STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365940	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Aegis Nursing Home	1130 Tower Blvd Lorain, OH 44052

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on medical record review, review of a care conference audit tool, resident and resident representative interview, staff interview, and review of a facility policy, the facility failed to conducted care conferences quarterly and with a significant change in condition as required. This affected five (#25, #32, #36, #62, and #64) of six residents reviewed for care planning meetings. The facility census was 86. Findings include: 1. Record review for Resident #32 revealed an admitted [DATE]. Diagnoses included sequelae of cerebral infarction, chronic obstructive pulmonary disease (COPD), viral hepatitis C, major depressive disorder, dysphagia, speech and language deficits, muscle weakness, and anxiety disorder. Review of the annual Minimum Data Set (MDS) assessment for Resident #32 dated 01/25/24 revealed Resident #32 was cognitively intact. Resident #32 had impairment to one side of the upper extremity and both sides to the lower extremities. Resident #32 used a wheelchair for mobility and was dependent for transfers to and from bed. Resident #32 required assistance with activities of daily living. Review of the plan of care meetings held for Resident #32 revealed a plan of care meeting was held on 07/31/23. The next plan of care meeting was held 03/13/24. Interview on 04/29/24 at 12:52 P.M. with Resident #32 revealed she did not attend her plan of care meetings and stated she was not invited. Interview on 04/30/24 at 12:28 P.M. with Social Service Director (SSD) #163 confirmed the social services department scheduled and initiated the resident plan of care meetings. SSD #163 revealed plan of care meetings should be held upon admission and quarterly. SSD #163 reviewed Resident #32's plan of care meetings and confirmed Resident #32's quarterly plan of care meetings were not held in October 2023 or January 2024. Interview on 05/01/24 at 2:00 P.M. with Resident #32's Representative revealed she was not always able to get to the facility daily, but she would like to participate in each plan of care meeting even if it was on the telephone. Resident #32's Representative revealed she was not invited each quarter to participate and was never offered to participate in a plan of care meeting on the telephone. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365940	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Autumn Aegis Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 Tower Blvd Lorain, OH 44052	

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review for Resident #62 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, type two diabetes mellitus, atherosclerotic heart disease, atrial fibrillation, anemia and obstructive sleep apnea. Review of the annual MDS assessment dated [DATE] for Resident #62 revealed Resident #62 was cognitively intact. Resident #62 had medically complex conditions, impairment on both sides of the upper and lower extremities, and required assistance with all activities of daily living. Review of the plan of care meetings held for Resident #62 from 03/01/23 through 02/01/24 revealed the plan of care meetings were held on 03/30/23 and 02/01/24. Record review revealed no further care plan meetings were held between 03/01/23 through 02/01/24. Interview on 05/01/24 at 2:36 P.M. with SSD #163 verified there were no plan of care meetings held for Resident #62 after 03/30/23 through 02/01/24. Interview on 05/01/24 at 4:26 P.M. with Resident #62 revealed he was unaware of attending any care plan meetings. 3. Record review for Resident #36 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus and adult failure to thrive. Review of the annual MDS assessment dated [DATE] for Resident #36 revealed the resident was severely cognitively impaired. Resident #36 had impairment to one side of the upper extremity and both sides of the lower extremities and required assistance with all activities of daily living. Record review of the plan of care meetings for Resident #36 from 01/01/23 through 05/01/24 revealed no plan of care meetings were held from 01/01/23 through 08/14/23 and from 10/13/23 through 03/13/24. Interview on 05/01/24 at 2:40 P.M. with SSD #163 confirmed Resident #36 did not have a plan of care meeting for March 2023, June 2023, and December 2023 documented. 4. Record review for Resident #25 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, bipolar disorder, benign prostatic hyperplasia and cognitive communication deficit. Review of the quarterly MDS assessment dated [DATE] revealed Resident #25 was cognitively intact. Resident #25 had impairment on one side of the lower extremities and required assistance with activities of daily living. Record review of the plan of care meetings for Resident #25 revealed no plan of care meeting was held from 03/10/23 through 09/18/23. Interview on 05/01/24 at 2:41 P.M. with SSD #163 confirmed Resident #25 did not have a plan of care meeting documented for 03/10/23 through 09/18/23. Interview on 05/01/24 at 4:14 P.M. with Administrator confirmed the plan of care meetings were documented in the medical records. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/01/24 at 4:26 PM with Resident #25 revealed he was unaware of attending any care plan meetings. 5. Review of the medical record for Resident #64 revealed an admitted [DATE]. Medical diagnoses included cerebral infarction, moderate protein-calorie malnutrition, chronic obstructive pulmonary disease, and type II diabetes with neuropathy. Resident #64 was hospitalized from 01/26/24 to 02/06/24 for sepsis (bloodstream infection). Resident #64 was admitted to hospice care on 02/16/24. Resident #64 had previously elected for hospice care from 03/23/23 to 06/16/23. Review of Resident #64's MDS significant change in status assessment, dated 02/25/24, identified the resident had severe cognitive impairment. Resident #64 was not identified to have any behaviors or rejection of care. Resident #64 was identified to have an impairment to both sides of her lower extremities and was coded as being completely dependent on staff for all activities of daily living, mobility, and transfers. Resident #64 was identified to be at risk for developing pressure ulcers and had four unhealed pressure ulcers. The resident was identified to be on hospice with a terminal prognosis and a life expectancy of six months or less. A performance improvement action plan for plan of care meetings, dated 01/02/24, was provided by the Administrator during the survey. Review of the action plan identified all residents should have care plan meetings within the first week of admission and at least quarterly thereafter. Current documentation of care plan meetings were noted as reviewed for all residents, with a tracking log attached with a list of each resident who was reviewed, when their last plan of care meeting was held, and when the next one was due. Review of the attached tracking log revealed Resident #64 was missing from the audit log. Review of the plan of care meetings for Resident #64 revealed care plan meetings were held on 02/24/23, 10/10/23, 11/21/23, and 12/28/23. An interview on 05/01/24 at 2:44 P.M. with MDS Coordinator #144 revealed the Resident #64's significant change in status assessment was prompted by the resident's hospice election on 02/16/24. An interview on 05/02/24 at 1:19 P.M. with the Administrator verified Resident #64 was not present on the care conference audit tool. The Administrator verified all residents should be on the tracking tool as it was a full building, ongoing audit. The Administrator stated she was unsure what had happened, but Resident #64 should not have been missed. The Administrator verified the last care conference for Resident #64 was held on 12/28/23 and confirmed she had no care conference between 12/28/24 and 05/02/24, including around the time Resident #64 elected for hospice care. An interview with a family member of Resident #64 on 05/02/24 at 1:33 P.M. stated most of the time the facility keep her informed of Resident #64's care. The family member indicated she had not been invited to a plan of care meeting since the resident first initiated hospice in March of 2023. Record review of the facility policy titled, Plan of Care Meetings Policy, dated April 2022, revealed it is the policy of the facility to engage the resident and the resident representative in the plan of care for our residents. Plan of care meetings are held following admission and at least quarterly or with any significant change in condition. 47990

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. 49793 Based on review of banking records and staff interview, the facility failed to notify residents when their resident funds accounts were within $200.00 of the Medicaid resource limit as required. This affected four (#12, #60, #65, and #79) of five residents reviewed for personal funds. The facility census was 86. Findings include: 1. Review of the banking records for Resident #12 revealed a current balance of $6,595.42 and was over the Medicaid resource limit of $2,000.00 as of 02/12/24. Further review of the banking records for Resident #12 on 05/02/24 revealed no notification of spend down was provided to the resident as required. 2. Review of the banking records for Resident #60 revealed a current balance of $6,061.71 and was over the Medicaid resource limit of $2,000.00 as of 01/03/23. Further review of the banking records for Resident #60 on 05/02/24 revealed no notification of spend down was provided to the resident as required. 3. Review of the banking records for Resident #65 revealed a current balance of $2,404.86 and was over the Medicaid resource limit of $2,000.00 as of 02/02/24. Further review of the banking records for Resident #65 on 05/02/24 revealed no notification of spend down was provided to the resident as required. 4. Review of the banking records for Resident #79 revealed a current balance of $12,850.52 and was over the Medicaid resource limit of $2,000.00 as of 02/12/24. Further review of the banking records for Resident #79 on 05/02/24 revealed no notification of spend down was provided to the resident as required. Interview with Administrative Assistant (AA) #195 on 05/02/24 at 1:47 P.M. confirmed and verified no spend down letters or notifications were provided to Resident #12, Resident #60, Resident #65, or Resident #79 or their responsible parties as required.

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730 Based on observation and staff interview, the facility failed to ensure required information was posted and updated as required. This affected all 86 residents residing in the facility. The facility census was 86. Findings include: Observation on 05/01/24 at 3:30 P.M. of the common area located adjacent to the 100 hall, revealed a facility document titled Resident Advocate Contact Information in a picture frame hanging on the wall. Review of the document revealed outdated long-term ombudsman contact information with no information regarding the Medicaid fraud unit, Adult Protective Services, or information informing residents and/or families on how to file a complaint with the Ohio Department of Health (ODH). Interview on 05/02/24 at 9:47 A.M. with Ombudsman Program Director (OPD) #902 revealed the posted ombudsman information was approximately [AGE] years old. Interview on 05/02/24 at 3:30 P.M. with the Administrator confirmed and verified the above findings.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 42730 Based on observation, review of survey history, and staff interview, the facility failed to make reports of complaint investigations during the three pervious years readily available as required. This had the potential to affect all 86 residents currently residing in the facility. The facility census was 86. Findings Include: Observation on 04/30/24 at 8:00 A.M. of the facility's main entrance and common area revealed no readily available survey book. The survey book was located by a state surveyor in a closed drawer of a nightstand, not publicly visible, near the front entrance with no recent surveys observed. Review of previous survey activity for the facility revealed the Ohio Department of Health conducted complaint investigation surveys on 05/04/22, 09/12/22, 12/09/22, 01/05/23, 02/17/23, 05/08/23, 09/28/23, and 03/01/24. The results of these surveys were not present in the survey book at the time of observation on 04/30/24. An interview with the Administrator on 04/30/24 at 4:22 P.M. confirmed and verified the above findings.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38091 Based on medical record review, resident and staff interview, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to code resident Minimum Data Set (MDS) assessments accurately. This affected five (#53, #60, #78, #47, and #64) 18 sampled residents reviewed for accuracy of MDS assessments. The facility census was 86. Findings Include: 1. Review of the medical record revealed Resident #53 was admitted to the facility on [DATE] with diagnoses that included unspecified intellectual disabilities, seizures, and unspecified delirium. Review of the Pre-Admission Screening and Resident Review (PASRR) Level Two evaluation from the state department of developmental disabilities dated [DATE] revealed Resident #53 had a level two developmental disability. Review of section A of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the facility answered no to the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? 2. Review of the medical record revealed Resident #60 was admitted to the facility on [DATE] with diagnoses that included paranoid schizophrenia, bipolar disorder, and anxiety disorder. Review of the PASRR Level Two evaluation from the state department of mental health dated [DATE] revealed Resident #60 had a level two mental illness. Review of section A of the MDS 3.0 assessment dated [DATE] revealed the facility answered no to the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? 3. Review of the medical record revealed Resident #78 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder, psychosis, and disorientation. Review of the PASRR Level Two evaluation from the state department of mental health dated [DATE] revealed Resident #78 had a level two mental illness. Review of section A of the MDS 3.0 assessment dated [DATE] revealed the facility answered no to the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? Interview with Social Service Designee (SSD) #162 verified the PASRR Level Two statuses of Resident #53, Resident #60, and Resident #78 were coded incorrectly on each resident's MDS assessment in an interview on [DATE] at 2:30 P.M. 4. Review of the medical record for Resident #47 revealed an admitted [DATE]. Medical diagnoses included neuralgia and neuritis, anxiety, and depression. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS 3.0 annual assessment, dated [DATE], revealed Resident #47 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Resident #47 was recorded as having intact hearing with no hearing device used and was not recorded as having any behaviors or rejection of care. Review of Resident #47's care plan for hearing, initiated on [DATE], revealed a focus of potential for altered communication related to hearing loss. Goals included the hearing deficit would not interfere with communication with others. Interventions listed included to make referrals as needed, speak clearly, minimize environmental noise, and validate understanding as needed. The plan of care did not include a hearing appliance used. Review of Resident #47's interdisciplinary progress notes revealed notes dated [DATE] at 3:59 P.M., [DATE] at 3:22 P.M., and [DATE] at 8:00 A.M. referencing Resident #47 was hard of hearing and used a hearing appliance. Review of Resident #47's audiology progress notes included an outside audiology note dated [DATE] indicating a hearing evaluation was completed and the resident needed hearing aids. An audiology note from a visiting provider, dated [DATE], revealed Resident #47 had bilateral sensorineural hearing loss, received care from an outside audiologist, and was in the process of getting hearing aids. Review of Resident #47's previous appointments revealed the resident had an appointment with an outside provider on [DATE] to pick up her hearing aids. An interview on [DATE] at 10:12 A.M. with Resident #47 revealed she was hard of hearing and required the use of hearing aids. Resident #47 stated she had only three percent hearing in her left ear and 43 percent hearing in her right ear. During conversation, the resident was observed to turn her head, providing direct access to her right ear. Resident #47 stated she wore bilateral hearing aids but they picked up a lot of background noise which was frustrating. The resident stated her hearing aid batteries recently died and she was waiting on Maintenance Director (MD) #210 to purchase her new hearing aids. A subsequent interview on [DATE] at 11:09 AM with Resident #47 verified she received new hearing aid batteries but since had lost one of her hearing aids. Resident #47 stated she reported it to her nurse. An interview on [DATE] at 1:41 P.M. with Licensed Practical Nurse (LPN) #140 revealed she was familiar with Resident #47 and knew she was hard of hearing and wore hearing aids in bilateral ears. LPN #140 verified she heard about the resident's missing hearing aid and reported it to Social Services Director (SSD) #163. An interview on [DATE] at 2:23 P.M. with SSD #163 confirmed she was informed of Resident #47's missing hearing aid. SSD #163 stated the resident was mobile in her motorized wheelchair, went outside when it was nice out, and the hearing appliance could have been lost anywhere. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on [DATE] at 2:44 P.M. with MDS Coordinator #144 revealed she coded Resident #47's MDS assessment as hearing intact with no device used as she believed the resident to be faking her hearing loss. MDS Coordinator #144 stated she interacted with the resident on various occasions and did not notice the resident having any difficulty hearing nor did she see a hearing appliance used. MDS Coordinator #144 confirmed Resident #47 had a plan of care in place for impaired hearing which pre-dated her employment with the facility, which did not include the resident having hearing aids. MDS Coordinator #144 verified part of her role included reviewing documentation including progress notes, and visits with outside providers, to accurately complete assessments and care plans. MDS Coordinator #144 verified hearing impairment and hearing appliance should have been marked on the resident's MDS assessment and included in her care plan. Review of the RAI manual, dated [DATE], revealed the steps for assessment for hearing included prior to beginning the hearing assessment, ask the resident if they own a hearing aid or other hearing appliance and, if so, whether it is used at the nursing home. The instructions additionally included to check the medical record for evidence that the resident had a hearing appliance in place when hearing ability was recorded. Ask staff and significant others whether the resident was using a hearing appliance when they observed the resident's hearing ability. 5. Review of the medical record for Resident #64 revealed an admitted [DATE]. Medical diagnoses included cerebral infarction, moderate protein-calorie malnutrition, chronic obstructive pulmonary disease, and type II diabetes with neuropathy. Resident #64 was hospitalized from [DATE] to [DATE] for sepsis (bloodstream infection). Resident #64 was admitted to hospice care on [DATE]. Resident #64's current weight was documented as 116 pounds (lbs) on [DATE]. Review of Resident #64's MDS 3.0 significant change in status assessment, dated [DATE], identified the resident to have severe cognitive impairment. Resident #64 was not identified to have any behaviors or rejection of care. Resident #64 was identified to have an impairment to both sides of her lower extremities and was coded as being completely dependent on staff for all activities of daily living, mobility, and transfers. Resident #64 was identified to be at risk for developing pressure ulcers and had four unhealed pressure ulcers including one stage three pressure ulcer (a full thickness wound involving damage into the subcutaneous tissue) and three stage four pressure ulcers (a full thickness wound with exposed muscle, tendon, or bone). The resident was identified to be on hospice with a terminal prognosis and a life expectancy of six months or less. Review of Resident #64's wound assessment documentation, dated [DATE], revealed the resident had four unhealed pressure ulcers including an unstageable area (full thickness pressure injury where the true depth of the wound cannot be determined due to the presence of dead tissue) to the left plantar foot by the great toe, an unstageable area to the right lateral foot near the fifth toe, an unstageable area to the right medial heel, and an unstageable area to the left gluteal fold. Each of the wounds was recorded as being unstageable due to slough or eschar (dead tissue). An interview on [DATE] at 4:08 P.M. with MDS Coordinator #144 verified Resident #64's MDS assessment related to wounds was coded incorrectly. MDS Coordinator #144 stated she referenced the wrong documentation when completing the original MDS assessment. MDS Coordinator #144 stated she has modified the assessment with the correct information. Review of the RAI manual, dated [DATE], revealed pressure ulcer stages should be coded in terms of what is assessed during the seven-day look-back period of the assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	47990

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on medical record review, resident and staff interview, and policy review, the facility failed to ensure resident care plans were updated to reflect individualized and necessary components of their care. This affected two (#47 and #64) of 22 residents reviewed for care planning. The facility census was 86. Findings include: 1. Review of the medical record for Resident #47 revealed an admitted [DATE]. Medical diagnoses included neuralgia and neuritis, anxiety, and depression. Review of the Minimum Data Set (MDS) 3.0 annual assessment, dated [DATE], revealed Resident #47 was assessed as cognitively intact. Resident #47 was recorded as having intact hearing with no hearing device used and was not recorded as having any behaviors or rejection of care. Review of Resident #47's care plan for hearing, initiated on [DATE], revealed a focus of potential for altered communication related to hearing loss. Goals included the hearing deficit would not interfere with communication with others. Interventions listed included to make referrals as needed, speak clearly, minimize environmental noise, and validate understanding as needed. The plan of care did not include a hearing appliance used. Review of Resident #47's interdisciplinary progress notes revealed notes dated [DATE] at 3:59 P.M., [DATE] at 3:22 P.M., and [DATE] at 8:00 A.M. referencing Resident #47 was hard of hearing and used a hearing appliance. Review of Resident #47's audiology progress notes included an outside audiology note dated [DATE] stating that a hearing evaluation was completed and resident needed hearing aids. An audiology note from a visiting provider, dated [DATE], revealed Resident #47 had bilateral sensorineural hearing loss, received care from an outside audiologist, and was in the process of getting hearing aids. Review of Resident #47's previous appointments revealed she had an appointment with an outside provider on [DATE] to pick up her hearing aids. An interview on [DATE] at 10:12 A.M. with Resident #47 revealed she was hard of hearing and required the use of hearing aids. Resident #47 stated she had only three percent hearing in her left ear and 43 percent hearing in her right ear. Resident #47 stated she wore bilateral hearing aids but they picked up a lot of background noise which was frustrating. The resident stated her hearing aid batteries recently died and she was waiting on Maintenance Director (MD) #210 to purchase her new hearing aids. A subsequent interview on [DATE] at 11:09 AM with Resident #47 verified she received new hearing aide batteries but since had lost one of her hearing aids. Resident #47 stated she reported it to her nurse. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Autumn Aegis Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 1130 Tower Blvd Lorain, OH 44052	

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on [DATE] at 1:41 P.M. with Licensed Practical Nurse (LPN) #140 revealed she was familiar with Resident #47 and knew she was hard of hearing and wore hearing aids in bilateral ears. An interview on [DATE] at 2:44 P.M. with MDS Coordinator #144 confirmed Resident #47 had a plan of care in place for impaired hearing that did not include the use of hearing aids which pre-dated her employment with the facility, and verified she did not realize the resident had hearing aids. MDS Coordinator #144 verified part of her role included reviewing documentation including progress notes, and visits with outside providers, to accurately complete assessments and care plans. 2. Review of the medical record for Resident #64 revealed an admitted [DATE]. Medical diagnoses included cerebral infarction, moderate protein-calorie malnutrition, chronic obstructive pulmonary disease (COPD), and type II diabetes with neuropathy. Resident #64 was hospitalized from [DATE] to [DATE] for sepsis (bloodstream infection). Resident #64 was admitted to hospice care on [DATE]. Review of Resident #64's MDS 3.0 significant change in status assessment, dated [DATE], identified the resident to have a severe cognitive impairment. The resident was identified to be on hospice care with a terminal prognosis and a life expectancy of six months or less. Review of Resident #64's facility care plan revealed a focus of a potential for decline in condition, grief, anxiety, terminal restlessness, and agitation. The plan of care revealed the resident previously received hospice services which discontinued on [DATE], and did not identify the resident was actively receiving hospice care. Interview on [DATE] at 1:42 P.M. with LPN #140 confirmed Resident #64 had been under hospice care for months with a local hospice provider. An interview on [DATE] at 9:41 A.M. with the Director of Nursing (DON) verified Resident #64's facility-initiated plan of care did not identify Resident #64 was currently receiving hospice services. The DON verified the plan of care needed to be updated. Review of the policy titled, Interdisciplinary Care Plan Process, revised ,d+[DATE], revealed it is the facility's policy to ensure immediate and ongoing actual or potential problems, needs and strengths of all residents are addressed through the interdisciplinary care plan meeting. Care plans are to be updated and reviewed on an ongoing basis, and at the minimum, on admission, quarterly, annually, and with a significant change in status. When updating the care plan review all physician's orders, progress notes, ancillary notes, laboratory values, and reports. A comprehensive review must be completed on all admission, annual, and significant change assessments. 42011

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F 0686

Level of Harm - Minimal harm or potential for 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 47990

Based on observation, staff interview, medical record review, review of an air mattress operation manual, and policy review, the facility failed to ensure interventions were in place to treat existing pressure ulcers and prevent new pressure ulcers from developing as ordered. This affected one (#64) of two residents reviewed for pressure ulcers. The facility census was 86.

Findings include:

Review of the medical record for Resident #64 revealed an admitted [DATE]. Medical diagnoses included cerebral infarction, moderate protein-calorie malnutrition, chronic obstructive pulmonary disease (COPD), and type II diabetes with neuropathy. Resident #64 was hospitalized from 01/26/24 to 02/06/24 for sepsis (bloodstream infection). Resident #64 was admitted to hospice care on 02/16/24. Resident #64's current weight was documented as 116 pounds (lbs) on 04/05/24.

Review of Resident #64's Minimum Data Set (MDS) 3.0 significant change in status assessment, dated 02/25/24, identified the resident to have a severe cognitive impairment. Resident #64 was not identified to have any behaviors or rejection of care. Resident #64 was identified to have an impairment to both sides of her lower extremities and was coded as being completely dependent on staff for all activities of daily living, mobility, and transfers. Resident #64 was identified to be at risk for developing pressure ulcers and had four unhealed pressure ulcers. The resident was identified to be on hospice with a terminal prognosis and a life expectancy of six months or less.

Review of Resident #64's care plan, dated as initiated on 02/21/23 and revised on 04/29/24, revealed the resident was identified as having the potential for skin integrity impairment. The care plan noted Resident #64 had a history of an unstageable pressure ulcer (full thickness pressure ulcer where the true depth of the wound cannot be determined due to the presence of dead tissue) and a diabetic ulcer both of which were healed. The care plan did not identify any active, current skin integrity issues. The preventative skin care plan included an intervention for Resident #64 to wear bilateral Prevalon boots (soft boots used for offloading pressure from the feet) while in bed and for a low air loss mattress to the resident's bed. Resident #64's care plan was noted to have been revised twice on 04/29/24 by Wound Nurse #104. The first revision added there was a pressure injury to bilateral feet to the care plan focus description. The second revision, also completed by Wound Nurse #104, included the addition that resident frequently kicks off Prevalon boots.

Review of Resident #64's re-admission nursing assessment, dated 02/06/24, revealed the resident was identified to have pressure ulcers to her bilateral feet and right gluteal fold upon her return from the hospital to the facility. The resident's Braden scale assessment (for predicting pressuring ulcer risk), dated 02/06/24, revealed the resident was at high risk for developing pressure injuries.

Review of Resident #64's physician's orders revealed an order dated 02/07/24 for bilateral Prevalon boots to be worn at all times, and may remove the boots for hygiene and to assess skin integrity with each application and removal. Resident #64 also had an order dated 02/07/24 to have a low air loss mattress to the bed.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 04/29/24 at 10:05 A.M. of Resident #64 revealed her lying in bed covered with a white sheet and the resident's legs appeared to be curled underneath her. An air mattress was noted in place to Resident #64's bed, with the control box hanging on the end of the bed's footboard. The air mattress had various controls which included one to select the weight of the resident. The air mattress was set for a patient weight of 250 lbs. Two Prevalon boots were observed lying on top of Resident #64's sheet at the foot of the bed. An interview on 04/29/24 at 10:10 A.M. with Restorative Nurse #117 verified Resident #64's Prevalon boots were not on. Restorative Nurse #117 stated Resident #64 does not like the Prevalon boots. A subsequent observation on 04/29/24 at 11:48 A.M. revealed Resident #64 remained in bed covered by a sheet. The resident was not wearing her bilateral Prevalon boots, as the boots were again observed lying on top of the covers at the foot of the bed unchanged from the prior observation. The air mattress remained at the setting for a 250 lbs. resident. An interview on 04/29/24 at 12:07 P.M. with State tested Nurse Aide (STNA) #134 revealed she was fairly new to working at the facility but familiar with Resident #64's care. STNA #134 verified the resident had heel boots she was supposed to wear because the resident had wounds on both of her feet. STNA #134 stated she was recently told by an unnamed staff member that Resident #64 could kick the Prevalon boots off, but she had never seen it herself. STNA #134 verified Resident #64 required total care and assistance for all activities of daily living and had contractures to her bilateral lower extremities. An interview on 04/29/24 at 12:13 P.M. with the Director of Nursing (DON) verified Resident #64's air mattress settings were incorrect and should not be set at 250 lbs. as that was more than twice of Resident #64's body weight. The DON additionally verified the heel boots lying on top of Resident #64's covers and stated they should be in place. The DON stated she would check with the wound nurse to correct the air mattress settings as she was unaware of how to change the settings. Subsequent observations of Resident #64 lying in bed on 04/30/24 at 8:01 A.M., 10:51 A.M., and 2:36 P.M. revealed the resident remained lying in bed and had her bilateral Prevalon boots in place. During each observation Resident #64 appeared comfortable, and free from non-verbal signs of pain. There were no observations of Resident #64 moving or attempting to move her bilateral legs. An interview on 04/30/24 at 2:46 P.M. with STNA #118 revealed she cared for Resident #64 at the facility for many years and was very familiar with her care needs. STNA #118 verified Resident #64 has bilateral leg contractures and her legs stayed in a bent, curled up position. STNA #118 stated Resident #64 was unable to bear any weight or make any spontaneous or purposeful movement due to her contractures. STNA #118 verified she never saw the resident kick her leg and stated the resident would be unable to do so. STNA #118 confirmed Resident #64 was totally dependent on staff for all activities of daily living and transfers. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 05/01/24 at 8:57 A.M. revealed Resident #64's weekly wound assessment and wound care was completed with Wound Nurse #104, Registered Nurse (RN) Assistant Director of Nursing (ADON) #124 and Certified Nurse Practitioner (CNP) #222 present in the room. Resident #64 was in bed and appropriately positioned by staff for the procedure. Resident #64 had had her bilateral Prevalon boots in place, which were removed by Wound Nurse #104 and RN ADON #124. Resident #64's legs appeared significantly bent and stiff as Wound Nurse #104 and RN ADON #124 removed her Prevalon boots. An interview with CNP #222 at the time of the observation confirmed Resident #64 had significant contractures to her bilateral lower extremities, which was how she got the pressure injuries to her bilateral feet. CNP #222 verified Resident #64's significant contractures and stated the resident was not capable of kicking her legs nor making even slight extensions of her bilateral legs to attempt to relieve pressure off her feet. A follow up interview on 05/01/24 at 9:18 A.M. with Wound Nurse #104 verified Resident #64 had contractures and verified she added that the resident kicks her legs to the care plan on 04/29/24. Wound Nurse #104 stated upon Resident #64's hospital return in February 2024 the resident was able to move easier. Wound Nurse #104 stated she added the addition to the care plan to reflect how the resident used to be upon her hospital return, but it did not reflect Resident #64's current functional abilities. Review of the air mattress operator's manual, copyrighted in 2016, revealed the air mattress contained weight setting buttons that can be used to adjust the pressure of the inflated cells based on the patient's weight. As the weight setting increases, the pressure level indicator lights light up green with each added level of pressure. Review of the policy, Wound Prevention and Management Policy, revised 10/2022, revealed all residents will have a comprehensive skin assessment to identify current skin breakdown and identify pressure ulcer risk factors. An appropriate treatment will be implemented for any existing skin breakdown. A care plan will be initiated and updated as necessary until the area is resolved. A preventative plan of care and interventions will be initiated for any residents determined to be at risk to reduce the possibility of further breakdown.

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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** 38091 Based on medical record review, review of a list of residents who smoke, resident and staff interview, and review of a facility policy, the facility failed to complete smoking assessments as required. This affected one (#25) of three residents reviewed for smoking. The facility census was 86. Findings include: Record review for Resident #25 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, bipolar disorder, benign prostatic hyperplasia, and cognitive communication deficit. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 was cognitively intact, had impairment on one side of the lower extremities, and required assistance with activities of daily living. Review of the care plan for Resident #25 dated 08/09/23 revealed Resident #25 had potential for injury and was a chronic smoker. Interventions included to secure cigarettes and lighter at the nurses station and complete a smoking assessment quarterly and with significant change. Review of Resident #25's medical record revealed two smoking assessments were completed since admission with the first assessment dated [DATE] and the second assessment dated [DATE]. Further review revealed both assessments indicated Resident #25 was a smoker and was not at risk for injury related to smoking. Review of the list of residents who smoke in the facility provided to the survey team identified Resident #25 as a resident who smoked. Interview on 04/30/24 at 2:52 P.M. with MDS Nurse #144 revealed Restorative Nurse #117 completed smoking assessments for residents. Interview on 04/30/24 at 2:55 P.M. with Restorative Nurse #117 stated she did not complete the resident smoking assessments, and it was Social Service Director (SSD) #163 who completed the smoking assessments. Interview on 04/30/24 at 2:58 P.M. with SSD #163 stated she never did smoking assessments for residents and did not know who did them. Interview on 04/30/24 at 2:59 P.M. with the Director of Nursing (DON) revealed the admitting nurse completed each new resident's smoking assessment then SSD #163 completed each assessment after that. The DON revealed she was not sure how frequently smoking assessments should be done. The DON verified Resident #25's last smoking assessment was completed 03/12/23 and was not completed quarterly. Interview on 05/01/24 at 4:26 P.M. with Resident #25 revealed he had to temporarily ceased smoking on 03/30/24 until after his upcoming surgery in May 2024 per the surgeon's request. Resident #25 revealed after the surgery he may go back to smoking again. (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 policy titled, Smoking, revised April 2019, revealed to provide an environment that allows residents to safely utilize tobacco products and other smoking devices in non smoke-free campuses, smoking assessment will be completed upon admission and with significant changes. If resident is found to be a smoker, smoking assessments will be completed quarterly.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, resident and staff interview, and medical record review, the facility failed to offer and provide dental services for residents with dentures. This affected one (#36) of three residents reviewed for ancillary services. The facility census was 86. Findings include: Record review for Resident #36 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus and adult failure to thrive. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] for Resident #36 revealed the resident was assessed as severely cognitively impaired. Further review revealed Resident #36 was assessed with no broken or loosely fitting full or partial dentures, and Resident #36 had natural teeth. Interview on 04/29/24 at 10:35 A.M. with Resident #36 revealed his upper dentures were lost. Observation at the time of the interview revealed Resident #36 had natural teeth to the lower gums and was edentulous to the upper gums. Interview on 04/30/24 at 1:04 P.M. with Social Service Director (SSD) #163 revealed residents dental services were arranged by the Receptionist #195. Interview on 04/30/24 at 3:51 P.M. with Receptionist #195 confirmed she scheduled ancillary services for residents. Receptionist #195 revealed when a resident was newly admitted she would send the resident's name and referral to the dentist. Receptionist #195 stated the dentist visited the facility every three months and rotated residents and saw each resident every six months and as needed. Receptionist #195 confirmed she did not see where Resident #36 had been seen by the dentist but would check with the dentist. Interview on 04/30/24 at 4:15 P.M. with Licensed Practical Nurse (LPN) #140 revealed she was unsure if Resident # 36 had dentures when he was admitted and was not aware of any missing dentures. Interview on 04/30/24 at 4:16 P.M. with Receptionist #195 revealed Resident #36 was never put on the dental list and never had the dental consent signed, and confirmed Resident #36 was never seen by the dentist while at the facility. Receptionist #195 revealed she was not sure how Resident #36 was missed for the consent and dental service, and confirmed Resident #36 did not refuse the service. Interview on 04/30/24 at 5:28 P.M. with State tested Nurse Aide (STNA) #211 revealed Resident #36 had upper dentures in his drawer and he did not like them because they hurt his mouth as they were too big since he lost weight. STNA #211 stated the resident had not been wearing the dentures for the previous two months and he would ask to try them frequently, but would take them out because they did not fit correctly. STNA #211 revealed she told one of the nurses about two month ago when Resident #36 complained for the first time. Observation with STNA #211 during the observation revealed an upper denture placed in a denture cup in Resident #36's top drawer of his night stand.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 38091 Based on observation and staff interview, the facility failed to maintain a clean, sanitary, and safe environment. This had the potential to affect all 86 residents. The facility census was 86. Findings Include: Observation of the facility environment on 05/02/24 between 9:30 A.M. and 10:00 A.M., with Maintenance Director (MD) #210, revealed the carpeting throughout common areas, hallways, and resident rooms showed significant instances of large stains. Further observation of the common areas of the facility revealed the handrails in the common hallways were observed to be discolored and rough to the touch in numerous areas. There were numerous instances of dead bugs noted in light fixtures throughout the facility including in resident dining areas. There were numerous water-stained ceiling tiles noted around the 100 hall nurse's station. Observation of resident rooms on 05/02/24 between 9:30 A.M. and 10:00 A.M., during the environmental tour with MD #201, revealed the privacy curtains in the rooms of Resident #1, Resident #22, Resident #26, Resident #27, Resident #50, Resident #70, Resident #73, Resident #79, and Resident #90 were significantly stained with various unknown substances. The bathroom doors in Resident #9, Resident #25, Resident #46, Resident #51, Resident #67, and Resident #87's rooms were noticeably scuffed and scrapped. The air vent in Resident #61's bathroom was coated in dust. Resident #51 was observed laying in bed covered by a white blanket with noticeable yellow staining. The sliding closet door in Resident #33 and Resident #84's room was missing a handle. The floor in Resident #11's room was noticeable dirty. The base of the tube feeding pole in Resident #64's room was also noted dried residual tube feeding supplement on other unknown substances encrusted on the pole. Interview with MD #210 verified the findings and observations from the environmental tour on 05/02/24 between 9:30 A.M. and 10:00 A.M. and the time of discovery.