires two staff members. During an observation on 08/26/24 at 9:48 A.M., Resident #50 was in bed and noted with dried food on his upper chest area. Resident #50 had a soaked incontinent brief, and the bed linen had a yellow wet circular area around the resident. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation on 08/26/24 at 9:48 A.M., there were two STNAs present working the floor at the current time. STNA #148 was covering all of 200 and 300 halls except the memory care unit and one covering the mental health unit. There were 40 residents on 200 hall, 10 residents on the 300 hall, and 25 residents on the mental health unit. During an interview on 08/26/24 at 9:55 A.M., STNA #148 stated she had not been in Resident #50 ' s room since 7:00 A.M., the start of the shift due to not enough staff this morning. There were only two STNA in the whole building at that time and since the start of the shift, one STNA covering mental health and one covering the rest of the building. STNA #148 confirmed Resident #50 had old, dried food on his chest, not the same food as breakfast that was served. She also confirmed Resident #50 was wet with urine and the bed linens were wet with a yellow ring surrounding the resident. 4. Review of the Facility Assessment for the year 2023-2024, dated 05/31/24, identified staffing and staffing assignments would be determined using various reports to analyze the number of patients, velocity of expected admission and discharges, diagnoses and the total number and types of tasks and services required of nursing, nursing assistants and ancillary personnel. The facility assessment did not address the staffing needs required for the specialized units, the memory care unit and mental health unit. During an interview on 08/26/24 at 8:24 A.M., the Administrator stated she was unaware of any other reports identified in the facility assessment that would be used to determine staffing. She ensures the facility meets the state licensure requirements of 2.5 hours of care per resident per day and used the punch detail to collect the data for that report. The facility does not use agency staff as they do not have a budget for it. The Administrator referred questions related to how staffing levels impact the residents to the Interim Director of Nursing (IDON). The Administrator stated she has not received any complaints from any residents in the last three months. They offer a bonus for shifts that are picked up and if they are not filled, they will pull facility staff that are STNAs to fill the open shifts. The Administrator stated the facility has a Registered Nurse (RN) in the facility to meet the eight-hour requirement daily. Review of the facility ' s Nursing Staff Daily Schedule dated June 2024 through August 2024 revealed the facility scheduled five STNA ' s consistently to care for up to 105 residents residing in the facility. Review of the facility ' s Nursing Staff Daily Schedule dated 08/26/24 for the day shift revealed STNAs #54, #102, #148, #34 and #46 were scheduled to work from 7:00 A.M. to 7:00 P.M. and LPNs #18, #32, #162, and #148 were scheduled to work from 7:00 A.M. to 7:00 P.M. Review of the facility ' s Punch Details for 08/26/24 from 7:00 A.M. to 7:00 P.M. revealed two STNA were in the facility for the day shift starting at 7:00 A.M. Additional STNA ' s clocked in at 7:33 A.M., 9:02 A.M., 10:53 A.M. and 11:58 A.M. Review of the day shift STNA schedule dated August 2024 revealed two STNA ' s were scheduled for 08/26/24. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 08/26/24 at 8:56 A.M., RCN #222, the acting Director of Nursing, stated she was not involved in the staffing determination. RCN #222 stated she has been in the DON position since the survey started and does not have extensive history of the facility. She stated the facility has had a staff scheduler in place for about three weeks. During an interview on 08/26/24 at 9:22 A.M., STNA #46 verified she was on the schedule for today and not called in for staff coverage. STNA #46 verified she was not present at 7:00 A.M. and arrived at the facility late. STNA #46 stated she was the only STNA on the assigned unit. STNA #46 stated she was looking through the Kardex for resident instructions as she had not worked in the area before. STNA #46 verified the nurse assigned to the area also had rooms on the outside of the locked memory care unit and was not available to confirm care and services required by the STNA. During an interview on 08/26/24 at 1:01 P.M., Certified Nurse Practitioner (CNP) #218 stated staffing is an issue in the facility, and it is possible that the in house acquired pressure ulcers occurred and worsened due to the facility staffing levels. The facility has always had a staffing concern which affects the care. Just like today, there is a staffing concern. During an interview on 08/27/24 at 8:50 A.M., STNA #10 stated she has twenty-five residents assigned to her today. STNA #10 stated she did not work yesterday and no one from the facility contacted her to see if she was able to come in. STNA #10 verified the facility has four STNA ' s at this time with three nurses for 105 residents. STNA #10 stated there have been times that she is unable to complete her assigned showers and will report it to the oncoming staff. STNA #10 stated it is very hard to supervise all the residents and provide care to them as well. Nurses will assist but they have forty residents sometimes and do not have time to help either. The nurses that are assigned the specialized units have residents in the other outside hallways as well. STNA #10 stated there have been times when the residents have complained about the length of time, they had to wait for help but nothing formal like a grievance that she is aware of. STNA #10 stated the residents here do not have family members looking after them or advocate for them. During an interview on 08/27/24 at 10:10 A.M., Facility Staffing Coordinator (FSC) #78 verified she has been in the current position for three weeks and is still learning the new position. FSC #78 states she was given the Nursing Staff Daily Schedule template and has been using that to schedule staff. FSC #78 stated the goal is to have all positions filled but they do not have the staff to reach that at the time but have been hiring additional staff recently. FSC #78 states she has not been given any other guidelines for staffing only the daily schedule template. FSC #78 stated the schedule template has seven positions for the STNAs and four positions for nurses for both twelve-hour shifts in a twenty-four-hour day. FSC #78 verified there were staff running late and one call off on 08/26/24, but she would have to check her paper to make sure she had her staffing numbers correct. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation on 08/27/24 at 2:10 P.M., STNA #210 took a meal tray out of the food cart and was walking down the South Hall. STNA #210 stated she had to help in the dining room for all meals to assist with resident meal selection, meal tray delivery and supervision. STNA #210 stated when the resident ' s trays are passed, she must stay in the dining area for supervision until they are finished. STNA #210 states then she can return to her assignment. STNA #210 stated the nurse realized what was going on today and started to help with tray delivery on the hall. STNA #210 stated the tray she is delivering is the last one. STNA #210 stated the resident requires assistance with all meals and she was not able to feed the resident until now. STNA #210 stated she has not completed all the baths scheduled for today and is not sure she will be able to get them all done before she goes home. STNA # 210 verified the lunch tray had to be heated up prior to serving. During an interview on 08/27/24 at 4:30 P.M., Unit Manager LPN #50 stated she assists with the facility nursing schedule but has not received any other training regarding staffing, how to assess for staffing needs or determine if more staffing is needed. LPN #50 stated she uses the daily template that allows us to have seven STNAs and four nurses for both twelve-hour shifts. LPN #50 verified the staffing has been very low at times on day shift with all the staff slots going unfilled. During an interview on 08/28/24 at 8:40 A.M., the Administrator stated she does not have any access to reports regarding staff or staffing level requirements. She has a budget that allows staffing levels from 2.5 hours to 2.75 hours per resident per day. A staffing report is run by the Administrator daily to ensure compliance with the staffing levels. She stated they have struggled to meet the state minimum staffing level at times in the last few weeks. She has requested a budget for agency staff and has been denied each time. If the facility is staffed over the 2.5 hours per resident per day, it is brought up in the operational meeting with staff from the corporate level staff. The Administrator said she was asked not to attend the daily staffing meetings approximately two to three months ago. She is only to attend on Mondays and Fridays and does not understand why she was asked to step away. During an interview on 08/28/24 at 9:00 A.M., Chief Executive Officer (CEO) #240 and [NAME] President of Clinical Operations (VPCO) #230 stated the facility has meetings with staff regarding concerns related to the facility. Corporate staff have meetings with the facility management to talk about the acuity of the residents and meeting the PDPM requirements. CEO #240 stated the corporate has a standard level of 2.75 hours per resident per day daily for the facilities. VPCO #230 stated the staffing numbers are run globally and not individually as that is the responsibility of the Administrator. Both CEO #240 and VPCO #230 stated they are adding staff to the schedule by utilizing agency and will have the signed contract in place soon. During an interview on 08/28/24 at 2:10 P.M., STNA #210 stated she did not work on 08/24/24 or 08/25/24 and no one from the facility contacted her to see if she was willing to come in to work on either day. STNA #210 stated the facility works with four STNAs a lot of the time. They will have a staff member that comes in at 11:00 A.M. and that is helpful, but they need more staff. STNA #210 stated the biggest problem is when she is helping another resident in a room, she cannot be in the common areas supervising the residents. Care is completed but it is not always timely or as thorough as it should be. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 08/28/24 at 3:30 P.M., LPN #50 stated she was not on call 08/24/24 through 08/25/24 but did see that requests came through on the WhatsApp(WhatsApp is a messaging app that uses the internet to send messages, images, audio or video) saying the facility needed help. The request was sent out to the Administrator, the MDS nurse and herself, along with a unit manager who no longer works for the facility. The facility staff in the building did not receive any contact from the Administrator, or MDS Nurse to come in and assist due to low staffing levels. LPN #50 verified the staff member identified as being on call is not employed by the facility at the time of the assignment. During an interview on 08/29/24 at 6:48 A.M., STNA #52 stated she is unable to get showers done because there is no one else to watch the residents when she is in the shower room for extended periods of time. They give bed baths, but the residents want showers at times, and they cannot provide them. STNA #52 stated she gave four showers last night because they had two staff members scheduled. STNA #52 stated there was only one nurse working in the memory care unit adding that she also had resident rooms in the rehabilitation area. STNA #52 stated it was difficult to provide good care, complete incontinence care and showers with only one staff member. STNA #52 has approached the management staff regarding concerns but there has been such staff turnover that issues do not get addressed. During an interview on 08/29/24 at 7:00 A.M., STNA #34 stated the facility does not have enough linen to provide care to the residents at times. STNA #34 stated the staff at night must do laundry to be able to provide care adding that the facility has three dryers, but only one is operational. STNA #34 stated she worked on 08/26/24 and heard the facility started out with only two STNA ' s during report from the nurse assigned to the hall. STNA #34 stated when she left at 7:00 P.M. there had been five aides to care for 105 residents in the facility. During an observation on 08/29/24 at 7:10 A.M, the linen room for the locked mental health unit contained no washcloths, no bath towels, no draw sheets, and only two blankets, and six bed sheets. During an interview on 08/29/24 at 7:45 A.M., the Administrator verified there was no linen available for use to provide care in the mental health unit. During an interview on 08/29/24 at 8:00 A.M., VPCO #230 verified the linen closet lacked sufficient linen supplies to complete care and services on the unit. During an observation on 08/29/24 at 9:21 A.M., the linen room for the locked mental health unit still had no linen. During an interview on 08/29/24 at 9:22 A.M., STNA #34 stated some of the residents had supplies in their room for incontinent care (disposable wipes), but they still had residents that were waiting for linens to be delivered to the unit for care. During an interview on 08/29/24 at 10:27 A.M., STNA #34 stated some of the residents were still waiting for clean linen to complete A.M. care. STNA #34 verified they borrowed linen from other units but if they took anymore the staff on those units would be waiting for linens as well. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a telephone interview on 08/29/24 at 11:25 A.M., Physician #232 stated there had been several people in the role of Director of Nursing in the last few months. Physician #232 stated he would follow-up with facility management but had mostly been engaging with the Administrator lately due to the changes with nursing management. He was aware of staffing challenges to a certain degree but had not been advised of any significant negative resident outcomes. During an interview on 08/29/24 at 3:27 P.M., Registered Nurse (RN) #166, the MDS nurse, stated the Administrator asked if she would fill in for the DON. RN #166 stated she never ended up taking any duties for the position, the last DON was only at the facility for a week before resigning. The facility couldn ' t keep a consistent DON or unit managers, and it affected the continuity of care. Things were being missed. She did not attend the morning meetings or QAPI (Quality Assurance and Performance Improvement) meetings, was not present for nutrition at risk meetings and was told MDS did not need to be involved. During an interview on 09/03/24 at 12:21 P.M., LPN #212 verified on 08/26/24 at 7:00 A.M., there were only two STNAs present to care for 105 residents residing in the facility. The nurse let management, and the staff scheduler know scheduled staff were not present at the start of the shift. LPN #212 stated the nurses present just started getting the residents awakened for breakfast, assisting with tray delivery and answering call lights as needed. LPN #212 verified that there were three nurses in the facility and that her current assignment consisted of 28 rooms, and she was not sure how many residents there were on that day. LPN #212 stated the facility uses an electronic application that has specific groups of management and staff. Staff send messages to the management group when there is a call off. The scheduler also receives the messages and works Monday through Friday. The scheduler is a trained STNA and will help when there is a call off as well. During an interview on 09/03/24 at 12:30 P.M., LPN #38 verified on 08/26/24 at 7:00 AM, there were only two STNAs present to care for 105 residents residing in the facility. LPN #38 stated there were more staff on the schedule, but she was unable to recall what had happened to each one that was not there. LPN #38 stated there were some managers in the facility because the surveyors were returning to the facility, and they were advised on the missing staff. LPN #38 stated there was only one nurse assigned to the mental health unit at the beginning of the shift and was there by herself until the staffing was figured out. LPN #38 stated the scheduler came out and covered a unit but was not sure what area she was assigned. LPN #38 stated it was very chaotic when the shift started. LPN #38 stated the assigned workload is heavy and it does not help when staffing is challenged to start with. LPN #38 stated the office staff that are STNAs will come to the floor and assist but they do not take a unit, they just get the bare minimum done. LPN #38 stated the recent staffing shortage occurred when the management left the facility, and they took their staffing with them. LPN #38 was unable to state if anything specific was not being completed for the residents just a lot of short cuts to get the basic care completed. LPN #38 stated she had 21 residents, or 14 rooms assigned to her on 08/26/24 with one STNA assigned to her unit. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 09/03/24 at 2:00 P.M. with FSC #78 stated she was only able to confirm staffing that was on the Daily Staff Schedules. FSC #78 stated she does not have access to the facility punches and does not keep track of what staff is working, where they are working and when there are changes made to the schedule. Initially she stated she was not working on the day in question (08/26/24), then recanted her statement stating she couldn ' t remember what happened every day. FSC #78 stated there were six STNAs scheduled for 08/26/24, there was one call off, and two staff members were running late. The sixth staff member was schedule for 11:00 A.M. to 7:00 P.M. FSC #78 stated she covered the memory care unit until the scheduled staff arrived at the facility at noon but was not sure of the exact time. FSC #78 verified the LPN scheduled for the mental health unit was the only staff member present until the STNA arrived at the facility at an unknown time. FSC #78 verified she was working in the memory care unit until the scheduled staff member showed up around noon. FSC #78 stated she was helping in both specialty units. When the nurse was passing medications in the memory care unit, she went to the mental health unit and assisted with breakfast trays and answered call lights. FSC #78 stated staff did not always call her when there was a call off initially, they were calling several different people and that is when errors were made. FSC #78 was unable to identify who staff was calling to notify when there was a call off, but they now use the mobile application called What ' s app. FSC #78 stated the facility uses the app to notify groups of management related to staffing needs. FSC #78 verified the nurses have a separate group as well as the STNAs. Not everyone in the facility is able to see comments on all the app groups. FSC #78 denied any knowledge of an RN working that day, adding she may have been assisting the corporate team. During an interview on 09/03/24 at 2:15 P.M., LPN #186 verified the facility had three nurses and two STNAs on 08/26/24 at the beginning of the shift. LPN #186 verified she was in the mental health unit caring for 25 residents and the South Hall caring for 16 residents until STNA #46 arrived about 9:00 A.M. STNA #46 was in

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 39702 Based on observation, interview and policy review the facility failed to post nurse staffing information in a clear visible place. This had the potential to affect all residents residing in the facility. The facility census is 105. Findings include: During an observation on 08/26/24 at 8:30 A.M., no staffing information was found identifying the current nursing staff. During an interview on 08/26/24 at 8:41 A.M., the Administrator verified the required posted nurse staffing information was not available for accessible to visitors or residents. During an interview on 08.26.24 at 8:42 A.M., Facility Scheduling Coordinator (FSC) #78 verified the absence of posted nurse staffing information. She stated she was unaware of the requirements and has not posted the information for three weeks since taking the scheduling position. Review of the facility policy titled Staff, daily Posting, dated September 2021 revealed the facility will post daily for each shift the number of nursing personnel responsible for providing direct care to residents. Number one of the policy states the information will include facility name, current date, resident census, and the total number of registered nurses, licensed practical nurses and certified nurse aides.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on interview and record review, the facility failed ensure medically related social services was provided to a resident discharging from the facility. This affected one (Resident #100) out of three residents reviewed for transfer or discharge. The facility census was 105. Findings include: Review of the Resident #100's chart revealed Resident #100 admitted to the facility on [DATE] with diagnoses including spinal stenosis, polyneuropathy, paresthesia of skin, radiculopathy, major depressive disorder and other specified arthritis. Resident #100 was discharged from the facility on 05/22/24. Review of Resident #100's discharge Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and Resident #100 required set up with eating, oral hygiene, toileting, and personal hygiene. Resident #100 required supervision with showering, upper body dressing, and moderate assistance with lower body dressing, putting on and taking off footwear, sitting to standing, chair transfers, toilet transfers and walking ten feet. Resident #100 was independent with rolling left and right, sitting to lying, and lying to sitting. Review of Resident #100's progress notes from 03/20/24 to 05/20/24 revealed no information related to Resident #100 receiving a formal discharge notice from the facility. Review of Resident #100's progress note dated 03/20/24 revealed Resident #100 was admitted to the facility on [DATE]. Review of Resident #100's progress note dated 05/21/24 written by Social Services Director (SSD) #36 revealed Resident #100 presented with her termination letter from her insurance company. At first Resident #100 stated she would be amenable to going to a homeless shelter then she came to the office and began berating SSD #36 and Social Services Aide (SSA) #206 about how they were not helping her, they should have told her this was going to happen when she first came to the facility and that they were all lying. SSD #36 and SSA #206 tried to explain how the process works and that she must leave tomorrow. Resident #100 stated she had nowhere to go and that SSD #36 and SSA #206 must find her a place. SSD #36 and SSA #206 explained that they don't find places for residents to go and we will help her get in the homeless shelter. At that point, Resident #100 became very verbally aggressive and started yelling at both SSD #36 and SSA #206 and stated they were lying to her. SSD #36 presented the determination letter to her, and she was escorted out of our office by the DON. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #100's progress note dated 05/22/24 written by SSD #36 revealed SSD #36 went to Resident #100 to ask who her pharmacist was so it could be entered on her discharge paperwork. Resident #100 refused to provide that information. Resident #100 was then asked to sign the discharge paperwork, but she refused to sign. Resident #100 stated were that SSD #36 had done nothing for her the whole time she was at the facility and SSD #36 did not help her mother who resided on the secured unit. Resident #100 went so far as to say the social worker 'manufactured' the termination letter from her insurance company in an effort to get rid of her. Resident #100 was picked up by a friend who then took her away from the building for the discharge. Review of Resident #100's physician order from 03/20/24 to 05/22/24 revealed no discharge order was listed in the chart. Review of Resident #100's insurance notice of adverse determination dated 05/21/24 revealed Resident #100's continued stay in a skilled nursing facility could not be approved. The dates of service from 05/20/24 to 05/21/24 were approved but starting on 05/22/24 the stay would be denied. Resident #100's records did not show a need for skilled nursing daily. Resident #100 had no therapy notes and there was no records showing that Resident #100 needed hands on help with at least two daily needs. There was no record showing Resident #100 needed help with medications or 24 hour care for her memory. Resident #100 did not meet the rules to stay, and her needs could be managed at a lower level. Discharge plans were being worked on per the determination letter. Review of Resident #100's discharge assessment initiated on 05/21/24 and locked on 05/22/24 revealed Resident #100 was discharged to a homeless shelter on 05/21/24. No follow up doctor's appointments were made, and the discharge assessment stated resident will arrange follow up appointments. Interview with the Administrator, SSD #36 and SSA #206 on 08/22/24 at 1:27 P.M. verified Resident #100 received an insurance denial letter around 05/21/24. SSD #36 verified he told Resident #100 that she must leave tomorrow and that the facility does not find places for residents. SSD #36 stated that Resident #100 discharged on [DATE] and her friend picked her up, but SSD #36 did not know where Resident #100 went to live. SSD #36 verified Resident #100's discharge location was listed as a homeless shelter on the discharge assessment. The Administrator and SSD #36 verified Resident #100 did not want to discharge from the facility and she was not given a 30 day or other type of formal discharge notice. Review of the SSD #36's social services job description dated 10/23/23 revealed the social services position was responsible for providing medically related social services so that each resident may attain or maintain the highest practicable level of physical, mental and psychosocial well being. Responsibilities included initiating, coordinating an evaluating effective, safe and appropriate discharge planning for residents. The job description was signed by SSD #36 on 10/23/23. Review of the SSA #206's undated social services job description revealed the social services position was responsible for providing medically related social services so that each resident may attain or maintain the highest practicable level of physical, mental and psychosocial well being. Responsibilities included initiating, coordinating an evaluating effective, safe and appropriate discharge planning for residents. The job description was signed by SSA #206. Review of the facility's facility assessment dated [DATE] revealed the facility provides for discharge planning for residents per individualized care plans that meet current regulations. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Transfer and Discharge Notice, dated September 2021, revealed the facility shall provide a resident and/or the resident's representative with a thirty day written notice of an impending transfer or discharge.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on record review, interview and policy review, the facility failed to ensure laboratory tests were obtained per physician orders. This affected two (Residents #16 and #77) of five reviewed for unnecessary medications. The facility census was 105. Findings include: 1. Review of Resident #16's medical record revealed an admitted [DATE] with diagnoses including but not limited to syncope and collapse, cognitive communication deficit, dementia severe with other behavioral disturbance, schizoaffective disorder, paranoid personality, insomnia, major depressive disorder, anxiety disorder, hypertension and anxiety. Review of the plan of care for Resident #16 dated 03/18/22 revealed the resident had an impaired neurological status related to dementia. Interventions include administer medications as ordered, monitor and report to physician of declines in cognitive functioning, orientation, changes in communication, and monitor laboratory and diagnostic testing per physician orders. Review of the active physician's orders for Resident #16 revealed an order for the anti-seizure medication Depakote levels to be drawn every six months in May and November dated 04/07/22, and Depakote delayed-release 125 milligrams (mg) give one tablet by mouth two times a day related to schizoaffective disorder dated 11/17/23. Review of the laboratory results in Resident #16's electronic medical record dated 09/23/23 through 07/18/24 was silent for any Depakote levels since ordered. Interview on 08/26/24 at 1:30 P.M. with Corporate Registered Nurse (CRN) #222 verified the Depakote levels were not obtained as ordered for Resident #16. 2. Review of the medical record for Resident #77 revealed an admitted [DATE]. Diagnoses included dementia, major depressive disorder, and type two diabetes mellitus. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #77 had moderate cognitive impairment and was assessed to require setup with eating, toileting, dressing, supervision with bathing, and was independent with transfers. Review of the physician order dated 07/14/24 revealed Resident #77 was ordered a basal metabolic panel (BMP) laboratory draw every two weeks on Monday. Review of the laboratory results dated [DATE] revealed Resident #77 had not had labs completed since 07/11/24. Interview on 08/28/24 at 4:14 P.M. with CRN #222 verified Resident #77 did not have laboratory values completed per physician orders. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated facility policy titled, Request for Diagnostic Services, revealed all requests for diagnostic services must be ordered by a physician. Orders for diagnostic services will be carried out as instructed by the physician's orders.

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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 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** 48570 Based on observation, medical record review, resident and staff interview, and policy review, the facility failed to schedule an oral surgeon appointment timely for one (Resident #62) of one resident reviewed for dental concerns. The facility census was 105. Findings include: Review of the medical record for Resident #62 revealed an admitted [DATE] with diagnoses of Alzheimer's disease, type II diabetes mellitus with other specified complication, and bipolar disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 was cognitively intact, had impairment to bilateral upper and lower extremities, and required set-up assistance with eating, oral hygiene, and wheelchair mobility. Review of the care plan dated 03/10/24 revealed Resident #62 was at risk for altered nutritional/hydration status related to therapeutic diet and history of mouth sores with intervention of refer to ancillary services, i.e. dental. Review of Resident #62's dental health service post-visit note dated 07/24/24 revealed an oral surgeon referral for recommended treatment to extract tooth #15 due to the special nature of the procedure involved, and in consideration of the resident's comfort and well-being, a referral for these services was recommended. Review of Resident #62's progress notes revealed on 08/07/24 at 1:20 P.M. a referral was sent to the oral surgeon to start the process to make the resident an appointment and was awaiting a call back. Resident #62 was aware. On 08/21/24 at 2:17 P.M., a message was left with the office to schedule oral surgery at that time, and was waiting on a return call. On 08/21/24 at 2:55 P.M., a packet needed to be filled out to schedule Resident #62 for oral surgery and the office was faxing a form on that date. Interview on 08/19/24 at 2:20 P.M. with Resident #62 revealed he has needed a dentist appointment for quite a while. Interview with Resident #62 also revealed it has not been taken care of and he reports pain from his left teeth issues. Observation on 08/21/24 at 1:53 P.M. of Resident #62 teeth revealed multiple cavities in the left upper back teeth, with the last two teeth missing the inside part of each tooth. Interview on 08/21/24 at 2:10 P.M. with Licensed Practical Nurse (LPN) #50 confirmed Resident #62 had multiple cavities in the left upper back teeth, with last two teeth missing the inner side of each tooth. (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 08/21/24 at 3:58 P.M. with LPN #50 confirmed Resident #62 was seen by the in-house dentist on 07/24/24 at which time the dentist wrote a referral to see an oral surgeon. Interview also confirmed that a referral to an oral surgeon was not attempted until 08/07/24 due to the lack of communication in the facility that referrals were needed. Interview also confirmed an appointment has not been made as of 08/21/24, but a referral has been sent. Review of the ancillary services policy, dated September 2021, revealed ancillary services will be provided to our residents. The facility will provide any ancillary services it offers affiliated or related companies in accordance with all statutes, regulations, and standards of professional practice applicable to such services.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on observation, medical record review, and staff interview, the facility failed to ensure residents received drinks of their preference and request in a timely manner. This affected one (Resident #13) of 25 residents residing in the memory care unit. The facility census was 105. Findings include: Medical record review for Resident #13 revealed an admitted [DATE] with diagnoses including but not limited to schizophrenia, protein calorie malnutrition, chronic obstructive pulmonary disease (COPD), alcohol abuse, tachycardia, and dementia. Review of the Minimum Data Set (MDS) assessment for Resident #13 revealed the resident was assessed with impaired cognition. Resident #13 required set up for eating, and supervision for toileting, transfers, and bed mobility, Resident #13 was on a mechanically altered diet with thin liquids. Review of the plan of care for Resident #13 dated 04/15/22, and revised on 08/19/24, revealed the resident was at risk for altered nutritional status/dehydration related to diagnosis of COPD, dementia, depression, consumed less than 75 percent (%) of meals at times, heart failure, malnutrition, risk of aspiration, swallowing problems, mechanically altered diet, and took psychotropic medications. Interventions include administered medication as ordered, encourage and provide intake throughout the day, and notify dietician, family, and physician of any signs and symptoms of dehydration. Review of the active physician orders for the month of August 2024 revealed Resident #13 had an order for regular diet with mechanical soft texture with thin consistency liquids. Observation on 08/20/24 at 5:04 P.M. revealed the second food cart left the kitchen and entered the memory care unit at 5:07 P.M. State tested Nurse Aide (STNA) #216 began passing drinks to 11 residents in the dining room. STNA #172 advised STNA #216 that the kitchen did not send enough coffee cups or coffee, and she would have to call or text the kitchen and let them know. STNA #172 was observed to have her phone in her hand and typing. Observation on 08/20/24 at 5:09 P.M. revealed STNA #216 left the dining area with the coffee carafe. Observation on 08/20/24 at 5:29 P.M. revealed Resident #13 was heard asking staff for coffee and was advised there was no coffee available at that time. Interview on 08/20/24 at 6:00 P.M. with STNA #172 verified the coffee was not delivered to the residents prior to the completion of the evening meal. STNA #172 stated the kitchen staff only sent six coffee cups and one coffee carafe to the memory care unit, and they now have about nine residents that want to have coffee with meals. STNA #172 stated Resident #13 will drink a lot of coffee and verified Resident #13 did not receive coffee when requested. STNA #172 stated they have asked management for a coffee maker for the unit but was advised that it was not permitted in the unit. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/21/24 at 6:15 P.M. with Dietary Manager #98 stated she only sent one coffee carafe to the memory care unit on 08/20/24 and no one notified her of the need for additional coffee mugs or coffee. Dietary Manager #98 stated she was notified of the need to have additional coffee and coffee mugs sent to the memory care unit today when the rumors were being told about what the surveyors were looking at. Dietary Manager #98 stated she would find out which of the residents were wanting more coffee and put that on their dietary ticket. Dietary Manager #98 further stated the problem was the residents will hoard the mugs in their rooms and then the dietary department has to order more. Dietary Manager #98 stated she did not receive a message form the staff in the unit requesting additional coffee and coffee mugs last evening.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 44069 Based on record review, review of Quality Assurance Performance Improvement (QAPI) sign-in sheets, and staff interview, the facility failed to be administered in a manner to ensure proper care and services for residents. This had the potential to affect all 105 residents residing in the facility. The census was 105. Findings include: During the annual, extended survey, and complaint survey, many area of deficient practice were identified under resident quality of life and quality of care area. Those areas included providing residents with activities of daily living assistance, providing wound care, assisting residents with range of motion needs, preventing accidents and hazards, providing catheter care, obtaining resident weights to address nutritional needs, care of a gastrostomy tube, and treatment pressure ulcers which resulted in an Immediate Jeopardy. Additionally, the facility was identified deficient in the area of sufficient staffing which also resulted in an Immediate Jeopardy. Review of the QAPI sign-in sheets for 08/14/23, 12/04/23, 02/12/24, and 06/10/24 revealed multiple different people in the role of Director of Nursing (DON). The sheets also lacked information regarding the governing body's involvement with the QAPI meetings. Review of a list provided by the facility revealed there had been four individuals in the DON position since 09/21/23. Interview on 08/29/24 at 3:27 P.M. with Registered Nurse (RN) Minimum Data Set (MDS) Coordinator #166 revealed the Administrator had asked her to fill in as the Interim DON when the facility was between DONs, but that she had never taken on responsibilities of the position. RN MDS Coordinator #166 stated she had not attended QAPI meetings or participated in addressing concerns as she was informed she did not need to be involved. RN MDS Coordinator #166 reported the lack of consistency with nursing management affected continuity of care and contributed to resident care issues being missed.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 44069 Based on record review, review of Quality Assurance Performance Improvement (QAPI) sign-in sheets, staff interview, and policy review, the facility failed to have an effective governing body to oversee the functions of the facility. This had the potential to affect all 105 residents in the facility. The census was 105. Findings include: Review of the QAPI sign-in sheets for 08/14/23, 12/04/23, 02/12/24, and 06/10/24 revealed multiple people in the role of Director of Nursing (DON). The sheets also lacked information regarding the governing body's involvement with the QAPI meetings. Review of a list provided by the facility revealed there had been four individuals in the DON position since 09/21/23. Interview on 08/29/24 at 11:25 A.M. via telephone with Physician #232 verified there had been significant turnover in nursing management at the facility. Interview on 08/29/24 at 3:15 P.M. with [NAME] President of Operations (VPO) #242 revealed the information he was learning regarding staffing levels at the facility had given him great pause and concern. Interview on 08/29/24 at 3:27 P.M. with Registered Nurse (RN) Minimum Data Set (MDS) Coordinator #166 revealed the Administrator asked her to fill in as the Interim DON when the facility was between directors, but that she had never taken on responsibilities of the position. RN MDS Coordinator #166 stated she had not attended QAPI meetings or participated in addressing concerns as she was informed she did not need to be involved. RN MDS Coordinator #166 reported the lack of consistency with nursing management affected continuity of care and contributed to resident care issues being missed. Review of the facility policy titled, Governing Body Policy and Procedure, dated 2024, revealed the governing body was responsible for establishing and implementing facility-wide policies, appointing the facility's administrator, and for the QAPI program.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on facility assessment review and staff interview, the facility failed to include staffing needs for each resident unit within the facility and time frames for adjustments as necessary with changes in the resident population. This has the potential to affect all residents in the facility. The facility census was 105. Findings include: Review of the facility assessment dated 2023 and 2024 revealed an initial approval signature page with three signatures on it. The signatures included the Administrator, the Director of Nursing (DON), and the Medical Director with a date of 05/31/24. Review of the Letter B of the facility assessment addressed staffing and staffing assignments. Further review revealed staffing would be determined using various reports to analyze the number of patients, velocity of expected admission and discharges, diagnoses and the total number and types of tasks and services required of nursing, nursing assistants and ancillary personnel. The facility assessment did not address the staffing needs required for the specialized units or the inclusion of residents in the assessment. Further review of the facility documentation revealed a lack of direct care staff involvement and how the facility will address staffing determination on weekends. Further review of the facility assessment dated [DATE] revealed on page one, the document lacked a signature for completion and a date reviewed with Quality Assurance Committee. Review of page two of the document revealed no information was initiated in the revision history page. Interview on 08/28/24 at 9:20 A.M. with the Administrator verified the facility assessment was not completed and does not include all the new requirements that became effective 08/08/24. The Administrator stated the facility did not have a policy related to the development of their facility assessment.

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. 44069 Based on record review, staff interview, and policy review, the facility failed to ensure appropriate and adequate oversight by the Medical Director. This had the potential to affect all 105 residents residing in the facility. The census was 105. Findings include: Review of the facility documentation revealed no evidence of the Medical Director's participation in addressing identified concerns and overall coordination of resident care and services. Interview on 08/29/24 at 11:25 A.M. via telephone with Physician #232 revealed he was unaware of the severity of identified concerns despite being a member of the Quality Assurance and Performance Improvement (QAPI) committee. Physician #232 stated he had not always provided the facility with his completed documentation related to resident visits. Review of the facility policy titled, Medical Director, dated 09/2021, revealed the Medical Director should be meeting periodically with nursing and other professional staff to discuss clinical and administrative issues, care problems, and offering solutions to problems.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on record review and interview, the facility failed to ensure resident medical records were complete and accurately documented. This affected one (Resident #87) one resident reviewed for notification. The facility census was 105. Findings include: Review of the medical record for Resident #87 revealed an admitted [DATE] with diagnoses of acute transverse myelitis in demyelinating disease of central nervous system and major depressive disorder. Review of the Discharge Return Anticipated Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #87 was cognitively intact. Resident #87 was assessed as independent for eating, oral hygiene, personal hygiene, and bed mobility. Resident #87 required partial assistance with toileting hygiene, transfers, and ambulating 10 feet, and required substantial assistance with bathing and dressing. Review of Resident #87's physician orders revealed no documentation that the resident was ordered to be sent to the hospital on 07/06/24. Review of Resident #87's progress notes revealed no documentation of the resident leaving the facility and being transferred to the hospital on 07/06/24. Further review of the progress notes revealed there was no documentation present that Resident #87's resident representative was made aware of resident being sent to the hospital on 07/06/24 until a phone call to the facility on [DATE] at 12:47 P.M., when the representative called to check on the resident and was informed Resident #87 was sent to the hospital on 07/06/24. Interview on 08/29/24 at 12:10 P.M., with Regional Clinical Nurse #222 confirmed there was no documentation in Resident #87's medical record related to the resident being discharged to the hospital on 07/06/24.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 44069 Based on record review, staff interview, and policy review, the facility failed to make good faith attempts to correct identified concerns with appropriate oversight from leadership as part of their Quality Assurance and Performance Improvement (QAPI) program. This had the potential to affect all 105 residents residing in the facility. The census was 105. Findings include: During the annual, extended survey, and complaint survey, many area of deficient practice were identified under resident quality of life and quality of care area. Those areas included providing residents with activities of daily living assistance, providing wound care, assisting residents with range of motion needs, preventing accidents and hazards, providing catheter care, obtaining resident weights to address nutritional needs, care of a gastrostomy tube, and treatment pressure ulcers which resulted in an Immediate Jeopardy. Additionally, the facility was identified deficient in the area of sufficient staffing which also resulted in an Immediate Jeopardy. Review of the facility QAPI program revealed the facility had no documentation regarding attempts made to improve identified deficiencies, including any goals or measures to track improvement. Interview on 08/29/24 at 3:27 P.M. with Registered Nurse (RN) Minimum Data Set (MDS) Coordinator #166 revealed the Administrator asked her to fill in as the Interim Director of Nursing (DON) when the facility was between DONs, but that she had never taken on responsibilities of the position. RN MDS Coordinator #166 stated she had not attended QAPI meetings or participated in addressing concerns as she was informed she did not need to be involved. Interview on 08/29/24 at 4:10 P.M. with Regional Clinical Nurse (RCN) #222 verified staffing was an identified concern dating back to February 2024, but there was no documentation the facility attempted to increase staffing levels at the facility to address that area of concern. Review of the facility policy titled, Quality Assurance/Performance Improvement, dated 09/2021, revealed the Quality Assessment and Assurance Committee had the responsibility to conduct a confidential and privileged review of resident care and service trends to identify opportunities for performance improvement, identify quality issues, and develop plans of action.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure staff followed infection control precautions related to handling soiled linens, providing care for residents on enhanced barrier precautions, and providing meals and eating assistance with proper hand hygiene. This had the potential to affected all 105 residents residing in the facility. The facility census was 105. Findings include: 1. Observation on 08/29/24 at 7:15 A.M. of the facility laundry room revealed Laundry Staff #176 was on the side of the room designated for sorting dirty laundry from the units. Laundry Staff #176 was sorting linens from a large plastic laundry bin with dark brown stains on them. Laundry Staff #176 was wearing a cotton uniform jacket over her uniform with gloves and no goggles. Interview on 08/29/24 at 7:20 A.M. with Laundry Staff #176 verified she was not wearing the approved personal protective equipment (PPE) when she should have been. Laundry Staff #176 verified a plastic coated jacket and goggles were available for use when sorting contaminated laundry. 2. Medical record review for Resident #41 revealed an admitted [DATE] with diagnoses including but not limited to traumatic hemorrhage of the cerebrum, hemiplegia on the right and left sides, epilepsy, respiratory failure, dysphagia, coma, persistent vegetative state, acute cystitis without hematuria, hypertension, anxiety disorder, tracheostomy status, and gastrostomy tube (g-tube) status. Review of the annual assessment for Resident #41 revealed the resident was in a persistent coma state. Resident #41 had impairments on both sides. Resident #41 was dependent for all care. Resident #41 had a feeding tube and receives 51 percent (%) of nutritional calories through parenteral feedings. Resident #41 had a tracheotomy. Review of the plan of care for Resident #41 revealed the resident was at risk for altered nutritional status related to nothing by mouth status and dependence on enteral nutrition, history of unintentional weight loss, history of feeding tube intolerance, history of skin alteration, history of weight gain with distended stomach and weight fluctuations. Interventions include to administer medication and/or vitamin/mineral supplement per physician order, change irrigation syringe every night and as needed, check placement of g-tube and if there are any concerns with placement, notify the medical provider immediately, check g-tube placement before feeding, flush, meds and as needed, elevate the head of the bed at least 30 degrees during feeding, any medication administration, and for 30 minutes after any bolus feeding/bolus flush, and enhanced barrier precautions (EBP) due to enteral tube use. Review of the active physician orders for Resident #41 was silent for any orders related to EBP. Review of the discontinued physician orders for Resident #41 revealed an order dated 08/21/24 and discontinued on 08/21/24 for EBP precautions for tracheostomy and wounds. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 08/22/24 at 12:40 P.M. of signage on Resident #41's door encased in a plastic cover advising staff of EBP. The sign indicated to stop, and everyone must clean their hands, including before entering and when leaving the room. The EBP sign revealed providers and staff must also wear gloves and a gown for the following high contact activities including; dressing, bathing and showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use including central line, urinary catheter, feeding tube, tracheostomy, and wound care as any skin opening requiring a dressing. There was a three-drawer chest outside Resident #41's room sitting on the floor with personal protective equipment (PPE) supplies including gloves, gown, and facemasks. Observation on 08/22/24 at 12:40 P.M. revealed Licensed Practical Nurse (LPN) #162 entered Resident #41's room without donning a gown and proceeded to administer medications and a treatment to the resident via g-tube. Interview on 08/22/24 at 12:52 P.M. with LPN #162 verified she did not put a gown on when providing care to Resident #41, and stated she was not aware that she needed to. LPN #162 stated there was not an order for EBP for Resident #41. Interview on 08/28/24 at 10:40 A.M. with the Director of Nursing (DON) verified Resident #41 was on EBP for her tracheostomy and g-tube. Additionally, the DON stated the residents do not have to have an order for EBP it will just be noted on the plan of care. 3. Review of the medical record for Resident #205 revealed an admitted [DATE]. Diagnoses included pleural effusion, chronic obstructive pulmonary disease (COPD), atrial fibrillation, and generalized anxiety disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #205 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 15. The resident was assessed to require setup with eating, partial assistance with toileting, bathing, and dressing, and supervision with transfers. Review of the care plan dated 08/20/24 revealed Resident #205 had an indwelling catheter for scrotal swelling. Interventions included EBPs, monitor for signs and symptoms of urinary tract infection and report to the physician, report signs of peri-area redness, irritation, and document output, staff to keep tubing free of kinds and twists, and provide peri-care prior to application and after removal of external catheter. Observation on 08/21/24 at 8:38 A.M. revealed LPN #18 emptied Resident #205's urinal without applying a gown due to EBP. Interview on 08/21/24 at 8:43 A.M. with LPN #18 verified she did not apply a gown when handling Resident #205's urinal. LPN #18 verified she did not know why Resident #205 was in EBP. Review of the facility policy titled, Enhanced Barrier Precautions (EBP), dated 01/2024, revealed EBPs are an infection control method used in the facility to reduce transmission of drug-resistant organisms. Under the title of policy interpretation and implementation EBP refers to the use of gown and gloves during high contact care for residents that have known infections or colonization of a resistant organism, chronic wounds and indwelling medical devices. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. Observation on 08/20/24 at 5:07 P.M. revealed two dietary members placed the memory care unit food cart just inside the unit doors. State tested Nurse Aide (STNA) #172 pushed the food cart to the dining room where eleven residents sat at dining room tables. STNA #216 began removing trays from the food cart and taking them into the hallway. Observation on 08/20/24 at approximately 5:09 P.M. revealed STNA #172 began pulling evening meal trays from the food cart and serving residents one table at a time. STNA #172 was observed uncovering the main entree, removing plastic lids from soup bowls, uncovering chocolate chip cookies from a small plate covered with plastic, and placing them in front of the residents. Observation on 08/20/24 at 5:11 P.M. revealed STNA #172 removed a tray from the food cart for Resident #24 and placed the tray in front of her. STNA uncovered the chocolate chip cookies and when she placed them on the table they slide to the side of the plate touching her fingers. STNA continued to crush the crackers in the plastic package and empty them into the soup bowl. STNA #172 did not complete hand hygiene. Observation on 08/20/24 at 5:19 P.M. revealed STNA #172 removed a food tray from the cart and left the dining area. STNA #172 returned to the dining room at 5:22 P.M. and all trays were delivered to the residents in the dining room at that time. Interview on 08/20/24 at 5:32 P.M. with STNA #172 stated the staff did not have to complete hand hygiene between each tray as long as they were not touching the food. STNA #172 verified she did not complete hand hygiene between trays for all residents currently in the dining room. Observation on 08/20/24 at 5:39 P.M. revealed STNA #172 sat with Resident #204 and Resident #69. Resident #204 was prompted to eat his meal and Resident #69 was spoon fed by the nurse aide. STNA #172 got up and left the residents when she observed another resident carrying her tray from the table towards the food cart. While STNA #172 was away from the table, Resident #204 began to pull apart the saturated meal ticket with his fork and placed a section of the paper into his mouth. STNA #172 was advised of the action and returned to the table when she used her bare hands to remove the paper hanging out of Resident #204's mouth. STNA #172 then picked up a chocolate chip cookie and broke it in half using her bare hands and handed it to Resident #69. STNA #172 observed another resident picking up food left on a tray by another resident and attempted to eat it. STNA intervened and removed the food from that resident's hands. STNA #172 then picked up the dishes and silverware and placed them on the tray, returning the tray to the food cart. STNA #172 then returned to Resident #204 and Resident #69 and picked up spoon and feed Resident #69 his soup. Interview on 08/20/24 at 5:41 P.M. with STNA #172 verified she did not complete hand hygiene after picking up trays from other residents and retuning to feed Resident #69. STNA #172 stated she was usually always by herself back on the memory care unit. STNA #172 stated Resident #69 could feed himself at times but today he needed more help and Resident #204 had only been on the unit for a few days. Interview on 08/29/24 at 11:39 A.M. with the DON verified staff should be using hand sanitizer between each tray or handling a dirty tray.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on medical record review, staff interview, and policy review, the facility failed to ensure residents received pneumococcal vaccinations as ordered. This affected two (Residents #38 and #71) of five residents reviewed for immunizations. The facility census was 105. Findings include: 1. Medical record review for Resident #38 revealed an admitted [DATE] with diagnoses including but not limited to schizophrenia, type two diabetes, peripheral vascular disease, and Charcot's joint. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #38 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 10. The resident was assessed as dependent with eating, toileting, bathing, dressing, and transfers. Review of the facility's vaccine informed consent form for Resident #38 dated 11/21/23 at 7:17 A.M. revealed the resident was offered and accepted pneumococcal vaccinations of Pneumococcal 15-valent conjugate vaccine (PCV-15) PVC-20, and PVC-23. Under the acknowledgement section of the document, it revealed the resident's representative indicated they received the vaccine information and understand the risks and benefits of receiving the vaccine. Review of the physician orders for Resident #38 revealed an order to administer the pneumococcal vaccine Prevnar 20 intramuscular (IM) suspension prefilled syringe 0.5 milliliters (ml) intramuscularly one time only dated 11/21/23. Review of the medication administration record (MAR) for Resident #38 for the month of 11/01/23 through 11/30/23 revealed the resident did not receive the Prevnar 20 vaccine as ordered. 2. Medical record review for Resident #71 revealed an admitted [DATE] with diagnoses including but not limited to suicidal ideation, hyperparathyroidism, hypertension, type two diabetes, osteoarthritis and obesity. Review of the MDS assessment dated [DATE] revealed Resident #38 had moderate cognitive impairment as evidenced by a BIMS score of 10. The resident was assessed as dependent with eating, toileting, bathing, dressing, and transfers. Review of the facility's vaccine informed consent form for Resident #71 dated 11/20/23 at 2:40 P.M. revealed the resident was offered and accepted PVC-15, PVC-20, and PVC-23. Under the acknowledgement section of the document, it revealed the resident's representative indicated they received the vaccine information statements and understand the risks and benefits of receiving the vaccine. Review of the physician orders for Resident #71 revealed an order to Prevnar 20 IM suspension prefilled syringe 0.5 ml intramuscularly one time only dated 11/20/23. Review of the MAR for Resident #71 for the month of 11/01/23 through 11/30/23 revealed the resident did not receive the Prevnar 20 vaccine as ordered. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/28/24 at 4:48 P.M. with the Director of Nursing (DON) verified Resident #38 and Resident #71 were ordered pneumococcal vaccine and did not received them as ordered. Review of the undated facility policy titled, Pneumococcal Vaccine, revealed residents will be offered pneumococcal vaccines to aid in the prevention of the infections. Residents will be assessed for the eligibility to receive the vaccine, and before receiving the vaccine the resident or resident legal representative will be provided with information and education of the vaccine.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44069 Based on observation, medical record review, and staff interview, the facility failed to maintain a safe environment. This affected one (Resident #76) out of one resident reviewed for environment. The facility census was 105. Findings include: Review of the medical record for Resident #76 revealed an admitted [DATE]. Diagnoses included schizoaffective disorder, bipolar disorder, hypertension, paranoid schizophrenia, and unspecified psychosis not due to a substance or known physiological condition. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #76 was cognitively intact. Resident #76 was assessed to require set-up assistance for eating, oral hygiene, toileting, bathing, dressing, personal hygiene, bed mobility, and transfer. Interview on 08/29/24 at 10:00 A.M. with the Administrator revealed Resident #76 fell while engaging in an activity outside the facility. The Administrator stated there was an uncovered pipe in the grassy area near the facility's sign. Interview on 08/29/24 at 10:23 A.M. with Maintenance Director (MD) #72 revealed he was just informed about the area outside the facility. Observation on 08/29/24 at 10:30 A.M. with MD #72 of the area outside the facility revealed an uncovered vertical white pipe that measured approximately nine inches wide. MD #72 stated the pipe was a water pipe that belonged to the city, and he was going to keep it covered with orange cones until a cover was received. This deficiency represents non-compliance investigated under Complaint Number OH00156885 and Complaint Number OH00155787.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on observation, medical record review, staff interview, review of pest control visit documentation, and review of a facility policy, the facility failed to maintain an environment which was free from pests. This affected two (Residents #4 and #5) of two reviewed for environment. The facility census was 105. Findings include: 1. Review of the medical record for Resident #5 revealed an admitted [DATE] with diagnoses of cervical disc disorder with myelopathy, mid-cervical region and contractures of bilateral hips and knees. Review of the Minimum Date Set (MDS) assessment dated [DATE] revealed Resident #5 required set-up assistance with eating and oral hygiene, and was dependent on staff assistance for toileting hygiene, bathing, dressing, personal hygiene, bed mobility, and wheelchair mobility. Review the care plan dated 01/17/24 revealed Resident #5 required a two-person assistance with bed mobility. Observation on 08/19/24 at 2:03 P.M. revealed Resident #5 lying in bed with multiple flies flying around and landing on the resident. Interview on 08/19/24 at 2:04 P.M. with Manager of Activities #20 confirmed multiple flies present in the resident's bed and on the resident's buttocks and feet. Manager of Activities #20 also confirmed the resident had multiple flies on her right hip. Manager of Activities #20 also confirmed she was not aware of any interventions to reduce the pests in Resident #5's room. Observation on 08/20/24 at 8:27 A.M. revealed Resident #5 lying in bed, with gnats flying above the resident's head. Interview on 08/20/24 at 8:29 A.M. with Licensed Practical Nurse (LPN) #50 confirmed the presence of gnats flying around Resident #5. Observation on 08/26/24 at 10:34 A.M. revealed Resident #5 had flies flying around the resident and flies landing on her right hip. Interview on 08/26/24 at 10:34 A.M. with LPN #50 confirmed Resident #5 had flies flying around her and had flies on her right hip while resident was lying in bed. 44412 2. Review of the medical record for Resident #4 revealed an admitted [DATE]. Diagnoses included psychosis, dementia, major depressive disorder, and schizoaffective disorder. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS assessment dated [DATE] revealed Resident #4 was not able to complete a Brief Interview for Mental Status (BIMS) because she was rarely or never understood. The resident was assessed to be dependent with eating, toileting, bathing, dressing, and transfers. Review of the care plan dated 07/26/24 revealed Resident #4 had impaired skin integrity as evidenced by a pressure area to the coccyx. Interventions included assist with turning and repositioning as needed, complete skin inspection every seven to 10 days and as needed, complete wound evaluation to monitor the progress of the skin condition, enhanced barrier precautions, medications per orders, and good nutrition and hydration. Observations from 08/19/24 through 08/29/24 at various times revealed Resident #4 had flies in her room and on her body near the wound. Interview on 08/22/24 at 12:24 P.M. with State tested Nurse Aide (STNA) #46 verified Resident #4's room had flies present and were noted on her body near her coccyx wound. Interview on 08/27/24 at 1:01 P.M. with LPN #18 verified Resident #4's room had flies present and were noted on her body near the coccyx wound. Review of the Pest Control invoices dated 07/12/24, 07/26/24, 08/05/24, and 08/23/24 revealed no pest control treatment completed during the visits listed for gnats, flies, or flying insects. Review of the facility policy titled, Pest Control, dated September 2021, revealed the facility would provide an environment free of pests. Monitoring of the environment would be done by the facility's staff. Pest control problems would be reported promptly to the contractor.