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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365898	A. Building B. Wing	03/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Divine Rehabilitation and Nursing at Sylvania	5757 Whiteford Rd Sylvania, OH 43560

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 41528 Based on medical record review, observation, staff interview and review of facility policy, the facility failed to ensure residents were treated in a dignified manner. This affected one (#31) of three residents reviewed for dignity. The facility census was 75. Findings include: Review of the medical record revealed Resident #31 was admitted on [DATE]. Diagnoses included polyosteoarthritis, dementia, and presence of cerebrospinal fluid drainage device. Review of the Minimum Data Set (MDS) assessment, dated 01/29/25, revealed Resident #31 was severely cognitively impaired. Resident #31 required set-up or clean-up assistance with eating. Review of the most recent care plan revealed Resident #31 required assistance with activities of daily living and needs supervision and set up assistance with all meals. Observation on 03/05/25 at 8:11 A.M. revealed Certified Nursing Assistant (CNA) #353 standing over Resident #31 while in bed providing him a bite of a banana and two spoonfuls of yogurt. Interview on 03/05/25 at 8:16 A.M. with CNA #353 stated Resident #31 at times needs assistance with eating and will come and go out of his room to offer a few bites to eat at a time. CNA #353 verified standing over Resident #31 while assisting him with the breakfast meal. Review of the policy titled Promoting/Maintaining Resident Dignity dated 2024 revealed all staff members are involved in providing care to residents to promote and maintain resident dignity and respect for resident rights. This deficiency represents non-compliance investigated under Complaint Number OH00161509.

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

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

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F 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** 41528 Based on medical record review, observation, resident interview, staff interview, and review of facility policy, the facility failed to ensure call lights were accessible to residents. This affected two (#49 and #70) of two residents reviewed for call lights. The facility census was 75. Findings include: 1. Review of the medical record revealed Resident #49 was admitted on [DATE]. Diagnoses included Parkinson's disease with dyskinesia, neurocognitive disorders with lewy bodies, dementia, and major depressive disorder. Review of the care plan, revised 07/04/24, revealed Resident #49 was at risk for falls due to gait/balance problems, Parkinson's disease, dementia with lewy body, arthritis, and required assistance with transfers and incontinence. Interventions include to educate the resident on the use of walker and call light and to reinforce the resident to call for assistance. Review of the Minimum Data Set (MDS) assessment, dated 12/30/24, revealed Resident #49 was moderately cognitively impaired and required partial/moderate assistance with toileting, showers, and upper and lower body dressing. Observation on 03/05/25 at 8:00 A.M. revealed Resident #49 was lying in bed with the head of the bed in an upright position with pillows behind the resident's head. Resident #49 appeared to be in an uncomfortable position. The bed remote was observed to be hung above the foot of the bed near the door and the call light was unreachable on the floor on the other side of the bedside table. Interview on 03/05/25 at 8:01 A.M. with Resident #49 stated she was uncomfortable and was unable to adjust the bed due to the bed remote being unreachable. Resident #49 stated the call light was out of reach because the staff do not like her. Interview on 03/05/25 at 8:05 A.M. with Unit Manager Licensed Practical Nurse (LPN) #390 verified the bed remote and call light were inaccessible to Resident #49. 51528 2. Review of the medical record for Resident #70 revealed an admitted [DATE]. Diagnoses included anoxic brain damage, myocardial infarction, tracheostomy status, and generalized idiopathic epilepsy and epileptic syndromes. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #70 has moderate cognitive impairment and was dependent on staff for all activity of daily living (ADLs). Review of Resident #70's care plan dated 11/13/24 revealed an intervention to ensure Resident #70's call light device was always placed in her right hand and encourage the resident to use the call light for assistance as needed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/03/25 at 10:00 A.M. revealed Resident #70 was lying in bed with her call light on the left side of bed around bed rail hanging towards the ground. Interview on 03/03/25 at 10:05 A.M. with Licensed Practical Nurse (LPN) #500 confirmed Resident #70's call light was not within reach. LPN #500 stated Resident #70 was unable to use the call light. LPN #500 stated she was not aware Resident #70 couldn't use her right side. Observation on 03/04/25 at 8:30 A.M. revealed the facility had changed Resident #70's call light from a call button to a tap call light. The call light remained on the left side. Additional observation on 03/04/25 at 10:45 A.M. and 3:04 P.M. revealed the call button continued on the left side of Resident #70. Interview on 03/04/25 at 3:22 P.M. with LPN #313 confirmed Resident #70's call light was on the left side of the bed. LPN #313 stated the reason it was on the left side was because it could not reach to the right side. LPN #313 stated Resident #70 could use both hands equally. LPN #313 was not aware of the care plan stating to keep the call light on the right side of the bed. Interview on 03/04/25 at 3:29 P.M. with the Director of Nursing (DON) confirmed Resident #70's call light should be placed on the right side of the resident. Review of the policy titled Call Lights: Accessibility and Timely Response dated 09/26/24 revealed all staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light. Staff will ensure the call light is within reach of the resident and secured, as needed.

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on medical record review, resident and staff interview, and review of facility policy, the facility failed to provide timely access to medical records as requested. This affected one (#26) of 24 residents reviewed for medical record access in a facility census of 75. Findings include: Review of Resident #26's medical record revealed the was resident was admitted to the facility on [DATE]. Diagnoses included anxiety disorder, borderline personality disorder, and insomnia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 had intact cognition, and had no behaviors recorded. On 03/03/25 at 11:19 A.M., an interview with Resident #26 revealed he was experiencing dental pain and concerns. Resident #26 had requested access and copies of dental information contained in his medical record. Resident #26 indicated the verbal request was made to the Director of Nursing (DON) approximately two weeks ago and no access had been provided. Interview with the DON on 03/04/25 at 11:32 A.M. confirmed Resident #26 had requested copies of dental records from his medical record approximately two weeks ago. The DON indicated she had not yet provided copies as requested. Review of the facility's undated policy titled Release of Medical Records revealed requests for records should be referred to Director of Nursing or Administrator, or another staff member previously designated by the facility. The resident's record is accessible to him/her within 24 hours (excluding weekends and holidays) notice, following an oral or written request.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	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** 35033 Based on review of the medical record, staff interview, and policy review, the facility failed to ensure residents and/or resident representatives were provided with the notice of transfer/discharge. This affected four (#78, #79, #180, and #181) of four residents reviewed for transfer/discharge. The facility identified 12 residents sent to the hospital in the past 90 days. The facility census was 75. Findings include: 1. Review of the medical record for Resident #78 revealed an admitted [DATE] and a discharge date d of 12/04/24. Review of a nursing note dated 12/04/24 at 12:03 P.M. revealed Resident #78 was sent to the hospital for shortness of breath. There was no documentation the resident was provided with a notice of transfer/discharge to the hospital. Interview on 03/06/25 at 8:10 A.M. with the Administrator verified the facility had not provided the notice of transfer/discharge to Resident #78 or resident representatives who transferred/discharged to the hospital on 12/04/24. 2. Review of the medical record for Resident #180 revealed an admitted [DATE] and a discharge date of [DATE]. Review of a nursing note dated 12/27/24 at 2:07 P.M. revealed Resident #180 was sent to the hospital for abnormal laboratory values. There was no documentation the resident was provided with a notice of transfer/discharge to the hospital. Interview on 03/06/25 at 8:10 A.M. with the Administrator verified the facility had not provided the notice of transfer/discharge to Resident #180 or resident representatives who transferred/discharged to the hospital on 12/27/24. 3. Review of the medical record for Resident #181 revealed an admitted [DATE] and a discharge date of [DATE]. Review of a nursing note dated 01/11/25 at 8:15 A.M. revealed Resident #181 was sent to the hospital. There was no documentation the resident was provided with a notice of transfer/discharge to the hospital. Interview on 03/06/25 at 8:10 A.M. with the Administrator verified the facility had not provided the notice of transfer/discharge to Resident #181 or resident representatives who transferred/discharged to the hospital on 01/11/25. 4. Review of the medical record for Resident #79 revealed an admitted [DATE] and a discharge date of [DATE]. Review of a nursing note dated 02/07/25 at 1:13 P.M. revealed Resident #79 had a change in condition and sent to the hospital for evaluation. There was no documentation the resident was provided with a notice of transfer/discharge to the hospital. Interview on 03/06/25 at 8:10 A.M. with the Administrator verified the facility had not provided the notice of transfer/discharge to Resident #79 or resident representatives who transferred/discharged to the hospital on 02/07/25. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the facility policy titled Transfer and Discharge, dated 2025, revealed the facility transfer/discharge notice would be provided to the resident and resident's representative in a language and manner in which they can understand.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on review of the medical record, staff interview, and policy review, the facility failed to ensure residents and/or resident representatives were provided a bed hold notice at the time of transfer. This affected four (#78, #79, #180, and #181) of four residents reviewed for transfer/discharge. The facility identified 12 residents sent to the hospital in the past 90 days. The facility census was 75. Findings include: 1. Review of the medical record for Resident #78 revealed an admitted [DATE] and a discharge date d of 12/04/24. Review of a nursing note dated 12/04/24 at 12:03 P.M. revealed Resident #78 was sent to the hospital for shortness of breath. There was no documentation the resident was provided a bed hold notice at the time of transfer. Interview on 03/06/25 at 8:10 A.M. with the Administrator verified the facility had not provided the bed hold notice at the time of transfer to Resident #78 or resident representatives who transferred to the hospital on 12/04/24. 2. Review of the medical record for Resident #180 revealed an admitted [DATE] and a discharge date of [DATE]. Review of a nursing note dated 12/27/24 at 2:07 P.M. revealed Resident #180 was sent to the hospital for abnormal laboratory values. There was no documentation the resident was provided a bed hold notice at the time of transfer. Interview on 03/06/25 at 8:10 A.M. with the Administrator verified the facility had not provided the bed hold notice at the time of transfer to Resident #180 or resident representatives who transferred to the hospital on 12/27/24. 3. Review of the medical record for Resident #181 revealed an admitted [DATE] and a discharge date of [DATE]. Review of a nursing note dated 01/11/25 at 8:15 A.M. revealed Resident #181 was sent to the hospital. There was no documentation the resident was provided a bed hold notice at the time of transfer. Interview on 03/06/25 at 8:10 A.M. with the Administrator verified the facility had not provided the bed hold notice at the time of transfer to Resident #181 or resident representatives who transferred to the hospital on 01/11/25. 4. Review of the medical record for Resident #79 revealed an admitted [DATE] and a discharge date of [DATE]. Review of a nursing note dated 02/07/25 at 1:13 P.M. revealed Resident #79 had a change in condition and sent to the hospital for evaluation. There was no documentation the resident was provided a bed hold notice at the time of transfer. Interview on 03/06/25 at 8:10 A.M. with the Administrator verified the facility had not provided the bed hold notice at the time of transfer to Resident #79 or resident representatives who transferred to the hospital on 02/07/25. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the facility policy titled Bed Hold Notice Upon Transfer, revised 09/26/24, revealed at the time of transfer for hospitalization or therapeutic leave, the facility would provide the resident and/or representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41528 Based on medical record review, resident and staff interview, and review of facility policy, the facility failed to ensure care plan conferences were conducted quarterly for the resident and/or resident representative. This affected six (#14, #18, #43, #49, #58 and #60) of seven residents reviewed for care plan conferences. The facility census was 75. Findings include: 1. Review of the medical record revealed Resident #14 was admitted on [DATE]. Diagnoses included injury at T1 level of thoracic spinal cord, paralytic syndrome, diffuse traumatic brain injury with loss of consciousness of unspecified duration, paraplegia, major depressive disorder, and heart failure. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #14 was moderately cognitively impaired. Review of the care plan conferences, from 01/01/24 to 03/04/25, revealed Resident #14 had two care conferences on 02/05/24 and 12/25/24. Interview on 03/05/25 at 8:35 A.M. with Social Services #401 verified Resident #14 had only two care conferences the past year. 2. Review of the medical record revealed Resident #18 was admitted on [DATE]. Diagnoses included unspecified dementia, dysphagia oropharyngeal phase, cognitive communication deficit, type two diabetes mellitus without complications, major depressive disorder recurrent, hypothyroidism, and essential hypertension. Review of the Minimum Data Set (MDS) assessment, dated 01/03/25, revealed Resident #18 was moderately cognitively impaired. Review of care plan conferences from 01/01/24 to 03/04/25 revealed Resident #18 had one care conference on 02/15/24. Interview on 03/05/25 at 8:35 A.M. with Social Services #401 verified Resident #18 had only one care conference the past year. 3. Review of the medical record revealed Resident #43 was admitted on [DATE]. Diagnoses included chronic obstructive pulmonary disease, heart failure, muscle weakness, and major depressive disorder recurrent. Review of the Minimum Data Set (MDS) assessment, dated 02/10/25, revealed Resident #43 was moderately cognitively impaired. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of care plan conferences from 01/01/24 to 03/04/25 revealed Resident #43 had two care conferences on 01/17/24 and 11/26/24. Interview on 03/05/25 at 8:35 A.M. with Social Services #401 verified Resident #43 had only two care conferences the past year. 4. Review of the medical record revealed Resident #49 was admitted on [DATE]. Diagnoses included Parkinson's disease with dyskinesia, neurocognitive disorders with lewy bodies, dementia, major depressive disorder recurrent, and essential hypertension. Review of the Minimum Data Set (MDS) assessment, dated 12/30/24, revealed Resident #49 was moderately cognitively impaired. Review of care plan conferences from 01/01/24 to 03/04/25 revealed Resident #49 did not have a care conference during this time period reviewed. Interview on 03/03/24 at 10:42 A.M. with Resident #49 stated she did not have knowledge of care conferences. Interview on 03/05/25 at 8:35 A.M. with Social Services #401 verified Resident #49 did not have any care conferences the past year. 5. Review of the medical record revealed Resident #58 was admitted on [DATE]. Diagnoses included primary generalized osteoarthritis, acute kidney failure, essential hypertension, hyperlipidemia, delusional disorders, and generalized anxiety disorder. Review of the Minimum Data Set (MDS) assessment, dated 02/27/25, revealed Resident #58 was cognitively intact. Review of care plan conferences from 01/01/24 to 03/04/25 revealed Resident #58 had two care conferences on 02/11/24 and 02/21/25. Interview on 03/06/25 at 9:26 A.M. with Social Services #401 verified Resident #58 had only two care conferences in the past year. 6. Review of the medical record revealed Resident #60 was admitted on [DATE]. Diagnoses included hemiplegia affecting left dominant side, acute cholecystitis, cerebral infarction, acute kidney failure, chronic atrial fibrillation, and chronic systolic congestive heart failure. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 was cognitively intact. Review of care plan conferences from 01/01/24 to 03/04/25 revealed Resident #60 had one care conference on 02/28/24. Interview on 03/06/25 at 9:26 A.M. with Social Services #401 verified Resident #60 had only one care conference in the past year. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy titled Care Planning- Resident Participation dated 2024 revealed the facility supports the resident's right to be informed of, and participate in, his or her care planning and treatment. The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences and allow them to see the care plan, initially at routine intervals, and after significant changes. The facility will make an effort to schedule the conferences at the best time of the day for the resident/resident's representative.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 15816 Based on observation, medical record review, resident and staff interview, and facility policy review, the facility failed to ensure residents who were dependent on staff for activities of daily living (ADL) were provided with adequate assistance with grooming and hygiene. This affected three (#14, #42 and #60) of 24 residents reviewed for ADL. The facility census was 75. Findings include: 1. Medical record review for Resident #42 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, type II diabetes mellitus, morbid obesity, acute and chronic respiratory failure, depression, lymphedema, congestive heart failure, and anxiety disorder. On 07/23/24, a nursing plan of care was implemented to address Resident #42's ADL self-care performance deficit related to activity intolerance, shortness of breath with exertion, morbid obesity, heart failure, and unable to reach all body parts. Interventions included Resident #42 required physical assistance of staff with bathing. Provide sponge bath when a full bath or shower cannot be tolerated. Needs physical assistance of staff to turn and reposition in bed. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #42 had intact cognition and had no behaviors or refusal of care, Resident #42 required substantial to maximal assistance with ADL including bathing/showering. Resident #42 required supervision to touching assistance with personal hygiene. Review of the certified nursing assistance (CNA) task for Resident #42 revealed Resident #42 was to receive scheduled showers on day shift Wednesday and Saturday. Review of comprehensive CNA shower review documentation revealed Resident #42 was provided with bed baths on 02/05/25, 02/08/25, 02/12/25, 02/15/25, 02/19/25, 02/22/25, and 02/26/25. No documentation recorded a bath provided on 03/01/25. There was no documentation indicating Resident #42's hair was washed or facial hair was removed. Observation on 03/03/25 at 11:38 A.M. revealed Resident #42 was lying in bed. Resident #41 stated she did not get bed baths twice weekly as scheduled and had not had her hair washed in an undetermined amount of time. Resident #42 was noted with long orange facial hair to the chin and upper lip. Resident #42's hair appeared long, matted and greasy. Resident #42 stated she preferred to have facial hair removed. Interview on 03/04/25 at 3:13 P.M. with Unit Manager Licensed Practical Nurse (UMLPN) #390 verified no information was available indicating when Resident #42's facial hair was last groomed or hair washed. In addition, Resident #42 was not provided with a documented bath as scheduled on 03/01/25. 41528 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record revealed Resident #14 was admitted on [DATE]. Diagnoses included injury at T1 level of thoracic spinal cord, paralytic syndrome, diffuse traumatic brain injury with loss of consciousness of unspecified duration, and paraplegia. Review of the Minimum Data Set (MDS) assessment, dated 02/09/25, revealed Resident #14 was moderately cognitively impaired and dependent on staff for showers/bathes. Review of the care plan, revised on 08/19/24, revealed Resident #14 had an ADL self-care performance deficit due to paraplegia, weakness, and pain. Resident #14 was totally dependent on one staff to provide showers and a sponge bath should be provided when a full bath or shower cannot be tolerated. Review of the shower task list, revealed Resident #14 was scheduled for a shower every Monday, Wednesday, and Friday. Review of the shower task, reviewed the last thirty days, revealed three showers (02/10/25, 02/12/25, and 03/05/25), three bed baths (02/19/25, 02/26/25, and 03/04/25), and one sponge bath (03/03/25) was provided. Interview on 03/03/25 at 1:36 P.M. with Resident #14 stated it had been a while since he had been provided a shower. Resident #14 stated he always prefers a shower but staff often provided a bed bath instead. Subsequent interview on 03/10/25 at 9:04 A.M. with Resident #14 stated he was never offered a shower on Friday 03/07/25. Interview on 03/10/25 at 10:18 A.M. with the Director of Nursing (DON) verified Resident #14 did not receive showers as scheduled. The DON reported Resident #14 will often refuse and verified there was no documentation of resident refusals. 3. Review of the medical record revealed Resident #60 was admitted on [DATE]. Diagnoses included hemiplegia affecting left dominant side, acute cholecystitis, cerebral infarction, acute kidney failure, chronic atrial fibrillation, and chronic systolic congestive heart failure. Review of the Minimum Data Set (MDS) assessment, dated 01/23/25, revealed Resident #60 was cognitively intact and was dependent on staff for showers/baths. Review of the care plan, revised 06/2024, revealed Resident #60 had an ADL self-performance deficit due to activity intolerance, congestive heart failure, cardiomyopathy, cirrhosis, hemiplegia, and cerebrovascular accident. Resident #60 was dependent on staff for bathing/showering. A sponge bath should be provided when a full bath or shower cannot be tolerated. Review of the shower task list revealed Resident #60 was scheduled for a shower every Tuesday and Friday. Review of the shower task, reviewed the last thirty days, revealed three bed baths (02/11/25, 02/14/25, and 03/04/25) were provided. No showers were provided to Resident #60 in the last 30 days. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Divine Rehabilitation and Nursing at Sylvania	5757 Whiteford Rd Sylvania, OH 43560

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/04/25 at 7:56 A.M. with Resident #60 stated he was scheduled showers two times a week but rarely receives a shower. Resident #60 stated he has not received a shower since 01/17/25. Resident #60 stated the aides report the shower cot was broken and a shower cannot be provided. Interview on 03/05/25 at 3:39 P.M. with Certified Nursing Assistant (CNA) #374 stated the shower cot Resident #60 uses has a stuck wheel and the other shower chairs were not safe for the resident so he has only been provided bed baths for some time. Interview on 03/05/25 at 4:11 P.M. with Unit Manager Licensed Practical Nurse (LPN) #390 verified the shower cot was available for use and had no knowledge of a broken or stuck wheel. Subsequent interview with CNA #385 stated the shower cot wheel may stick and be difficult to use with weight however two staff would be able to assist Resident #60 safely on the shower cot. CNA #385 stated there was also another shower chair option that would be appropriate for Resident #60. Interview on 03/06/25 at 8:35 A.M. with the Administrator and Director of Nursing (DON) verified Resident #60 had four bed baths and no showers in the last thirty days. Review of the ADL facility policy last reviewed/revised on 09/26/24 revealed care and services will be provided for the following ADLs: Bathing, dressing, grooming, and oral care. A resident who is unable to carry out ADLs will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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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 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** 15816 Based on observation, medical record review, resident interview, and physician and staff interview, the facility failed to ensure wound treatments and edema management equipment were implemented in accordance with physician orders. This affected two (Residents #42 and #44) of two residents reviewed with skin conditions in a facility census of 75. Findings include: 1. Review of the medical record revealed Resident #44 was admitted to the facility on [DATE]. Diagnoses included encephalopathy, type II diabetes mellitus, congestive heart failure, and right and left lower leg contracture. On 11/08/24, a nursing plan of care was developed to address Resident #44's behavior of picking at skin causing numerous scabbed area on both arms and upper chest. Interventions included the following: Apply any treatment per orders and monitor effectiveness. Monitor/document/report scabbed areas for signs and symptoms of infection (redness, drainage, swelling, pain). Refer to wound care as needed. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #44 had intact cognition, bilateral lower extremity range of motion impairments, dependent on staff for the completion of activities of daily living, and was at risk for pressure ulcer development with no skin breakdown. According to wound specialist physician evaluation and management summary dated 02/26/25, Resident #44 was referred to wound management due to a trauma wound injury to the knee. The wound was described as a cluster and measured 20.0 centimeters (cm) long by (x) 0.7 cm wide x 0.1 cm deep with no exudate. On 02/26/25, a physician order was initiated to cleanse area to left knee with normal saline, pat dry, apply Xeroform and cover with Border gauze on day shift, every Monday, Wednesday, and Friday for wound care. Observation on 03/03/25 at 10:53 A.M. revealed Resident #44 was lying in with bed with his left leg exposing a dressing to the knee. The dressing was dated 02/26 and the exterior of the wound dressing noted small amount of red dried drainage penetrating the dressing. Interview on 03/03/25 at 10:59 A.M. with Licensed Practical Nurse (LPN) #407 verified documentation contained in the medical record noted the dressing last changed on 02/26/25. Observation at the time confirmed the dressing was dated 02/26/[25] and was to be changed on 02/28/25. On 03/05/25 at 12:04 P.M., an observation and interview with Wound Specialist Physician (WSP) #700 verified the wound origin was trauma from an existing scar with Resident #44 scratching causing the wound to open. The wound was measured as a cluster measurement 19 centimeters (cm) by (x) 0.8 cm x 0.1 cm. WSP #700 confirmed Resident #44's dressing was to be changed every Monday, Wednesday and Friday. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record revealed Resident #42 admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, type II diabetes mellitus, morbid obesity, acute and chronic respiratory failure, lymphedema, congestive heart failure, and anxiety disorder. On 07/16/24, a nursing plan of care was developed to address Resident #42's impaired circulation related to chronic lymphedema. Interventions included to apply lymphedema pumps per orders. Elevate legs when resting. On 07/23/24, a plan of care was developed to address Resident #42's diuretic therapy related to edema. Interventions included the resident uses lymphedema pumps, apply as ordered. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #42 had intact cognition, no behaviors or refusal of care, required substantial to maximal assistance with activities of daily living (ADL) including lower body dressing, incontinent of bowel and bladder, and received oxygen therapy. On 09/20/24, a physician order was obtained for lymphedema pumps twice daily for one hour every shift for lymphedema. The order lacked pump settings or designated times to apply the lymph edema pumps. Review of Resident #42's medication administration records (MAR) revealed the lymphedema boots were applied at an undetermined time or time frame on 03/03/25 during the 7:00 P.M. to 7:00 A.M. (03/04/25) shift. Licensed Practical Nurse (LPN) #386 had made the entry in the medical record. Observation and interview on 03/03/25 at 11:37 A.M. revealed the lymphedema boots and pump placed at Resident #42's foot of the bed. The pump setting was 55 millimeters of mercury (mmHg). Resident #42 stated the pumps were not applied daily and when the pumps were applied, they were left on too long causing pain to her legs. On 03/04/25 at 5:45 A.M., an interview with LPN #386 stated Resident #42 had refused the application of the lymphedema boots during the 7:00 P.M. to 7:00 A.M. (03/04/25) shift. LPN #386 verified she documented the boots were applied and and did not document Resident #42 refused. On 03/06/25 at 11:58 A.M., an interview with the Director of Nursing (DON) confirmed Resident #42 did not have a setting order for lymphedema boots. Subsequent review of the medical record noted on 03/06/25 at 7:00 P.M., an order was obtained for the lymphedema settings: right (R) Leg: 20 mmHg, left (L) leg: 20 mmHg; cycle time: 60 seconds; treatment time: 60 minutes. Observation and interview on 03/10/25 at 9:50 A.M. with Unit Manager LPN #390 verified Resident #42's lymphedema boot settings were at 55 mmHg. LPN #390 verified the lymphedema pump was not set at the pressure settings ordered by the physician.

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F 0686

Level of Harm - Actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 35033

Based on observation, interviews with facility staff and the wound physician, review of the medical record, review of the guidelines from the National Pressure Ulcer Advisory Panel (NPUAP), and policy review, the facility failed to ensure a resident's skin impairment was identified timely and a treatment initiated. This resulted in Actual Harm to Resident #68 on 01/30/25 when the facility failed to assess a resident's wound and obtain physician orders for wound treatments resulting in Resident #68 developing an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed) requiring debridement. This affected one (#68) of two residents reviewed for pressure ulcers. The facility identified five residents with pressure ulcers. The facility census was 75.

Findings include

Review of the medical record revealed Resident #68 had an admitted [DATE] and a readmitted [DATE]. Diagnoses included dementia, heart failure, and type two diabetes mellitus.

Review of the hospital progress notes dated 01/30/25 revealed Resident #68 had excoriation to the buttocks. There was no documentation the resident had a pressure ulcer to the coccyx.

Review of a nursing admission skin assessment dated [DATE] revealed Resident #68 was noted with skin impairment to the coccyx and right and left inner buttocks. There was no wound assessment completed. There was no description of the impaired skin area to the coccyx, no description of the wound bed or type of wound, and no wound measurements. There was no documentation a wound assessment had been completed until 02/05/25.

Review of a skin risk assessment dated [DATE] revealed Resident #68 was at high risk for skin breakdown.

Review of the physician orders dated 01/30/25 revealed no orders for treatments to the coccyx. No physician orders were placed for a wound treatment to the coccyx for two days until 02/01/25. Review of a physician order dated 02/01/25 at 7:00 P.M. revealed an order to cleanse the coccyx with wound cleanser, pat dry, apply Triad, cover with silicone dressing every shift for wound care for 30 days.

There was no baseline care plan-initiated addressing Resident #68's high risk for skin breakdown. A care plan was initiated on 02/10/25, five days after the unstageable pressure ulcer was found.

Review of the medication administration record (MAR) and treatment administration record (TAR) revealed no wound treatments were completed for the coccyx wound until 02/01/25 after 7:00 P.M. Further review of the record revealed no treatment was completed on first shift on 02/04/25.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a physician wound assessment completed on 02/05/25 revealed Resident #68 had an unstageable full thickness pressure ulcer to the coccyx. The wound measured 3.3 centimeters (cm) in length, by 6.4 cm in width, and a depth of 0.2 cm with moderate serous drainage. The wound had 20 percent slough, 20 percent necrotic tissue, 10 percent intact skin, and 50 percent granulation tissue. The physician debrided the wound of devitalized tissue and necrotic subcutaneous level tissues along with slough and biofilm at a depth of 0.3 cm. The physician ordered a new wound treatment to cleanse coccyx with wound cleanser, pat dry, apply medihoney, calcium alginate with silver and cover with gauze island and border dressing. The physician also recommended a group two mattress (air loss mattress.) Review of a nutritional assessment dated [DATE] revealed the assessment included no documentation of the resident's new pressure ulcers or nutritional interventions for the resident's pressure ulcers. Review of the MAR revealed the low air loss mattress ordered on 02/05/25 was not in place until 02/10/25 after 7:00 P.M. Review of the care plan initiated 02/10/25 for pressure ulcers revealed Resident #68 had an unstageable pressure ulcer to the coccyx. Interventions include completing treatment to all wounds as ordered, keeping skin clean and well lubricated, turn and reposition frequently, low air loss mattress, and wounds to be monitored by the wound care group. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #68 had severe cognitive impairment. Resident #68 was dependent on staff for toileting, bed mobility and transfers. Resident #68 was always incontinent with bowel and bladder. Resident #68 had unhealed pressure ulcers including one stage three pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed), one unstageable pressure ulcer, and one deep tissue injury (Purple or maroon area of discolored intact skin due to damage of underlying soft tissue). The resident was at risk for skin breakdown. Interview on 03/04/25 at 3:36 P.M., the Director of Nursing (DON) stated Resident #68 had skin impairment upon readmission to the facility. The DON stated the hospital documentation only noted excoriation to the buttocks. The DON verified she was unable to find any hospital documentation indicating the resident had a pressure ulcer while in the hospital. The DON verified there was no documentation in the nurse's admission skin assessment of the type of wound, assessment of the wound or wound measurements. Further interview on 03/06/25 at 9:01 A.M., the DON verified a wound treatment was not initiated for Resident #68's coccyx wound until 02/01/25. The DON stated the nurses were probably waiting for the physician to respond with a wound care order. The DON verified that the low air loss mattress was not implemented until 02/10/25. The DON stated the facility had no air loss mattresses and had to order it. The DON verified the wound treatment on day shift on 02/04/25 was not documented as completed. The DON stated the facility dietitian no longer worked at the facility. Interview on 03/05/25 at 10:41 A.M., Consultant Dietetic Technician (CDT) #640 stated she had not yet been to the facility to assess residents. CDT #640 stated if a resident had skin breakdown, then it should be noted in the nutritional assessment and the resident should be ordered double protein at meals or protein supplements for healing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 03/05/25 at 11:26 A.M., Registered Nurse (RN) #345 stated a resident's wound should be assessed and measured on admission. RN #345 stated the facility would not allow a Registered Nurse to stage a pressure ulcer wound. RN #345 verified Resident #68 had no additional nutritional interventions in place for wound healing. Interview on 03/05/25 at 11:38 A.M., Wound Physician (WP) #710 stated Resident #68 had an unstageable pressure ulcer to the coccyx which was now a stage three pressure ulcer. WP #710 stated the pressure ulcer to the coccyx was currently showing improvement. Observation on 03/05/25 at 11:45 A.M., of wound care with WP #710 revealed Resident #68 had a stage three pressure ulcer to the coccyx. The wound measured 3.2 cm in length, 1.1 cm in width, and 0.2 cm in depth. The surrounding wound was intact and showed improvement per WP #710. The wound had no odor and minimal serosanguinous drainage, there was no tunneling or undermining. WP #710 administered wound treatment per physician orders. Interview on 03/05/25 at 1:19 P.M., Licensed Practical Nurse (LPN) #398 stated she completed Resident #68's admission skin assessment. LPN #398 stated she usually measured and assessed wounds and was not sure why she had not completed the wound assessment for the resident's coccyx. LPN #398 stated upon admission, Resident #68 had an area to the coccyx that looked like an open skin tear or skin flap. LPN #398 stated the area was not deep maybe 0.1 cm and was just red in color with no drainage. LPN #398 stated there was no slough or eschar in the wound upon readmission. LPN #398 stated the area to the coccyx was approximately one-half inch by one-half inch. LPN #398 thought she had spoken with wound care and had an order for cream or something for the area. Review of the facility policy titled Documentation of Wound Treatments, dated 08/01/22 revealed the facility would complete accurate documentation of wound assessments upon admission and weekly and as needed when wound condition deteriorates. A wound assessment would include the type of wound, the wound stage, wound measurements including height, width, depth, undermining, tunneling, and a description of the wound characteristics including the color of the wound bed, type of tissue in the wound bed, condition of the surrounding skin, drainage amount and characteristics, presence or absence of odor and pain. Review of the facility policy titled Pressure Injury Prevention and Management, revised 09/26/24, revealed the facility would establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment, intervening to stabilize, reduce or remove underlying risk factors, monitoring the impact of the interventions, and modifying the interventions as appropriate. Training in the completion of pressure injury risk assessment, full body skin assessment, and pressure injury assessment would be provided as needed. Review of the NPUAP guidelines dated 2014 revealed facilities should educate health professionals on how to undertake a comprehensive skin assessment that includes the techniques for identifying blanching response, localized heat, edema, and induration. Ongoing assessment of the skin was necessary to detect early signs of pressure damage. Visual assessment for erythema (redness of the skin) was the first component of every skin inspection. Skin redness and tissue edema resulting from capillary occlusion was a response to pressure, especially over bony prominences. Staff should conduct a head-to-toe assessment with particular focus on skin overlying bony prominences including the sacrum, ischial tuberosities, greater trochanters and heels and each time the patient was repositioned was an opportunity to conduct a brief skin assessment.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observations, medical record review, and resident and staff interview, the facility failed to ensure range of motion exercises were provided as ordered by the physician. This affected one (#44) of one resident reviewed for contracture management in a facility census of 75. Findings include: Review of the medical record revealed Resident #44 was admitted to the facility on [DATE]. Diagnoses included encephalopathy, type II diabetes mellitus, congestive heart failure, right and left lower leg contracture, and adjustment disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #44 had intact cognition, had bilateral lower extremity range of motion impairments, and dependent on staff for the completion of activities of daily living (ADL). On 04/22/24, a physician order was initiated to address Resident #44's contractures of the bilateral lower extremities. The physician ordered to provide gentle range of motion with all cares, two times a day related to contrature of muscle to left and right lower leg. On 05/07/24, a nursing plan of care was revised to address Resident #44 had an ADL self-care performance deficit related to chronic conditions, weakness, and was non-ambulatory. Interventions for Resident #44's contractures of the bilateral lower extremities included to provide gentle range of motion with all cares. Responsible staff was Certified Nurse Aide (CNA) or State tested Nurse Aide (STNA). Observations on 03/04/25 at 6:30 A.M., 10:47 A.M., 1:45 P.M., on 03/05/25 at 6:20 A.M. and 10:06 A.M., and on 03/06/25 at 6:38 A.M. revealed Resident #44 was lying in bed with his bilateral legs in the flexed position. Interview with Resident #44 stated he does not receive range of motion to his lower extremities daily. Interview on 03/06/25 at 7:35 A.M. with CNA #344 and CNA #381 stated they were frequently assigned to provide care to Resident #44. The CNAs stated they do not provide range of motion to Resident #44 daily. In addition, both CNAs stated they have not observed nurses provide range of motion to Resident #44 at anytime during their shifts. Interview on 03/06/25 at 8:02 A.M. with Unit Manager Licensed Practical Nurse (LPN) #390 verified CNAs reported no knowledge regarding the provision of range of motion (ROM) to Resident #44's lower extremities twice daily.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528 0Based on medical record review, observation, staff interview, review of hospital report, and review of the facility policy, the facility failed to timely report a fall and monitor a resident status post fall and failed to ensure a resident's fall interventions were in place for a resident at risk for falls. This affected two (#18 and #68) of three residents reviewed for falls. The facility census was 75. Findings include: 1. Review of the medical record revealed Resident #18 was admitted on [DATE]. Diagnoses included unspecified dementia, dysphagia oropharyngeal phase, cognitive communication deficit, type two diabetes mellitus without complications, major depressive disorder recurrent, hypothyroidism, and essential hypertension. Review of the Minimum Data Set (MDS) assessment, dated 01/03/25, revealed Resident #18 was moderately cognitively impaired. Resident #18 required partial/moderate assistance with toileting and had a history of falls. Review of the most recent care plan revealed Resident #18 was at risk for falls due to confusion, gait/balance problems, and unaware of safety needs. Interventions included post signage to call for help, ensure appropriate footwear, bed in the lowest position when in bed, perimeter mattress to bed, check frequently throughout shift, and declutter room. Review of the fall risk evaluation, dated 12/15/24, revealed Resident #18 was at risk for falls. There was no fall documented in Resident #18's medical record on 01/21/25. Review of the fall assessment, dated 01/22/25 at 10:26 A.M., revealed Resident #18 was holding her right arm and stating that her arm was broken from falling out of bed. Resident #18 stated she was trying to get up out of bed and rolled out of bed onto the floor during the night and broke her arm. The physician was notified of a suspected fracture of the right forearm and stat x-rays were ordered for right arm. The interdisciplinary team met to discuss the fall and determined the fall was witnessed by a Certified Nursing Assistant (CNA). CNA #501 verified (on 01/21/25) she was assisting Resident #18's roommate and observed Resident #18 become unsteady while standing and attempted to intervene by assisting Resident #18 to the ground. Resident #18 complained of right-hand pain and the nurse was notified. The assessment was completed, and Registered Nurse (RN) #345 assisted CNA #501 to transfer Resident #18 from the floor to bed. Resident #18 scored at risk for falls and all previous interventions were in place. Head-to-toe assessment was completed, and notification was completed. X-rays were obtained, indicating a fracture and Resident #18 was sent to the emergency room for evaluation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the internal fall investigation, 01/22/25, revealed a written statement signed by the Director of Nursing (DON) and Unit Manager Licensed Practical Nurse (LPN) #390 and they conducted an interview with RN #345 regarding Resident #18's fall on 01/21/25. Initially, RN #345 denied knowledge of a fall that occurred during the shift on 01/21/25. Upon further inquiry, RN #345 stated she was aware that Resident #18 was lowered to the floor by CNA #501 that requested her assistance with transferring the resident back into bed. RN #345 stated Resident #18 did express hand pain during the transfer with no visible injury noted at the time. Additional documented interviews and written statements revealed CNA #337 and CNA #408 verified on third shift from 01/21/25 from 10:00 P.M. to 01/22/25 at 6:00 A.M., there was no fall with residents on the memory care unit. Review of the portable x-ray service, dated 01/22/25, verified Resident #18 had an acute-appearing fracture of the right distal radius (wrist). Review of the hospital summary, dated 01/22/25, revealed Resident #18 had the right distal radius fracture with splint immobilized. Interview on 03/05/25 at 10:41 A.M. with RN #345 stated on 01/21/25 at approximately 8:00 P.M., CNA #501 reported that while in Resident #18's room, she was assisting the roommate when Resident #18 began to fall. CNA #501 lowered Resident #18 to the floor. RN #345 stated she had completed an assessment and put the resident back to bed. RN #345 stated she did not document the assessment or report the resident fell due to Resident #18 being lowered to the ground and did not believe this was considered a fall. Interview on 03/05/25 at 11:09 A.M. with the DON stated Resident #18 had stated she fell out of bed during the night; however, the facility's internal investigation determined the fall occurred on 01/21/25 with RN #345 on duty. The DON verified RN #345 did not document an assessment of the fall. The DON verified through interviews with third shift staff the resident had not fallen through the night on 01/22/25. In addition, Resident #18 would not have been able to get herself off the floor without assistance. Subsequent interview on 03/05/25 at 4:14 P.M. with the DON verified CNA #501 reported the next day that Resident #18 complained of arm pain the evening of the fall on 01/21/25. Interview on 03/06/25 at 10:17 A.M. with CNA #501 revealed on 01/21/25 at approximately 3:15 P.M. to 3:30 P.M., she was assisting Resident #18's roommate when Resident #18 began to get out of bed and appeared to be losing her balance. CNA #501 attempted to reach Resident #18 quickly nearly tripping herself. Resident #18 began to fall forward, and CNA #501 caught Resident #18 from behind, grabbing her right ribcage and scooping her arms around her middle then lowering her to the floor. CNA #501 sat Resident #18 on the floor with her back against the bed and notified RN #345. CNA #501 stated RN #345 came to look at her and they put her in the wheelchair then back to bed ensuring she was changed and dry. CNA #501 stated Resident #18 reported the top of her right hand was hurting and CNA #501 stated she had reported the resident's complaint of pain to RN #345. Interview via telephone on 03/06/25 at 1:15 P.M. with CNA #337 verified on third shift beginning 01/21/25, Resident #18 did not have a fall and was not found out of bed. CNA #337 verified if Resident #18 had fallen out of bed, she would not be able to get herself off the floor. CNA #337 stated she also had spoken with CNA #408 who had worked on the memory care unit that night and stated no fall had occurred. 44815 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Divine Rehabilitation and Nursing at Sylvania	5757 Whiteford Rd Sylvania, OH 43560

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #68 revealed an admitted [DATE] with diagnoses including metabolic encephalopathy, dementia, and foot drop. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/26/25, revealed Resident #68 had impaired cognition and was dependent on staff for all mobility. Review of the Fall Risk Evaluation, completed 01/30/25, revealed Resident #68 was at risk for falls. Review of a progress note dated 02/04/25 at 10:59 A.M. revealed Resident #68 was found face down on the floor next to her bed. Resident #68 was assessed, and no injuries were identified. Review of an interdisciplinary team (IDT) progress note dated 02/06/25 revealed the team developed an intervention for Resident #68 to be placed in her chair and kept in common areas during periods of restlessness. Review of the current care plan revealed Resident #68 had potential for falls related to an unawareness of safety needs. Interventions included an update on 02/07/25 for staff to assist Resident #68 into a chair and position in the common area during periods of restlessness. Observation on 03/06/25 at 3:02 P.M. in the secured unit revealed Resident #68 was alone in a room labeled dining room in a Broda chair (a wheelchair designed to tilt, recline, and provide positioning support). Resident #68 was lying diagonally in the chair with both legs hanging over the right arm of the chair, her head tilted back over the left side of the backrest, with her back supported by the left arm of the chair. Resident #68 was intermittently yelling out very loudly, appearing to have a conversation. Several residents and staff members were gathered on the opposite end of the unit in a larger dining room engaged in activities. Continued observations of Resident #68 on 03/06/25 from 3:02 P.M. until 3:19 P.M. revealed Resident #68 moving herself around in the chair, sometimes straightening her legs, and then returning to a position with both legs hanging over the right arm of the chair. Resident #68 continued to loudly yell out fragments of sentences. At no time did Resident #68 appear to be calling for help. No staff were observed in the area during the observations. Observation on 03/06/25 at 3:20 P.M. revealed Licensed Practical Nurse (LPN) #367 and Certified Nursing Assistant (CNA) #365 entered the secured unit. CNA #365 sat at the nurses' station and began charting. Resident #68 could be heard calling out. Interview on 03/06/25 at 3:21 P.M. with CNA #365 stated she felt adequately trained to work with residents diagnosed with dementia and behaviors and was familiar with Resident #68. Observation and interview on 03/06/25 at 3:26 P.M. revealed CNA #365 walked past the doorway to the dining room where Resident #68 was and answered a call light down the hall. At 3:27 P.M., CNA #365 stated Resident #68 was kept in the dining room alone because Resident #68 yelled out and would swing at other residents on the unit. CNA #365 stated her behaviors of loud yelling and swinging her arms and kicking triggered other residents' behaviors. CNA #365 repositioned Resident #68 calmly and gently, changed the channel on the television, covered Resident #68 with a blanket and upon leaving the room, Resident #68 was calm and positioned correctly in the chair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/10/25 at 9:12 A.M. revealed Resident #68 lying in a Broda chair alone in the dining room. Resident #68 was positioned correctly in the chair and appeared to be sleeping. Interview on 03/10/25 at 9:13 A.M. with CNA #356 confirmed Resident #68 was in the dining room alone. CNA #356 stated Resident #68 was placed there by third shift staff because Resident #68 was attempting to climb out of bed. CNA #356 confirmed Resident #68 was supposed to be kept in common areas but was not placed in common areas because her behavior was disruptive to other residents. CNA #356 further stated staff would place Resident #68 within view of the nurse's station while they were actively charting; however, at the time of the interview, CNA #356 was leaving the nurse's station to provide cares for other residents. CNA #356 further confirmed she fed Resident #68 breakfast in the same dining room where she currently was sleeping. Review of the policy titled Fall Prevention Program dated 09/26/24, revealed when any resident experiences a fall the facility will assess the resident, complete a post-fall assessment, complete an incident report, and notify the physician and family. The facility will implement additional interventions based on the resident's assessment to prevent additional falls. This deficiency represents non-compliance investigated under Complaint Number OH00161892.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51528 Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure water was readily available for proper hydration. This affected one (#20) of two residents reviewed for hydration. The facility census was 75. Findings include: Review of the medical record for Resident #20 revealed an admission of 09/24/24. Diagnoses included aphasia, chronic obstructive pulmonary disease, chronic kidney disease, and dementia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 had severe cognitive impairment and required substantial assistance with activities of daily living (ADLs). Observation on 03/03/25 at 11:14 A.M. revealed Resident #20 was sitting in his geriatric chair at the nurse's station. Resident #20 had visible creases in his tongue were observed. There was no access to water present during this time. Observation on 03/04/25 at 11:30 A.M. revealed Resident #20 was in the memory care dining room in his geriatric chair, independently eating and drinking during the lunch meal. Fluids provided to Resident #20 were four ounces of juice, and eight ounces of coffee. Resident #20 drank all fluids provided. Observation on 03/05/25 at 9:20 A.M. revealed Resident #20 was lying in bed with his eyes open. Resident #20 stated they had not passed fresh water, and he was thirsty. There was no water in Resident #20's room. Interview on 03/05/25 at 9:22 A.M. with Certified Nurse Aide (CNA) #318 stated staff offer water every hour and they make sure the residents have their ice and water. They put cups in their room and date them. CNA #318 was unsure if water had been passed on this day or not. CNA #318 verified Resident #20 had no water in his room and confirmed he was thirsty. Observation on 03/06/25 at 11:29 A.M. of Resident #20's bedroom revealed no water cup was in h is room. Resident #20 was in the dining room at this time. Interview on 03/06/25 at 11:40 A.M. with CNA #356 stated water had been passed to residents' rooms. CNA #356 stated she wasn't sure if Resident #20 took his water to lunch with him. Observation on 03/06/25 at 11:42 A.M. in the memory care dining room revealed Resident #20 in his geriatric chair without water. Interview on 03/06/25 at 11:45 A.M. with CNA #356 confirmed Resident #20 did not have water. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/10/25 at 10:40 A.M. in the memory care dining room revealed Resident #20 in this geriatric chair with his eyes closed. No water was present with the resident. Additional observation on 03/10/25 at 10:42 A.M. revealed no water in his room. Interview on 03/10/25 at 10:43 A.M. with Licensed Practical Nurse (LPN) #398 confirmed water had not been passed. Coinciding interview with LPN #398 confirmed Resident #20 had no water in his room. LPN #398 stated she gave Resident #20 four-ounce drinks of water with medication pass and was unsure why Resident #20 had no water in his room. Interview on 03/10/25 at 10:45 A.M. with CNA #356 stated Resident #20 would spill his water, and other residents go into rooms and take the water cups. This surveyor questioned why all other residents had water in their rooms except Resident #20. CNA #356 was not able to answer this question. Review of the facility policy titled Hydration dated 09/26/24 revealed signs of dehydration include dry mucous membranes. Staff were to offer the residents a variety of fluids between meals, providing assistance with drinking as needed, and ensuring beverages are available and within reach. This deficiency represents non-compliance investigated under Complaint Number OH000162077.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, resident and staff interview, and review of facility policy, the facility failed to ensure oxygen equipment was maintained and applied as ordered by the physician. This affected one (#42) of two residents reviewed for respiratory services in a facility census of 75. Findings include: Medical record review revealed Resident #42 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD, morbid obesity, acute and chronic respiratory failure, shortness of breath, and congestive heart failure. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #42 had intact cognition, had no behaviors or refusal of care, required substantial to maximal assistance with activities of daily living (ADL). and received oxygen therapy. On 10/02/24, physician orders included Auto C-Pap settings 8-20 cmH2O with full facemask and nasal mask with four liters (L) oxygen bled in, patient to wear at bedtime (HS) and with naps for sleep apnea related to COPD and chronic respiratory failure. Every four hours as needed for sleep apnea put C-Pap on every HS and while napping. HS scheduled for 9:00 P.M. Please use distilled water in CPAP at night. Please allow resident to have one to two bottles at bedside for use with CPAP. Additional physician oxygen orders included on 10/17/24, change C-pap/Bi-Pap tubing and oxygen tubing connected weekly and as needed at bedtime every Thursday for infection control. On 07/12/24, oxygen via nasal cannula one to four liters per minute as needed for dyspnea, hypoxia (Oxygen (O2) saturation less than 88%) or acute angina. Call provider/practitioner with nursing report every shift for COPD. There was no documentation contained in the medical record indicated oxygen saturation levels were being obtained every shift. On 10/03/24, a nursing plan of care was initiated to address Resident #42's COPD and chronic respiratory failure and dependent on O2 therapy with potential for complications. On 10/03/24 as result of sleep study, the resident has new order for CPAP at HS. Interventions included to monitor pulse oxygen per orders/protocol. Monitor/document/report for difficulty breathing (Dyspnea). Oxygen settings: O2 via nasal cannula at one to four L to keep oxygen saturation level above 88%. BIPAP/CPAP/VPAP SETTINGS: Titrated pressure: 8.0 to 20 cmH2O with four L O2 bled via nose mask and full-face mask every HS and naps. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/03/25 at 11:37 A.M. noted Resident #42 was in bed. Interview and observation noted Resident #42 had a CPAP machine but was out of distilled water for humidification. No distilled water had been provided for an undetermined amount of time. Resident #42 stated staff were unaware where distilled water was located and this results in Resident #42 not having the CPAP machine applied as ordered each night. Additional observation identified no dated oxygen of tubing or equipment indicating date the equipment was changed or maintained as ordered. Resident #42 was also identified with a heavily soiled oxygen nasal cannula with a yellow substance identified on the surface of the tubing. On 03/03/25 at 11:55 A.M., an observation and interview with Unit Manager Licensed Practical Nurse (LPN) #390 verified Resident #42's oxygen equipment and monitoring were not maintained as indicated. Review of Noninvasive Ventilation (CPAP, BiPAP, AVAPS) policy reviewed/revised 09/26/24 revealed the facility will obtain an order for the use of a CPAP, BiPAP, AVAPS device and settings from the practitioner. The facility will follow manufacturer's instruction for use of the machine. Nursing to document use of the machine. Replace equipment immediately when it is broken or malfunctions. Review of the facility's Oxygen Administration policy reviewed/revised 09/26/24 revealed staff shall practice infection control measures to include, changing oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51528 Based on record review, staff interview, and review of a contract, the facility failed to document communication and assessments before and after dialysis, failed to monitor fluid intake and output, and monitor the resident's dialysis access port. This affected one (#75) of one resident reviewed for dialysis. The facility identified one resident as receiving dialysis services. The facility census was 75. Findings include: Review of the medical record for Resident #75 revealed an admitted [DATE]. Diagnoses included bilateral pleural effusion, and end stage chronic kidney disease. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #75 had intact cognition. Review of the care plan for dialysis, last revised 03/03/25, revealed Resident #75 attended dialysis three times per week on Mondays, Wednesdays, and Fridays. Interventions included monitoring a fluid restriction of 1,500 milliliters (ml) per day and monitor fluid intake and output, and monitor the dialysis access port for signs of infection, swelling, or bleeding. Review of the physician orders dated February 2025 and March 2025 revealed orders for Clopidogrel (blood thinner) 75 milligrams (mg), skilled assessment each shift, daily weights, fluid restriction of 1,500 ml/day, monitor dialysis catheter to right upper jugular for signs and symptoms of swelling or bleeding every shift, and midodrine (treats blood pressure) 10 mg to be sent to dialysis every Monday, Wednesday, and Friday to be given if systolic blood pressure was below 120. Review of the Treatment Administration Record (TAR) from 02/14/25 through 03/03/25 revealed there was no documentation Resident #75's dialysis port was monitored for bleeding and signs and symptoms of infection every shift. There was no documentation in the medical record the facility was monitoring Resident #75's fluid intake and output daily. Review of the dialysis monitoring and communication records revealed communication with the dialysis center was completed twice on 02/14/25 and 02/17/25. No further forms communication records were completed for Resident #75 from 02/14/25 through 03/03/25. Interview on 03/04/25 at 2:07 P.M. with Licensed Practical Nurse (LPN) #313 stated the facility would send Resident #75 to dialysis with his face sheet, physician order form, Midodrine 10 mg and a medication list. She stated they would weigh him in the morning and then the next shift would weigh him when they came on. The dialysis center typically sent back no information after his appointment. LPN #313 was unable to explain how the facility would know if Resident #75 received the Midodrine while at dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/05/25 at 3:17 P.M. with the Director of Nursing (DON) stated dietary was providing a breakdown of how much fluid was being placed on the meal trays. The DON stated staff would give Resident #75 water upon request and confirmed there was no documentation of how much water he consumed or what Resident #75's intake was during meals. The DON verified communication between the dialysis center and the facility was only documented on 02/14/25 and 02/17/25. The DON verified there was no documentation in the medical record of monitoring for the resident's dialysis port. The DON confirmed the facility does not have a dialysis policy. Review of the undated dialysis contract with the facility revealed the facility and the dialysis center would keep documentation of care throughout the patients stay at the facility and treatment.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528 Based on medical record review, resident interview, staff interview, and facility policy review, the facility failed to ensure the resident's prescribed pain medication was available to administer as physician ordered. This affected one (#60) of three residents reviewed for pain. The facility census was 75. Findings include: Review of the medical record revealed Resident #60 was admitted on [DATE]. Diagnoses included hemiplegia affecting left dominant side, acute cholecystitis, and chronic systolic congestive heart failure. Review of the Minimum Data Set (MDS) assessment, dated 01/23/25, revealed Resident #60 was cognitively intact and received scheduled and as needed pain medication. Review of the physician order, dated 11/26/24, revealed an order for tramadol oral tablet 50 milligram (mg) with instructions to give 50 mg by mouth every six hours for pain. Review of the Medication Administration Record (MAR), dated March 2025, revealed Resident #60 did not receive the physician order for tramadol four times on 03/04/25 at 12:00 P.M. and 6:00 P.M. and on 03/05/25 at 12:00 A.M. and 6:00 A.M. Interview on 03/05/25 at 7:56 A.M. with Resident #60 stated the facility has been out of his pain medication tramadol for two days. Interview on 03/05/25 at 9:27 A.M. with Unit Manager Registered Nurse (RN) #319 stated she was not aware of Resident #60's pain medication was not available. Interview on 03/05/25 at 9:32 A.M. with Unit Manager Licensed Practical Nurse (LPN) #390 verified the nurse practitioner was notified on 03/04/25 at 1:55 P.M. that Resident #60's pain medication needed ordered. LPN #390 and RN #319 verified the controlled medication was accessible in the facility but a physician would need to complete a controlled medication form. Review of the policy on Pain Management, dated 2025, revealed the facility must ensure pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on review of the medical record, review of pharmacy recommendations, staff interview, and policy review, the facility failed to ensure a physician responded timely to pharmacy recommendations. This affected three (#10, #15, #34) of five residents reviewed for unnecessary medications. The facility census was 75. Findings include 1. Review of the medical record revealed Resident #15 had an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, schizophrenia, bipolar disorder, depressive disorder, anxiety and osteoarthritis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 had intact cognition. Review of pharmacy recommendations dated 04/23/24, 09/09/24, 11/25/24, and 01/23/25 revealed Resident #15 received Alendronate for the treatment of bone health but was not receiving a calcium supplement. The pharmacist made the same recommendation on 04/23/24, 09/09/24, 11/25/24, and 01/23/25 to initiate calcium carbonate 600 milligrams (mg) with vitamin D3 ten micrograms twice daily with food adjusting for dietary intake. There was no documentation the physician had declined or accepted the recommendation. Review of the monthly physician order for 03/2025 revealed no orders for calcium carbonate 600 mg with vitamin D3 ten micrograms. Interview on 03/06/25 at 2:51 P.M. with the Director of Nursing (DON) verified there was no documentation the physician had addressed the pharmacy recommendations made on 04/23/24, 09/09/24, 11/25/24, and 01/23/25. 41528 2. Review of the medical record revealed Resident #34 was admitted on [DATE]. Diagnoses included diabetes mellitus with diabetic neuropathy, two diabetes mellitus with diabetic nephropathy. Review of the MDS assessment, dated 11/29/24, revealed Resident #34 was cognitively intact. Review of the pharmacy recommendations, dated 07/18/24, revealed Resident #34 receives insulin and a sulfonylurea, glipizide concomitantly, increasing the risk of hypoglycemia. This individual also receives the antidiabetic medication metformin. The recommendation included to consider reducing the dose of glipizide and eventually discontinuation while maximizing insulin therapy with lantus and sliding scale insulin. Close monitoring should accompany any change in diabetic therapy and guide further adjustments. There was a written notation on the document that was undated and stated glipizide discontinued on 01/31/25 and lantus adjustment to 33 units was made on 06/07/24 and 09/04/24 and 35 units on 09/04/24 to 11/15/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/06/25 at 1:00 P.M. with the Director of Nursing (DON) verified the facility did not timely respond to pharmacy recommendations. 44815 3. Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses of depression, anxiety, vascular dementia, and mood disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had intact cognition. Review of a physician order dated 04/15/24 revealed Resident #10 received Donepezil HCl (hydrochloride) oral tablet five milligrams (mg) by mouth at bedtime for cognition. Depakote oral tablet delayed release 250 mg, one tablet by mouth two times daily for borderline personality disorder. Review of a Consultation Report, dated 05/29/24 revealed the contracted pharmacist provided a recommendation to the facility to increase Resident #10's Donepezil to 10 mg once daily to provide additional benefit. There was no physician response to the consultation report. There were no physician orders to change Donepezil. Review of three Consultation Reports, dated 09/09/24, 11/25/24, and 01/24/25 revealed the contracted pharmacist requested the facility provide a laboratory assessment to monitor Resident #10's Depakote levels. There were no Depakote levels in Resident #10's medical record in response to the consultation reports. Interview on 03/10/25 at 10:19 A.M. with the Director of Nursing (DON) confirmed Donepezil was not increased per the pharmacist's recommendations and no rationale for not increasing the medication was provided by the physician. Additionally, the DON confirmed no Depakote laboratory test was completed in response to the three pharmacist's recommendations until the facility reviewed the recommendations during the annual survey, and an order was placed for a Depakote level for Resident #10 in March 2025. Review of the facility policy titled Medication Regimen Review dated 12/01/07 revealed the facility would encourage physicians to act upon recommendations contained in the pharmacy monthly medication reviews. The medical director would be provided with recommendations requiring follow-up.

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NAME OF PROVIDER OR SUPPLIER: Divine Rehabilitation and Nursing at Sylvania		STREET ADDRESS, CITY, STATE, ZIP CODE: 5757 Whiteford Rd Sylvania, OH 43560	

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, resident and staff interview and facility policy review, the facility failed to monitor effectiveness of medications utilized to manage the resident's mood and behavior. This affected five of five residents (#10, #15, #26, #34, and #45) reviewed for unnecessary medications in a facility census of 75. Findings include: 1. Medical record review revealed Resident #26 admitted to the facility on [DATE]. Diagnoses included anxiety disorder, borderline personality disorder, major depression disorder, and insomnia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 had intact cognition, no behaviors, and received antianxiety, antidepressant, antibiotic, hypoglycemic, and anticonvulsant medications. Review of the physician orders noted Resident #26 to receive the following medications: 03/03/25 venlafaxine extended release 75 milligrams (mg) once daily for major depressive disorder with psychotic symptoms, 02/24/25 trazodone 175 mg at bedtime for the treatment of insomnia administered at bedtime, 03/03/25 bupropion 150 mg once daily for depression, 02/06/25 sertraline 100 mg once daily for anxiety disorder, 02/22/25 buspirone 5.0 mg three times daily for anxiety. On 06/25/24, a nursing plan of care was implemented to address Resident #26's behavior problem related to refusing medications, including diabetic medications. Accusatory toward staff. Making false allegations about missing money. Manufactures and manipulate facts to elicit or desire a response from desired authority. Instigates and provoke other residents with passive aggressive or condescending response to obtain a negative response. Interventions included the following; The resident needs encouragement and active support by family/caregivers when the resident was having episodes of behaviors. Monitor the resident for safety. The resident was taking antianxiety medications which were associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia and increases risk of falls, broken hips and legs. Resident #26 uses antidepressant medication related to depression. Monitor/document side effects and effectiveness every shift. Educate the side effects and/or toxic symptoms of anti-depressant drugs being given. Monitor/document/report as needed (PRN) adverse reactions to antidepressant therapy. Resident #26 uses psychotropic medications related to Borderline Personality Disorder. Monitor for side effects and effectiveness every shift. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. Monitor/record occurrence of for target behavior symptoms pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc. and document per facility protocol. Resident #26 has mood problem related to borderline personality disorder. Has episodes of impulsiveness, self injury, mood swings, anger, unstable self image and sense of self and episodes of attention seeking. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The medical record did not have any behavior tracking contained in the medical record indicating behavior medications were being monitored for effectiveness or the availability of non-pharmacological interventions when undesirable behaviors occur. Interview with Unit Manager Licensed Practical Nurse (LPN) #390 on 03/06/25 at 8:04 A.M. verified no tracking documented in the medical record regarding resident behaviors or mood. In addition no documentation indicated non-pharmacological interventions were attempted to address Resident #26's insomnia and increased depressed mood. 2. Record review revealed Resident #45 was admitted to the facility on [DATE]. Diagnoses included major depressive disorder, extrapyramidal and movement disorder, schizoaffective disorder-bipolar type, anxiety disorder, and insomnia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #45 had intact cognition, feeling down, dressed, or hopeless, trouble falling asleep or staying asleep, or sleeping too much, social isolation sometimes. Resident #45 received antipsychotic, antidepressant, diuretic, opioid, and anticonvulsant medications. On 07/10/24, a plan of care was revised to address Resident #45's behavior problem related to refusing to go to scheduled appointments, refusing medications, showers, activity of daily living care, and refusing to wear non skid footwear. Interventions included to monitor/document for side effects and effectiveness. The resident needs encouragement and active support by family/caregivers when the resident use these strategies. Additionally on 07/24/24, a plan of care was revised to address Resident #45's psychotropic medication related to suicidal ideations, major depressive disorder, generalized anxiety disorder with an intervention including to monitor for side effects and effectiveness every shift. On 07/24/24, a plan of care was also revised to address Resident #45's antidepressant medication related to depression with interventions including to monitor/document side effects and effectiveness every shift. The medical record lacked documented evidence Resident #45's mood and behavior medications were being monitored for effectiveness. Review of the physician orders revealed Resident #45 was receiving the following medications: 06/08/23 trazodone 200 milligrams (mg) by mouth at bedtime for depression with insomnia; 04/13/23 wellbutrin extended release 24-hour 300 mg one time a day for depression; 04/08/23 viibryd oral tablet 20 mg in the morning for depression; and 01/25/22 invega tablet extended release 24-hour three mg give one tablet by mouth one time a day related to recurrent moderate major depressive disorder. Review of behavioral health certified nurse practitioner (CNP) evaluation notes dated 01/23/25 noted Resident #45 alert and oriented times four (person, place, time, and circumstance) and able to name current president. Resident #45 stated feeling a little depressed lately and still has insomnia with trouble getting to sleep and staying asleep. Resident #45 was not a candidate of a gradual dose reduction (GDR) at this time. Assessment and plan noted schizoaffective disorder, bipolar type plan continue invega, trazadone, wellbutrin, viibrd- for mood disorder, has depression at this time. Continue to document any changes in mood or behavior. Encourage non-pharmaceutical techniques including sunlight exposure, regular human contact, and reducing stimulants. Primary insomnia plan continue melatonin, trazodone for difficult sleeping, effective in treatment of insomnia. No changes- will monitor. Encourage increased activity, good sleep hygiene, balanced diet, sunlight exposure, practice relaxation technique, and monitor. (continued on next page)

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F 0758

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

No documentation contained in the medical record indicated mood or behavior medications were being monitored to ensure effectiveness or non-pharmacological interventions were attempted to address Resident #45 ongoing complaint of depressed mood and associated insomnia.

On 03/04/25 at 10:55 A.M., observation of Resident #45 noted the resident on her bed, in a dark room. Resident #45 was noted with a flat affect and stated she had been unable to sleep for the past five days. Resident #5 also reported increased depression and had informed the nurse (unable to state name). Additional observations discovered the resident exhibiting the same behavior on 03/05/25 at 6:23 A.M. and 03/06/25 at 7:45 A.M.

On 03/05/25 at 6:58 A.M., an interview with Licensed Practical Nurse (LPN) #386 verified she was assigned to Resident #45's care the past two nights, stated no concerns regarding sleep had been reported to her by the resident. LPN #386 went on to state Resident #45 has been depressed for some time (no time determined) since a friend passed away. No attempts to inform the physician or implement non-pharmacological interventions had been attempted.

On 03/05/25 at 7:50 A.M., an interview with Unit Manager LPN #390 confirmed Resident #45 experienced the death of a friend in December 2024 and confirmed no documentation contained in the medical record indicated Resident #45's mood or behavior medications were being monitored for effectiveness.

On 03/06/25 at 8:04 A.M.,a subsequent interview with Unit Manager LPN #390 verified no tracking documented in the medical record regarding resident behaviors or mood. In addition, no documentation indicated non-pharmacological interventions were attempted to address Resident #45's insomnia and increased depressed mood.

35033

3. Review of the medical record revealed Resident #15 had an admitted [DATE]. Diagnoses included schizophrenia, bipolar disorder, depressive disorder, and anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 had intact cognition.

Review of the plan of care last revised 07/18/24 revealed Resident #15 was resistive to care at times related to anxiety and schizophrenia disorder. The resident was on an antipsychotic medication, antianxiety medication, and antidepressant medication for anxiety, depression, behavior, and schizophrenia. The care plan noted the resident had behavior problems including pacing, repetitive questions, focus on bowel function and weight. Interventions included to monitor medication effectiveness, monitor and record behaviors symptoms/interventions and alternate therapies attempted and their effectiveness.

Review of the monthly physician orders dated 07/21/24 revealed an order for Ativan 0.5 milligrams (mg) every morning and bedtime for anxiety. An order dated 07/20/24 for clozapine 50 mg daily for anxiety, and 200 mg at bedtime for schizophrenia. An order dated 07/20/24 for paroxetine 10 mg in the morning for depression.

Review of the nursing notes and medication administration records from 11/01/24 through 03/04/25 revealed no documentation Resident #15 had received daily monitoring for behaviors and medication effectiveness.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/06/25 at 2:20 P.M. with the Director of Nursing (DON) stated the nurses charted by exception. The DON verified the nurses were not charting daily on behaviors and medication effectiveness. The DON stated currently the facility had no process in place for monitoring behaviors for psychotropic medications. 41528 4. Review of the medical record revealed Resident #34 was admitted on [DATE]. Diagnoses included vascular dementia and schizoaffective disorder. Review of the Minimum Data Set (MDS) assessment, dated 11/29/24, revealed Resident #34 was cognitively intact and medications included insulin, antipsychotic, antidepressant, diuretic, hypoglycemic, and anticonvulsant. Review of the most recent care plan revealed Resident #34 takes psychotropic medication. Interventions included to monitor/record target behavior symptoms including pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, and document per facility protocol. Review of the Medication Administration Review (MAR) and Treatment Administration Review (TAR), dated since 02/01/25, revealed no monitoring or recording of resident behaviors. Further review of the medical record review revealed no documentation of monitoring or recording of resident behaviors. Interview on 03/06/25 at 1:00 P.M. with the Director of Nursing (DON) verified the facility did not document or record Resident #34's behaviors. 44815 5. Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses including depression, anxiety, vascular dementia, and mood disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had intact cognition. Review of the physician orders dated 04/15/24 revealed Resident #10 was ordered Donepezil HCl (hydrochloride) oral tablet five milligrams (mg) by mouth at bedtime for cognition, Depakote oral tablet delayed release 250 mg. one tablet by mouth two times daily for borderline personality disorder, bupropion HCl 150 mg. by mouth twice daily for depression, buspirone HCl five mg by mouth three times daily for anxiety, and trazodone HCl 50 mg once daily for sleep disturbance. Review of a consulting behavioral care Nurse Practitioner (NP) progress note, dated 12/20/24, revealed the NP wrote new orders to increase Wellbutrin (generic: bupropion HCl) from 150 mg twice daily to 200 mg twice daily due to increased depression. Review of a consulting behavior care NP progress note dated 01/20/25 revealed Resident #10 continued with some depression and recommended continuing non-pharmacological interventions such as creating a calm environment and removing stressors when possible; implementing soothing rituals; and limiting caffeine use. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the current care plan for Resident #10 revealed she used an antidepressant medication due to depression and personality disorder. Interventions included monitoring, documenting, and reporting, as needed, adverse reactions, including change in behavior/mood/cognition. Resident #10 used anti-anxiety medications. Interventions included monitoring/documenting/reporting as needed any adverse reactions, including mania, rage, and aggressive or impulsive behaviors. Review of Resident #10's medical record revealed no evidence of ongoing behavior monitoring related to Resident #10's use of psychotropic medication. Additionally, no evidence of staff using non-pharmacological interventions was documented. Interview on 03/10/25 at 8:19 A.M. with the Director of Nursing (DON) confirmed no behavior or side effect monitoring was in place for Resident #10. Subsequent interview on 03/10/25 at 10:19 A.M. with the DON confirmed Resident #10's dose of Wellbutrin (bupropion HCl) was not increased per the NP's progress note. The DON stated the consulting NP was responsible for entering her own orders in the electronic medical record. Review of the facilities Use of Psychotropic Medication policy reviewed/revised 09/26/24 revealed psychotropic medications are to be used only when the practitioner determines the medication is appropriate to treat a residents specific, diagnoses and documented condition and the medication is beneficial to the resident. The indications of initiating, maintaining, or discontinuing medication(s), as well as the use of non-pharmacological approaches will be determined by the physician through evaluation which may included but not limited to resident's physical, behavioral, mental, and psychosocial signs and symptoms in order to identify and rule out any underlying medical conditions, taking into account the relative benefits and risks, and the preferences and goals for treatment. The attending physician/designee will assume leadership in medication management by developing, monitoring, and modifying the medication regimen in collaboration with residents, their families and/or representatives, other professionals, and the interdisciplinary team. The effects of the psychotropic medication on a resident's physical, mental, and psychosocial well-being with be evaluated on an ongoing basis. The resident's response to medication (s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51528 Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure medications were administered per physician's orders resulting in a medication error rate exceeding five percent. 25 opportunities were observed with five medication errors, resulting in a medication error rate of 20 percent. This affected two (#37 and #64) of three residents reviewed for medications. The facility census was 75. Findings include: 1. Review of the medical record for Resident #37 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, peripheral vascular disease, and metabolic encephalopathy. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 had intact cognition. Review of the physicians order for 03/2025 revealed Resident #37 had orders including for vitamin B1 (vitamin) 1,000 units, docusate sodium (stool softener) 100 milligrams (mg.), and magnesium oxide (antacid) 400 mg. Observation on 03/05/25 at 7:50 A.M. revealed Licensed Practical Nurse (LPN) #312 setting up morning medication for Resident #37. After the medication set up was complete, LPN #312 spilled three pills on the medication cart. LPN #312 then picked up what was identified as docusate sodium and threw it in the medication cart waste container. LPN #312 replaced the docusate sodium in the medication cup and gave Resident #37 the medication then returned to the medication cart. After surveyor intervention, LPN #312 was made aware of two medications later identified as vitamin B1 and magnesium oxide which had spilled and were hidden under the blood pressure cuff on the medication cart. Interview on 03/05/25 at 8:00 A.M. with LPN #312 verified she had missed two pills which had spilled on the medication cart and would not have administered the medication to Resident #37 as she was unaware the medication had spilled out of the cup. LPN #312 was able to determine one of the medications was vitamin B1, however, was not able to identify the second medication. She threw both of the medications in the medication cart waste container. 2. Review of the medical record for Resident #64 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD) and type two diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #64 had intact cognition. Review of the monthly physician orders for 03/2025 revealed Resident #64 had orders for Breo Inhaler (treats asthma and a corticosteroid), Flonase (treats allergies) nasal spray, and Incruse (treats COPD and was a bronchodilator) 62.5 micrograms (mcg). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/05/25 at 8:36 A.M. revealed Licensed Practical Nurse (LPN) #366 setting up Resident #64 morning medication. Resident #64 had an order for Flonase Nasal Spray one spray to each nostril every morning, which was not available at this time. LPN #366 then took the medication into Resident #64's bedroom, including a Breo Inhaler and an Incruse inhaler. She placed all Resident #64's medication on a tray table in front of him and walked back out to the medication cart. At 8:43 A.M., Resident #64 took the Incruse inhaler. At 8:45 A.M. LPN #366 returned into the room where she administered the Breo Inhaler. Interview on 03/05/25 with LPN #366 confirmed the Flonase Nasal spray was unavailable, and the physician would be contacted. LPN #366 also verified she should have waited five minutes between administering the Breo Inhaler and the Incruse Inhaler. LPN #366 verified the Incruse inhaler should have been administered then waited five minutes to administer the Breo inhaler. Interview on 05/05/25 at 2:54 P.M. with the Director of Nursing (DON) verified the nurses should follow the manufacturers guidelines for each inhaler medication to administer five minutes apart. Review of the policy titled Administration of Metered-Dose Inhaler dated 09/26/24 revealed if the resident is using a corticosteroid and a bronchodilator, administer the bronchodilator first then wait five minutes before administering the corticosteroid.

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F 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.

51528

Based on observation, staff interview and policy review, the facility failed to ensure medications were dated when opened and the safe disposal of medications. This affected two of three medication carts inspected and had the potential to affect two residents (#19 and #48) the facility identified as cognitively impaired and independently mobile. The facility census was 75.

Findings include:

1. Observation during medication administration on 03/05/25 at 7:50 A.M. revealed Licensed Practical Nurse (LPN) #312 placed a tablet of Lasix (diuretic) 40 milligrams (mg) in the medication cup and then stated that it was the wrong dose. LPN #312 then took the Lasix 40 mg tablet and threw it away in the trash can connected to the side of the medication cart. After the medications were prepared, LPN #312 spilled three medications on the cart. LPN #312 identified one of the medications as Senna (stool softener) and disposed of it in the trash connected to the medication cart. LPN #312 then went into Resident #37's room and administered his morning medication, leaving the other two medications on top of the cart.

Interview on 03/05/25 at 8:05 A.M. with LPN #312 confirmed two medications vitamin B1 (vitamin) and magnesium oxide (antacid) were left on the cart. LPN #312 then disposed of the two medications left on the medication cart in the trash can connected to the medication cart. LPN #312 stated she had disposed of three pills in the trash can. LPN #312 verified the medications should not have been disposed of in the trash can on the side of the medication cart.

Observation on 03/05/25 at 8:24 A.M. on the [NAME] hallway medication cart revealed the following medications were open with no opened date; Vitamin B-12 500 micrograms (mcg), Iron 325 mg, aspirin 81 mg, allergy relief medication 10 mg, Tylenol 500 mg, vitamin D 3 1,250 mcg, Albuterol Sulfate Inhaler, Pro Air Respiclick 90 mcg Inhaler, Symbicort inhaler, folic acid 1,000 mcg, One-a-day multivitamin, calcium plus D 600 mg/5.0 mcg, Metformin Liquid 500 mg. Observation on 03/05/25 at 8:34 A.M. of the [NAME] hall medication storage room also revealed a bottle of Trazodone in a refrigerator that was opened and undated.

Interview on 03/05/25 at 8:30 A.M. with LPN #312 confirmed vitamin B-12 500 mcg, iron 325 mg, aspirin 81 mg, allergy relief medication 10 mg, Tylenol 500 mg, vitamin D 3 1,250 mcg, Albuterol Sulfate Inhaler, Pro Air Respiclick 90 mcg Inhaler, Symbicort inhaler, Folic Acid 1,000 mcg, One-a-day multivitamin, calcium plus D 600 mg/5.0 mcg, Metformin liquid 500 mg were opened and not dated. LPN #312 also verified the bottle of Trazodone in the refrigerator was opened and not dated.

2. Observation on 03/05/25 at 8:36 A.M. revealed Licensed Practical Nurse (LPN) #366 setting up Resident #64's morning medications. LPN #366 had taken the resident's medications into the resident's bedroom, leaving Metoprolol (treats blood pressure) 25 milligrams (mg) tablet card on top of the medication cart.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/05/25 at 8:48 A.M. with LPN #366 verified the medication card Metoprolol 25 mg was left unattended while she was administering medications in a resident room. Observation on 03/05/25 at 08:53 A.M. of the Evergreen hallway medication cart revealed a bottle of Chlorhexidine oral rinse, a bottle of Lactulose, a bottle of Imodium liquid, and an Incruse Ellipta inhaler had been opened and not dated with the open date. Interview on 03/05/25 at 08:55 A.M. with LPN #366 verified the Evergreen hallway medication cart had bottles of Chlorhexidine oral rinse, Lactulose, and Imodium liquid, along with an Incruse Ellipta inhaler which were all opened and not dated. Review of the policy titled Medication Storage, dated 09/26/24 revealed all drugs would be stored in locked compartments. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. Further review of the policy revealed no guidelines for dating medications when opened.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528 Based on medical record review, observation, resident interview, and staff interview, the facility failed to ensure a resident received his food preference of double portions. This affected one (#30) of three residents reviewed for meals. The facility census was 75. Findings include: Review of the medical record revealed Resident #30 was admitted on [DATE]. Diagnoses included hyperlipidemia, anxiety disorder, hypoglycemia, bipolar disorder, hypotension, and paranoid schizophrenia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #30 was cognitively intact and required set-up/clean-up assistance with eating. Review of the physician order dated 02/11/25 revealed Resident #30 received a regular diet, regular texture, regular/thin consistency, and double portions per the resident request. Interview on 03/03/25 at 10:13 A.M. with Resident #30 stated there was not enough food and he was often hungry. Resident #30 reported at times they give him extra food. Review of the dinner meal ticket dated 03/05/25 revealed Resident #30 was to receive double portions. Observation on 03/05/25 at 5:40 P.M. of the dinner meal revealed Resident #30 one chicken quesadilla cut in half, a scoop of rice, and a cup of peaches. Interview on 03/05/25 at 5:42 P.M. with Resident #30 stated he did not receive a double portion of the dinner meal. Interview on 03/05/25 at 5:45 P.M. with Certified Nursing Assistant (CNA) #374 verified Resident #30 did not received double portions of the dinner meal. Observation on 03/06/25 at 7:36 A.M. of the breakfast meal revealed Resident #30 received two cups of corn flakes, one slice of French toast, and two sausage links. Interview on 03/06/25 at 7:37 A.M. with CNA #334 verified Resident #30 did not receive double portions of the French toast and sausage links.

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NAME OF PROVIDER OR SUPPLIER: Divine Rehabilitation and Nursing at Sylvania		STREET ADDRESS, CITY, STATE, ZIP CODE: 5757 Whiteford Rd Sylvania, OH 43560	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41528 Based on observation and staff interview, the facility failed to ensure staff hand sanitized between serving resident's meals. This affected four (#1, #33, #44, and #45) of 26 residents reviewed for dining services. The facility census was 75. Findings include: Observation on 03/03/25 at 11:24 A.M. revealed meal trays delivered to the 200 hall. Unit Manager Licensed Practical Nurse (LPN) #390 was observed passing the meal tray to Resident #44 without prior hand sanitizing. LPN #390 touched the bedside table and used cup then placed the meal tray on the bedside table. LPN #390 did not hand sanitize then passed the meal tray to Resident #45. LPN #390 was observed adjusting the bedside table and setting up the meal tray. LPN #390 was observed to not hand sanitize then entered Resident #1 and Resident #33's room with two meal trays and provided the meal tray. LPN #390 exited without hand sanitizing. Interview on 03/03/25 at 11:33 P.M. with LPN #390 verified she did not complete hand sanitizing between serving the resident's meal trays to their room.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on observation, staff interview, record review, and review of Centers for Disease Control and Prevention (CDC) guidance, the facility failed to ensure staff wore personal protective equipment (PPE) when providing care to residents in Enhanced Barrier Precautions (EBP). This affected one resident (#11). The facility identified 16 residents on EBP. The facility census was 75. Findings include: Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses of cerebral palsy and gastrostomy (an artificial opening into the stomach) status. Review of the significant change comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had intact cognition and required more than 51% of her nutrition and more than 501 milliliters (ml) of fluid daily through her gastrostomy tube. Review of the current physician order dated 03/03/25 revealed Resident #11 was on EBP for infection control. Review of the current care plan revealed Resident #11 was on EBP due to a feeding (gastrostomy) tube. Interventions included staff implementing EBP during personal care. Observation on 03/05/25 at 7:47 A.M. revealed Licensed Practical Nurse (LPN) #312 providing medications to Resident #11. LPN #312 was observed to be wearing gloves and no additional PPE. Further observation revealed a sign outside Resident #11's room stating staff must wear gloves and a gown during feeding tube care or use. Interview on 03/05/25 at 7:50 A.M. with LPN #312 confirmed she did not wear a gown while providing medication to Resident #11 through her feeding tube. LPN #312 confirmed PPE was available but stated she was nervous which caused her to forgot to use a disposable gown while providing medications to Resident #11. Review of the CDC guidance titled Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) found at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html and dated 04/02/24 revealed MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51528 Based on observation, medical record review, staff interview, and review of the manufacturer guidelines, the facility failed to ensure a mattress was compatible with a bed. This affected one (#70) of seven resident reviewed for accident hazards. The facility census was 75. Findings include: Review of the medical record for Resident #70 revealed an admitted [DATE]. Diagnoses include anoxic brain damage, tracheostomy status, and generalized idiopathic epilepsy. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #70 had moderate cognitive impairment and was dependent on staff for all activities of daily living (ADLs). There was no documentation of Resident #70's assessment for a modified bed in the medical record. Observation on 03/03/25 at 10:23 A.M. revealed Resident #70's mattress did not fit the bed. A large gap between the end of the bed footboard and the mattress was noted. Interview on 03/04/25 at 2:58 P.M. with Maintenance Supervisor (MS) #375 stated he was not sure if the bed was a rental or a bariatric bed from the facility. MS #375 measured nine inches between the mattress and the end of the bed. MS #375 stated the facility had no program in place for the regular inspections of bed frames, mattresses and bedrails. Interview on 03/04/25 at 3:29 P.M. with the Director of Nursing (DON) stated the bed was a rental. The DON stated they would have to get an extender or longer mattress for the bed. The DON verified there should not be a space between the mattress and the bed. Review of the manufacturer's guidelines titled Bariatric Homecare Bed, dated 2021 revealed the mattress should be sufficiently wide and long enough to prevent any part of the patients body from falling between the bed and mattress.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 51528 Based on observation, staff and resident interview, review of a job description, and facility policy review, the facility failed to maintain a clean and functional environment for the residents. This affected seven (#2, #9, #12, #29, #39, #70, and #72) of thirteen residents reviewed for physical environment. Findings include: 1. Observation on 03/04/25 at 11:07 A.M. of Resident #9's room revealed the blinds on the window were broken. Interview on 03/04/25 at 3:07 P.M. with Maintenance Supervisor (MS) #375 verified the broken window blinds for Resident #9. Interview on 03/05/25 at 1:38 P.M. with Resident #9 stated she would prefer her blinds to be repaired. 2. Observation on 03/04/25 at 11:10 A.M. revealed Resident #72 had broken window blinds. There gloves placed in the holes of window blinds. Interview on 03/04/25 at 3:07 P.M. with Maintenance Supervisor (MS) #375 verified the broken window blinds for Resident #72. Interview on 03/05/25 at 1:34 P.M. with Resident #72 stated she had placed the gloves in the window because she does not like the sun coming through the window. Resident #72 also stated she had not liked the window blinds being broken. 3. Observation on 03/04/25 at 11:12 A.M. revealed Resident #2 had broken window blinds. Interview on 03/04/25 at 3:07 P.M. with Maintenance Supervisor (MS) #375 verified the broken window blinds for Resident #2. Interview on 03/05/25 at 1:43 P.M. revealed Resident #2 stated she does not like having broken window blinds. 4. Observations on 03/03/25 at 9:58 A.M. and 03/04/25 at 8:29 A.M. revealed Resident #70's window was slightly opened and there was excess buildup of dirt on the windowsill. Observation on 03/04/25 at 11:05 A.M. revealed loose wiring on the wall above Resident #12's bed and the blinds on the window were broken. Observation on 03/04/25 at 11:30 A.M. revealed Resident #29 had broken window blinds. Observation on 03/04/25 at 11:31 A.M. revealed Resident #39 had broken window blinds. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/04/25 at 3:07 P.M. with Maintenance Supervisor (MS) #375 verified the broken window blinds for Residents #12, #29 and #39. MS #375 verified the loose wiring on the wall above Resident #12's bed. Interview on 03/04/25 at 3:17 P.M. with Housekeeping Supervisor (HS) #351 confirmed there was dirt buildup on Resident #70's windowsill. HS #351 stated housekeeping was supposed to clean rooms everyday including windowsills. Review of the undated job description titled Maintenance Director Job Description revealed maintenance would ensure the entire facility was in good working order and maintained in accordance with company standards, and ensure timely response and resolution to all maintenance concerns for the facility. Review of the undated policy titled Resident Environmental Quality revealed it was the responsibility of the facility to provide equipment for comfort and privacy of residents.