STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365977	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Circle of Care	1985 East Pershing Street Salem, OH 44460

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on record review and interview, the facility failed to provide spend-down notices to Residents #9 and #10. This affected two residents (#9 and #10) of five reviewed for resident funds. The facility census was 40. Findings include: 1. Review of the medical record for Resident #9 revealed an admitted [DATE] with diagnoses including cognitive communication deficit, bipolar disorder, major depressive disorder, vascular dementia, and anxiety. Review of Resident #9's payer source information revealed he was covered by Caresource Managed Medicaid. Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/15/25, revealed Resident #9 had moderate cognitive impairment. Review of Resident #9's Resident Fund Management Services (RFMS) authorization form indicated the facility had managed Resident #9's funds since 05/18/17. Review of the quarterly account statements revealed Resident #9 had a quarterly ending balance of $2,349. 22 on 03/29/24, $1,991.58 on 09/30/24, and $2,011.85 on 12/31/24. 2. Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses including neurocognitive disorder with Lewy bodies, major depressive disorder, altered mental status, cognitive communication deficit, dementia, personal history of traumatic brain injury, and anxiety. Review of Resident #10's payer source information revealed he was covered by United Healthcare Managed Medicaid. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/18/25, revealed Resident #10 had no cognitive impairment. Review of Resident #10's Resident Fund Management Services (RFMS) authorization form indicated the facility had managed Resident #10's funds since 05/18/17. (continued on next page)

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

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

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly account statements revealed Resident #19 had a quarterly ending balance of $5,129. 91 on 09/30/24 and $3,820.98 on 12/31/24. On 03/31/25 at 3:27 P.M., an interview with Business Office Manager (BOM) #358 confirmed Medicaid had an assets limit of $2,000 for individuals. BOM #358 verified the quarterly statements for Resident #10 indicated he was above the allowable limit for Medicaid and confirmed no spend-down notices were provided to Resident #10. She further stated no spend down notices were provided for any residents. On 03/31/25 at 4:32 P.M., an interview with BOM #358 verified the quarterly statements for Resident #9 indicated he was above the allowable limit for Medicaid. On 03/31/25 at 5:20 P.M., an interview with the Director of Nursing (DON) stated Resident #10 was losing his Medicaid coverage because he was over his allowable assets limit. The DON further stated once Resident #10's money was spent down, he could then go back on Medicaid.

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on record review and interview, the facility failed to complete a new Pre-Admission Screening and Resident Review (PASRR) level two evaluation for Resident #29 after a new diagnosis of Schizoaffective disorder. This affected one resident (#29) of one reviewed for PASRR. The facility census was 40. Findings include: Review of the medical record for Resident #29 revealed an admitted [DATE] with diagnoses including muscle weakness, hypothyroidism, protein-calorie malnutrition, encephalopathy, cellulitis of the left and right lower limbs, hypokalemia, hypertension, and cognitive communication deficit. Review of the Pre-Admission Screening and Resident Review (PASRR) level one identification screening tool, dated 03/14/24, indicated Resident #29 had other psychotic disorder and had no functional limitations within the previous six months related to maintaining personal hygiene, maintaining adequate diet, maintaining prescribed medication regimen, and securing necessary support services. The screening tool also indicated Resident #29 had not been prescribed any psychotropic medications within the previous six months. The PASRR results notice, dated 03/14/24, indicated Resident #29 had no indications of serious mental illness. Review of the hospital paperwork, with a facsimile (fax) transmission date of 03/15/24, revealed Resident #29 arrived to the emergency roiagnom on [DATE] for evaluation of lower extremity pain and generalized weakness after a neighbor called emergency services for a wellness check. The hospital established that Resident #29 was living in deplorable conditions at home with no running water, no heat, had not eaten in days, and had to be placed in decontamination for a shower. The competency evaluation completed while in the hospital indicated Resident #29 had unspecified psychosis, unspecified adjustment disorder, refused medical treatment, refused to take prescribed medications, and was deemed incompetent to make informed healthcare decisions. Diagnoses at the time of discharge from the hospital on 03/15/24, as listed on the discharge summary, were bilateral lower leg cellulitis, generalized weakness, inability to walk, intractable pain, hypothyroidism, hypokalemia, and moderate protein-calorie malnutrition. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's orders for Resident #29 revealed the following: On 04/18/24, a physician's order was added for Risperidone (antipsychotic) solution one milligram per milliliter (mg/ml) to give 0.5 ml by mouth in pudding once daily in the morning for delusions (discontinued on 04/25/24). On 04/25/24, a physician's order was added for Risperidone solution one mg/ml to give 0.5 ml by mouth in pudding three times daily for delusions (discontinued on 04/26/24). On 04/27/24, a physician's order was added for Risperidone solution one mg/ml to give 0.5 ml by mouth in food in the morning, afternoon, and evening for delusions (discontinued on 04/29/24). On 04/30/24, a physician's order was added for Invega (antipsychotic) oral tablet extended release tablet 24 hour six milligrams (mg) to give one tablet by mouth at bedtime for other symbolic dysfunctions and cognitive communication deficit. On 04/30/24, a physician's order was added for Zyprexa (antipsychotic) oral tablet five mg to give five mg by mouth once daily at bedtime for mood disorder related to other symbolic dysfunction and cognitive communication deficit (discontinued on 08/19/24). On 08/19/24, a physician's order was added for Zyprexa oral tablet 2.5 mg to give 2.5 mg by mouth at bedtime for Schizoaffective disorder. Review of the facility's comprehensive diagnoses list for Resident #29 revealed a new diagnosis of Schizoaffective disorder was added on 08/19/24. On 03/24/25 at 3:38 P.M., an interview with Admissions Coordinator #329 verified Resident #29 had a new diagnosis of Schizoaffective disorder added on 08/19/24 and no new PASRR was completed. Admissions Coordinator #329 further stated a significant change PASRR should have been completed for Resident #29.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on record review, interview, and review of facility policy, the facility failed to provide evidence that Resident #145's baseline care plan was developed in a timely manner. This affected one resident (#145) of one reviewed for dialysis. The facility census was 40. Findings include: Review of the medical record for Resident #145 revealed an admitted [DATE] with diagnoses including hypertension, iron deficiency anemia, bronchiectasis, atrial fibrillation, dementia, adult failure to thrive, severe protein-calorie malnutrition, type two diabetes mellitus, pressure induced deep tissue damage of the left and right heels, stage two pressure ulcer of the back, enterocolitis due to clostridium difficile, open wound to right wrist, and end stage renal disease. Review of the handwritten document titled Care Plan on Admission/Re-admission (Interim CP/Baseline CP) revealed there was no date of completion and there was no signature or name of the person who completed the form. Review of the comprehensive care plan for Resident #145 revealed care plans for the following focus areas were developed later than 48 hours after admission: nutrition and hydration risk (initiated 03/06/25), end-stage renal disease and hemodialysis up to five times weekly (initiated 03/10/25), hypertension (initiated 03/11/25), fall risk (initiated 03/11/25), activities of daily living self care deficit (initiated 03/11/25), incontinence (initiated 03/11/25), renal failure (initiated 03/11/25), clostridium difficile (initiated 03/11/25), episodes of refusal of care (initiated 03/11/25), acute/chronic pain (initiated 03/11/25), polypharmacy (initiated 03/11/25), discharge planning (initiated 03/11/25), activities (initiated 03/11/25), coronary artery disease (initiated 03/11/25), altered cognition (initiated 03/11/25), infection potential due to skin and wounds (initiated 03/11/25), and psychosocial well-being (initiated 03/11/25). On 03/27/25 at 5:12 P.M., an interview with the Director of Nursing (DON) verified Resident #145's baseline care plan document did not have a date of completion, there was no indication as to who completed it, and there was no indication the resident or representative received a copy of the baseline care plan. The DON further stated baseline care plans were always completed on paper and not in the electronic health record. Review of the facility's policy titled Care Plans - Preliminary, dated November 2010, indicated the facility would develop a preliminary plan of care to meet resident needs within 24 hours of admission. The preliminary care plan would be used by staff until a comprehensive assessment was conducted and an interdisciplinary care plan was developed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on review of medical records, interviews, and review of facility policy, the facility failed to initiate and implement person-centered comprehensive care plans that addressed their identified needs for two residents (#11 and #20) of 19 residents whose care plans were reviewed during the annual survey. The facility census was 40. Findings include: 1. Review of the medical record for Resident #11 revealed an initial admitted [DATE] and a re-entry date of 05/30/21 with diagnoses including end stage renal disease, type two diabetes mellitus, unspecified heart failure, hypertension, anxiety, major depressive disorder, necrotizing fasciitis, overactive bladder, and neuromuscular dysfunction of the bladder. Review of the quarterly Minimum Data Set (MDS) assessment completed on 01/19/25 revealed Resident #11 had intact cognition and was dependent for toileting hygiene. Further review of the MDS revealed Resident #11 had an indwelling catheter and frequently experienced bowel incontinence. Review of the care plan dated 11/07/18 through 05/15/25 revealed no care planning regarding Resident #11's elimination status, including indwelling catheter care or interventions related to bowel incontinence. Interview on 04/01/25 at 10:35 A.M. with Licensed Practical Nurse (LPN) #352 confirmed care plan interventions for catheter care should be found in resident care plans and should be also be linked to trigger an aide task for documentation related to catheter care. Interview on 04/01/25 at 4:00 P.M. with the Director of Nursing (DON) confirmed there was no care plan related to a Foley catheter on Resident #11's care plan. Review of the undated policy titled Care Plan - Comprehensive revealed the comprehensive care plan was based on thorough assessment data and was to incorporate identified problems, risk factors, areas triggered during the care area assessments and should reflect current standards of practice for each problem area or condition. The comprehensive care plan was to be individualized to help meet the medical, nursing, mental, and psychosocial needs of each resident. 2. Review of the medical record for Resident #20 revealed an admitted [DATE] with diagnoses including encephalopathy, weakness, major depressive disorder, anxiety, abnormal reflex, history of opioid abuse, alcohol dependence with persisting dementia, tobacco use, ataxic gait, and lack of coordination. Review of the annual Minimum Data Set (MDS) 3.0 assessment completed on 02/06/25 revealed Resident #20 had intact cognition and required supervision or touching assistance for ambulating 10 feet in a room, corridor, or similar space. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan dated 02/11/25 revealed there was no care planning or interventions related to Resident #20 being at risk for falls; however, there was one historical care plan focus listed as RESOLVED for a fall that occurred on 01/18/24, when Resident #20 sustained a displaced fracture of her right ankle. The interventions for the resolved actual fall care plan included completing fall risk assessments quarterly and following the facility's fall protocols. Review of the Fall Risk Evaluations completed on 01/18/24, 01/27/24, and 02/05/24 revealed Resident #20 remained at moderate risk for falls. There were no evaluations indicating that Resident #20 no longer was at risk for falls. Interview on 04/01/25 at 10:35 A.M. with Licensed Practical Nurse (LPN) #352 confirmed care plan interventions for a resident with a moderate risk for falls should be noted in their care plan. Interview on 04/01/25 at 4:00 P.M. with the Director of Nursing (DON) confirmed there was no care plan for fall preventions. The DON further confirmed the care plan should have indicated Resident #20 was at risk for falls and included interventions to prevent falls if there were no subsequent fall risk assessments conducted to determine she was no longer at risk for falls. Review of the undated policy titled Falls - Clinical Protocol revealed facility staff were to identify and document risk factors for falling, including multiple medications, gait and balance disorders, cognitive impairment, and weakness, and interventions were to be implemented to prevent subsequent falls or complications related to falls.

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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** 44808 Based on record review, review of fall investigations, interview, and review of facility policy, the facility failed to re-evaluate care planned fall interventions for effectiveness and update the care plan with new interventions after multiple falls for Resident #10. This affected one resident (#10) of three reviewed for falls. The facility census was 40. Findings include: Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses including neurocognitive disorder with Lewy bodies, major depressive disorder, altered mental status, cognitive communication deficit, dementia, personal history of traumatic brain injury, and anxiety. Review of the fall risk data collection tool, dated 02/23/24, indicated Resident #10 was at high risk for falls, with a score of 23, and had experienced multiple falls within the previous six months. Review of the facility's incident log indicated Resident #10 had falls on 08/02/24 at 5:00 P.M., 09/08/24 at 2:51 A.M., 09/10/24 at 3:20 A.M., 10/25/24 at 9:35 A.M., 10/27/24 at 10:32 P.M., 02/01/25 at 10:20 P.M., and 03/01/25 at 9:00 P.M. The incident log did not include a fall on 02/27/25 for Resident #10. Review of the progress note dated 08/02/24 at 6:40 P.M. indicated Resident #10 fell while a friend was assisting him into his wheelchair. The nurse attempted to educate Resident #10 on asking for assistance with transfers and the resident became agitated. Review of the fall investigation dated 08/02/24 revealed Resident #10 fell while a friend was assisting him with a transfer. No injuries were identified. The new interventions were Resident #10 was placed in the dining room for monitoring, his room was decluttered, and the resident was educated on using the call light and not transferring without staff. Review of the progress note dated 09/08/24 at 3:56 A.M. indicated Resident #10 was sitting on the floor on his bottom and the resident stated he slid off the edge of the bed while trying to transfer. Resident #10 was assessed and no injuries were identified. Neurological checks were initiated and Resident #10 was educated on the importance of wearing non-skid socks and using the call light. Review of the fall investigation dated 09/08/24 revealed Resident #10 slid off the edge of his bed during a self-transfer. No injuries were identified. The new interventions were initiation of neurological checks and Resident #10 was educated on using the call light and the importance of wearing non-skid socks. Review of the fall risk data collection tool, dated 09/08/24, indicated Resident #10 was at high risk for falls, with a score of 22, and had experienced multiple falls within the previous six months. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 09/10/24 at 3:31 A.M. indicated Resident #10 was found laying on the floor on his left side and the bed alarm was sounding. Resident #10 was assessed and no injuries were identified. Resident #10 was educated on using the call light, neurological checks were initiated, the resident was to wear non-skid socks while in bed due to recent increase in falls, 15 minute checks, and a request was made to have a clip alarm placed in addition to the bed alarm. Review of the fall investigation dated 09/10/24 revealed Resident #10 was found on the floor and his bed alarm was sounding. No injuries were identified. The new interventions were initiation of neurological checks, non-slip socks while in bed, 15 minute checks, clip alarm in addition to bed alarm, and Resident #10 was educated on using the call light. Review of the progress note dated 09/21/24 at 12:15 P.M. indicated Resident #10 was observed in a squatting position with one hand on the bed and one hand on the wheelchair, staff lowered him to the ground, and Resident #10 was assisted from the ground to his wheelchair by staff using a gait belt. Review of the progress note dated 09/25/24 at 11:32 P.M. indicated Resident #10 transferred himself from his wheelchair to his bed and the alarm was sounding. Resident #10 was educated on using the call light. Review of the progress note dated 10/25/24 at 9:55 A.M. indicated Resident #10 was found on the floor in front of his bed and the resident stated he slipped off the edge of the bed while eating breakfast. Resident #10 was assessed and no injuries were identified. Neurological checks were initiated. Review of the fall investigation dated 10/25/24 revealed Resident #10 was found on the floor in front of his bed and the resident stated he slipped out of bed. No injuries were identified. The new intervention was initiation of neurological checks. Review of the fall risk data collection tool, dated 10/25/24, indicated Resident #10 was at high risk for falls, with a score of 24, and had experienced multiple falls within the previous six months. Review of the progress note dated 10/27/24 at 11:23 P.M. indicated Resident #10 slid out of bed onto the floor and his feet were straight out in front of him. Resident #10 was assessed and no injuries were identified. Review of the fall investigation dated 10/27/24 revealed Resident #10 was found sitting upright on the floor with his legs straight out in front of him. No injuries were identified. The new interventions were Resident #10 was educated on using the call light and staff demonstrated how to use bed controls. Review of the fall risk data collection tool, dated 10/27/24, indicated Resident #10 was at high risk for falls, with a score of 24, and had experienced multiple falls within the previous six months. Review of the progress note dated 11/03/24 at 8:29 P.M. indicated Resident #10's wheelchair was removed from his room at bedtime for safety. Review of the progress note dated 12/22/25 at 5:43 P.M. indicated Resident #10 was having difficulty with transfers and positioning in wheelchair. The sit to stand lift was utilized for all transfers. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 02/01/25 at 10:28 P.M. indicated Resident #10 slid out of his wheelchair onto the floor as staff was approaching the room. Resident #10 was assessed and no injuries were identified. The bed was put in the lowest locked position and the call light was placed within reach. Review of the fall investigation dated 02/01/25 revealed Resident #10 slid out of his wheelchair as staff were approaching the room. No injuries were identified. The new interventions were Resident #10's bed was put in the lowest locked position and call light was placed within reach. Review of the fall risk data collection tool, dated 02/01/25, indicated Resident #10 was at high risk for falls, with a score of 16, and had experienced one to two falls within the previous six months. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/18/25, indicated Resident #10 had no cognitive impairment, was dependent for going from sitting to standing, dependent for transfers, and had one fall without injury since the last assessment. Review of the progress note dated 02/27/25 at 11:30 P.M. indicated Resident #10's bed alarm was sounding and the resident was yelling out for help. Upon arriving to the room, staff observed Resident #10 laying on the floor on his left side and the resident reported he was sitting up when he leaned over too far and fell . Resident #10 was assessed and a scrape measuring two centimeters long by two centimeters wide was noted to his right shin. The bed alarm placement and function was confirmed. Resident #10 was assisted back to bed. Resident #10's tray table with personal belongings was placed alongside his bed within reach, neurological checks were initiated, bed in lowest position, call light was placed within reach, and Resident #10 was educated to not sit on the edge of his bed due to instability. Review of the fall investigation dated 02/28/25 revealed Resident #10 was found laying on the floor while his bed alarm was sounding and the resident was yelling out for help. An injury was identified as a scrape to the right shin measuring two centimeters long by two centimeters wide. The new interventions were Resident #10 was educated to not sit on the edge of the bed, 15 minute checks, and initiation of neurological checks. Review of the progress note dated 03/01/25 at 9:57 P.M. indicated Resident #10 was found on the floor in his room, laying on his side with his head toward the door and feet toward the bed. Resident #10 was assessed and no new injuries were identified. Resident #10 was assisted back to bed, his call light was placed within reach, and the resident was educated on using the call light. Review of the fall investigation dated 03/01/25 revealed Resident #10 was found on the floor with his head toward the door and feet toward the bed. No injuries were identified. The new intervention was Resident #10 was educated on using the call light. Review of the fall risk data collection tool, dated 03/01/25, indicated Resident #10 was at moderate risk for falls, with a score of 14, and had experienced one to two falls within the previous six months. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the fall risk care plan, revised 12/26/24, indicated Resident #10 was at risk for falls due to a history of falls, unsteady gait, generalized muscle weakness, and difficulty walking. Interventions included: assist with proper footwear as needed (initiated 04/04/17), ensure call light is within reach (initiated 04/04/17), encourage use of enabler bar with turning and repositioning and for safety (revised 04/29/22), ensure a safe environment with floors free from spills or clutter (revised 04/29/22), ensure adequate and glare free light (revised 04/29/22), ensure a working and reachable call light (revised 04/29/22), ensure bed is in lowest position at night (revised 04/29/22), ensure personal items are within reach (revised 04/29/22), encourage the resident to wear non-skid socks while in bed (initiated 05/04/22), apply pressure alarm to wheelchair and bed at all times (initiated 05/26/22), ensure shoes are within reach and obtain labs as ordered (initiated 07/10/22), bed against the wall for added comfort per the resident's request (initiated 07/11/22), sensor alarm to chair and bed to alert staff for needed assistance (initiated 03/30/23), treatments as ordered to any injury sustained from a fall (initiated 06/06/23), and 15 minute checks as ordered (added to the care plan on 12/12/24 and back-dated to 09/10/24). There were no new interventions added to the fall risk care plan related to the falls on 08/02/24, 09/08/24, 10/25/24, 10/27/24, 02/01/25, 02/27/25, and 03/01/25. On 03/25/25 at 4:28 P.M., an interview with the Director of Nursing (DON) confirmed Resident #10 had experienced multiple falls due to the resident liking to sit on the edge of his bed and propping his feet up in his wheelchair. On 03/26/25 at 1:15 P.M., an interview with the DON confirmed Resident #10's care plan was not updated to include new interventions after falls and there were duplicate fall interventions on the care plan with different dates. The DON stated they kept re-educating Resident #10 on safety and using his call light, but his Lewy Body Dementia was getting worse and he had trouble remembering. The DON further stated she could not think of any additional measures that could be taken to keep Resident #10 from sliding off his bed because he liked to sit on the edge of the bed. Review of the facility's policy titled Care Plans - Comprehensive, dated November 2010, revealed an individualized comprehensive care plan would be developed for each resident within seven days of the completion of the resident's comprehensive assessment. Care plans are revised as information about the resident and the resident's condition change. The interdisciplinary team is responsible for the review and updating of care plans when there has been a significant change in the resident's condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay, and at least quarterly. Review of the facility policy titled Managing Falls and Fall Risk, not dated, revealed facility staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. In conjunction with the attending physician, staff will identify and implement relevant interventions to try to minimize serious consequences of falling. Staff will monitor and document each resident's response to interventions intended to reduce falling or reduce the risks of falling. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions.

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	365977	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Circle of Care	1985 East Pershing Street Salem, OH 44460

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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 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** 48567 Based on observation, interviews, and review of facility policy, the facility failed to ensure smoking materials were stored in a safe and secure location. This affected two residents (#17 and #20) of four residents reviewed for accidents. Residents #17 and #20 were also two of the six residents identified by the facility as smokers. The facility census was 40. Findings include: 1. Review of the medical record for Resident #20 revealed an admitted [DATE] with diagnoses including encephalopathy, weakness, major depressive disorder, anxiety, abnormal reflex, history of opioid abuse, alcohol dependence with persisting dementia, tobacco use, ataxic gait, and lack of coordination. Review of the annual Minimum Data Set (MDS) 3.0 assessment completed on 02/06/25 revealed Resident #20 had intact cognition and required supervision or touching assistance for ambulating 10 feet in a room, corridor, or similar space. The MDS also revealed Resident #20 was a current tobacco user. Review of the care plan dated 02/11/25 revealed Resident #20 was a long-term smoker. Interventions included educating Resident #20 on storing her cigarettes and lighter and only smoking in designated smoking areas. The care plan also revealed Resident #20 was allowed independent leaves of absence (LOAs) and could smoke when she was on an LOA, but that she was to be reminded to return all her smoking materials after a LOA. Review of the Smoking Observation Tool - V 2 assessment completed on 01/09/20 revealed Resident #20 was cognitively intact, smoked all hours of the day, 5-10 times/day, had no visual or dexterity issues, and was able to safely light and extinguish her own cigarettes' safely. There had been no additional or follow-up smoking observation assessments completed in the last five years, even after a fall with major injury Resident #20 sustained on 01/18/25. Observation on 03/17/25 at 11:33 A.M. revealed an odor of smoke (smelling like a non-tobacco product) from just outside the closed bedroom door. Upon cracking the door open, observers immediately encountered a strong odor which caused slight burning of the surveyor's eyes. Resident #20 was observed in bed with her eyes closed and oxygen on via a nasal cannula from the oxygen concentrator next to the head of her bed. When her name was called, she was observed squeezing her eyes more tightly closed with a slight smile on her face with no verbal response. Observation and interview with Certified Nurse Aide (CNA) #368 on 03/17/25 at 11:35 A.M. revealed a blue colored vape cartridge on the floor near the head of Resident #20's bed, just to the left of the oxygen concentrator. CNA #368 confirmed the vape on the floor and the strong odor emitting from the room. CNA #368 could not confirm nor deny whether the vaping of the substance occurred in the resident room. During the interview, CNA #368 did confirm residents were not allowed to smoke or vape in the building and that she was not sure whether residents deemed as independent smokers were allowed to keep their smoking materials in their rooms. The vape was left on Resident #20's floor at that time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/17/25 at 11:38 A.M. with CNA #335 confirmed she would need to check the policy regarding possession of smoking materials in resident's room and could not confirm nor deny whether Resident #20 was permitted to keep her vape or other smoking materials in her room. Interview on 03/17/25 with Administrator #373 confirmed all residents' smoking supplies should be locked up. A follow-up interview with Administrator #373 on 03/17/25 at 12:21 P.M. confirmed there was a vape on the floor under the bed of Resident #20, the vape was retrieved by staff, found to be empty at that time, and was placed in secure storage. Interview on 03/19/25 at 11:46 A.M with Resident #20 confirmed she was an independent smoker and went out to the smoking area, out front or out back whenever she wanted and that she kept her smoking materials in her drawer in her room, pointing to her bedside dresser. Interview on 03/25/25 at 4:28 P.M. with CNA #303 confirmed all smoking supplies were to be locked in the second-floor nurses medication cart. Interview on 03/25/25 at 4:45 P.M. with Resident #20, observed by CNA #300, confirmed she went outside in the front or the back to smoke whenever she wanted and all of her smoking materials, including her lighter, were currently in her coat pocket, pointing to her coat across the room. Directly after the resident interview, CNA #300 stated that she did not think residents were allowed to keep their own smoking supplies in their room. No effort to secure the smoking materials was observed during these encounters. Observation on 03/26/25 at 12:57 P.M. revealed Resident #20 outside the front door smoking. At 12:59 P.M., a surveyor rode the elevator with Resident #20 from the first floor to the third floor and observed Resident #20 left the elevator and immediately went into her room and closed the door. At no point did the resident stop and provide smoking materials to a staff member. Observation and interview on 03/26/25 at 1:03 P.M. with Licensed Practical Nurse (LPN) #301 confirmed smoking materials from the whole building were stored in the second-floor medication cart in bottom right drawer. When asked about Resident #20, LPN #301 stated she was independent, so all her smoking materials, including cigarettes and a lighter, were kept in her room. At the time of the interview, observation of the second-floor medication cart verified none of Resident #20's smoking materials were stored in the cart. Review of the Smoking Policy Compliance Agreement signed by Resident #20 on 06/03/22 revealed smoking was to be done in designated areas only, no smoking was allowed in the building, and cigarettes and other smoking items would be kept locked up for the health and safety of all residents. The signed agreement further revealed that any infraction of this policy would result in smoking privileges being taken away from the offending resident. Review of the undated document titled Circle of Care Smoking Times and Department Responsibilities revealed the designated smoking place was on the side patio and smoking materials were to be locked in a box which was kept by the nurses and supposed to be taken out with the smokers. Review of the Circle of Care Smoking Policy and Procedure dated 10/09/24 revealed that smoking was only to be outside at the far end of the patio and cigarettes and other smoking items were to be kept locked in a locked box, in a locked cabinet. (continued on next page)

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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 #17 revealed an admitted [DATE] with diagnoses including alcohol dependence, nicotine dependence, major depressive disorder, anxiety, and cognitive communication deficit. Review of the admission Minimum Data Set (MDS) assessment, dated 06/10/24, revealed Resident #17 utilized tobacco. Review of the most recent quarterly MDS assessment, dated 03/13/25, revealed Resident #17 was cognitively intact. Review of the smoking care plan, revised 05/31/24, revealed Resident #17 was an independent smoker. Interventions included educating Resident #17 on the facility policy for storing cigarettes and lighter, review facility policy on resident smoking and smoking areas, educate resident on side effects and health issues associated with smoking, monitor and notify physician of respiratory changes with smoking, and completing a smoking assessment quarterly and as needed (PRN). Review of the most recent smoking observation tool, dated 09/25/24, indicated Resident #17 was an active smoker, cognitively intact, no visual deficit, no dexterity problem, smoked five to 10 times daily, could safely light a cigarette, did not require any adaptive equipment, and could safely extinguish a cigarette. Review of the assessment titled Smoking Safety Evaluation V 2.0, dated 10/23/24, indicated Resident #17 utilized tobacco, would follow the facility's policy on location and time of smoking, could safely light a cigarette, hold a cigarette, extinguish a cigarette, and use an ashtray. The assessment indicated Resident #17 did not require supervision during designated smoking times. Review of the facility's Smoking Policy Compliance Agreement, signed by Resident #17 on 05/28/24, revealed smoking was to be done in designated areas only and cigarettes and other smoking items would be kept locked up for the health and safety of all residents. The signed agreement further revealed that any infraction of this policy would result in smoking privileges being taken away from the offending resident. Interview with Certified Nurse Aide (CNA) #368 on 03/17/25 at 11:35 A.M. revealed Resident #17, along with another resident (Resident #20) were independent smokers and went to smoke at will, but she was not sure whether they were allowed to keep their smoking materials in their rooms. Interview on 03/17/25 at 11:38 A.M. with CNA #335 confirmed she would need to check the policy regarding possession of smoking materials in resident's room and was unable to confirm whether independent smokers were permitted to keep smoking materials in their rooms. Interview on 03/17/25 with Administrator #373 confirmed all residents' smoking supplies should be kept locked up. Interview on 03/25/25 at 4:28 P.M. with CNA #303 confirmed all smoking supplies were to be locked in the second-floor nurses medication cart. Interview on 03/25/25 at 4:50 P.M. with Resident #17 confirmed he did not have to keep his smoking materials locked up at the nurses' station and he kept them in his room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 03/26/25 at 1:03 P.M. with Licensed Practical Nurse (LPN) #301 confirmed smoking materials from whole building were stored in the second-floor medication cart in bottom right drawer. When asked about Resident #17, LPN #301 stated he was independent, so all his smoking materials, including cigarettes and a lighter, were kept in his room. At the time of the interview, observation of the second-floor medication cart verified none of Resident #17's smoking materials were stored in the cart. Review of the undated document titled Circle of Care Smoking Times and Department Responsibilities revealed the designated smoking place was on the side patio and smoking materials were to be locked in a box which was kept by the nurses and supposed to be taken out with the smokers. Review of the Circle of Care Smoking Policy and Procedure dated 10/09/24 revealed that smoking was only to be outside at the far end of the patio and cigarettes and other smoking items were to be kept locked in a locked box, in a locked cabinet.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on observation, interview, review of the medical record, and review of facility policy, the facility failed to ensure appropriate and timely services related to an intravenous (IV) midline catheter. This affected one of one resident (#28) reviewed who had an IV. The facility census was 40. Findings include: Review of the medical record revealed Resident #28 was admitted on [DATE] with diagnoses including type two diabetes mellitus with other skin complications, acute kidney failure, necrotizing fasciitis, osteomyelitis, atrial fibrillation, sepsis, cellulitis, partial traumatic amputation of two or more right lesser toes, and non-pressure chronic ulcer of unspecified foot. Review of the annual Minimum Data Set (MDS) 3.0 completed on 03/07/25 revealed Resident #28 had intact cognition and no behaviors or rejection of care. Further review of the MDS revealed Resident #28 received IV medications. Review of the physician orders revealed an order dated 03/05/25 for ertapenem sodium injection solution, one gram intravenously in the afternoons for sepsis/cellulitis for seven days through the IV midline to begin on 03/06/25, as well as 0.9% sodium chloride (NaCl) flushes of 10 milliliters (ml) before and after IV medication administration for seven days. Further review of the orders revealed there were no orders for flushing of the midline for line maintenance/patency once the antibiotic was discontinued and there were no orders for IV/midline dressing changes. Review of the Medication Administration Record (MAR) and the treatment administration record (TAR) revealed the last dose of Ertapenem Sodium was administered on 03/12/25, the last normal saline flush of the IV was the night of 03/12/25, and there was no documentation of any IV dressing changes. Observation on 03/17/25 at 10:40 A.M. revealed an IV pole with an empty IV antibiotic bag with tubing hanging on the pole dated 03/12/25. Resident #28 had an IV midline in his left upper arm with a dressing that was dated 03/05/25. During the observation, Resident #28 stated he had not received any IV antibiotics or IV flushes in several days and the dressing had never been changed. Interview on 03/17/25 at 12:25 P.M. with Licensed Practical Nurse (LPN) #301 confirmed midline dressings were typically changed about every three days and as needed. During the interview, LPN #301 was unable to find an order for IV site dressing changes and confirmed Resident #28's current dressing was unfortunately dated 03/05/25. Review of the policy titled Flushing Midline and Central Line IV Catheters last reviewed on 04/29/24 revealed each lumen of a midline catheter was to be flushed at least once every 24 hours to maintain patency and prevent occlusion. Review of the undated policy titled Guidelines for Preventing Intravenous Catheter-Related Infections revealed the initial IV catheter dressing changes should be performed within 24 hours of insertion and then every five to seven days thereafter, and as needed if loose or visibly soiled.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on record review and interview, the facility failed to provide evidence that the physician conducted in-person examinations of all residents. This affected four residents (#3, #94, #145, and #146) of four reviewed for new admissions. The facility census was 40. Findings include: 1. Review of the medical record for Resident #3 revealed an admitted [DATE] with diagnoses including epilepsy, type two diabetes mellitus, atrial fibrillation, chronic obstructive pulmonary disease, Alzheimer's disease, hypertension, hypokalemia, hyperlipidemia, hypothyroidism, adult failure to thrive, depression, and dementia with anxiety. Review of the admission Minimum Data Set (MDS) assessment, dated 02/17/25, indicated Resident #3 admitted to the facility from a short-term general hospital. Review of the progress notes since admission revealed there were no notes in the electronic health record written by Physician #369 (who was also the facility's Medical Director) for Resident #3. The progress note dated 02/06/25 at 8:25 P.M., written by Certified Nurse Practitioner (CNP) #380, had no mention of Physician #369 participating in the admission examination of Resident #3 and stated the evaluation had been completed via telehealth. The progress note dated 02/16/25 at 1:22 P.M., written by CNP #380, indicated Resident #3 was assessed in-person by CNP #380 with Physician #369 assisting via telehealth. The progress note dated 03/04/25 at 8:23 P.M., written by CNP #380, had no mention of Physician #369 participating in the examination of Resident #3 and stated the evaluation had been completed via telehealth. The progress note dated 03/12/25 at 8:49 P.M., written by CNP #380, indicated Physician #369 ordered an extra dose of Xanax for restlessness and agitation and stated the evaluation was completed via telemedicine. The progress note dated 03/12/25 at 8:52 P.M., written by CNP #380, provided an addendum to new orders placed and made no mention of Physician #369 evaluating Resident #3. The progress note dated 03/14/25 at 9:33 P.M., written by CNP #380, had no mention of Physician #369 participating in the examination of Resident #3 and stated the evaluation had been completed via telemedicine. 2. Review of the medical record for Resident #94 revealed an admitted [DATE] with diagnoses including sepsis, dependence on respirator ventilator, stage four pressure ulcer of sacral region, iron deficiency anemia, dysphagia, osteomyelitis, quadriplegia, depression, anxiety, hypertension, and urinary tract infection. Review of the admission MDS assessment, dated 03/10/25, indicated Resident #94 admitted to the facility from a short-term general hospital. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the progress notes since admission revealed there were no notes in the electronic health record written by Physician #369 for Resident #94. The progress note dated 03/04/25 at 8:35 P.M., written by CNP #380, had no mention of Physician #369 participating in the admission examination of Resident #94 and stated the evaluation had been completed via telemedicine. The progress note dated 03/10/25 at 8:30 P.M., written by CNP #380, indicated Physician #369 ordered Trazadone for sleep problems and stated the evaluation had been completed via telemedicine. The progress note dated 03/14/25 at 9:20 P.M., written by CNP #380, had no mention of Physician #369 participating in the examination of Resident #94 and stated the evaluation had been completed via telemedicine. The progress note dated 03/16/25 at 8:06 P.M., written by CNP #380, had no mention of Physician #369 participating in the examination of Resident #94 and stated the evaluation had been completed via telemedicine. 3. Review of the medical record for Resident #145 revealed an admitted [DATE] with diagnoses including hypertension, bronchiectasis, gastritis, atrial fibrillation, dementia, dysphagia, adult failure to thrive, severe protein-calorie malnutrition, type two diabetes mellitus, pressure induced deep tissue damage to the left and right heels, cognitive communication deficit, hyperlipidemia, iron deficiency anemia, enterocolitis due to clostridium difficile, acquired absence of part of lung, ischemic heart disease, hyperparathyroidism, and end stage renal disease. Review of the admission MDS assessment, dated 03/10/25, revealed Resident #145 admitted to the facility from a short-term general hospital. Review of the progress notes since admission revealed there were no notes in the electronic health record written by Physician #369 for Resident #145. The progress note dated 03/05/25 at 8:48 P.M., written by CNP #380, had no mention of Physician #369 participating in the admission examination of Resident #145 and stated the evaluation had been completed via telemedicine. 4. Review of the medical record for Resident #146 revealed an admitted [DATE] with diagnoses including chronic respiratory failure with hypoxia, adult failure to thrive, dementia with behavioral disturbance, dysphagia, generalized idiopathic epilepsy, hypertension, hypothyroidism, major depressive disorder, pneumonitis, severe protein-calorie malnutrition, conversion disorder with seizures or convulsions, normal pressure hydrocephalus, schizoaffective disorder, sepsis, and Parkinson's disease. Review of the admission MDS assessment, dated 03/12/25, revealed Resident #146 admitted to the facility from a short-term general hospital. Review of the progress notes since admission revealed there were no notes in the electronic health record written by Physician #369 for Resident #146. The progress note dated 02/28/25 at 6:59 P.M., written by CNP #380, had no mention of Physician #369 participating in the admission examination of Resident #146 and stated the evaluation had been completed via telemedicine. The progress note dated 03/03/25 at 7:16 P.M., written by CNP #380, had no mention of Physician #369 participating in the examination of Resident #146 and stated the evaluation had been completed via telehealth. The progress note dated 03/07/25 at 5:08 P.M. , written by CNP #380, had no mention of Physician #369 participating in the examination of Resident #146 and stated the evaluation had been completed via telehealth. The progress note dated 03/10/25 at 1:35 P.M. , written by CNP #380, had no mention of Physician #369 participating in the examination of Resident #146 and stated the evaluation had been completed via telemedicine. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 04/01/25 at 12:11 P.M., an interview with the Director of Nursing (DON) stated Physician #369 attended meetings via telephone because he could not leave his wife due to her condition. On 04/01/25 at 12:34 P.M., an interview with the DON stated CNP #380 usually conducted resident visits with Physician #369 participating via telemedicine. On 04/01/25 at 2:29 P.M., an interview with Licensed Practical Nurse (LPN) #352 stated Physician #369 did a lot of resident visits via telemedicine due to his wife's health status. LPN #352 said the facility nurses would initiate a video call with Physician #369 and take the telecommunication device from room to room. LPN #352 further stated most communication with Physician #369 was conducted via phone. On 04/01/25 at 2:55 P.M., an interview with CNP #380 verified visits with residents were conducted virtually via telemedicine if the progress note indicated as such. CNP #380 claimed that Physician #369 also virtually contributed to visits via telemedicine despite the lack of documentation for Physician #369's participation. CNP #380 said the progress note would specify if the physician or CNP conducted any portion of the visit in-person.

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F 0714 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure the physician properly assigns and delegates tasks to a physician assistant, nurse practitioner or clinical nurse specialist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on record review and interview, the facility failed to provide evidence that the physician did not delegate tasks to non-physician providers that were specified to be completed by the physician personally. This affected four residents (#3, #94, #145, and #146) of four reviewed for new admissions. The facility census was 40. Findings include: 1. Review of the medical record for Resident #3 revealed an admitted [DATE] with diagnoses including epilepsy, type two diabetes mellitus, atrial fibrillation, chronic obstructive pulmonary disease, Alzheimer's disease, hypertension, hypokalemia, hyperlipidemia, hypothyroidism, adult failure to thrive, depression, and dementia with anxiety. Review of the admission Minimum Data Set (MDS) assessment, dated 02/17/25, indicated Resident #3 admitted to the facility from a short-term general hospital. Review of the progress notes since admission revealed there were no notes in the electronic health record written by Physician #369 (who was also the facility's Medical Director) for Resident #3. The progress note dated 02/06/25 at 8:25 P.M., written by Certified Nurse Practitioner (CNP) #380, had no mention of Physician #369 participating in the admission examination of Resident #3 and stated the evaluation had been completed via telehealth. 2. Review of the medical record for Resident #94 revealed an admitted [DATE] with diagnoses including sepsis, dependence on respirator ventilator, stage four pressure ulcer of sacral region, iron deficiency anemia, dysphagia, osteomyelitis, quadriplegia, depression, anxiety, hypertension, and urinary tract infection. Review of the admission MDS assessment, dated 03/10/25, indicated Resident #94 admitted to the facility from a short-term general hospital. Review of the progress notes since admission revealed there were no notes in the electronic health record written by Physician #369 for Resident #94. The progress note dated 03/04/25 at 8:35 P.M., written by CNP #380, had no mention of Physician #369 participating in the admission examination of Resident #94 and stated the evaluation had been completed via telemedicine. 3. Review of the medical record for Resident #145 revealed an admitted [DATE] with diagnoses including hypertension, bronchiectasis, gastritis, atrial fibrillation, dementia, dysphagia, adult failure to thrive, severe protein-calorie malnutrition, type two diabetes mellitus, pressure induced deep tissue damage to the left and right heels, cognitive communication deficit, hyperlipidemia, iron deficiency anemia, enterocolitis due to clostridium difficile, acquired absence of part of lung, ischemic heart disease, hyperparathyroidism, and end stage renal disease. Review of the admission MDS assessment, dated 03/10/25, revealed Resident #145 admitted to the facility from a short-term general hospital. (continued on next page)

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Circle of Care	1985 East Pershing Street Salem, OH 44460

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F 0714 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the progress notes since admission revealed there were no notes in the electronic health record written by Physician #369 for Resident #145. The progress note dated 03/05/25 at 8:48 P.M., written by CNP #380, had no mention of Physician #369 participating in the admission examination of Resident #145 and stated the evaluation had been completed via telemedicine. 4. Review of the medical record for Resident #146 revealed an admitted [DATE] with diagnoses including chronic respiratory failure with hypoxia, adult failure to thrive, dementia with behavioral disturbance, dysphagia, generalized idiopathic epilepsy, hypertension, hypothyroidism, major depressive disorder, pneumonitis, severe protein-calorie malnutrition, conversion disorder with seizures or convulsions, normal pressure hydrocephalus, schizoaffective disorder, sepsis, and Parkinson's disease. Review of the admission MDS assessment, dated 03/12/25, revealed Resident #146 admitted to the facility from a short-term general hospital. Review of the progress notes since admission revealed there were no notes in the electronic health record written by Physician #369 for Resident #146. The progress note dated 02/28/25 at 6:59 P.M., written by CNP #380, had no mention of Physician #369 participating in the admission examination of Resident #146 and stated the evaluation had been completed via telemedicine. On 04/01/25 at 12:11 P.M., an interview with the Director of Nursing (DON) stated Physician #369 attended meetings via telephone because he could not leave his wife due to her condition. On 04/01/25 at 12:34 P.M., an interview with the DON stated CNP #380 usually conducted resident visits with Physician #369 participating via telemedicine. On 04/01/25 at 2:29 P.M., an interview with Licensed Practical Nurse (LPN) #352 stated Physician #369 did a lot of resident visits via telemedicine due to his wife's health status. LPN #352 said the facility nurses would initiate a video call with Physician #369 and take the telecommunication device from room to room. LPN #352 further stated most communication with Physician #369 was conducted via phone. On 04/01/25 at 2:55 P.M., an interview with CNP #380 verified visits with residents were conducted virtually via telemedicine if the progress note indicated as such. CNP #380 claimed that Physician #369 also virtually contributed to visits via telemedicine despite the lack of documentation for Physician #369's participation. CNP #380 also stated she was unaware of any law specifying that she could not complete initial visits via telemedicine.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 48567 Based on medical record reviews, review of pharmacy consultation reports, and interview, the facility failed to ensure the pharmacist recommendations for Resident #11 were reviewed and addressed by the physician. This affected one resident (#11) of five residents who were reviewed for unnecessary medications. The facility census was 40. Findings include: Review of the medical record for Resident #11 revealed an initial admitted [DATE] and a re-entry date of 05/30/21 with diagnoses including end stage renal disease, unspecified heart failure, hypertension, anxiety, major depressive disorder, necrotizing fasciitis, overactive bladder, neuromuscular dysfunction of the bladder, and type two diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) assessment completed on 01/19/25 revealed Resident #11 had intact cognition with medically complex conditions. Further review of the MDS revealed Resident #11 received hypoglycemic, antidepressant, diuretic, opioid, and anticonvulsant medications. Review of the medication orders revealed an order dated 11/12/24 for Resident #11 to receive Metformin 500 milligrams by mouth every morning and at bedtime for hyperglycemia. Review of the pharmacist consultation report dated 12/31/24 revealed the pharmacist recommended to increase Metformin to 500mg three times a day. Further review of the consultation report revealed no evidence this recommendation had been reviewed by the physician or other prescribing provider. Review of the Medication Administration Records (MAR) and the Metformin order history from December 2024 through March 2025 revealed no changes had been made to the Metformin order after the pharmacist sent the recommendation dated 12/31/24. Review of the progress notes from 12/31/24 through 03/20/25 revealed no notes from the physician or Nurse Practitioner regarding this recommendation. Interview on 03/20/25 at 11:15 A.M. with the Director of Nursing (DON) confirmed the pharmacy recommendations made on 12/31/25 did not contain evidence it was reviewed by the physician and Resident #11's medication orders for Metformin had not been changed since prior to the pharmacist's recommendation. No policy related to monthly medication regimen reviews was provided by the facility upon request.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on observation, record review, and interview, the facility failed to renew their food service operation license in a timely manner. This affected all 35 residents who received food from the kitchen (except Residents #14, #37, #41, #94, and #96 who had orders for nothing by mouth). The facility census was 40. Findings include: On [DATE] at 7:00 A.M., an initial tour of the kitchen revealed the food service operation license posted on the bulletin board expired on [DATE]. On [DATE] at 7:49 A.M., an interview with Dietary Manager #304 verified the facility's posted food service operation license expired on [DATE]. On [DATE] at 5:14 P.M., an interview with Administrator #373 confirmed the food service operation license renewal application was submitted late and the facility's corporate office did not cut a check for the renewal until [DATE]. Review of the facility's application for a license to conduct a food service operation indicated it was to be completed and submitted by [DATE]. Further review of the application revealed it was signed by Administrator #373 on [DATE]. The check issued by the facility for the cost of the license was dated [DATE]. Review of the updated food service operation license revealed it was issued on [DATE] with an expiration date of [DATE]. There was no valid food service operation license from [DATE] to [DATE].

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on observation, record review, and interview, the facility failed to maintain Resident #34's record in a complete and accurate manner. This affected one resident (#34) of nineteen records reviewed. The facility census was 40. Findings include: Review of the medical record revealed Resident #34 was admitted on [DATE] with diagnoses including end stage renal disease, chronic obstructive pulmonary disease, pleural effusion, and type one diabetes mellitus. Resident #34 was discharged to the hospital on 02/20/25. Review of the discharge (return anticipated) Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #34 discharged on [DATE] to a short-term general hospital. Review of the assessment titled Legionella Signs and Symptoms for Potential Exposure - V 2, dated 03/24/25 at 11:39 A.M., indicated Resident #34 had no symptoms of Legionella and the following vital signs were documented on 03/24/25 between 11:39 A.M. and 11:41 A.M.: blood pressure 128 systolic over 78 diastolic while lying, temperature of 97 degrees Fahrenheit obtained via forehead, pulse of 74 beats per minute, and oxygen saturation of 99% via vent. The assessment was completed by Licensed Practical Nurse (LPN) #365. Review of the resident census information, progress notes, and MDS assessments revealed there was no evidence Resident #34 returned to the facility from the hospital. On 03/26/25 at 5:25 P.M., an observation of Resident #34's room revealed the room was empty and there was no resident in the room. Interview at the time of observation with Certified Nursing Assistant (CNA) #303 verified Resident #34 had not returned from the hospital. On 03/26/25 at 5:35 P.M., an interview with the Director of Nursing (DON) confirmed Resident #34 was still in the hospital. The DON also confirmed the assessment for Legionella signs and symptoms was dated 03/24/25 and included vitals dated 03/24/25 for Resident #34. On 03/27/25 at 9:35 A.M., Interview with LPN #365 confirmed she completed the Legionella signs and symptoms assessments for all residents. LPN #365 did not recall completing Resident #34's assessment specifically because she did so many of them and she was unable to state where the information on the assessment came from since Resident #34 was still in the hospital at the time the assessment was completed. This deficiency represents non-compliance investigated under Complaint Number OH00162299.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 48567 Based on review of the facility Quality Assurance and Performance Improvement Program (QAPI) and Quality Assurance (QA) sign-in sheets and meeting minutes, policy review and interview, the facility failed to ensure the QA committee consisted of the minimum required members. This had the potential to affect all 40 residents residing in the facility. Findings include: Review of the QAPI meeting sign-in sheets from July 2024 through February 2025 revealed no evidence of attendance by Medical Director #369. Further review of the sign-in sheets revealed Licensed Practical Nurse (LPN) #302, the current (since 01/04/25) Infection Preventionist (IP) signed the QAPI attendance sheet as the IP on 10/31/24 and 12/19/24 and was not in attendance for the meeting held on 01/30/25. There were no staff members with the required qualifications listed in attendance for any meetings held between 08/01/24 and 02/28/25. Review of the meeting minutes from April 2024 through February 2025 alongside the Director of Nursing (DON) revealed a combination of hand-written notes and various reports submitted by department heads, but no written evidence of participation from the Medical Director. Interview on 04/01/25 at 12:11 P.M. with the DON revealed Medical Director #369 attends QAPI meetings by phone because he can't leave home due to his wife's condition, though there was no notation on the sign-in sheets to support this. During this interview, the DON confirmed the previous IP nurse's last day worked was 08/19/24 and acknowledged IP #302's required certification was not obtained until 01/04/25. Telephone interview with Medical Director #369 on 04/01/25 at 1:00 P.M. confirmed he knew he was supposed to attend QAPI meetings quarterly but could not recall when he last attended one. He further stated his attendance was typically virtual and his participation consisted of the facility providing him with important updates when he does virtually attend. Review of the QAPI Policies and Procedures titled Quality Assurance Performance Improvement last revised October 2017 revealed no information regarding QAPI committee member requirements. No other QAPI policies were provided by the facility during the survey.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on observation, medical record review, review of the facility water management plan and maintenance logs, review of legionella water test results, review of the Centers for Disease Control and Prevention (CDC) guidance related to legionella, review of infection control tracking, and interviews with staff and representative from the Local Health Department (LHD), the facility failed to develop, implement and follow a comprehensive and effective infection control program/water management plan to prevent the continued presence of legionella bacteria in their water supply. Upon identification of elevated legionella levels, the facility failed to re-evaluate or update their water management risk assessment and water management plan or provide effective intervention to mitigate the risk of legionella growth. The facility also failed to ensure residents did not have access to or use water from areas where legionella could be present. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm, negative health outcomes, and/or death beginning on 01/30/25 when second water sample testing results from testing conducted on 01/23/25 by the facility showed an increase in legionella bacteria growth in the facility water system and the facility failed to implement water maintenance interventions to mitigate the risk of legionella and/or as recommended by the local health department (LHD). On 02/05/25 additional water sampling testing was completed with results obtained 02/12/25 which revealed the presence of legionella was considerably increased from the testing done on 01/23/25. The facility's failure to implement and/or revise appropriate water management measures to mitigate the growth of legionella placed all 40 current residents in the facility at risk of developing serious life-threatening illness and/or death from Legionnaire's disease. In addition, concerns that did not rise to the level of Immediate Jeopardy were identified when the facility failed to establish and implement an effective infection surveillance system to track infections and monitor infection trends. Lastly, the facility failed to ensure appropriate infection control techniques were followed when performing wound care for Resident #37 to prevent the spread of infection. This affected 42 of 42 residents, which included one resident, Resident #37 observed for wound care and two residents, Resident #18 and #95 who no longer resided in the facility at the time of the survey. On 03/19/25 at 3:37 P.M., the Administrator, Director of Nursing (DON), Infection Preventionist (IP) #302, and Maintenance Manager #322 were notified that Immediate Jeopardy began on 01/30/25 when the facility received water testing results positive for legionella and failed to take immediate action and implement effective corrective including actions recommended by the LHD to address water testing samples that were positive for legionella growth. Between 01/23/25 and 02/12/25 additional water testing conducted by the facility showed the legionella levels continued to rise with no evidence of effective measures to mitigate the risk for Legionnaire's disease. The lack of comprehensive and effective water management plan and the identification of legionella in the facility water supply placed all residents at risk for developing serious illness and complications, including the potential for death, related to legionella infection/Legionnaire's disease. The Immediate Jeopardy was removed on 03/28/25 when the facility implemented the following corrective actions: o On 03/06/25 an all-staff in-service was completed on risks, signs and symptoms and interventions for legionella by the DON and IP Nurse #302. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	o On 03/19/25 by 6:30 P.M. water to each sink in all facility rooms was shut off to prevent accidental use by residents and staff. Gallon jugs of purified water were put in place to wash hands with dates and names on each. o Beginning 03/20/25 the DON/designee would audit employee call-offs weekly for the next two weeks, monitoring for any symptoms related to legionella illness. Any concerns would be immediately reported to the Administrator and addressed by the Quality Assessment Performance Improvement (QAPI) committee as necessary. o On 03/21/25 the facility contracted with PT enterprises to assist with the water management plan. PT enterprises came to the facility and took twelve water samples (four swabs and eight additional 250 ml potable water samples). o On 03/21/25 point of use filters for all water sources in the facility were ordered. o On 03/23/25 the DON brought in hot and cold-water dispensers for use on the second and third floors. This water was provided for residents' use for any residents who did not want to drink bottled water and staff were responsible for bringing the water to residents. Additional bottled water was supplied to the fourth floor. o On 03/23/25 the DON educated the weekend staff and agency staff working on-site on not using the room sinks or shower on the second floor, as well as signs and symptoms of legionella. o On 03/24/25 a Legionella assessment data collection form was created in point click care (PCC), which included a set of vital signs, a review of potential symptoms of legionella, a place for a narrative, and a yes or no question as to whether or not the resident experienced more than three symptoms beyond their baseline. All nurses would be educated on this form by 04/09/25. Any nurse not educated by this date would not be allowed to work the floor until the education was completed. Nurses would complete this assessment on resident admission and with resident change of respiratory condition. o On 03/24/25 new legionella filters were received and placed on the main floor bathroom sink, therapy room sink, room [ROOM NUMBER] sink faucet, shower heads on the second, third and forth floors, at the nursing station sinks on the second, third and forth floors and on the dialysis center sinks by Maintenance Manager #322. o On 03/24/25 Legionella tests for six residents who were transferred from the facility for signs and symptoms of respiratory distress were completed. o On 03/25/25 a contracted plumbing company ([NAME] Plumbing) came to the facility to evaluate appropriate adapters to fit on the sink filters. They also evaluated sanitation. The water remained off to the room sinks at this time. *On 03/26/25 the DON/designee completed resident assessments (legionella assessment data collection form) for all facility residents. The resident assessments would continue to be conducted weekly by the DON/designee and/or Infection Preventionist for three weeks beginning 03/31/25. Any concerns would be immediately reported to the Administrator and Medical Director for follow-up (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	o On 03/27/25 the facility Water Management Committee, including the Administrator, DON, IP #302, Maintenance Manager #322, Housekeeping/Laundry Supervisor, RT Director and Dietary Manager met to further discuss the facility's Water management -Legionella plan. o On 03/27/25 the facility QAPI committee met to review any updates to the water management plan and complete audits. The facility new water management protocols initiated on 03/27/25 included: a.) Each faucet and shower head aerator would be cleaned with an approved scale and lime build-up cleaner semi-annually to ensure proper water flow quarterly beginning in June 2025. b.) Beginning 03/28/25 the hot water boilers would be set at 140 or greater, differing from previous plans where they were set at 135 degrees. Facility staff would record the temperature of each hot water device weekly and adjust immediately if less than 140 . To ensure compliance to policy, staff would retest the following day to confirm appropriate temperature. c.) Hot water holding tanks would be set at a minimum of 140 versus previous 135 F to inhibit the growth of Legionella and other opportunistic pathogens. Facility staff would record the temperature weekly and adjust immediately if less than 140 to ensure compliance. d.) Beginning 03/27/25 regular cleaning and changing of filters would be done per manufacturers' recommendations. The facility would remove scale and clean using approved cleaning agents semi- annually and changing the filters every six months or per manufacturer recommendations. Maintenance Manager #322 would audit monthly to ensure compliance and audits will be reviewed in QAPI meetings. e.) Beginning 03/28/25 weekly flushing of water would be added to housekeepers assignments to be completed Monday or Tuesday each week which would consist of flushing for three minutes each faucet and showers also flush all toilets at least once every week. The supervisor would review documentation weekly to ensure compliance. Audits would be reviewed, and the facility would determine where the failure occurs during QAPI meetings. f.) If the facility experiences one or more positive cases of legionellosis, the facility would conduct semi-annual testing to determine if the water management plan (WMP) was effective in controlling legionella and the Maintenance Manager #322 will follow up with the vendor to determine failure to conduct and correct this. g.) Beginning on 03/27/25 for any positive legionella in the water, the facility would contact PT enterprises, to conduct testing on water samples, provide alternate water sources for bathing and patient care, inspect all faucets for built-up scaling and cleaning with appropriate cleaner and replace all filters on incoming water sources. h.) Legionella filters would be changed per manufacturers' recommendations beginning on 06/01/25. On 03/30/25 the facility received ordered parts which were being installed with a plan to have all installation of parts/filters completed by 04/01/25. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Interviews on 04/01/25 between 11:46 A.M. and 12:15 P.M. with Licensed Practical Nurse (LPN) #353, Respiratory Therapist (RT) #330, Certified Nurse Aide (CNA) #368, CNA #335, LPN #352, and LPN #301 confirmed they had received instruction not to use any sinks or other running water unless the faucet had a new filter in place (which was visible to the observer) and that water remained turned off to sinks on the fourth floor and some unoccupied rooms on the second floor where filters were not yet applied. During these staff interviews, each confirmed they had received education on risks of legionella in the water and signs and symptoms of legionella related infection. Although the Immediate Jeopardy was removed on 03/28/25, the deficiency remained at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: 1. Review of the facility LEGIONELLA ENVIRONMENTAL ASSESSMENT FORM revealed the facility water risk assessment was last completed on 05/16/23. The risk assessment revealed the facility had encountered a prolonged period of reduced occupancy on the second floor and toilets were flushed and faucets were run during that unspecified timeframe. Review of the assessment revealed the facility tested for legionella but did not include summaries, acceptable control levels, or legionella response policy or procedures. The risk assessment revealed the facility did not use water filters or thermostatic mixing valves. The risk assessment further revealed the facility used Salem City Municipal Water and did not ever measure disinfectant levels at the point of use. The facility maintenance activities were to include routine running water and flushing toilets in unused areas of the building and checking hot water temperatures on all floors. Review of the facility Water Management Template revealed the water management team (WMT) consisted of the Administrator, the DON, Maintenance Manager #322, IP #320, Dietary Manager #312, Housekeeping Manager #320, and Director of Respiratory #311. The WMT was responsible for overseeing implementation of the water risk management. Review of a facility Microbiology Analysis Report from Cardinal Environmental Laboratories, LLC dated 01/15/25 revealed the water sampled from the facility on 01/08/25 identified legionella test results were 7.97 most probable number (MPN) per milliliter (ml). There was only one testing location, one test sample from the dialysis den. Review of a facility Microbiology Analysis Report from Cardinal Environmental Laboratories, LLC dated 01/30/25 revealed the water sampled from the facility on 01/23/25 identified legionella tests results were 13.4 MPN/ml. There was only one testing location, one test sample from the dialysis den. This result was noted to be higher than the result of the water sampled on 01/08/25. The facility failed to provide evidence of additional investigation as to why the levels were this high or evidence of interventions to mitigate the presence of legionella at this time. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Review of a facility Microbiology Analysis Report from Cardinal Environmental Laboratories, LLC dated 02/12/25 revealed the water sampled from the facility on 02/05/25 identified legionella tests results were 121 MPN/ml, a considerable increase from the test results received on 01/30/25. There was only one testing location, one test sample from dialysis den. The facility failed to provide evidence of additional investigation as to why the levels were this high or evidence of interventions to mitigate the presence of legionella at this time. Review of the Circle of Care Water Management Program policy (last updated 01/08/24) revealed the facility was to revise and update their legionella risk assessment annually and as needed. The policy further revealed their water management practices were to include documentation of the following: - Weekly hot water temperatures and as needed - Weekly temperatures of the hot water tanks - Weekly cold-water temperatures - Running water and flushing toilets in resident areas where low water use has occurred (frequency unspecified) - Routine maintenance of the ice machine, unoccupied resident rooms, whirlpool hot tubs, shower head, and shower hoses (frequency unspecified) - Plumbing and fixtures throughout the facility due to the age of the building The policy itself was not updated to reflect changes in the facility's floor plan. Review of the weekly Water Maintenance Monitoring logs revealed documentation of weekly room hot and cold-water temperature monitoring and hot water tank temperature monitoring. There were no logs indicating routine maintenance or cleaning of showers, whirlpools, tubs, shower hoses, or flushing and running water in unoccupied resident rooms. Interview on 03/17/25 from 3:55 P.M. to 4:15 P.M. with Maintenance Manager #322 revealed the facility's routine water maintenance included checking the hot water tank temperatures and the hot and cold-water temperatures weekly on each floor, with the Weekly Resident Room Temperature Monitoring Log only containing four slots per week to document water temperatures. A follow-up interview on 03/18/25 at 8:25 A. M. with Maintenance Manager #322 confirmed the facility water management did not include use of any disinfectant, sanitizer, or regular descaling or cleaning of the whirlpool tubs or shower heads on the second, third, and fourth floors, and the facility did not keep a log noting all unoccupied rooms were maintained according to their water management plan. No evidence was provided that any residents were assessed for symptoms of Legionnaires' Disease between 01/30/25 and 03/18/25. This included assessment and/or testing for two residents, Resident #95 and #18 who had respiratory symptoms/hospitalization during this time period. In addition to all facility residents being at risk for complications associated with legionella, the facility identified 11 residents with tracheostomies and/or ventilators, Resident #3, #7, #26, #27, #34, #36, #37, #42, #94, #95, #96 and five residents who received on-site hemodialysis, Resident #26, #31, #34, #95 and #145. (continued on next page)

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	365977	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Circle of Care	1985 East Pershing Street Salem, OH 44460

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	On 03/18/25 at 1:21 P.M. interview with the LHD Environmental Health Director (EHD #356) revealed he was made aware of legionella growth in the facility water supply on 01/22/25 during a visit to the facility for another reason. EHD #356 revealed he provided verbal direction to facility management when on-site on 01/22/25 and 02/06/25 in response to the legionella which included super-heating the water, which he described as turning the water up to a minimum of 175 degrees Fahrenheit (F) over night, draining the water system, flushing, and sanitizing the water. EHD #356 further revealed it was his belief the facility had sanitized their water and installed point of use filters before residents began using the water for bathing. During this interview, EHD #356 confirmed there was a risk at the sink if residents were using their room sinks to brush their teeth and the filters were not placed at the point of use. EDH #356 further stated the facility wanted to run their own legionella water tests and attempt to work on the issue on their own for the first few weeks, but the levels kept climbing, reaching 121 MPN/ml. On 03/07/25, EDH #356 contacted Maintenance Manager #322 and arranged to come to the facility to perform their own water sampling for legionella testing (taken from two sites on 03/10/25, one near the holding tanks and one from the fourth-floor dialysis den). Interview on 03/18/25 from 2:30 P.M to 2:36 P.M. with Resident #28 revealed he used the sink in his bedroom for washing his hands and brushing his teeth. During the interview, he pointed out the toothbrush and tube of toothpaste sitting on the sink, next to the hot water knob. Further interview with Resident #28 revealed he was told he could not shower for a week or two about a month ago, then started using the shower room thereafter (he was uncertain of exact dates). The resident was then instructed on 03/17/25 that residents were no longer able to use the second-floor shower but could use the shower on the third floor and then on 03/18/25 he stated he was told he could start using the second-floor shower room again. Resident #28 confirmed he showered in the second-floor shower room on Friday, 03/14/25, before being informed residents were not supposed to shower on the second floor. Interview on 03/18/25 at 2:40 P.M with Resident #17 revealed he had been using the sink in his room to wash his hands, brush his teeth, and shave. Interview on 03/18/25 at 3:10 P.M. with IP #302 and the DON confirmed residents were not to be using the sinks in their rooms to brush their teeth and were not to shower in the second-floor shower room. Both the DON and IP #302 confirmed the second-floor shower door was not locked and there were no signs or other visual cues reminding residents not to use their sinks or the second-floor shower room. During the interview, IP #302 stated she spoke with a nurse at the health department and the local health department nurse did not recommend testing residents for legionella if they were asymptomatic, stating they were told the residents would present as unstable if they did have an infection caused by legionella. On 03/18/25 at 3:35 P.M., interview with Maintenance Manager #322 confirmed the facility flushing process did not involve completely emptying the entire system and filters were not applied to the faucets in any sinks, including those in resident rooms, or the second-floor shower room. Maintenance Manager #322 also confirmed the increase of legionella growth from 7.97 MPN/ml from the water sample taken on 01/08/25 to 13.4 MPN/ml from the water sample taken on 01/23/25 to 121 MPN/ml from the water sample taken on 02/05/25. He was unable to provide any additional steps the facility took to mitigate the risk of legionella after the last test result came back, except for placing a shower head filter on the third and the fourth-floor showers. However, it was identified the facility water supply was on an open loop and water moved throughout the whole building and not just to designated areas. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Interview on 03/19/25 3:45 P.M. with the Administrator, the DON, and IP #302 revealed they were unaware the legionella test results from water sampled on 02/05/25 rose to 121 MPN/ml. Interview on 03/19/25 at 4:28 P.M. with Medical Director #369 revealed his understanding of the facility's legionella issue was that their water tested positive for legionella and the facility shut off the water, had the local health department (LHD) come to the facility, and the numbers were trending down to a more appropriate level. Medical Director #369 denied knowledge the LHD ruled out that legionella came from outside the facility or that the legionella growth counts in the facility water had increased to 121 MPN/ml by 02/05/25 with no further available test results since. During the interview, the Medical Director expressed concern that the facility resident population was high risk for legionella related disease and complication due to their acuity level and comorbidities. On 03/19/25 at 4:40 P.M., interview with the DON revealed the facility just discontinued use of the ice machine because the filter in the ice machine did not specify it was approved for legionella. On 03/20/25 at 4:10 P.M., interview with the Maintenance Manager #322 confirmed the water was turned off to all sinks in the building on 03/19/25 by 6:03 P.M. and the ice machine was not in use because it did not have a filter appropriate for water with legionella. On 03/24/25 at 9:00 A.M. a telephone interview with Lab Manager #370 from Cardinal Environmental Laboratories revealed the laboratory runs water screening tests for legionella using 200 test tubes to find the most probable number (MPN) versus colony-forming units (CFU). He further confirmed 121 MPN/ml far exceeds the allowable from the CDC and that corrective action should be taken by any facility with a positive number, especially if results were greater than 10 MPN/ml and if they housed the elderly or residents who may be immunocompromised. He stated the difference in the tests is the CFUs measured the number of colonies and the MPN could mean there was one colony or numerous colonies for each measured number. Interview on 03/24/25 at 10:20 A.M. with the Administrator and Maintenance Manager #322 revealed a shower filter from the third floor was placed on the second-floor showerhead on the evening of 03/18/25. Both stated the facility had ordered two shower heads with filters in them and two additional filters, allowing a filter from one of two shower heads on the third floor to be taken to the second floor. Neither was able to provide proof that more than two shower heads and/or filters were ever ordered. Interview on 03/25/25 at 3:05 P.M. with the DON confirmed the facility had not begun screening residents for signs and symptoms of legionella when the legionella count initially started to increase and did not complete legionella screening on all residents on 03/24/25. Review of the assessments titled Legionella Signs and Symptoms for Potential Exposure - V 2 revealed the legionella screening assessments were completed on all residents who were in the facility on 03/24/25, except Residents #11, #20, #31, and #144. Additionally, no assessment was found for Resident #29 who was in the hospital on 03/24/25 but returned to the facility on [DATE]. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Interview on 03/24/25 at 8:58 A.M. with the LHD DON #371 revealed the facility reached out to her on 02/04/25 to inquire about testing residents who were ventilator dependent for legionella since they had some legionella growth in their water. LHD DON #371 stated she reached out to the Ohio Department of Health (ODH) Infectious Disease (ID) nurse, who returned her call on 02/05/25. Further interview with LHD DON #371 confirmed she spoke with the facility on 02/05/25 and let them know that the ODH ID nurse stated that residents with legionella would present with symptoms beyond baseline. During the interview, LHD DON #371 confirmed she instructed the facility to contact her of any residents that had symptoms that were outside of their baseline, and they would discuss testing at that time. During the interview, LHD DON #371 confirmed the facility had not informed her of any residents with any respiratory symptoms or any ventilator residents with assessments outside of their norm. A follow-up phone interview with LHD EHD #367 on 03/26/25 at 9:15 A.M revealed it was his understanding the facility had already contracted Eco Labs to assist with disinfecting the water and that they were placing appropriate filters made specifically for legionella on all the faucets and showers when he met with the DON, IP #302, and Maintenance Manager #322 in early February 2025. During the interview, EHD #367 reiterated he was unaware the facility had not installed point of use filters or proceeded with the water disinfection evaluation process at that time. Interview on 03/26/25 at 4:35 P.M. with the DON confirmed the Legionella Signs and Symptoms for Potential Exposure - V 2 form had a prompt to indicate whether the resident had three symptoms that varied from their baseline. The DON stated she utilized the CMS website guidance to determine that three symptoms listed on the legionella screening questionnaire would indicate a need to test for legionella. Review of the CDC guidance titled What Clinicians Need to Know about Legionnaires' Disease revealed no direction related to the requirement of three symptoms before testing for Legionnaires' Disease but did indicate people at risk for healthcare associated pneumonia and who may have other risk factors should be considered for testing when there is a potential concern related to legionella. Interview on 03/26/25 at 5:41P.M. with the DON verified the legionella assessments for five residents who were currently in the facility (Resident #11, #20, #29, #31, and #144) were not completed. The DON added Resident #29 had just returned from the hospital on 03/25/25 so she wasn't in the facility when these assessments were completed Monday 03/24/25. Interview on 03/31/25 at 11:27 A.M. with Maintenance Manager #322 confirmed the facility had not yet received all the point of use filters but had installed all the filters on the second and third floor room sinks but were waiting for adapters to install the last eight or nine filters on room sinks on the fourth floor. He further revealed the water to those sinks were turned on, but staff and residents were not yet informed they were allowed to use their sinks because he was waiting for all the filters to be installed before notification was made. Regarding the main water breaks that had occurred, Maintenance Manager #322 revealed there was one on the street where the facility was located about a month ago around 02/12/25, after the facility's water initially tested positive for legionella, but was not positive about the date. Interview on 03/31/25 at 3:04 P.M with a representative from the City of Salem Water Department confirmed there was a waterline break near the facility was on 02/05/25. No other water line breaks were reported near the facility. Note- the water line break on 02/05/25 corresponds to the high level of legionella (121 MPN) noted in the facility's water samples taken on that same date. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Review of Maintenance Manager #322's notes from 01/08/25 to 03/11/25 revealed he super-heated the water in the facility on 01/22/25 from 1:00 P.M. to 4:30 P.M. by turning the water heater up to 160 F before flushing the water throughout the building. The notes also revealed the water was super-heated to 150 F on 02/03/25 for three hours before flushing. On 01/23/25, 01/24/25, 01/27/25, 01/28/25, 01/29/25, 01/30/25, and 02/04/24, the water heaters were turned up to 135 F and all faucets were run for 10 minutes. On 02/06/25, 02/07/25, 02/10/25, 02/11/25, 02/12/25, 02/14/25, 02/17/25, 02/18/25, 02/19/25, 02/21/25, 02/24/25, 02/26/25, 02/28/25, and 03/04/25 the water heaters were turned up to 130 F and all faucets were run for 10 minutes. Further review of these notes revealed the filters were changed and clean. There was no reference as to what filters were changed or how they were cleaned. Review of the facility New Water Management Plan (WMP) dated March 2025 revealed the facility had 62 certified beds and three shower heads. In addition, on 03/27/25 review of the WMP dated as revised March 2025 revealed the plan failed to contain a component that specifically addressed what immediate action steps the facility would implement with a water test sample that was positive for legionella. An interview on 03/27/25 at 9:15 A.M. with the Administrator revealed the new water management plan had not yet been reviewed or implemented by the facility and the water management team would be meeting at a yet to be determined time to discuss the new plan. She also confirmed the new WMP contained some misinformation, including the facility certified bed capacity was 55, not 62 and that aside from three stationary shower heads, the facility also used two additional hand-held shower wands for bathing purposes. Review of an addendum to the facility's March 2025 WMP revealed additional direction in an addendum dated 04/01/25 that if the facility should test positive for legionella in their water in the future, the facility would contact PT Enterprises, a company the facility contracted with for water management support, to conduct additional water sampling and testing, provide alternate water sources for bathing and resident care, inspect all water outlets for built-up scaling, cleaning with appropriate cleaners, and replacement of all filters on incoming water sources. Review of the Centers for Disease Control (CDC) website (https://wwwn.cdc.gov/elite/Public/EliteHome.aspx) revealed laboratories can test their Legionella isolation techniques against standardized samples through the Environmental Legionella Isolation Techniques Evaluation Program. Participating labs receive a panel of lyophilized test samples each year from the Wisconsin Sate Laboratory of Hygiene. Some of the test samples are Legionella positive and some are Legionella negative. The test samples may also include other organisms commonly found in water. Participating labs process the test samples and report their results. The labs that correctly identify Legionella in two consecutive panels receive documentation for passing the proficiency test. Review of the Centers for Disease Control (CDC) Environmental Legionella Isolation Techniques Evaluation (ELITE) Program revealed Cardinal Environmental Laboratories, LLC was not a member of CDC's ELITE program. Review of the Centers for Disease Control and Prevention (CDC) website direction on legionella control measures at https://www.cdc.gov/investigate-legionella/php/healthcare-resources/control-measures.html revealed healthcare facilities should avoid use of water from sinks or tub faucets in resident rooms, restrict showers, and limit use of non-sterile ice from ice machines for anyone at risk for aspiration or who have swallowing difficulties. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	2. Review of the closed medical record for Resident #95 revealed an admitted [DATE] and a discharge date of [DATE]. Resident #95 had diagnoses including respiratory failure, pleural effusion, osteomyelitis, stage four pressure ulcer of sacral region, type two diabetes mellitus with autonomic neuropathy, end stage renal disease, chronic obstructive pulmonary disease (COPD), necrotizing fasciitis, tracheostomy status, dependence on a ventilator, and dependence on dialysis. Review of the annual Minimum Data Set (MDS) 3.0 assessment revealed Resident #95 had severely impaired cognition with debility and cardiorespiratory conditions. Further review of the MDS revealed Resident #95 required oxygen therapy, suctioning, tracheostomy care, invasive mechanical ventilator, dialysis, and isolation for infectious disease. Review of the progress notes revealed a note date [TRUNCATED]

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 48567 Based on review of training certificates, personnel files, and interview, the facility failed to ensure staff responsible for overseeing the infection prevention and control program (IPCP) completed specialized training in infection prevention and control. This had the potential to affect all 40 residents residing in the facility. Findings include: Interview on 03/20/25 at 10:32 A.M. with Infection Preventionist (IP) #302 revealed she began training to become the facility's IP toward the end of August 2024, but the previous IP who was responsible for training her quit approximately eight hours into her training, so she had to try to figure out the role on her own. During the interview, IP #302 stated she began taking some classes to learn more about infection control in the months that followed and completed the required training and earned her certificate in January 2025. Review of the training certificates awarded to the IP revealed she had not completed the required training requirements until 01/04/25. Interview with the Director of Nursing (DON) on 03/20/25 at 12:14 P.M. confirmed she did not possess the required training to oversee the facility's IPCP. During the interview, the DON called Minimum Data Set (MDS) nurse and Consultant #372 and verified there was no other staff employed by the facility who had the appropriate requirements to oversee the infection control program between the last IP leaving and IP #302 completing her training. At that time, the DON was unable to confirm the dates the facility was without a properly trained IP. Review of the personnel file for IP #302 revealed no date of transition from the role of LPN floor nurse to the role of IP. Further review of the personnel record revealed no evidence of completion of specialized training qualifications for the IP role prior to 01/04/25. A follow-up interview with the DON on 04/01/25 confirmed there was no qualified staff in the IP staff between 08/19/24 and 01/04/25. Review of the job description provided by the facility for the Infection Preventionist Director position, created in August 2020, revealed no listed requirement for the staff assigned that job role to have completed the required specialized training in infection prevention and control prior to assuming the role, or any time thereafter.