STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365978	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scarlet Oaks Nursing and Rehabilitation Center	440 Lafayette Avenue Cincinnati, OH 45220

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28193 Based on record review, staff interview and policy review, the facility failed to inform and provide written information regarding the resident's right to formulate an advance directive. This affected three (#16, #51, and #63) of three residents reviewed for advanced directives. The facility census was 65. Findings included: 1. Review of the admission record revealed Resident #51 was admitted on [DATE]. Resident #51 had a medical history that included diagnoses of chronic respiratory failure, atrial fibrillation, tracheostomy status, malignant neoplasm of the prostate, and type 2 diabetes mellitus. Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #51 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident was dependent on staff for all activities of daily living (ADLs). Review of Resident #51's care plan included a focus area revised on [DATE], indicating the resident was at risk for alteration in code status and was a DO NOT RESUSCITATE, DNR-CC, [do not resuscitate - comfort care]. Interventions directed staff to advocate for the resident's end-of-life preferences to ensure advanced directives were implemented in accordance with the resident's wishes (revised on [DATE]); to allow extra time for the resident to discuss feelings regarding advanced directives (revised on [DATE]); arrange visits from clergy and social services at the resident's request (revised on [DATE]); check for vital signs (revised on [DATE]); effectively communicate DNR wishes by placing it in the front of the chart or when the resident must be transferred outside of the facility (revised on [DATE]); if the DNR decision poses an ethical conflict for staff, reassign duties as needed and assign caregivers who are capable of advocating on behalf of the resident's wishes (revised on [DATE]); and provide comfort measure and symptom palliation to allow the dying process to occur as comfortably as possible (revised on [DATE]). Review of Resident #51's Order Summary Report with active physician orders as of [DATE] contained an order dated [DATE] for DNR-CC. Review of the DNR Order Form, dated [DATE], revealed Resident #51 had chosen the code status option of DNR Comfort Care to be effective immediately. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of Resident #51's medical record revealed there was no advanced directive available for review or an acknowledgment that information had been provided to the resident regarding their right to formulate an advanced directive if they wished. Interview on [DATE] at 1:27 P.M., with the Director of Nursing (DON) stated she believed advanced directives were discussed in the initial care conference, and Social Services was the person to speak to. Interview on [DATE] at 1:39 P.M., with the Social Services Director (SSD) stated no form was provided to families to fill out regarding information about advanced directives. She stated she did not discuss that information with the residents or their families. SSD stated she asked the resident or family what they wanted their code status to be while they were there, then the facility would get an order and complete the DNR form if needed. She stated she documented the information regarding their choice to be a full code or DNR in the progress notes. Interview on [DATE] at 9:37 A.M., with the SSD stated she did not offer information to the residents or families about advanced directives, only code status. Interview on [DATE] at 12:35 P.M., with the Admissions Director (AD) stated the facility did not offer to assist residents or their families with creating advanced directives if they did not have them nor explain what they were. The AD stated there was no documentation of the resident's choice to have or not have advanced directives. The AD stated she somewhat knew the difference between advanced directives and code status and that it was a clinical thing, like social services. Interview on [DATE] at 2:44 P.M., with the DON stated, I don't know the difference between code status and advanced directives. DON stated the facility had gone through multiple social service personnel recently, and there were areas of the program that were lacking. Interview on [DATE] at 4:08 P.M., with the Administrator stated her expectation was for staff to discuss code status with the residents and families initially, and information regarding advanced directives would be provided at their 72-hour care conference going forward, as well as the offer to assist them as needed. 2. Review of the admission record revealed Resident #63 was admitted on [DATE]. Resident #63 had a medical history including diagnoses of acute respiratory failure with hypoxia, convulsions, and a personal history of traumatic brain injury. Review of the Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #63 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on staff for all activities of daily living (ADLs). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #63's care plan included a focus area revised on [DATE] that indicated the resident was at risk for alteration in code status, and the resident was a FULL CODE. Interventions directed staff to allow extra time for the resident to discuss their feelings regarding the Full Code Status (initiated on [DATE]); call 911 immediately (initiated on [DATE]); effectively communicate FULL CODE STATUS wishes by placing in the front of the chart and/or when resident must be transferred outside the facility (initiated on [DATE]); intercede rapidly and begin immediate resuscitative efforts utilizing all life-sustaining measure available if the resident's heart stops beating or the resident stops breathing, such as CPR (cardio-pulmonary resuscitation), oxygen administration, and defibrillation (initiated on [DATE]); notify family or guardian of the resident's condition promptly (initiated on [DATE]); and obtain vital signs and notify the physician promptly (initiated on [DATE]). Review of Resident #63's Order Summary report with active physician orders as of [DATE] contained an order dated [DATE] for Full Code (CPR). Continued review of Resident #63's medical record revealed there was no advanced directive available for review or an acknowledgment that information had been provided to the resident regarding their right to formulate an advanced directive if they wished. Interview on [DATE] at 1:27 P.M., with the Director of Nursing (DON) stated she believed advanced directives were discussed in the initial care conference, and Social Services was the person to speak to. Interview on [DATE] at 1:39 P.M., with the Social Services Director (SSD) stated no form was provided to families to fill out regarding information about advanced directives. She stated she did not discuss that information with the residents or their families. SSD stated she asked the resident or family what they wanted their code status to be while they were there, then the facility would get an order and complete the DNR form if needed. She stated she documented the information regarding their choice to be a full code or DNR in the progress notes. Interview on [DATE] at 9:37 A.M., with the SSD stated she did not offer information to the residents or families about advanced directives, only code status. Interview on [DATE] at 12:35 P.M., with the Admissions Director (AD) stated the facility did not offer to assist residents or their families with creating advanced directives if they did not have them nor explain what they were. The AD stated there was no documentation of the resident's choice to have or not have advanced directives. The AD stated she somewhat knew the difference between advanced directives and code status and that it was a clinical thing, like social services. Interview on [DATE] at 2:44 P.M., with the DON stated, I don't know the difference between code status and advanced directives. DON stated the facility had gone through multiple social service personnel recently, and there were areas of the program that were lacking. Interview on [DATE] at 4:08 P.M., with the Administrator stated her expectation was for staff to discuss code status with the residents and families initially, and information regarding advanced directives would be provided at their 72-hour care conference going forward, as well as the offer to assist them as needed. 49044 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the admission record revealed Resident #16 admitted on [DATE]. Resident #16 had a medical history including diagnoses of nontraumatic intracranial hemorrhage, type 2 diabetes mellitus without complications, morbid (severe) obesity due to excess calories, aphasia following cerebral infarction, tracheostomy status, gastrostomy status, and dependence on respiratory ventilator status. Review of the admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #16 had severe impairment in cognitive skills for daily decision making and had short-term and long-term memory problems per a Staff Assessment of Mental Status (SAMS). Review of Resident #16's care plans revealed a focus area initiated on [DATE], indicating the resident was at risk of alteration in code status and was a FULL CODE. Review of the Order Summary Report, with active physician orders as of [DATE], revealed Resident #16 had an order for Full Code (CPR [cardio-pulmonary resuscitation]) dated [DATE]. Review of the Progress Note dated [DATE] at 4:32 P.M., revealed the Social Service Director (SSD) wrote, resident code status was verified, resident is full code. Resident's chart, orders, and care plans all coincide. The Progress Note did not indicate that the SSD discussed with the resident or family if the resident had an advance directive. Interview on [DATE] at 1:39 P.M., with the Social Services Director (SSD) stated no form was provided to families to fill out regarding information about advanced directives. She stated she did not discuss that information with the residents or their families. She stated she asked the resident or family what they wanted their code status to be while they were there, then the facility would get an order and complete the DNR form if needed. She stated she documented the information regarding their choice to be a full code or DNR in the progress notes. Interview on [DATE] at 12:34 P.M.,with the Admissions Director (AD) stated she did not offer to help the new admissions with advanced directives; that was more social work. AD stated she somewhat understood the difference between code status and advanced directives, but that was why she did not do it; it was more clinical. Interview on [DATE] at 3:50 P.M., with the Administrator stated when they had a new admission, social services should be asking if they had an advance directive or if they wanted one. The Administrator stated staff should have a care conference to determine if the resident had advance directives or if they wanted one. The Administrator stated staff should be asking the residents quarterly after that. The Administrator stated they were supposed to have a 72-hour care conference and that should be when the residents were offered the advance directive. Review of the policy titled, Advance Directives, dated [DATE], revealed, the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. The policy revealed, Determining Existence of Advance Directive 1. Prior to or upon admission of the resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The resident or representative is provided with written information concerning the right to refuse medical or surgical treatment, and to formulate an advance directive if he or she chooses to do so. 3. Written information about the right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive is provided in a manner that is easily understood by the resident of representative. The policy revealed, If the Resident Does not have an Advance Directive: 1. If the resident or representative indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. a. The resident or representative is given the option to accept or decline assistance, and care will not be contingent on either decision. b. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49044 Based on record review, staff interview, provider interview, email communication reviews and policy reviews, the facility failed to implement the policy to ensure a nurse practitioner (NP) immediately reported an allegation of abuse to facility management when made aware of the allegation, resulting in late reporting to the state agency by the facility. This affected one (#59) of three residents reviewed for abuse. The facility census was 65. Findings included: Review of the admission record revealed Resident #59 was admitted on [DATE]. Resident #59 had a medical history including diagnoses of chronic respiratory failure with hypoxia, epilepsy, tracheostomy status, gastrostomy status, dependence on respiratory (ventilator) status, and dependence on supplemental oxygen. Review of the quarterly Minimum Data Set assessment (MDS), with an Assessment Reference Date (ARD) of 12/04/24, revealed Resident #59 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident had no behaviors during the assessment period. The MDS revealed the resident had two or more falls with no injury since the prior assessment or reentry. Review of Resident #59's care plan included a focus area, initiated 06/06/24, indicated the resident was dependent on staff for meeting emotional, intellectual, physical and social needs related to cognitive deficits, disease process (ventilator dependency, tracheostomy status, aphasia, pulmonary fibrosis, chronic obstructive pulmonary disease, and pneumonia), and immobility and physical limits. The care plan also included a focus area, initiated on 07/29/24, that indicated the resident had a behavior problem and was at risk for falls and injuries related to overt behaviors. The focus area revealed the resident pulled at the ventilator circuit and held their breath at times, causing the ventilator alarm to sound. Review of an email dated 01/06/25 at 1:35 P.M., addressed from Nurse Practitioner (NP) #11 to the Assistant Director of Nursing (ADON), revealed, last week [Resident #59] complained to me about a night shift nurse being abusive. Per the email, Resident #59 reported when they fell out of bed, the nurse was verbally abusive to them, and had kicked them while they were on the floor and also pinched them. Per the email, the resident was unable to remember the nurse's name, but identified them as a male night shift nurse and reported that the nurse had been verbally abusive on several occasions and had also pinched them on several occasions. Review of the Self Reported Incident Form, dated 01/03/25, revealed the facility became aware of the abuse allegation on 01/03/25. Per the form, the date, time, and location of the occurrence was 01/03/25 at 12:00 P. M. in the resident's room. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/23/25 at 1:41 P.M., via telephone, with NP #11 stated she was informed of the allegation of abuse reported by Resident #59 against a nurse on 12/31/24. She stated she did not believe that reporting the allegation was urgent at that moment because the resident said it occurred a couple weeks prior, and it had not happened since. NP #11 stated it was also a holiday, so there was no one around to whom to report the allegation. NP #11 stated, on 01/03/25, the resident remembered the name of the nurse (alleged perpetrator), and she reported the allegation to Registered Nurse #16 at that time. Review of an email confirmation titled, Immediate (24 Hour) Facility Reported Incident #255730, indicated the facility notified the state survey agency of the abuse allegation on 01/03/25 at 3:16 P.M., which was not in compliance with the required reporting timeframe for an abuse allegation received on 12/31/24. An email confirmation titled, Final Facility Reported Incident #255730 revealed the facility submitted the required 5-day investigation report to the state agency on 01/08/25, which was not compliant with the required timeframe for an abuse allegation received on 12/31/24. Interview on 01/23/25 at 3:50 P.M., with the Administrator stated she expected staff to report allegations of abuse immediately. The Administrator stated if the allegation involved physical abuse, the allegation should be reported to the state agency within two hours. The Administrator said she thought she had reported the allegation within two hours. The Administrator stated she was unaware Resident #59 had reported an allegation of abuse to NP #11 on 12/31/24. Review of the policy titled, Abuse, Neglect, Exploitation and Misappropriation - Reporting and Investigating, revised in 09/2022, revealed, If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown or source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The policy revealed, Immediately is defined as: Within two hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Review of the policy titled, Abuse and Neglect Protocol, dated 09/18/24, revealed, Employees, facility consultants and/or Attending Physicians must immediately report any suspected abuse or incidents of abuse to the Director of Nursing Services. In the absence of the Director of Nursing Services such reports may be made to the Nurse Supervisor on duty. This deficiency represents the non compliance investigated under Complaint Number OH00161750.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 49044 Based on record review, staff interviews, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual review, and policy review, the facility failed to identify and complete a Significant Change in Status Assessment (SCSA) when a resident was discharged from Hospice care. This affected one (#48) of 20 sampled residents reviewed. The facility census was 65. Findings included: Review of the admission record revealed Resident #48 was on 03/20/23. Resident #48 had a medication history including diagnoses of unspecified sequelae of nontraumatic intracerebral hemorrhage, vascular dementia with other behavioral disturbance, hemiplegia (partial paralysis) affecting the left nondominant side, dysarthria (difficulty speaking) following cerebral infarction (stroke), acute respiratory failure with hypoxia, tracheostomy status, and gastrostomy status. Review of the quarterly minimum data set (MDS) assessment, with an assessment reference date (ARD) of 10/23/24, revealed Resident #48 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was receiving hospice care within the last 14 days from the ARD. Review of Resident #48's care plan revealed a focus area initiated 06/03/24, that indicated the resident had the potential for/or decline in condition; receiving hospice services, met criteria with an admitting diagnosis of unspecified sequelae of nontraumatic intracerebral hemorrhage. The focus area listed the hospice service provider who was providing care to the resident. The focus area was revised on 01/20/25 and was marked as resolved. Review of Resident #48's clinical census revealed the resident had been receiving hospice services from 06/04/24 through 11/26/24. Review of Resident #48's Order Recap [Recapitulation] Report, for the timeframe from 01/01/24 through 01/23/25, revealed a physician order for May utilize services of hospice care to evaluate resident one time only for Hospice evaluation for 1 Day, with an order date of 04/25/24 and discontinuation date of 04/27/24. The Order Recap Report revealed a physician order for May utilize services of [Hospice Provider Name] hospice care for evaluation and care/treatment, with an order date of 05/10/24 and discontinuation date of 12/23/24. Review of a Resident #48's Progress Notes revealed a skin and wound note dated 11/25/24 at 5:12 P.M., that indicated the resident was under hospice care but was going to transition out of hospice care. The note revealed once Resident #48 was no longer under hospice, they recommended an appointment with a gastro-intestinal physician to evaluate the wound around the gastrostomy tube and discussed the plan of care with the wound nurse. Review of Resident #48's Progress Notes revealed Psychiatry Progress Note dated 11/27/24 at 12:59 A.M., indicated the resident did not respond when spoken to and staff said Resident #48 was no longer on hospice services as they felt the resident's current state was chronic. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #48's Progress Notes revealed a skin and wound note, dated 12/04/24 at 3:15 P.M., indicated the resident was under hospice care but was now transitioned out of hospice care. Review of Resident #48's electronic health record revealed staff had not completed a SCSA within 14 days of the resident being discharged from hospice care. Interview on 01/23/25 at 11:58 AM, MDS Coordinator (MDSC) #7 stated she completed the MDS assessments and some of the care plans. MDSC #7 stated when identifying a SCSA, they would look at changes in ADLs, diagnoses that would impact functional abilities, being admitted to or discharged from hospice, and two areas of change under functional abilities. MDSC #7 stated she would complete an SCSA if a resident was discharged from hospice. MDSC #7 stated typically, it would be announced if a resident were being discharged from hospice in clinical meetings, or it would go out in an email to the interdisciplinary team. MDSC #7 stated the staff person who was notified of the discharge from hospice would send the email. MDSC #7 stated she was familiar with Resident #48. MDSC #7 stated the resident was discharged from hospice on 11/26/24, and she was not notified. MDSC #7 stated she was notified this week the resident was discharged from hospice after the survey team brought it to the facility's attention. Interview on 01/23/25 at 2:45 P.M., with the Director of Nursing (DON) stated she expected the MDS assessments to be completed and completed on time. The DON stated MDSC #7 needed to communicate with everyone to make sure everyone was completing MDS assessments like they should. The DON stated the MDS should reflect whatever was going on with the resident. She stated she expected a SCSA to be completed when a resident was discharged from hospice. Interview on 01/23/25 at 3:50 P.M., with the Administrator stated she expected staff to follow the policy, complete the MDS timely and she expected them to be accurate. She stated she expected a SCSA to be completed if a resident had a change in condition. Review of the policy titled, Resident Assessments, revised October 2023, revealed 1. OBRA [Omnibus Budget Reconciliation Act] -Required Assessments are federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. OBRA assessments include: d Significant Change in Status Assessment (SCSA). The policy revealed, 5. The RAI [Resident Assessment Instrument] User's Manual (Chapter 2) provides detailed information on timing and submission of assessments. 6. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely appropriate resident assessments. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.19.1 October 2024, revealed, An SCSA is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The ARD [Assessment Reference Date] must be within 14 days from one of the following: 1) the effective date of the hospice election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 2) the expiration date of the certification of terminal illness; or 3) the date of the physician's or medical director's order stating the resident is no longer terminally ill.

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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** 52203 Based on observations, staff interviews, record reviews, and policy reviews, the facility failed to ensure comprehensive person-centered care plans were developed and implemented. This affected four (#6, #11, #60, and #63) of 20 sampled residents reviewed. The facility census was 65. Findings included: 1. Review of the admission record revealed Resident #6 was admitted on [DATE]. Resident #6 had a medical history including diagnosis of Alzheimer's disease. Review of the quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/10/24, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. The MDS indicated the resident required partial to moderate assistance with all activities of daily living (ADLs). Review of Resident #6's care plan revealed no evidence of a focus, goal, or interventions related to the administration of oxygen therapy. Review of Resident #6's Order Summary Report, with active orders as of 01/20/25, revealed no evidence of a physician's order for supplemental oxygen administration. Observation on 01/20/25 at 12:39 P.M., revealed Resident #6 was receiving supplemental oxygen via nasal cannula, and the concentrator was set at 2 liters per minute (L/M). Observation on 01/21/25 at 12:37 P.M. revealed Resident #6 lying in bed and appearing to watch television. Resident #6's eyes were open, but the resident did not respond to verbal stimuli. Resident #6 was receiving supplemental oxygen, and the concentrator was set at 2 L/M. Interview on 01/21/25 at 12:58 P.M., with Licensed Practical Nurse (LPN) #2 confirmed Resident #6 was receiving oxygen therapy and had been on supplemental oxygen for a while. LPN #2 checked the resident's physician's orders and said she was unable to confirm when the oxygen therapy started. LPN #2 confirmed the use of supplemental oxygen should be reflected on the resident's care plan. Interview on 01/23/25 at 11:58 A.M., with MDS Coordinator (MDSC) #7 confirmed she was responsible for the development and revision of care plans. MDSC #7 stated care plan focus areas and interventions were based on the MDS and data retrieved from a facility checklist. MDSC #7 stated the facility checklist contained data such as diagnoses, behaviors, and medications that would also be added to the care plan. MDSC #7 confirmed care plans were reviewed in the daily IDT meeting and during the weekly utilization meeting; care plans were revised and updated at that time if needed. MDSC #7 stated focus areas were added to the care plan based on new orders. MDSC #7 stated she would expect a resident receiving supplemental to have interventions on the care plan that would direct care activities. Interview on 01/23/25 at 2:24 P.M., with the Director of Nursing (DON) stated her expectation was that the use of supplemental oxygen should be reflected on the resident's care plan. (continued on next page)

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	365978	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scarlet Oaks Nursing and Rehabilitation Center	440 Lafayette Avenue Cincinnati, OH 45220

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/23/25 at 3:50 P.M., with the Administrator confirmed it was her expectation that oxygen therapy be reflected on the resident's care plan. 2. Review of the admission record revealed Resident #11 was admitted on [DATE]. Resident #11 had a medical history including diagnosis of post-traumatic stress disorder (PTSD). Review of the quarterly MDS assessment, with an ARD of 11/29/24, revealed Resident #11 had a BIMS score of 10, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident required supervision to moderate assistance with all activities of daily living (ADLs). The MDS revealed the resident had a diagnosis of PTSD. Review of Resident #11's care plan revealed no evidence of a focus, goal, or interventions related to their PTSD diagnosis. Review of Resident #11's Psychiatry Progress Note, dated 01/10/25, revealed the Chief Complaint/Reason for this Visit included a follow-up for PTSD. Observation on 01/21/25 at 12:34 P.M., Resident #11 was observed seated in their room and watching television, dressed, and groomed. An interview was attempted with the resident; however, the resident declined. Interview on 01/21/25 at 12:38 P.M., with Certified Nursing Assistant (CNA) #3 stated there were no issues with Resident #11's behavior. CNA #3 stated the resident was cooperative and mostly understood what was being asked. CNA #3 stated the resident liked to stay in their room but would occasionally come out to the day room and watch television. CNA #3 stated she was unaware the resident had a diagnosis of PTSD. Review of Resident #11's Brief Trauma Questionnaire, dated 03/06/24, revealed the resident was involved in a transportation accident, had been physically punished or beaten, assaulted with a weapon, pressured into unwanted sexual contact, experienced a life-threatening illness or injury, and witnessed someone being seriously injured or killed. Interview on 01/23/25 at 9:24 A.M., with the Social Service Director (SSD) confirmed she completed the trauma questionnaire and entered the data into the medical record. The SSD stated the trauma questionnaire was initiated when someone identified a need to her, such as a family trauma or an incident that had happened at the facility. The SSD stated the information gathered from the trauma questionnaire was discussed at the Interdisciplinary Team Meeting (IDT), which met every morning. The SSD stated she does not do care plans; and that Minimum Data Set Coordinator (MDSC), who also attended the morning IDT meeting, was responsible for the care plans. Interview on 01/23/25 at 11:58 A.M., with MDSC #7 confirmed she was responsible for the development and revision of care plans. MDSC #7 stated care plan focus areas and interventions were based on the MDS and data retrieved from a facility checklist. MDSC #7 stated the facility checklist contained data such as diagnoses, behaviors, and medications, which would also be added to the care plan. MDSC #7 confirmed that care plans were reviewed in the daily IDT meeting and during the weekly utilization meeting; care plans were revised and updated at that time if needed. MDSC #7 stated she was unfamiliar with PTSD and interventions, such as potential triggers; however, she would expect an active diagnosis of PTSD to be reflected on the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/23/25 at 2:24 P.M., with the Director of Nursing (DON) stated her expectation was that residents with a diagnosis of PTSD should have that addressed on their care plan with interventions that are specific to the care the resident needs, such as what may trigger behaviors. Interview on 01/23/25 at 3:50 P.M., with the Administrator confirmed it was her expectation that the care plan reflects the needs of the resident. 28193 3. Review of the admission record revealed Resident #60 was admitted on [DATE]. Resident #60 had a medical history including diagnoses of a nontraumatic subarachnoid hemorrhage and cognitive communication deficit. Review of the admission MDS, with an ARD of 11/07/2024, revealed Resident #60 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident was dependent on staff for all activities of daily living (ADLs). The MDS revealed the resident's preferred language was not English. Review of Resident #60's Progress Notes revealed an Admission Summary dated 10/31/24 at 2:59 P.M., indicated Resident #60 was unable to comprehend or speak English. The notes revealed family members had to answer all questions and provide the information needed for admission. Review of Resident #60's Progress Notes revealed a Psychiatry Progress Note dated 11/06/24 at 5:21 P.M., indicated it was hard for the physician to get a good medical history due to the resident's English being very broken and speech seems disrupted. Review of Resident #60's Progress Notes revealed a Psychiatry Initial Consult dated 11/13/24 at 12:59 A.M., that indicated the resident was only oriented to self and did not speak English. The notes revealed a family member had to call a translator to assist. Review of Resident #60's Progress Notes revealed a Psychiatry Progress Note dated 11/13/24 at 12:01 P.M. , indicated Resident #60 had endorsed some abdominal discomfort, but due to the language barrier it was difficult to assess other symptoms. The note revealed the resident's speech patterns were not able to be determined due to the language barrier, broken English, and difficulty with speech. Review of Resident #60's Progress Notes revealed a Psychiatry Progress Note dated 11/20/24 at 7:28 P.M., indicated Communication remains difficult with [him/her] due to the language barrier. Review of Resident #60's care revealed no focus area addressing the language barrier identified upon admission or interventions provided to assist the staff and resident in communicating effectively. Interview on 01/23/25 at 2:53 P.M., with the Director of Nursing (DON) stated the care plan process was driven from the MDS. The DON stated difficulty communicating related to a language barrier should be care planned, and care plans should be updated frequently in the daily clinical meeting or at least quarterly with the MDS. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/23/25 at 11:59 A.M., with MDS Coordinator (MDSC) #7 stated she created resident care plans through the MDS process. She stated care plans were reviewed quarterly with the MDS, at a daily clinical meeting, and at the weekly utilization review meeting, in which new orders and items that were discontinued were added or removed from resident care plans. MDSC #7 stated communication issues regarding language barriers should be care planned but she thinks they were not. She stated that if she did not do a thorough review of the care plans, they did not get revised; and if they were not revised, residents could potentially not receive accurate care. 4. Review of admission record revealed Resident #63 was admitted on [DATE]. Resident #63 had a medical history that included acute respiratory failure with hypoxia, a stage 3 pressure ulcer of the sacral region, convulsions, and a personal history of traumatic brain injury. Review of the admission MDS, with an ARD of 12/20/24, revealed Resident #63 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on staff for all activities of daily living (ADLs). The MDS revealed the resident had three stage 3 pressure ulcers, two unstageable pressure ulcers, and two deep tissue injuries (DTIs) upon admission. Review of Resident #63's Order Summary Report with active physician orders as of 01/21/25 revealed the following orders: Apply betadine to open area on left ankle, leave open to air every shift (start date 01/02/25); Cleanse darkened area, deep tissue injury (DTI) on left heel with normal saline, pat dry, apply betadine to the site, and leave open to air every shift (start date 12/26/24); Cleanse open site located on right elbow with normal saline, pat dry, apply Xerofoam (a non-adherent, occlusive dressing) to the wound bed as the primary dressing and secure in place with border gauze every shift (start date 12/19/24); Cleanse open site located on sacrum with normal saline, pat dry, apply medical grade honey as the primary dressing followed by calcium alginate, secure in place with a border gauze every day shift (start date 01/09/25); Cleanse open site on right lateral foot with normal saline, pat dry, apply Xerofoam to the wound bed as the primary dressing and secure in place with a border gauze every day shift (start date 12/19/24); and Cleanse open site on right scapula with normal saline, pat dry, apply Xerofoam gauze to the wound bed as the primary dressing and secure in place with border gauze (start date 12/27/2024). Review of Resident #63's Progress Notes revealed a skin and wound note dated 01/08/25 indicated the resident had a stage 3 pressure ulcer to their left lateral ankle, a DTI to their left heel, a stage 3 pressure ulcer to their right lateral foot, a stage 3 pressure ulcer to their right elbow, an unstageable pressure ulcer to their sacrum, and a stage 3 pressure ulcer to their right scapula (shoulder blade). Review of Resident #63's care plan included a focus area revised on 12/13/24 that indicated the resident had a pressure ulcer on their sacrum. Interventions directed staff to administer medications as ordered (initiated 12/13/24); administer treatments as ordered and monitor effectiveness (initiated 12/13/24); educate the resident/family/caregivers on the causes of skin breakdown (initiated 12/13/24); encourage small frequent position changes (initiated 12/13/24); and to follow facility policies and protocols for the prevention and treatment of skin breakdown (initiated 12/13/24). Further review revealed the care plan did not address Resident #63's stage 3 pressure ulcer to their left lateral ankle, a DTI to their left heel, a stage 3 pressure ulcer to their right lateral foot, a stage 3 pressure ulcer to their right elbow, and a stage 3 pressure ulcer to their right scapula. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/23/25 at 11:59 A.M., MDSC #7 stated she created resident care plans through the MDS process. MDSC #7 stated care plans were reviewed quarterly with the MDS at a daily clinical meeting and at the weekly utilization review meeting, in which new orders and items that were discontinued were added or removed from resident care plans. MDSC #7 stated care plans were removed from a resident's chart during the clinical meetings and quarterly. MDSC #7 stated wound care plans were supposed to have wound locations individually spelled out on the care plan. MDSC #7 stated that if she did not do a thorough review of the care plans, they did not get revised; and if they were not revised, residents could potentially not receive accurate care. Interview on 01/23/25 at 2:57 P.M., with the Director of Nursing (DON) stated each wound should be listed individually on the care plan due to having individual treatment orders for each wound. She stated a clinical meeting was held every morning, in which they read all the nurses' notes from the previous 24 hours. She stated that if they were aware of changes, they fixed the care plans in that meeting. She stated her expectation was for the nurses to communicate with the management staff so that the care plans could be kept up to date and current. Review of the policy titled, Care Planning - Interdisciplinary Team, dated 10/10/22, revealed, 2. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT). Review of the undated facility policy titled, Care Plans, Comprehensive Person-Centered, revealed A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident. The policy revealed, 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The policy revealed, 8. The comprehensive, person-center care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; g. Incorporate identified problem areas; o. Reflect currently recognized standards of practice for problem areas and conditions. Review of the policy titled, Oxygen Administration, revised October 2010, revealed The purpose of this procedure is to provide guidelines for safe oxygen administration. The policy revealed, Review the resident's care plan to assess for any special needs of the resident. Review of an undated facility policy titled, Trauma Informed Care, revealed Social service and nursing staff are trained on trauma screening tool/assessment and how to identify triggers associated with re-traumatization. The policy revealed Trauma-informed care is culturally sensitive and person-sensitive.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28193 Based on staff interview, record review, and policy review, the facility failed to ensure resident's who were at nutritional risk had weights completed per policy. This affected two (#60 and #63) of three residents reviewed for nutrition. The facility census was 65. Findings included: 1. Review of the admission record revealed Resident #60 was admitted on [DATE]. Resident #60 had a medical history including diagnoses of a nontraumatic subarachnoid hemorrhage (brain bleed), dysphagia (difficulty swallowing), and gastrostomy status. Review of the admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/07/24, revealed Resident #60 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on staff for all activities of daily living (ADLs). The MDS revealed and a (-) dash was placed where the resident's height and weight were to be recorded, as there was no admission height or weight obtained. Review of Resident #60's care plan included a focus area initiated 11/11/24, that indicated the resident required a tube feeding related to dysphagia. Interventions directed staff to keep the head of the bed elevated at 45 degrees and to look for signs and symptoms of aspiration. The care plan revealed no interventions related to obtaining the resident's weight. Review of Resident #60's census list revealed the resident was admitted to the facility on [DATE], was discharged to the hospital on 11/26/24, and was readmitted to the facility on [DATE]. Review of Resident #60's Order Recap [Recapitulation] Report for the timeframe from 10/01/24 through 01/20/25 revealed there was no order for an admission weight or weekly weights for four weeks placed in the computer for Resident #60's initial admission on 10/31/24 or an order for a weight upon the resident's readmission on 12/01/24. Further review of the Order Recap Report revealed an order for weekly weights one time a day, every Friday, with a start date of 12/13/24 and an end date of 12/17/24, and an order for weekly weights one time a day, every Friday, for four weeks, with a start date of 12/20/24 and an end date of 1/17/25. Review of Resident #60's Weight Summary revealed a weight of 175.5 pounds on 11/22/24, 174.8 pounds on 12/20/24, and 144.7 pounds on 01/10/25. Review of Resident #60's Medication Administration Record [MAR], for December 24 revealed a transcription of an order for weekly weights one time a day, every Friday, with a start date of 12/13/24 and a discontinuation date of 12/17/24. The MAR revealed staff had initialed the box dated 12/13/24 as completed; however, there was no weight present on the MAR. The MAR revealed a transcription of an order for weekly weights one time a day, every Friday for four weeks, with a start date of 12/20/24. The MAR revealed that staff documented that on 12/20/24 the resident weighted 174.8 and on 12/27/24 the resident weighted 174.8. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #60's MAR for January 25 revealed a transcription of an order for weekly weights one time a day, every Friday for four weeks, with a start date of 12/20/24. The MAR revealed the box for 01/03/25 was not initialed as complete and no weight was recorded on the MAR. The MAR revealed staff initialed the box for 01/10/25 as completed, and a weight of 144.7 was recorded. Interview on 01/22/25 at 1:47 P.M., with the Director of Nursing (DON) stated the process was for a weight to be obtained on admission and weekly for four weeks after that. DON stated that however, she was constantly on them (the certified nursing assistants) to do the weights, and they did not always do them. She stated the weights were to be recorded in the weight/vitals section of the computer, and the staff had missed weighing Resident #60 on admission and for almost a month after admission. The DON stated Resident #60 was readmitted and again did not receive an admission weight or consistent weekly weights for four weeks. She was not made aware of the potential 30.1-pound weight loss recorded for the resident. Interview on 01/22/25 at 1:59 P.M., with the Assistant Director of Nursing (ADON) stated she did not know why Resident #60 had not had an admission weight, weekly weights, or a readmission weight completed. She stated that she had not been made aware of a potential 30.1-pound weight loss. She stated there had been issues getting weights at times, and she had to stay after the CNAs to get them done. Interview on 01/22/25 at 12:20 P.M., via telephone, with the Registered Dietician (RD) pulled up Resident #60's weight and said, Oh wow, [he/she] has lost a lot of weight since I last saw [him/her] and no one has let me know about this. The RD stated the facility was not good about getting weights on residents on admission or the following four weeks, which made her job more difficult. Interview on 01/23/25 at 10:25 A.M., with Licensed Practical Nurse (LPN) #14 stated she had put in the weight of 144.7-pounds for Resident #60 that was given to her by the CNA. She stated the CNAs obtained the weights and wrote them down for the nurses to enter into the computer. She stated she was just data inputting numbers and did not recognize the potential 30-pound weight loss, so she did not notify anyone. Interview on 01/23/25 at 1:46 P.M., with LPN #10 stated she had initialed the box for the weight on 12/13/24 to acknowledge it needed to be done, Like an FYI [for your information], but the CNAs were the ones that got the weights and put them in the computer. 2. Review of the admission record revealed Resident #63 was admitted on [DATE]. Resident #63 had a medical history including diagnoses of acute respiratory failure with hypoxia, stage 3 pressure ulcer of the sacrum, convulsions, and a personal history of traumatic brain injury. Review of the admission MDS, with an ARD of 12/20/24, revealed Resident #63 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on staff for all activities of daily living (ADLs) and had an admission weight of 107 pounds. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #63's care plan included a focus area initiated on 12/18/24, that indicated the resident was at risk for a nutritional/fluid imbalance due to taking nothing by mouth, difficulty swallowing, having a feeding tube, multiple areas of altered skin integrity, a BMI (Basic Metabolic Index) that reflects an underweight status, altered labs, and poly pharmacy and the use of IV (intravenous) ATB (antibiotic therapy). Interventions directed staff to monitor, record, and report to the doctor as needed signs and symptoms of malnutrition, emaciation (cachexia), muscle wasting, significant weight loss: >(greater than) 5% in one month, >7.5% in three months, >10% in six months (initiated 12/19/24); monitor intake, weight, skin, labs, medication, diet tolerance and hydration status (initiated 12/19/24); inform POA (power of attorney) of significant weight changes (initiated 12/19/24); and to weigh at the same time of the day and record weekly weight for four weeks (initiated 12/19/24). Review of Resident #63's Order Recap [Recapitulation] Report for the timeframe from 12/01/24 through 01/21/25 revealed an order for weekly weights for four weeks, every Friday on dayshift, with a start date of 12/20/24 and end date of 01/17/25. Review of Resident #63's Weight Summary revealed a weight obtained by a Hoyer lift scale on 12/13/24 of 107 pounds. The Weight Summary revealed there were no other weights available for review. Review of Resident #63's Medication Administration Record [MAR], for December 24 revealed a transcription of an order for weekly weights for four weeks, every Friday on dayshift, with a start date of 12/20/24. The MAR revealed the box for 12/20/24 was left blank with no initial of completion and no weight recorded. The MAR revealed the staff had initialed the box for 12/27/24 as completed; however, there was no weight documented on the MAR. Review of Resident #63's Medication Administration Record for January 25 revealed a transcription of an order for weekly weights for four weeks, every Friday on dayshift, with a start date of 12/20/24. The MAR revealed staff initialed the boxes for 01/03/25 and 01/10/25 as completed; however, there were no weights documented on the MAR for either date. Interview on 01/23/25 at 10:45 A.M., with Licensed Practical Nurse (LPN) #9 stated that when she signed the MAR on 12/27/24, she was acknowledging there was supposed to be a weight done that day, and there was not a place to document the weight on the MAR. She stated the CNAs obtained the weights and put them into the facility's electronic health record themselves. Interview on 01/22/25 at 12:20 P.M., via telephone, with the Registered Dietician (RD) reviewed Resident #63's medical record and stated there had been no weight obtained since admission. She stated that she had reviewed her notes and had asked the facility to obtain weekly weights for four weeks more, and it had not occurred. The RD stated this was not a new occurrence, as she had to send emails to the Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Diet Technician frequently to obtain weights and reweighs. She stated the facility was not good at following a standard practice for weight loss and reweighs. She stated that a diet technician usually sent her an email with weight losses for her to review on her next visit; however, without them weighing Resident #63 at all, the resident would not have shown up on the report for her to address. The RD stated that the facility not obtaining weights was an ongoing issue, and it had made her job difficult to do when not given the necessary information to make decisions regarding the resident's nutritional health. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/22/25 at 1:59 P.M., with the ADON acknowledged Resident #63 had not been weighed since admission, and she was not aware why. She verified the resident's MAR was missing initials of completion for one date and had initials of completion for the other days; however, none of the designated days had weights recorded. Interview on 01/22/25 at 1:48 P.M., with the DON stated she was not familiar with Resident #63, as she had been away from work recently. She reviewed Resident #63's chart and stated no weekly weights had been obtained for the resident since admission, and the facility had been having problems getting the CNAs to put the weights into the computer. The DON stated there was not a weight variance meeting held weekly; however, a diet technician came in weekly to review weights and would address concerns. Interview on 01/23/25 at 3:02 P.M., with the DON stated her expectation was for all admissions to have admission weights completed and to follow the policy going forward for weekly weights for four weeks and then monthly after that. She stated that when the facility failed to weigh residents, there was the opportunity to miss a symptom like weight loss, which could be a sign of a larger underlying issue or a significant weight change. Review of the policy titled, Weight Assessment and Intervention, dated 9/30/24, revealed, Resident weights are monitored for undesirable or unintended weight loss or gain. The policy revealed, Weight Assessment 1. Residents are weighted upon admission and at intervals established by the Interdisciplinary team. 2. Weights are recorded in each unit's weight record chart and in the individual's medical record. 3. Any weight change of 5% [percent] or more since the last weight assessment is retaken the next day for confirmation. a. if the weight is verified, nursing will notify the dietician. The policy revealed, 5. The threshold for significant unplanned and undesired weight loss will be based on the following criteria [where percentage of body weight loss = (usual weight - actual weight)/ (usual weight) x 100]: a. 1 month - 5% weight loss is significant; greater than 5% is severe. b. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months - 10% weight loss is significant; greater than 10% is severe.

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	365978	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scarlet Oaks Nursing and Rehabilitation Center	440 Lafayette Avenue Cincinnati, OH 45220

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52203 Based on observation, staff interview, record review, and policy review, the facility failed to ensure staff obtained physician's orders for the use of supplemental oxygen. This affected one (#6) of two residents reviewed for oxygen therapy. The facility census was 65. Findings included: Review of the admission record revealed Resident #6 was admitted on [DATE]. Resident #6 had a medical history including diagnosis of Alzheimer's disease. Review of the quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/10/24, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. The MDS indicated the resident required partial to moderate assistance with all activities of daily living (ADLs). Review of Resident #6's care plan revealed no evidence of a focus, goal, or interventions related to the administration of oxygen therapy. Review of Resident #6's Order Summary Report, with active orders as of 01/20/25, revealed no evidence of a physician's order for supplemental oxygen administration. Observation on 01/20/25 at 12:39 P.M., revealed Resident #6 was receiving supplemental oxygen via nasal cannula, and the concentrator was set at 2 liters per minute (L/M). Observation on 01/21/25 at 12:37 P.M. revealed Resident #6 lying in bed and appearing to watch television. Resident #6's eyes were open, but the resident did not respond to verbal stimuli. Resident #6 was receiving supplemental oxygen, and the concentrator was set at 2 L/M. Interview on 01/21/25 at 12:58 P.M., with Licensed Practical Nurse (LPN) #2 confirmed Resident #6 was receiving oxygen therapy and had been on supplemental oxygen for a while. LPN #2 checked the resident's physician's orders and said she was unable to confirm when the oxygen therapy started. LPN #2 stated that when someone required supplemental oxygen, the process was to contact the physician and get an order. LPN #2 stated unless it was an emergency, supplemental oxygen should have a physician's order before it was administered to a resident. Interview on 01/23/25 at 2:24 P.M., with the Director of Nursing (DON) stated the process for supplemental oxygen administration was for the nurse to get an order from the physician before administering supplemental oxygen to a resident. The DON stated it was her expectation that residents receiving supplemental oxygen should have a physician's order documented in the record. Interview on 01/23/25 at 3:50 P.M., with the Administrator stated it was her expectation that residents receiving supplemental oxygen had an active physician's order. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled, Oxygen Administration, revised October 2010, revealed The purpose of this procedure is to provide guidelines for safe oxygen administration. The policy revealed, Preparation 1. Verify that there is a physician's order for this procedure. Review of the policy titled, Medication Orders, revised November 2014, revealed The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders. The policy revealed 3. Oxygen Orders - When recording orders for oxygen, specify the flow, route, and rationale.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 52275 Based on observation, staff interview, and policy review, the facility failed to ensure food was stored and served in accordance with professional standards for food safety. This deficient practice had the potential to affect all 65 residents who received food from the kitchen. The facility census was 65. Findings included: Observations, during initial tour of the kitchen, on 01/20/25 from 8:50 A.M. to 9:10 A.M., with the facility's Dietary Manager (DM) revealed the following: one 5-pound bag of frozen tater tots that was not in the original packaging and not labeled or dated with a use-by date in the walk-in freezer; one 16-ounce bag of broccoli that was not in the original package and was not labeled or dated with a use-by date in the walk-in freezer; one 5-pound container of peanut butter that was opened but not labeled with a date that was opened on the counter; and four 18-ounce containers of spices (one paprika, one garlic powder, one Italian seasoning, and one seasoned salt) that were opened but not labeled with a use-by date or the date they were opened that were noted on the shelf above the sink in the food preparation area. Observations in the kitchen on 01/21/25 at 10:45 A.M. with the DM revealed the following: four plastic bins of serving utensils that were uncovered with food crumbs and debris noted in the container with the utensils. Observations on 01/21/25 at 11:35 A.M., during observations of tray line/meal service, there were two male employees noted with facial hair that were not wearing beard restraints, and they were preparing plates of food for the residents. An interview with the DM, at the time of the observation, revealed he was unaware that staff needed to wear beard restraints because it had never been brought to his attention before. Interview on 01/22/25 at 10:04 A.M., with the DM stated he had been working at the facility for six years. He stated his role/responsibilities included managing the staff, ordering food, and ensuring staff knew what to do to avoid cross-contamination. He stated the facility policy was to label and date all food items with expiration dates but was unaware that items should be labeled with an opened date. Interview on 01/23/25 at 3:52 P.M., with the Administrator stated that she made weekly rounds in the kitchen. She stated the health department was at the facility about two months ago and they made them clean. She stated she expected the kitchen to be clean and policies to be followed to ensure food was served in a sanitary manner. Review of the policy titled, Food Receiving and Storage, revised October 2017, revealed Foods shall be received and stored in a manner that complies with safe food handling practices. The policy revealed 1. Food Services, or other designated staff, will maintain clean food storage areas at all times. The policy revealed, 8. All foods stored in the refrigerator or freezer will be covered, labeled and dated ('use by' date). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the policy titled, Food Preparation and Service, revised October 2017, revealed, Food and nutrition services employees shall prepare and serve food in a manner that complies with safe food handling practices. The policy revealed, 7. Food and nutrition services staff shall wear hair restraints (hair net, hat, beard restraint, etc. [et cetera; and so forth]) so that hair does not contact food.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28193 Based on observation, staff interview, and record review, the facility failed to maintain appropriate infection control practices while providing tracheostomy care. This affected one (#51) of one resident observed for tracheostomy care. The facility census was 65. Findings included: Review of the admission record revealed Resident #51 was admitted on [DATE]. Resident #51 had a medical history including diagnoses of chronic respiratory failure and tracheostomy status. Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/20/24, revealed Resident #51 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident was dependent on staff for all activities of daily living (ADLs) and received tracheostomy care while at the facility and within the last 14 days of the assessment period of the MDS. Review of Resident #51's care plan included a focus area initiated on 10/26/24, that indicated the resident had a tracheostomy related to impaired breathing mechanics. Interventions directed staff to ensure that tracheostomy ties were secured at all times (initiated 10/26/24), to monitor/document respiratory rate, depth, and quality (initiated 10/26/24), to suction as necessary (initiated 10/26/24), and to use universal precautions as appropriate (initiated 10/26/24). Review of Resident #51's Order Summary Report contained a physician order dated 11/29/24 for tracheostomy care every shift and as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of tracheostomy care on 01/21/25 at 12:20 P.M., revealed Respiratory Therapist (RT) #19 was observed entering Resident #51's room. RT #19 put on a gown, mask, and gloves and gathered supplies to include: four vials of normal saline, a tracheostomy kit, multiple individually packaged 4 x 4 gauze pads, and a prepackaged #6 Shiley inner cannula and placed these items on the resident's bedside table. RT #19 did not clean the bedside table or place a barrier down on the bedside table prior to placing the items on the table. RT #19 then opened the sterile tracheostomy kit and placed the provided sterile barrier from inside the kit onto the bedside table as his sterile field. RT #19 then picked up the normal saline, 4 x 4 gauze pads, and prepackaged inner cannula from the contaminated bedside table and placed them onto the sterile barrier, contaminating his sterile field. RT #19 then removed the remaining contents of the tracheostomy kit and placed them onto the contaminated sterile field and filled one of the sections of the kit with normal saline from the vials. RT #19 then realized he had not secured a trash container, so he grabbed a nearby box of normal saline vials, opened Resident #51's two-drawer bedside stand, and poured the remaining vials into the drawer, and used the empty box (a non-absorbent and non-leak proof container) as his trashcan for the remainder of the care. RT #19 then donned sterile gloves, and with his left hand he removed Resident #51's tracheostomy cap, placed the cap on the sterile field, and removed the soiled split gauze dressing from around Resident #51's tracheostomy, throwing it away in the empty box. This made RT #19's left hand no longer sterile. RT #19 removed the disposable inner cannula from Resident #51's tracheostomy with his right hand and placed it in the empty box, making his right hand no longer sterile. While the inner cannula remained out, RT #19 used multiple 4 x 4 gauze pads and normal saline to clean around Resident #51's stoma, then dried around the stoma with a 4 x 4 gauze pad. Without performing hand hygiene or changing gloves, RT #19 opened the new, sterile inner cannula, and with dirty gloves, placed it in Resident #51's tracheostomy. RT #19 then placed a clean split gauze around the tracheostomy and replaced the cap from on the bedside table back over the tracheostomy. RT #19 then gathered up the remaining supplies and the trash box, threw them away, took off his personal protective equipment, and washed his hands to exit the room. Interview on 01/22/25 at 2:35 P.M., with RT #19 about the issue with infection control during tracheostomy care, RT #19 stated I do this every day, all day long, sometimes it all runs together. Interview on 01/23/25 at 3:10 P.M., with the Director of Nursing (DON) stated her expectation was that she wanted the respiratory therapists to perform tracheostomy care correctly. DON stated she wanted infection control to be done correctly, wanted clean and dirty to be kept separate, wanted gloves changed and hands washed between clean and dirty tasks and for staff to follow facility policy for tracheostomy care to prevent infection.