STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366028	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodside Village Care Center	841 W Marion Rd Mount Gilead, OH 43338

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review and staff interview, the facility failed to provide and document all the required information at the time a beneficiary notice was given. This affected three residents (#11, #21, and #320) of three reviewed for beneficiary notices. The facility census was 62. Findings include: 1. Review of the medical record for Resident #11 revealed an admitted [DATE]. Diagnoses included myocardial infarction, chronic obstructive pulmonary disease (COPD), hyperlipidemia, type II diabetes, chronic kidney disease, hypertension, chronic respiratory disease, atrial fibrillation, osteoarthritis, gout, major depressive disorder, atherosclerotic heart disease, anxiety disorder, lymphedema, congestive heart failure, and anemia. Review of Resident #11's Minimum Data Set (MDS) assessment, dated 11/26/24, revealed the resident was cognitively intact. Review of Resident #11's intent to discharge from rehabilitation, dated 08/29/24, revealed Resident #11 was receiving physical and occupational therapy and had reached the highest potential and was beginning to plateau. The intent to discharge form did not indicate the last day of covered services and provided no place for Resident #11 or Resident #11's representative to sign indicating the information was provided. Review of Resident #11's updated notice titled Medicare Coverage Ending, revealed Resident #11's skilled service would end on 09/02/24. The notice contained no information on what skilled services would be ending, and no information about the residents appeal rights to contest the ending of the service. Also, there was no date listed on the form as to when the facility spoke with Resident #11 or obtained the residents signature on the form. Review of Resident #11's Advanced Beneficiary Notice of Non-Coverage (ABN) form, dated 08/30/24, revealed no information about what services were ending, and no information on appeal rights or how to formally filed an appeal. (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #21 revealed an admitted [DATE]. Diagnoses included pneumonia, dementia, gastric contents in larynx causing asphyxiation, atrial flutter, dysphagia, obstructive and reflux uropathy, muscle weakness, benign prostatic hyperplasia, osteoarthritis, insomnia, vitamin D deficiency, and sepsis. Review of Resident #21's MDS assessment, dated 11/14/24, revealed the resident had significant cognitive impairment. Review of Resident #21's intent to discharge from rehabilitation, dated 09/16/24, revealed Resident #21 was receiving speech therapy and had exhausted all of the skilled nursing days. There was no information on the intent to discharge stating the last day of covered services, and there was no place for Resident #21 or the resident's representative to sign acknowledging the notification was provided. Review of Resident #21 notice of Medicare coverage ending, dated 09/16/24, revealed skilled services would end on 09/20/24. There was no information on the notice about the residents appeal rights to contest the ending of skilled services, nor was there information about what skilled services would be ending. The notice contained no information as to when the facility contacted Resident #21's representative to report on the ending of services. Review of Resident #21's Advanced Beneficiary Notice of Non-Coverage (ABN) form, dated 09/17/24, revealed no information about what services were ending, the reason for the services ending. The ABN also contained no information on appeal rights or information on how to formally filed an appeal. 3. Review of the medical record for Resident #320 revealed an admitted [DATE]. Diagnoses included atherosclerotic heart disease, pneumonia, hyperlipidemia, benign prostatic hyperplasia, and acute respiratory failure. Review of Resident #21's Minimum Data Set (MDS) assessment, dated 11/23/24, revealed the resident was cognitively intact. Review of Resident #320's intent to discharge from rehabilitation, dated 12/12/24, revealed Resident #320 was receiving physical and occupational therapy and had exhausted all of the skilled nursing days for Medicare Part A on 11/23/24 and transitioned to Medicare Part B. The intent to discharge contained no place for Resident #320 or the resident representative to sign verifying discharge information had been provided. Review of Resident #320's updated notice of Medicare coverage ending revealed skilled services would end on 11/23/24 and Resident #320 would be transitioned to private pay on 11/24/24. The notice contained no information about appeal rights and contained no date as to when the facility notified Resident #320 of skilled services ending and the resident being transitioned to private pay. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Social Services #03 on 01/29/25 at 11:10 A.M. revealed the intent to discharge, the ABN and the Medicare notice were the only forms the facility used when discussing a service change with the resident or resident representative. Social Services #03 confirmed the only date on the forms were when the forms were filled out, and further verified there is no evidence on the form indicating when the resident or resident representative was notified of the service changes, when the documents were signed or when appeal information was provided. When asked where the appeal information was located, Social Service #03 stated the appeal information including appeal rights and the process of filing an appeal was a separate form given to the resident or the resident representative when there is a notification of service change or a discharge notification provided. Social Services #03 verified the facility had no proof of appeal information provided to Residents #11, #21 or #320 Interviews with the Administrator on 01/29/25 at 11:40 A.M. and 12:13 P.M. confirmed the ABN form and the Medicare notice of coverage ending did not contain the required appeal information on them. The Administrator also confirmed the forms contained no evidence of the date when the resident and or resident representative were notified of the service changes.

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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 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 51068 Based on record review, staff interview, and policy review, the facility failed to follow its abuse prevention policy by not completing reference checks for five out of five newly hired personnel reviewed. This failure had the potential to affect all 62 residents in the facility. The facility census was 62. Findings include: Review of the personnel file for Registered Nurse (RN) #80 revealed a hire date of 06/21/24. The reference check form for RN #80 contained her name, position, and signature dated 06/20/24; however, it lacked any documentation of previous work history or confirmation that a reference check had been completed. Review of the personnel file for RN #85 revealed a hire date of 02/06/24. The reference check form for RN #85 contained only a signature dated 02/06/24, with no evidence of previous work history or documentation confirming a reference check was completed. Review of the personnel file for Certified Nursing Assistant (CNA) #62 revealed a hire date of 05/15/24. There was no documentation indicating a reference check had been completed or initiated. Review of the personnel file for CNA #46 revealed a hire date of 10/10/24. There was no documentation indicating a reference check had been completed or initiated. Review of the personnel file for the Administrator revealed a hire date of 05/06/24. There was no documentation indicating a reference check had been completed or initiated. During an interview conducted on 01/30/25 at 12:57 P.M., with Administrative Management (AM) #24, AM #22, and the Administrator confirmed reference checks had not been completed for the five newly hired staff members (RN #80 and #85, CNA #62 and #46 and the Administrator) and further confirmed, per facility policy, reference checks should have been conducted for all new hires. Review of the facility's abuse prevention policy stated, All applicants for employment will be checked with previous and/or current employers, and reasonable efforts will be made to uncover information about any past criminal prosecutions. Applicants will be asked to supply references from their previous work history.

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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** 45751 Based on record review, interview, observation, and policy review the facility failed to ensure comprehensive care plans were updated. This affected two residents (#11 and #29) of two reviewed for falls. The facility census was 62. Findings include: 1. Review of medical record for Resident #11 revealed an admitted [DATE] with diagnoses including but not limited to type two diabetes, hypertension, atrial fibrillation, major depressive disorder, and anxiety disorder. Review of minimum data set (MDS) dated [DATE] revealed Resident #11 was cognitively intact. Resident #11 was independent for transfers. Review of care plan dated 04/08/22 revealed the following interventions regarding falls: physical educated to hang coat on the hook at the end of the bed (03/28/23), obtain orthostatic blood pressures every shift ordered 01/10/23, and orthostatic blood pressure monitoring for three days (09/09/22). Review of vitals in Matrix revealed no orthostatic blood pressure monitoring. Observation on 01/30/25 at 8:43 A.M. of Resident #11 room revealed no hook at the end of the bed for hanging the residents coat. Interview on 01/30/25 at 9:00 A.M. with the Director of Nursing (DON) revealed that she and the unit managers update the care plans. DON verified the fall care plan was not updated to discontinue fall interventions that were not in place any longer. DON verified the resident was moved to a different room and the hook was no longer at the foot of the bed in the new room. 2. Review of medical record for Resident #29 revealed an admitted [DATE] with diagnoses including but not limited to dementia, muscle weakness, depression, other specified disorders of bone density and structure left ankle and foot, calcaneal spur left foot, difficulty in walking, unsteadiness on feet, lack of coordination, pain in left shoulder, other displaced fracture of upper end of left humerus, and history of falling. Review of MDS dated [DATE] revealed Resident #29 was cognitively intact. Resident #29 required setup or clean-up assistance for activities of daily living. Review of care plan for fall interventions revealed the following interventions: visual aide reminder to remind resident to utilize walker (07/01/24), visual reminder to bedside table for resident to apply non-skid footwear (08/01/23), rollator walker basket de-cluttered so resident can carry necessary items to the bathroom (09/16/22). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/30/25 at 8:45 A.M. of Resident #29's room revealed no visual reminders present on bedside table or in room. Resident #29's rollator walker observed with three blankets and a pillow on the seat of the walker. Interview on 01/30/25 at 9:00 A.M. with the Director of Nursing (DON) revealed that she and the unit managers update the care plans. DON verified the fall care plan was not updated to discontinue fall interventions that were not in place any longer. DON verified the resident no longer required the visual reminders in the room. Review of policy titled Resident Assessment Comprehensive Care Plans updated 05/24/22 revealed the comprehensive care plan shall reflect changes in the residents preferences and goals as they change throughout their stay.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on record review, observation, staff interview, and facility policy review, the facility failed to have physician orders for a treatment that was being performed and did not clarify treatment orders for existing pressure injuries. This affected one resident (#7) of three residents reviewed for pressure ulcers. The facility census was 62. Findings include: Review of the medical record revealed Resident #7 was admitted to the facility on [DATE]. Diagnoses included sepsis, type II diabetes, chronic obstructive pulmonary disease (COPD), obstructive and reflux uropathy, dysphagia, unspecified protein calorie malnutrition, major depressive disorder, urinary tract infection, tachycardia, contracture of right hand and elbow, elbow, acute cystitis without hematuria, neuromuscular dysfunction of bladder, hypothyroidism, systemic inflammatory response syndrome, hypertension, edema, other malaise, retention of urine, mood disorder, primary optic atrophy, acute embolism and thrombosis, insomnia, osteoporosis, and multiple sclerosis. Review of Resident #7's Minimum Data Set (MDS) assessment, dated 11/07/24, revealed the resident had a mild cognitive impairment. Review of Resident #7 current physician orders found an order for the facility to clean his left posterior thigh with Dakins solution (a diluted bleach solution used to prevent and treat skin and tissue infections), half strength, pat dry, apply calcium alginate to the moisture associated skin damage (MASD) and cover with abdominal dressing daily. Resident #7 physician orders revealed no order for barrier cream to be applied. Observations on 01/29/25 at 9:55 A.M. found Licensed Practical Nurse (LPN) #17 performed wound care treatment on Resident #7. The treatment and dressing change was completed appropriately with three wounds cleansed with Dakins solution, half strength, with 4 by 4 gauze pads, LPN #17 then placed calcium alginate into the wounds on Resident #7's left buttock and right posterior thigh and covered the wounds with an abdominal pads. Prior to LPN #17 performing the dressing changes and wound care, Resident #7 had barrier cream located all over the buttocks and thigh areas which had to be removed by cleansing the skin prior to the wound care. Interview with LPN #17 at the time of the observation verified Resident #7 had barrier cream all over the buttocks and thigh areas that was required to be removed in order to complete the wound treatments. Interviews with Director of Nursing (DON) on 01/30/25 at 10:45 A.M. and 11:55 A.M. confirmed Resident #7 did not have current order for barrier cream and further verified an order should be in place if the barrier cream is being applied. The DON also confirmed the wound nurse received the order for Dakin's solution to be used on Resident #7's MASD. The DON stated the physician recommends that MASD is cleansed with soap and water, or Dakin's solution, confirming Dakin's solution is not typically used on MASD since it might break down the skin. The DON added she contacted the physician to clarify the order. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titiled Pressure Injury Prevention and Care, dated January 2025, revealed pressure injuries will be assessed and documented upon admission, readmission, upon discovery, and weekly thereafter. Potential/suggested procedure with pressure injury identification includes initiate treatment in accordance with facility protocols, standing orders, or physician order.

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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** 45751 Based on record review, staff interview, and observation the facility failed to ensure the resident had an understanding of pleasure foods. This affected one (Resident #03) of one reviewed for diet. The facility census was 62. Findings include: Review of medical record for Resident #03 revealed an admitted [DATE] with diagnoses including but not limited to Parkinson's disease, abnormal posture, cognitive communication deficit, altered mental status, pneumonia, adult failure to thrive, history of personality disorder, anxiety, major depressive disorder, schizophrenia, and bipolar disorder. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #03 had moderate cognitive impairment. Resident #03 required setup or clean-up assistance for eating. Review of current physician orders revealed Resident #03 was on puree diet, with a sugar substitute, no added salt, nectar thick liquids, and required the use of a cup with a lid, required a two handled cup for hot liquids and food in bowls. Resident #03 may have mechanical soft pleasure foods when requested. Review of hospice note dated 08/22/24 revealed routine visit was completed. Resident #03 was observed holding her right jaw. Staff informed hospice nurse that the resident had a bad tooth. Hospice changed Resident #03's diet to a pureed diet with no ice in drinks. Review of progress note dated 08/26/24 revealed Resident #03's diet changed to pureed due to the resident having issues with chewing and holding food in her mouth. Review of progress notes prior to 08/26/24 revealed no documentation regarding resident having issues with chewing or holding food in mouth. Review of the documentation in Resident #03's medical record revealed no other notes regarding tooth pain prior to or after the 08/22/24 note from the hospice visit. Review of 360 dental note dated 09/06/24 revealed Resident #03 did not complain of any tooth or mouth pain. Further review of Resident #03's diet orders between 06/29/23 and 12/09/24 revealed Resident #03 was ordered a mechanical soft diet with thin liquids from 06/29/23 to 01/19/24, a regular diet with thin liquids from 01/19/24 to 07/29/24, a regular diet with nectar thickened liquids from 07/29/24 to 08/26/24, a pureed diet with nectar thick liquids from 08/26/24 until 12/09/24. The current diet order for Resident #03 written on 12/09/24 is for a pureed diet with nectar thick liquids and includes direction Resident #03 may have mechanical soft pleasure foods per request. (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 01/27/25 at 2:43 P.M. with Resident #03 revealed she was on a pureed diet, and does not like the diet at all. Resident #03 stated she has her own teeth and has no trouble chewing food. Resident #03 stated she was told she choked once, but she does not remember doing that. Additional interview on 01/28/25 at 8:24 A.M. with Resident #03 revealed the resident denied any trouble swallowing food. Resident #03 stated she was unaware that she could request pleasure foods if she did not like the food that was served. Observation on 01/29/25 at 8:29 A.M. of Resident #03 in the dining room for breakfast revealed the resident had a bowl of cream of wheat, a bowl of pureed eggs, and a bowl of pureed sausage and biscuits. Resident #03 also had three two handle cups with orange juice, water, and thickened hot chocolate. Resident #03 was observed feeding herself with weighted silverware. Further observation on 01/29/25 at 8:47 A.M. of Resident #03 in the dining room for breakfast revealed the resident told staff she did not like the pureed sausage and biscuits. Resident #03 was told by staff well. Resident #03 then told the staff she had teeth and could eat the biscuits and gravy, and the staff stated they knew that she had teeth but regular biscuits and gravy was not the diet ordered for her. Resident #03 then asked for some more cream of wheat. A follow-up interview on 01/29/25 at 8:50 A.M. with Unit Manager #12 revealed she would have to check on why Resident #03 was on a pureed diet. Interview on 01/29/25 at 10:15 A.M. with the Director of Nursing (DON) revealed Resident #03's diet was downgraded to a pureed when the resident had pneumonia with a decline which caused the resident to pocket food and have trouble swallowing. The DON verified there was only the one note on 08/26/24 regarding the resident pocketing food. The DON stated that they had held a care conference in December and Resident #03's family wanted to be able to bring food in for the resident. The DON stated hospice was contacted at that time to see if they could upgrade her diet and got mechanically soft pleasure foods added to Resident #03's diet order. Follow up interview on 01/29/25 at 12:38 P.M. with the DON verified the diet was not changed on 08/22/24 to a pureed diet per hospice recommendation for dental pain. The DON verified the diet was not changed until 08/26/24 when the resident was pocketing food and having difficulty swallowing. The DON stated they talked to the kitchen regarding the resident being able to have mechanical soft pleasure foods per the physician order and to let the resident know what mechanical soft pleasure foods were and that she could request them when she did not like what was on the menu.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review, staff interview, and facility policy review, the facility failed to provide proper parameters for as needed pain medication orders and did not document pain levels for all uses of as needed pain medication. This affected one (Resident #39) of one residents reviewed for pain management. The facility census was 62. Findings include: Review of the medical record for Resident #39 revealed the resident was admitted to the facility on [DATE]. Diagnoses included pneumonia, hypotension, hypoxemia, chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure, tremor, cerebral infarction, transient cerebral ischemic attack, dysphagia, hypertension, pure hypercholesterolemia, glaucoma, diplopia, low back pain, and gastrostomy status. Review of Resident #39's Minimum Data Set (MDS) assessment, dated 12/30/24, revealed the resident had a mild cognitive impairment. Review of Resident #39's current physician orders revealed an order for acetaminophen 325 milligrams (mg), two tablets every four hours as needed for pain, and an order for tramadol 50 mg twice daily as needed for pain and discomfort. The orders contained no other parameters to determine which pain medication should be administered when. Review of Resident #39 medication administration records (MAR), dated December 2024 to January 2025, revealed tramadol was administered on an as needed basis when requested for pain. The MAR contained no documentation of Resident #39's pain level when the tramadol was administered. Review of Resident #39 pain care plan, dated 10/14/22, revealed the following interventions related to the care area of pain: administer pain medications as ordered, pain assessment quarterly and as needed, and assess characteristics of pain: location, severity on a scale of zero (no pain) to ten (worst pain), type, frequency, precipitating factors, and relief factors. Interview with Registered Nurse (RN) #12 on 01/29/25 at 2:42 P.M. revealed typically, there will be parameters in the order as to which as needed pain medication to administer. RN #12 stated if there are not any parameters, she will ask the resident what their pain level is or determine the pain level based on non-verbal gestures. After getting that information, RN #12 would provide the as needed pain medication based on that pain level, stating for pain one to five, she would typically give the lower strength pain medication and for pain six to ten, she would give the higher strength pain medication. RN #12 confirmed that a residents pain level should be documented in the medical record prior to administering any pain medication as needed. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Licensed Practical Nurse (LPN) #17 on 01/29/25 at 2:48 P.M. stated they will provide as needed pain medication based on pain level. LPN #17 stated there should be parameters for the as needed pain medication, but sometimes, some nurses do not get them and/or document the parameters in the order. LPN #17 also stated that when a resident's pain level was one to five, they will administer the lower strength medication, like acetaminophen, and if the pain level was six to ten, they would administered the higher strength medication such as Norco or tramadol. LPN #17 also confirmed documentation should be recorded in the medical record for a resident's pain level prior to administering as needed pain medications. Review of facility policy titled Pain Management, dated January 2025, revealed nurses will complete resident pain assessments upon admission, quarterly, and as needed. A pain scale or non-communication assessment tool may be used as needed to determine pain intensity. Pain will be assessed after interventions to evaluate the effectiveness of the intervention and to recognize undesirable side effects and documented in the medical record.

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Woodside Village Care Center	841 W Marion Rd Mount Gilead, OH 43338

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on record review and staff interview the facility failed to ensure a diet order was processed in a timely manner. This affected one (#03) of one resident reviewed for diet. The facility census was 62. Findings include: Review of medical record for Resident #03 revealed an admitted [DATE] with diagnoses including but not limited to Parkinson's disease, abnormal posture, cognitive communication deficit, altered mental status, pneumonia, adult failure to thrive, history of personality disorder, anxiety, major depressive disorder, schizophrenia, and bipolar disorder. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident #03 had moderate cognitive impairment. Resident #03 required setup or clean-up assistance for eating. Review of current physician orders revealed Resident #03 was on pureed diet, with a sugar substitute, no added salt, nectar thick liquids, and required the use of a cup with a lid, required a two handled cup for hot liquids and food in bowls. Resident #03 may have mechanical soft pleasure foods when requested. Review of hospice note dated 08/22/24 revealed routine visit was completed. Resident #03 was observed holding her right jaw. Staff informed hospice nurse that the resident had a bad tooth. Hospice changed Resident #03's diet to pureed with no ice in drinks. Review of progress note dated 08/26/24 revealed the residents diet changed to pureed due to resident having issues with chewing and holding food in her mouth. Review of progress notes prior to 08/26/24 revealed no documentation regarding resident having issues with chewing or holding food in mouth. Review of the documentation in Resident #03's medical record revealed no other notes regarding tooth pain prior to or after the 08/22/24 note from the hospice visit. Review of 360 dental note dated 09/06/24 revealed Resident #03 did not complain of any tooth or mouth pain. Further review of Resident #03's diet orders between 06/29/23 and 12/09/24 revealed Resident #03 was ordered a mechanical soft diet with thin liquids from 06/29/23 to 01/19/24, a regular diet with thin liquids from 01/19/24 to 07/29/24, a regular diet with nectar thickened liquids from 07/29/24 to 08/26/24, a pureed diet with nectar thick liquids from 08/26/24 until 12/09/24. The current diet order for Resident #03 written on 12/09/24 is for a pureed diet with nectar thick liquids and includes direction Resident #03 may have mechanical soft pleasure foods per request. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/27/25 at 2:43 P.M. with Resident #03 revealed she was on a pureed diet, and she does not like the diet at all. Resident #03 stated she has her own teeth and has no trouble chewing food. Resident #03 stated she was told she choked once, and she does not remember doing that. Follow up interview on 01/29/25 at 12:38 P.M. with the DON verified the diet was not changed on 08/22/24 to pureed per hospice recommendation for dental pain. The DON verified the diet was not changed until 08/26/24 when the resident was pocketing food and having difficulty swallowing.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48568 Based on observation, staff interview, and policy review, the facility failed to ensure the kitchen was kept in a clean and sanitary condition. This deficient practice had the potential to affect all residents in the facility except for Resident #52 who received nothing by mouth. The facility census was 62. Findings include: 1. Observation on 01/27/25 at 08:39 A.M. of the kitchen revealed there is a large hole-like area on the wall behind the steamer. Interview on 01/27/25 at 08:41 A.M. with Dietary Supervisor #41 confirmed the large hole-like area on the wall behind the steamer. Observation on 01/28/25 at 11:16 A.M. revealed there is a large hole like area on the wall behind the steamer. Interview on 01/28/25 at 11:16 A.M. with Dietary [NAME] #59 confirmed the large like hole area on the wall behind the steamer. Interview on 01/28/25 at 11:17 A.M. with Local Health Department Inspector #90 revealed she had cited the hole in the wall on the last three health inspection reports. Review of the County Health Department Food Inspection Report, dated 01/28/25 revealed there is damage to the wall near the ovens side of the kitchen. Review of the October 2024 Food Preparation and Sanitation Audit revealed the wall behind the steamer has chipped tiles or holes. Review of the November 2024 Food Preparation and Sanitation Audit revealed the wall behind the steamer is damaged. Review of the December 2024 Food Preparation and Sanitation Audit revealed that the wall behind the steamer is damaged. Review of the Kitchen Safety policy dated 01/25 stated Accidents are caused by unsafe conditions and unsafe actions which result from carelessness, lack of attention or concentration, moving too fast or improper training. 2. Observation on 01/27/25 at 08:39 A.M. revealed there is a hole in the floor underneath the oven. Interview on 01/27/25 at 08:41 A.M. with Dietary Supervisor #41 confirmed the hole in the floor underneath the oven. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 01/28/25 at 11:16 A.M. revealed there is a hole in the floor underneath the oven. Interview on 01/28/25 at 11:16 A.M. with Dietary [NAME] #59 confirmed the hole in the floor underneath the oven. Review of the County Health Department Food Inspection Report, dated 01/28/25 revealed there is damage to the floor near the ovens side of the kitchen. Review of the facility's October 2024 Food Preparation and Sanitation Audit revealed there are damaged areas on the floor. Review of the facility's November 2024 Food Preparation and Sanitation Audit revealed there are damaged areas on the floor. Review of the facility's December 2024 Food Preparation and Sanitation Audit revealed there are damaged areas on the floor. Review of the Kitchen Safety policy dated 01/25 stated Keep floors cleaned and waxed with non-slip wax, and free of hazardous objects. The policy also stated, Have all floors in good repair and free from grease and rubble.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on record review, resident interview, family interview, and policy review the facility failed to ensure residents and/or representatives were informed in a manner that was understandable regarding arbitration agreements. This affected four residents (#30, #45, #317, and #318) of four residents reviewed for arbitration agreements. The facility identified 48 residents with signed arbitration agreements. The facility census was 62. Findings include: 1. Review of medical record for Resident #30 revealed an admitted [DATE] with diagnoses including but not limited to dementia, atrial fibrillation, type two diabetes, atherosclerotic heart disease, repeated falls, diverticulitis, gout, restless leg syndrome, and fibromyalgia. Review of Resident #30's Minimum Data Set (MDS) dated [DATE] revealed a brief interview of mental status (BIMS) score of 10 which indicated moderate cognitive impairment. Interview on 01/30/25 at 12:42 P.M. with Resident #30 revealed the resident stated her husband signed her admission paperwork with her present. Resident #30 stated she could not remember if the facility explained the arbitration agreement. Resident #30 stated her husband probably signed it. Resident #30 stated her husband can not remember things either as he is [AGE] years old. 2. Review of medical record for Resident #45 revealed an admitted [DATE] with diagnoses including but on limited to dementia, hypertension, and depression. Review of Resident #45's MDS assessment dated [DATE] revealed a BIMS score of 12 which indicated moderate cognitive impairment. Interview on 01/30/25 at 11:03 A.M. with Resident #45 revealed she did not remember signing an arbitration agreement when admitted . Resident #45 stated she could not begin to explain what an arbitration agreement was. Resident #45 stated she was not sure if she would sign one or not and it would depend on the situation. Interview on 01/30/25 at 11:22 A.M. with Family member for Resident #45 stated she probably signed an arbitration agreement for the resident on admission. Family member stated it was 14 months ago and she could not remember if the facility explained it or not. Family member stated she was handed a tablet and was just going through and signing things on it. Family member stated that is was a stressful time. 3. Review of medical record for Resident #317 revealed an admitted [DATE] with diagnoses including but not limited to type two diabetes with foot ulcer, atrial fibrillation, cellulitis of right lower limb, and depression. Review of Resident #317's MDS assessment dated [DATE] revealed a BIMS score of 15 which indicated the resident was cognitively intact. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/30/25 at 12:04 P.M. with Resident #317 revealed the resident did not know what an arbitration agreement was. Resident #317 stated she did not sign one on admission. When arbitration was explained the resident stated she does not think she would sign one. 4. Review of medical record for Resident #318 revealed an admitted [DATE] with diagnoses including but not limited to acute on chronic respiratory failure, type two diabetes, congestive heart failure, Parkinson's disease and chronic obstructive pulmonary disease. Review of Resident #318's MDS assessment dated [DATE] revealed a BIMS score of 13 which indicated cognitively intact. Interview on 01/30/25 at 11:09 A.M. with Resident #318 revealed the resident stated he did not know what an arbitration agreement was. Resident #318 stated he was not aware of signing one when he came into the facility. Resident #318 stated he probably did sign one. Interview on 01/30/25 at 10:57 A.M. with Social Worker (SW) #03 revealed each resident and/or the resident representative upon admission are told an arbitration agreement states if anything were to happen to the resident, the resident or the resident representative have the right to come after the facility or the company. SW #03 stated all forms are electronic and the resident and/or resident representative are given a tablet and must sign each sections of the admission packet. Review of policy titled Binding Arbitration Agreement Policy dated 03/2023 revealed when explaining the arbitration agreement, the facility shall explain to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 49793 Based on record review, observation, and staff interviews, and review of facility policy, the facility failed to ensure proper infection control practices were maintained for residents, team members, and visitors in the facility's water pathogen risk reductions. This had the potential to affect all residents residing at the facility. The facility census was 62. Findings include: Record review on 01/29/25 and 01/30/25 between 7:30 A.M. and 4:15 P.M. revealed the facility was unable to provide the water management team members and logs of the facility's continual assessment, mitigation, and monitoring of the facility's water system. Observation and tour of the facility on 01/29/25 and 01/30/25 between 7:30 A.M. and 4:15 P.M. revealed the facility's representative had not tested or provided the ability to test or assess the water system for controls such as chlorine. Review of the facility policy titled Water Pathogen Risk Reduction, originally dated 01/2016 and updated on 01/01/25, stated the facility will assign a water management team which included facility leadership (Administrator), Infection Control Coordinator/Preventionist, site water service provider representative, and Quality Assurance Performance Improvement Committee Staff (QAPI) who will review any initial completed risk assessment and follow up on water monitoring findings to identify risk factors for Legionella. The procedure outlined in the Water Pathogen Risk Reduction policy stated the facility, or its representative will complete an environmental screening and/or assessment of all water systems and provide results to the water team. The screening/assessment process is intended to identify the inherent hazards, physical design and existing monitoring and control measures for the water system. The facility or its representative must also provide a continual monitoring prevention plan which includes logs, tracking and/or monitoring sheets and control strategies and control limits (for example: monitoring of disinfectants/biocides, supplemental chlorine, or chlorine dioxide) to the water team. Additionally, the facility or its representative, and the water team shall perform walkthroughs or tours of the facility to confirm water temperatures, chlorine residuals or any other information regarding the water system. Interview with Maintenance Director (MD) #72 on 01/29/25 at 11:16 A.M. revealed a new Legionella Assessment policy and procedure dated 01/01/25 was just received from regional office and MD #72 has begun to fill out the assessment in accordance to the guidelines. MD #72 stated there was not a water management team in place according to the old facility policy and procedure titled Water Pathogen Risk Reduction, dated 01/2016 and updated on 01/01/25 and water monitoring was not occurring. MD #72 verified there are no logs, documentation, or water testing results for controls (chlorine) completed in the facility. MD #72 stated, the city supplies the facility with chlorinated water. MD #72 could not produce the city logs for water testing or documentation of city water controls. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the Administrator on 01/29/25 at 1:25 P.M. revealed there was no evidence of a water management team in place, and there was no monitoring or logs of water controls (chlorine) performed by the facility, or documented testing results of control testing from the city. The Administrator stated the facility will have a water management team put in place and water monitoring will be performed as required to include water temperature monitoring and seven other components outlined in the new Legionella Assessment policy.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review, staff interview, and facility policy review, the facility failed to provide adequate justification for the use of antibiotic medication. This affected two (Residents #7 and #21) of five residents reviewed for medication regimens. The facility census was 62. Findings include: 1. Review of the medical record for Resident #7 revealed an admitted [DATE]. Diagnoses included sepsis, type II diabetes, chronic obstructive pulmonary disease (COPD), obstructive and reflux uropathy, dysphagia, unspecified protein calorie malnutrition, major depressive disorder, urinary tract infection, tachycardia, contracture of right hand and elbow, elbow, acute cystitis without hematuria, neuromuscular dysfunction of bladder, hypothyroidism, systemic inflammatory response syndrome, hypertension, edema, other malaise, retention of urine, mood disorder, primary optic atrophy, acute embolism and thrombosis, insomnia, osteoporosis, and multiple sclerosis. Review of Resident #7's Minimum Data Set (MDS) assessment, dated 11/07/24, revealed the resident had a mild cognitive impairment. Review of Resident #7's current physician orders revealed the resident was ordered Amoxicillin (antibiotic) 500 milligrams (mg) on 10/31/24. The justification for this medication was listed as prophylactic for a urinary tract infection (UTI). Review of Resident #7 progress notes, dated 10/30/24, revealed the facility physician was in the facility for routine rounds. During those rounds, the physician assessed Resident #7 and determined he wanted to write an order for Amoxicillin 500 mg daily for the preventative use of UTIs, which was to start after his initial order for Amoxicillin for a confirmed diagnosis of UTI, had been completed. Resident #7's s last dose for the initial order for Amoxicillin was on 10/30/24. Review of Resident #7's McGeer Assessment (a tool used for infection surveillance), dated 10/30/24, revealed the Amoxicillin ordered did not met the criteria to be administered. Interview with Director of Nursing (DON) on 01/30/25 at 10:45 A.M. confirmed the physician wrote an order for Amoxicillin 500 mg daily for a prophylactic use. She also confirmed the McGeer's Assessment that was completed on 10/30/24, confirmed the antibiotic ordered for Resident #7 did not meet criteria. The DON confirmed they have no other justification for the use of the Amoxicillin and confirmed that Resident #7 did not have an infection in the months of November 2024, December 2024 or January 2025, and the Amoxicillin was administered as ordered. The DON also confirmed there was no order for evaluation of the prophylactic use of the Amoxicillin, to determine if it could be discontinued. 2. Review of the medical record for Resident #21 revealed an admitted [DATE]. Diagnoses included pneumonia, dementia, gastric contents in larynx causing asphyxiation, atrial flutter, dysphagia, obstructive and reflux uropathy, muscle weakness, benign prostatic hyperplasia, osteoarthritis, insomnia, vitamin D deficiency, and sepsis. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #21's MDS assessment, dated 11/14/24, revealed the resident had significant cognitive impairment. Review of Resident #21 current physician orders found the resident was ordered Amoxicillin 500 mg on 09/02/24. The justification for this medication was listed as prophylaxis. Review of Resident #21 progress notes, dated 08/23/24, revealed the facility physician determined Amoxicillin 500 mg daily was to be used prophylactically for a upper respiratory infection (URI) and was to start after the residents initial order for Amoxicillin for a confirmed URI had been completed. Resident #21's last dose from the initial order for Amoxicillin was on 08/22/24. Review of Resident #21 McGeers Assessment revealed the facility did not complete an assessment for either order of Amoxicillin. Interview with Director of Nursing (DON) on 01/30/25 at 10:45 A.M. confirmed the physician wrote an order for Amoxicillin 500 mg daily for a prophylactic use and confirmed the McGeer's Assessment was never completed for either order of Amoxicillin and should have been. The DON confirmed there is no other justification for the use of the Amoxicillin and confirmed Resident #21 did not have an infection in the months between September 2024 and January 2025 but was administered the Amoxicillin as ordered for prophylaxis. The DON confirmed there was no order for evaluation of the prophylactic use of the Amoxicillin, to determine if it could be discontinued. Review of facility Antibiotic Stewardship Program, dated January 2025, revealed it is the policy of the facility to implement an antibiotic stewardship program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The facility uses the Centers for Disease and Control Prevention (CDC) National Healthcare Safety Network (NHSN) surveillance definitions, and updated McGeer criteria to define infections. The facility will monitor the response to antibiotics, and use laboratory results when available, to determine if the antibiotic is still indicated or if adjustments should be made with at least one outcome measure associated with the antibiotic tracked monthly, as prioritized from the facility's infection control risk assessment and other infection surveillance data.