STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366051	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks at Northpointe	3291 Northpointe Drive Zanesville, OH 43701

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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** 43064 Based on interview, review of medical records, and facility policy review, the facility failed to report potential abuse between Resident #35 and #37 to the state agency. This affected two residents (#35 and #37) of three residents reviewed for abuse. The facility census was 69. Findings include: Review of the medical record for Resident #37 revealed an admitted [DATE] with diagnoses including dementia, depression, diverticulosis, age-related osteoporosis without pathological fracture, repeated falls, and mixed-receptive-expressive language. Review of Resident #37's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #37 had intact cognition. Review of Resident #37's progress note dated 04/30/24 revealed another resident (Resident #35) attempted to bite a staff member and Resident #37 slapped the other resident on her right arm and screamed at her not to bite people. Both residents were separated. Review of the medical record for Resident #35 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, dementia without behavioral disturbance, attention and concentration deficit, Crohn's disease, anxiety disorder, depression, unspecified convulsions, and overactive bladder. Review of Resident #35's comprehensive MDS 3.0 assessment dated [DATE] revealed the resident had a severe cognitive impairment. Review of Resident #35's progress note dated 04/30/24 revealed Resident #35 attempted to bite a staff member and another resident (Resident #37) slapped her on the right arm. The resident was assessed and denied pain. Both residents were separated. Review of the facility's self-reported incidents revealed no incidents were reported on 04/30/24 or related to Resident #35. (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 06/24/24 at 1:04 P.M. and 2:10 P.M. the Executive Director verified no incidents related to Resident #35 and #37 were reported to the state agency. She additionally verified there was no additional investigation or documentation related to the 04/30/24 incident between Resident #35 and Resident #37. Review of the facility policy 'Abuse and Neglect Procedural Guidelines' revealed abuse was the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. Willful is used to mean the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Any person with knowledge or suspicion of suspected violations should report them immediately. The Executive Director must be notified immediately, and the executive director was responsible for notification to the state department of health and other agencies, which include the ombudsman, adult protective services and/or local law enforcement agencies, as indicated.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43064 Based on interview and medical record review the facility failed to ensure residents #16, #18, #40, and #59, had comprehensive care plans that addressed activity of daily living (ADL), wandering behaviors, and contracture. This affected four residents (#16, #18, #40, and #59) of 22 residents whose care plans were reviewed. The facility census was 69. Findings include: 1. Review of the medical record for Resident #18 revealed an admitted [DATE] with diagnoses including multiple sclerosis, aphasia, dementia, heart failure, anxiety disorder, peripheral vascular disease, mixed receptive-expressive language disorder, depression, GERD, and dysphagia. Review of Resident #18 quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed severely impaired cognition. Review of Resident #18's plan of care profile care guide dated 06/12/24 revealed she required the extensive assistance of one person for incontinence care, showers, and transfers. Review of Resident #18's plan of care revealed it was absent for the residents needed level of assistance with bed mobility, ambulation, eating, oral hygiene, personal hygiene, and dressing. Review of Resident #18 plan of care dated 06/18/24 revealed she required staff assistance to complete ADL tasks completely and safely. She fed self with set up and improvements were expected with therapy. She was known to layer clothing at times. Interventions included allowing resident sufficient time to complete tasks, encouraging the resident to do as much as safely possible for self, observing for deterioration in ADL abilities, providing adequate rest periods between activities, and therapy evaluation as needed. Interview on 06/20/24 at 5:05 P.M. with Campus Support Resident Assessment (CSRA) #206 and MDS coordinator #182 verified Resident #18's plan of care did not specify her ADL needs before 06/18/24. 2. Review of the medical record for Resident #59 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, dementia with psychotic disturbance and mood disturbance, mood disorder due to known physiological condition, paranoid personality disorder, delusional disorders, major depressive disorder, anxiety disorder, and hypertension. Review of Resident #59's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed severely impaired cognition. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #59's plan of care dated 04/18/24 revealed she required staff assistance to complete ADL tasks completely and safely. She required up to extensive assistance of one for ADLs. She fed self with set up. She was noted to be on the locked unit for safe wandering. Interventions included offering facial shaving on shower days and as needed, notifying nursing of refusals, providing nail care on shower days and as needed, therapy evaluation and treatment as needed, allowing the resident sufficient time to complete tasks, encouraging the resident ot do as much as safely possible for self, and observing for deterioration in ADL abilities. Review of Resident #59's plan of care profile care guide revealed she required up to extensive assistance for continence care, up to limited assistance for transfers, and limited to extensive assistance for showers. Review of Resident #59's plan of care revealed it was absent for any interventions related to wandering. Additionally, Resident #59's assistance needs for mobility, oral hygiene, personal hygiene, and dressing were not addressed. Observation on 06/17/24 at 10:20 A.M. and 1:35 P.M. revealed Resident #59 wandering the unit and approaching the exit doors. At one point she was noted entering and exiting another resident's room. Interview on 06/20/24 at 5:05 P.M. with Campus Support Resident Assessment (CSRA) #206 and MDS coordinator #182 verified Resident #59's plan of care did not specify her ADL needs. They reported there was no care planning for Resident #59's wandering because she was determined to be safely wandering. 47987 3. Review of the medical record for Resident #16 revealed an admitted [DATE]. Diagnoses included but were not limited to metabolic encephalopathy, major depressive disorder, and anxiety disorder with a diagnosis of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety as of 12/25/23. Review of the most recent MDS 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 13 out of 15 indicating intact cognition. The resident was assessed to take an antipsychotic, antianxiety and antidepressant seven out of seven days with an active diagnosis of dementia and depression. Review of the active care plans for Resident #16 revealed none for the diagnosis of major depressive disorder which would include specific target behaviors to monitor for the resident with interventions that are of a measurable outcome. Further review of the active care plans for this resident revealed none for the diagnosis of unspecified dementia that would include specific target behaviors monitor for the resident with interventions that are of a measurable outcome. Interview on 06/20/24 at 4:01 P.M. with the Director of Nursing revealed Resident #16 did not have care plans for the diagnoses of major depressive disorder and unspecified dementia but was going to review with the MDS Coordinator Registered Nurse #82 who completes the care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/20/24 at 4:58 P.M. with the MDS Coordinator Registered Nurse #82 verified no care plans were in place for Resident #16 for the diagnoses of unspecified dementia and major mood disorder and stated, There were two for anxiety and I bet one of them was supposed to be for his depression, I will fix these now. 34298 4. Review of the medical record revealed Resident #40 was admitted on [DATE] with diagnoses that included but not limited to acute respiratory failure, right hemiparesis due to cerebral artery occlusion with cerebral infarction, and arthritis. The quarterly MDS dated [DATE] revealed Resident #40 had a Brief Interview Mental Status (BIMS) score of four out of 15 which indicated severe cognitive impairment. The MDS also revealed Resident #40 had impairment to one side of upper and lower extremity. Review of care plans dated 04/16/24 revealed Resident #40 was at risk for falls, episodes of incontinence, and risk for skin breakdown related to right side hemiplegia and right hand contracture. None of the care plans had interventions for right hand contracture. Observation and interviews on 06/17/24 at 2:24 P.M. revealed Resident #40's right hand appeared to be contracted. Resident #40's spouse stated Resident #40 had a brace for the right hand at home. Resident #40 verified he did not wear a brace or splint to the right hand at the facility. Interview on 06/18/24 at 1:54 P.M. Occupational Therapy Registered/Licensed (OT R/L) #205 revealed Resident #40 refused wearing a brace prior to coming to the facility. Resident #40 also got agitated with passive stretching of the right hand. OT R/L #205 stated therapy had Resident #40 grab things with the right hand to provide stretching. Interview on 06/20/24 at 5:09 P.M. MDS Coordinator #182 verified there was not a specific care plan with interventions in place for the contracture to Resident #40's right hand. MDS Coordinator #182 stated Resident #40 was transferred twice a day with a sit-to-stand lift and used the right hand to assist with the transfer. On 06/20/24 at 7:26 P.M. the facility provided a profile care plan for Resident #40 dated 12/30/23. The approach revealed Resident #40 was transferred with a sit-to-stand lift which encouraged gentle stretching of Resident #40's right hand. The frequency was not identified and there were no profile orders for Resident #40.

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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** 34298 Based on record review and interviews the facility failed to have an initial care conference in a timely manner for Resident #53. This affected one (Resident #53) out of one reviewed for care planning. Facility census was 69. Findings include: Review of the medical record revealed Resident #53 was admitted on [DATE] with diagnoses that included but not limited to joint replacement surgery, osteoarthritis, pain, and anxiety. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #53 was cognitively intact. A progress note dated 05/17/24 at 11:46 A.M. revealed a family first meeting was scheduled for 05/22/24. Interview on 06/17/24 at 9:51 A.M. Resident #53 revealed a care conference was not held until Resident #53's family requested a care conference. Interview on 06/20/24 at 4:42 P.M. Director of Social Services (DSS) #161 stated initial care conferences were to be held within five days of admission. DSS #161 verified an initial care conference for Resident #53 was not held until 26 days after admission.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on record review and interview the facility failed to provide a discharge summary when Resident #66 was discharged . This affected one (Resident #66) out of two residents reviewed for discharge. Facility census was 69. Findings include: Review of the medical record revealed Resident #66 was admitted on [DATE] with diagnoses that included but not limited to hemiplegia and hemiparesis, kidney disease, and dependence on renal dialysis. An order dated 05/17/24 revealed Resident #66 was to be discharged to the attached assisted living facility. An order dated 05/20/24 revealed Resident #66 needed a hospital bed with side rails. A notice of transfer/discharge date d 05/28/24 revealed the long-term care ombudsman was notified Resident #66 was transferred/discharged on [DATE] to an assisted living facility. On 06/18/24 at 2:20 P.M. Executive Director provided a handwritten discharge planning form dated 05/24/24. The discharge planning form revealed Resident #66 was discharged from the health care facility to an assisted living facility. Anticipated needs included a wheelchair which Resident #66 already had. The discharge planning form did not reveal the need for a hospital bed with side rails as ordered on 05/20/24. The discharge planning form also revealed Resident #66 had dialysis on Monday, Wednesday, and Friday with the facility to provide transportation. No caregiver information was listed on the form. Executive Director verified a discharge summary was not provided when Resident #66 was discharged to assisted living facility on 05/24/24.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on record review and interviews, the facility failed to provide Resident #53 with bathing as scheduled and per Resident #53's preference. This affected one (Resident #53) out of three reviewed for assistance with activities of daily living. Facility census was 69. Findings include: Review of the medical record revealed Resident #53 was admitted on [DATE] with diagnoses that included but not limited to joint replacement surgery, osteoarthritis, pain, and anxiety. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #53 was cognitively intact. The MDS also revealed Resident #53 required substantial to maximal assistance for bathing. Review of the bathing schedule revealed Resident #53 was scheduled to be bathed in the evenings of Wednesday and Saturdays. Review of the electronic record and paper documentation from 05/02/24 to 06/17/24 revealed Resident #53 received three showers, two bed baths, four partial bed baths, and refused bathing once. Interview on 06/17/24 at 9:53 A.M. Resident #53 revealed they were unsure when they were scheduled to be bathed. Resident #53 stated they were not getting bathed twice a week. Interview on 06/20/24 at 4:21 P.M. Director of Nursing (DON) verified the documentation did not show Resident #53 was bathed as scheduled. DON also verified Resident #53's preference was a shower twice a week.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on resident and staff interviews, medical record review, review of hospital records, and review of invoices for wound care equipment, the facility failed to ensure one resident's (Resident #63) wound vac and supplies were received prior to admission. This affected one resident (Resident #63) of one reviewed for medical equipment. The facility census was 69. Findings Include: Review of the medical record for Resident #63 revealed an admitted on 05/28/24 at 5:12 P.M. Medical diagnoses included sepsis, disruption of external operation (surgical) wound, generalized peritonitis (inflammation of the membrane lining of the abdominal wall and covering the abdominal organs), encounter for surgical aftercare following surgery on the digestive system- resection and infectious disease, volvulus (an obstruction due to twisting or knotting of the gastrointestinal tract), partial intestinal obstruction, ileus (inability of the intestine to contract normally and move waste out of the body), congenital malformations of intestinal fixation, generalized abdominal pain, nausea, abdominal distension, and diarrhea. Review of the Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #63 had intact cognition and scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #63 required dependence on staff to complete toileting and transfers and substantial assistance from staff to complete bed mobility. Resident #63 had surgical wounds present upon admission. Skin interventions surgical wound care. Review of the wound vac order request dated 05/25/24 at 12:29 A.M. confirmed Resident #63's wound vac and supplies request had been received by the medical supply company. Review of the email communications between the facility and the medical supply company revealed on 05/25/24 at 2:37 P.M., the facility was notified Resident #63's wound vac and supplies would be delivered on 05/28/24 at 5:00 P.M. (+/- two hours). On 05/28/24 at 1:48 P.M., the facility was notified Resident #63's wound vac and supplies would not be delivered until 05/29/24 at 11:00 A.M. (+/- two hours). Review of the hospital records revealed on 05/28/24 at 1:19 P.M., a Registered Nurse (RN) from the hospital noted the facility notified the nurse the wound vac would be delivered later in the afternoon (on 05/28/24) and Resident #63 was able to discharge to the facility at this time. The wound vac would be removed and a wet to dry dressing would be placed for discharge. On 05/28/24 at 3:39 P.M., a Licensed Practical Nurse (LPN) from the hospital noted Resident #63's wet to dry dressing was in place of wound vac. The resident's sister was notified of the resident's discharge to the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/28/24 at 10:13 P.M., another hospital RN noted Resident #63's sister notified the hospital the resident's wound vac had not been delivered to the facility. The RN contacted the facility and confirmed with LPN #181 the wound vac and supplies had not been delivered to the facility and the medical supply company stated it would be delivered on 05/29/24 in the morning. Resident #63 would continue with wet to dry dressings until the wound vac was received at the facility. Review of the physician discharge summary from the hospital dated 05/28/24 revealed Resident #63 would be discharged to the facility and the physician would place the wound vac on the resident himself. Review of the admission progress note dated 05/28/24 at 5:35 P.M. by the former Assistant Director of Health Services (ADHS) #146 revealed a new admission skin assessment was completed. Resident #63's wet to dry dressing was removed and the area measured approximately 15.5 centimeters (cm) long by five cm wide by 2.5 cm deep. The dressing was replaced after the assessment as the resident was to receive a wound vac for treatment. Review of the Visit Summary from the medical supply company dated 05/29/24 confirmed Resident #63's wound vac and supplies were delivered to the facility on [DATE] at 9:38 A.M. (approximately 16 hours after admission) Review of the Wound Management observation note dated 05/29/24 at 4:35 P.M. by former ADHS #146 revealed Resident #63's surgical incision was observed and the resident's surgeon placed a wound vac to the wound. (nearly 24 hours after admission) Review of the Treatment Administration Record (TAR) dated May 2024 revealed Resident #63 had an order for wet to dry dressing to abdominal wound every shift until wound vac was available. The order was dated 05/28/24. The treatment was marked completed twice on 05/29/24 and twice on 05/30/24. Resident #63 had an order for a negative pressure wound vac at 125 mm Hg continuous therapy twice daily dated 05/29/24 and and order for a negative pressure dressing change three times a week on Monday, Wednesday, and Friday and as needed dated 05/29/24. The wound vac treatment was marked as completed once during night shift on 05/29/24, and twice daily on 05/30/24, and 05/31/24. The dressing change was marked as completed on 05/29/24 and 05/31/24. Interview on 06/18/24 at 8:37 A.M. with Resident #63 revealed she was admitted to the facility following surgery on her colon. The resident had a wound vac in place for abdominal incision during hospitalization . Resident #63 stated the facility did not have the wound vac or supplies for two or three days when she arrived and she was not allowed to be off of the wound vac. Interview on 06/20/24 at 1:01 P.M. with Resident #63's sister via telephone revealed the facility told the hospital they had the resident's needed wound vac and supplies on 05/28/24. At that time, the hospital agreed to discharge Resident #63 from the hospital to the facility with the understanding the wound vac and supplies would be at the facility. Resident #63 arrived at the facility on 05/28/24 and the wound vac and supplies had not been delivered. The resident's surgeon did not want the resident to have a wet to dry dressing placed right after surgery but due to the facility not having the supplies needed, Resident #63 had a wet to dry dressing placed until the wound vac and supplies were delivered and the surgeon was able to place the wound vac on the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/20/24 at 3:15 P.M. with the Executive Director confirmed the facility did not receive Resident #63's needed wound vac and supplies until 05/29/24. Resident #63 was treated with wet to dry dressings instead until the proper supplies were received. The ED refused to confirm the facility's failure to follow up with the hospital again on 05/28/24 when the facility was notified the delivery of the supplies would be delayed.

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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** 41266 Based on medical record review, observation, staff interview, and facility policy review, the facility failed to timely identify, accurately assess, and timely treat one resident's (Resident #9) pressure ulcer areas of her right heel and ankle. This affected one resident (Resident #9) of two residents reviewed for pressure ulcers. The facility census was 69. Findings Include: Review of the closed medical record for Resident #9 revealed an admitted on 02/02/23 and a discharge date of [DATE]. Medical diagnoses included Alzheimer's Disease, Type II Diabetes Mellitus with unspecified complications, mixed receptive-expressive language disorder, difficulty in walking, unsteadiness on feet, generalized weakness, cognitive communication deficit, and need for assistance with personal care. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #9 had impaired cognition and scored three out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #9 required substantial assistance from staff to complete most Activities of Daily Living (ADLs), including bed mobility, transfers, dressing, and toileting. Resident #9 did not have any skin impairments at the time of the assessment. Review of the progress note dated 03/30/24 at 2:24 P.M. revealed Licensed Practical Nurse (LPN) #181 noted Resident #9 had a soft, spongy area to her right heel. The area was red/blue in color and was not open. The Certified Resident Care Associates (CRCAs) were educated to float the resident's heels while in bed. The resident's son was notified. There was no indication the physician or Director of Health Services (DHS) were notified of the area. Review of the Treatment Administration Record (TAR) dated March 2024 and April 2024 revealed Resident #9 had an order to paint right heel with betadine twice daily dated 03/30/24 and discontinued 04/01/24. An additional order to paint right heel with betadine twice daily and cover with allevyn foam dressing. May reuse dressing up to three days if unsoiled dated 04/01/24 and discontinued 04/22/24. An additional order to cleanse with normal saline, apply medihoney and cover with foam dressing. Change dressing daily dated 04/22/24 and discontinued 04/25/24. Review of progress note dated 03/31/24 at 10:31 A.M. revealed LPN #181 noted Betadine was applied to Resident #9's right heel as ordered. The resident's heels were floated when the resident would allow. Review of the initial skin assessment dated [DATE] (two days after the area was identified) by former Assistant Director of Health Services (ADHS) #146 of Resident #9's right heel revealed the area was an unstageable deep tissue injury (DTI) on her right heel that measured 4.5 centimeters (cm) long by 4.5 cm wide. The area was closed and purple in color. The periwound was pink and blanchable for a total of 7 cm long by 7 cm wide of discolored skin. A treatment was not indicated in the skin assessment. (continued on next page)

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	366051	A. Building B. Wing	06/25/2024

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Oaks at Northpointe	3291 Northpointe Drive Zanesville, OH 43701

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Weekly skin assessments of Resident #9's right heel DTI were completed on 04/04/24, 04/11/24, and 04/18/24 without any significant changes noted. There were not any progress notes documented on Resident #9 from 04/10/24 to 04/22/24 (12 days). Review of the progress note dated 04/25/24 at 1:11 A.M. by former ADHS #146 revealed a weekly skin assessment was completed. Resident #9 had a DTI pressure ulcer to her right heel that recently opened. Dressing was removed and a small amount of serosanguinous (thin, watery fluid that is pink in color) drainage was noted. The area was cleansed with wound cleanser. The wound bed measured approximately 3 cm long by 3 cm wide with 20% granulating (new connective tissue) tissue and 80% slough (dead tissue usually cream or yellow in color). There was no odor noted. Wound treatment included cleanse area with wound cleanser or normal saline, pat dry. Apply Solosite gel (used to create a moist wound environment and autolytic debridement of sloughy tissue) to wound bed and cover with an allevyn foam dressing. Change daily and as needed (PRN). The Nurse Practitioner (NP) was aware of the plan of care (POC). Review of the wound observation dated 04/25/24 and completed by former ADHS #146 revealed Resident #9's wound was noted as an Unstageable (US) pressure ulcer with slough and/or eschar. Review of the physician orders dated April 2024 revealed Resident #9 had an order for a right heel boot to be applied while in bed as resident allows twice daily dated 04/28/24. Review of the Treatment Administration Record (TAR) dated May 2024 revealed Resident #9's wound treatment for her right heel changed effective 05/08/24 to cleanse area with wound cleanser or normal saline, pat dry. Apply skin prep to peri wound and Calcium Alginate to wound bed. Cover with an allevyn foam dressing. Change the dressing every other day and as needed. This wound treatment was discontinued effective 05/10/24. Review of the wound observation dated 05/09/24 (one day after the wound treatment was changed) completed by former ADHS #146 revealed Resident #9's US pressure ulcer to her right heel measured 4 cm long by 3 cm wide with light seropurulent (a type of wound drainage that can indicate the beginning of an infection) drainage which was yellow or tan, cloudy and thick. The wound was covered with 70% necrotic (dead tissue) tissue and 30% granulating tissue. The wound edges were macerated (a condition that occurs when a wound experiences excessive moisture, leading to the softening and breaking down of the surrounding skin) and soft. Treatment order was changed. NP aware of the POC. Review of the TAR dated May 2024 revealed Resident #9's wound treatment for her right heel changed effective 05/10/24 to cleanse area with wound cleanser or normal saline and pat dry. Apply skin prep to peri wound and Durafiber to the wound bed. Cover with an allevyn foam dressing. Change the dressing every other day and as needed. The treatment order was discontinued 05/15/24. Review of the Physician Note dated 05/15/24 at 10:42 P.M. (six days after initial possible signs of a wound infection were noted) by Certified Nurse Practitioner (CNP) #300 revealed Resident #9's US pressure ulcer of her right heel was chronic and unstable. Ordered arterial duplex of bilateral lower extremities to be done at an outside facility. Ordered a two view X-ray of the resident's right heel, a wound clinic consult and a wound culture of the resident's right heel. (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 the TAR dated May 2024 revealed Resident #9's wound treatment for her right heel changed effective 05/15/24 to cleanse area with wound cleanser or normal saline and pat dry. Apply skin prep to peri wound and Durafiber to the wound bed. Cover heel with an allevyn heel foam dressing and abdominal pads (ABD's) to the top and bottom of the foot and wrap with Kerlix. Change the dressing daily and as needed. Do not put tape on skin. The treatment was discontinued 05/29/24. An order to set up an appointment for Resident #9 to have an arterial duplex of bilateral lower extremities one time only was dated 05/16/24. The order was marked as completed by LPN #171. An order for a wound culture of the left heel (not the right heel) was ordered one time only on 05/15/24 and marked completed by LPN #171. An order for a two view X-ray of Resident #9's right heel was ordered one time only on 05/15/24 but not administered. The X-ray was reordered one time only on 05/16/24 and marked as completed by LPN #167. Review of the right foot X-ray results dated 05/16/24 at 10:55 A.M. Central Time (11:55 A.M. Eastern Time) revealed the reason for the X-ray was pain and wound on the right heel. The impression was osteomyelitis could not be ruled out. The X-ray was reviewed by CNP #300 on 05/16/24 at 1:25 P.M. Review of the progress note dated 05/16/24 at 3:33 P.M. by LPN #167 revealed a wound clinic consult order was faxed to the wound center requesting an appointment for an evaluation and treatment. The wound culture was pending. Review of the progress note dated 05/16/24 at 4:30 P.M. by former ADHS #146 revealed a weekly skin assessment was completed on Resident #9's US pressure ulcer to her right heel. The dressing was removed and a small amount of purulent (a thick, milky or opaque fluid that oozes from a wound that is not properly healing and is a symptom of infection) drainage noted. Cleansed area with wound cleanser. The wound was noted to have an area to the right outer ankle connecting to the right heel wound making a total measurement of 4 cm long by 9 cm wide. Both areas were noted with 100% eschar (dead tissue) to the wound bed. The peri wound was noted with dry, calloused skin. A pungent (strong, sharp) odor was noted to the wound. NP was notified and received new orders for a wound culture, a right heel xray, and a consult for the wound clinic. The new wound treatment was also noted. Review of the wound observation dated 05/16/24 and completed by former ADHS #146 revealed Resident #9's US pressure ulcer of her right heel was noted to have an area on the right outer ankle connecting to current wound on right heel making the total measurement 4 cm long by 9 cm wide. The area was noted to be 100% eschar tissue. There were irregular wound edges, a light amount to seropurulent drainage, and a pungent odor noted. The wound was noted to be declining. Review of the progress note dated 05/17/24 at 11:51 A.M. by the Director of Health Services (DHS) revealed Resident #9 was referred to the wound clinic with a scheduled appointment on 05/22/24. Review of the Aerobic Bacterial Culture results of Resident #9's right foot ulcer collected on 05/15/24 at 11:50 P.M. and reported on 05/21/24 at 1:07 P.M. revealed there was moderate growth of Proteus mirabillis and Kebsiella oxytoca bacteriums. Both bacteriums were susceptible to Augmentin (an antibiotic). There was no evidence CNP #300 was notified of the abnormal wound culture results. (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 the progress note dated 05/21/24 at 3:03 P.M. revealed LPN #178 called to schedule an arterial duplex of Resident #9's bilateral extremities (five days after the test was ordered). The provider requested a signed order to be faxed before the test could be scheduled. An order was placed in CNP #300's box for signature. There was no evidence Resident #9 attended the scheduled wound consult at the wound clinic on 05/22/24. Review of the progress note dated 05/23/24 at 8:56 A.M. (two days after the wound culture results were reported) revealed LPN #167 noted an order for Augmentin 875 milligrams (mg) twice daily for ten days due to right heel wound. Review of the progress note dated 05/23/24 at 4:15 P.M. by former ADHS #146 revealed a weekly skin assessment was completed on Resident #9's US pressure ulcer to her right heel. The dressing was removed and a moderate amount of purulent drainage was noted. The area was cleansed with wound cleanser. A total wound circumference measured 5 cm long by 9 cm wide. Both areas were noted with 100% eschar tissue to the wound bed. The peri wound had dry, calloused skin. There was a pungent odor noted to the wound that became mildly pungent after the wound was cleansed. The wound treatment was not changed and was noted to be completed as ordered. Resident #9 had an appointment with the wound clinic, a scheduled arterial duplex, and was started on an antibiotic for a positive wound culture. Review of the progress note dated 05/25/24 at 9:04 A.M. revealed LPN #181 was informed Resident #9 continued with facial grimacing and had began groaning. LPN #181 notified the on-call provider and received a new order for Norco (a pain medication) 5-325 mg every six hours as needed for pain for seven days. Resident #9's son was notified of the new order and requested an update on the resident's right heel wound. LPN #181 informed the resident's son she had an appointment at the wound clinic scheduled for 05/29/24 (13 days after the order for a wound consult was made). Review of the wound consult notes dated 05/29/24 at 9:58 A.M. revealed Resident #9 received assessments on two wound areas, the right achilles (heel) and right lateral ankle. The right achilles wound measured 5.4 cm long by 4 cm wide by 0.3 cm deep. The right lateral ankle wound measured 2 cm long by 2.5 cm wide by 0.1 cm deep. The diagnosis was a diabetic ulcer of right heel associated with diabetes mellitus due to underlying condition, with fat layer exposed. There was no additional diagnosis indicated for the right lateral ankle wound. Wounds were debrided at the appointment. Review of the wound observation dated 05/30/24 (after wounds were debrided at wound clinic) and completed by former ADHS #146 revealed Resident #9's right heel wound was classified as an US pressure ulcer (not a diabetic ulcer as the wound center noted). The wound measured 5 cm long by 9 cm wide (does not match measurements from wound center). There was no depth indicated to the wound. A moderate amount of seropurulent drainage and a mildly pungent odor was noted. The wound was noted to be covered by 60% slough tissue and 40% eschar tissue with irregular wound edges. There was not a separate wound assessment or wound treatment initiated for Resident #9's right lateral ankle wound as indicated by the wound center consult visit. (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 the TAR dated May 2024 revealed Resident #9 had a wound treatment order to cleanse left (not right) heel wound with normal saline or wound cleanser daily. Apply santyl nickel thick to wound bed followed by aquacel, gauze, ABD, roll gauze, tape, and tubifast. Do not tape skin. Change the dressing daily and as needed with a start date on 05/30/24. The treatments were marked as completed on 05/30/24 and 05/31/24. Review of progress note dated 06/03/24 at 3:14 P.M. (approximately two weeks after the wound was noted to be declining) revealed former ADHS #146 consulted with the dietitian due to current skin impairments. New dietary recommendations to add Prostat twice daily and changed diet to fortified foods. A low air loss (LAL) mattress was ordered and pending delivery. Resident #9 had a scheduled appointment for the arterial duplex on bilateral lower extremities on 06/04/24 (nearly three weeks after the order was made). Review of the Lower Extremity Arterial Report dated 06/04/24 revealed there was no right lower extremity artery stenosis. There was normal flow velocities noted throughout the right lower extremity arteries. Calcification was present in the arteries of the right lower extremity. The right ankle brachial index was normal. There was no significant peripheral vascular disease (PVD) noted in the right posterior tibial artery and mild PVD in the right dosalis pedis artery. Ordering diagnoses included osteomyelitis and PVD. Review of the wound center notes dated 06/12/24 revealed Resident #9's right achilles wound was described with eschar, fragile, painful, pink, and full thickness. The peri wound was dry. The area measured 6.8 cm long by 4 cm wide by 0.4 cm deep. There was a large amount of serosanguineous drainage noted. The resident's right lateral ankle wound was described as dry with eschar. The area measured 2.2 cm long by 2.4 cm wide by 0.2 cm deep. Both dressings were changed. Both areas were surgically debrided. Review of the wound observation dated 06/13/14 (after debridement at wound clinic) and completed by Regional Nurse (RGN) #301 staged the area as an US pressure ulcer to the right heel (not a diabetic ulcer). The wound measured 4.5 cm long by 9 cm wide with no depth noted. (measurements do not match wound center assessment). There was a moderate amount of seropurulent drainage and the wound was covered by 20% granulation tissue and 80% slough (wounds were debrided on 6/12/24). The wound was noted to be improving. There was no mention of the debridement. There was not a separate wound assessment of Resident #9's right lateral ankle wound area or a treatment order initiated. Review of the TAR dated June 2024 revealed Resident #9's wound treatment order was indicated for the left heel (not the right heel). The treatments were marked as completed daily until the order was d/c'd on 06/20/24 and re-ordered for the right heel effective 06/20/24. Observations of Resident #9 on 06/17/24 at 2:02 P.M., 06/18/24 at 9:05 A.M., and 06/20/24 at 9:04 A.M. revealed pressure ulcer interventions were in place. Review of the progress note dated 06/20/24 at 9:52 A.M. revealed Resident #9 was admitted to hospice services effective 06/19/24 and passed away in the facility on 06/22/24 at 4:15 A.M. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews on 06/20/24 at 11:07 A.M. and 3:22 P.M. with the Director of Health Services (DHS) confirmed Resident #9 was not seen by CNP #300 for six days after signs of a possible wound infection were noted on the wound assessment. The DHS confirmed the wound center diagnosed Resident #9's right heel wound as a diabetic ulcer on 05/29/24, however, the facility's wound assessment had not changed the classification of the resident's wound and continued to stage the area as an US pressure ulcer. The DHS confirmed the facility's wound assessments should be very similar to the wound center's assessments. The DHS confirmed the facility did not identify Resident #9's area to her right lateral ankle as a separate area and had not completed weekly wound assessments or initiated a separate treatment for the area. The DHS confirmed Resident #9 was scheduled for a wound consult on 5/22/24 but the appointment was changed by a facility nurse and rescheduled for 5/29/24 for unknown reasons. The DHS confirmed the resident was not seen by the wound clinic for two weeks after CNP #300 ordered the consult when the resident's wound was declining. The DHS confirmed the arterial duplex study was not completed for three weeks after CNP #300 ordered the study. The DHS confirmed an antibiotic was not initiated to treat a positive wound culture for two days after the results had been reported to the facility. Review of the facility policy, Pressure/Stasis/Arterial/Diabetic Wound Guidelines, dated 12/31/23, revealed the policy stated, the purpose of the policy was to provide weekly documentation of wound measurements and condition. Complete an appropriate wound event for each impaired area. Re-assessment/measurement weekly or with significant change in wound noting the current treatment, medical interventions provided, and comments as needed.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on medical record review, observation, interview, and facility policy review, the facility failed to provide appropriate assistance and follow care planned interventions for Resident #48 to prevent a fall with an injury. The facility failed to complete a fall investigation and neurological checks as ordered for Resident #29 and failed to ensure appropriate interventions were in place to prevent Resident #37 from leaving the secured unit. Actual harm occurred on 04/03/24 when Resident #48, who was severely cognitively impaired sustained a fall and fractured left hip when ambulating wearing inappropriate footwear and without her walker. At the time of the incident, staff told the resident to go put shoes on but failed to provide any additional intervention or assistance to prevent the fall with injury. This affected three residents (#29, #37, and #48) of seven residents reviewed for accidents. The facility census was 69. Findings include: 1.Review of the medical record for Resident #48 revealed an admitted [DATE] with diagnoses including dementia, depression, hypertension, disorientation, dysphagia, osteoporosis, and fracture of unspecified part of neck of left femur acquired 04/04/24. Review of Resident #48 ' s quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she had severely impaired cognition. The assessment revealed Resident #48 required supervision or touching assistance with putting on her shoes and supervision or touching assistance with sit to stand transfers. Resident #48 used a walker for ambulation. Review of Resident #48 ' s first meeting (care conference) minutes dated 01/23/24 revealed she was at high risk for falls. This was due to her age being greater than [AGE] years (of age), incontinence with urgency and frequency, receiving two or more high fall risk drugs, requiring assistance or supervision for mobility, transfer, or ambulation, and a lack of understanding of physical and cognitive limitations. Review of Resident #48 ' s physical therapy progress report dated 03/01/24 revealed the resident required supervision or touching assistance for picking up an object and needed a walker for ambulation and transfers. Review of Resident #48 ' s progress note dated 04/03/24 revealed around 4:35 A.M. that morning Former Assistant Director of Health Services (ADHS) #210 was passing medications when Certified Resident Care Associate (CRCA) #211 informed her that there was a fall on the secured unit. The nurse found Resident #48 lying on her back on the floor between her table and the foot of her bed. Upon assessment, the resident ' s left leg was noticeably shorter in length and externally rotated outward. Resident #48 was holding her left hip and leg and stated that was the only area that hurt. Vital signs were assessed with no concerns and the resident denied hitting (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	her head. Emergency services were contacted and arrived around 4:45 A.M., they evaluated the resident, requested a splint for her leg, and initiated intravenous pain medication. The resident was transferred to the hospital at approximately 5:45 A.M. Statement from CRCA #141 revealed she was in the hallway talking to another resident when Resident #48 came to her doorway wearing only socks. CRCA #141 reminded the resident to go back to her room and put her shoes on. Within minutes, CRCA #141 heard a scream and went to Resident #48 ' s room to find her on the floor. Intervention was for therapy evaluation and neon tape to the walker. Review of Resident #48 ' s fall event dated 04/03/24 and closed on 04/08/24 revealed prior to the fall the resident was ambulating with improper or ill-fitting footwear (socks). She experienced 10 out of 10 pain and injury was noted to her left hip and leg. The resident had a cognitive or memory impairment that affected safety and judgement and required use of an assistive device and often forgets to use the device. Review of Resident #48 ' s x-ray dated 04/03/24 revealed an x-ray of the pelvis and left hip were completed. There was an angulated comminuted (producing multiple bone splinters) intertrochanteric fracture of the left hip. No osteoporosis to the area was noted. Review of Resident #48 ' s interdisciplinary team note revealed the team met to discuss Resident #48 ' s 04/03/24 fall. They indicated Resident #48 was attempting to sit in a chair to put her shoes on, she did not get the chair pulled out all the way, and it appeared as though she missed the chair when she went to sit down. The resident was transferred to the emergency room and the intervention upon return was a therapy referral and visual cue to use the walker. Review of Resident #48 ' s plan of care as of 04/04/24 revealed she required staff assistance to complete activity of daily living (ADL) tasks completely and safely. She ambulated without an assistance device and was able to feed herself with set up. It was noted that her ADL ' s may fluctuate with cognitive loss and dementia progression. Interventions included allowing sufficient time to complete all or parts of tasks, encouraging her to do as much as safely possible for self, observing for deterioration ADL abilities, and providing adequate rest periods between activities. The care plan did not address Resident #48 ' s assistance needs for dressing, applying footwear, or transfers from sit to stand. Review of Resident #48 ' s plan of care as of 04/04/24 revealed she was at risk for falling related to syncope and collapse, dementia, and poor safety awareness. Interventions included encouraging the resident to assume standing position slowly, ensuring the floor is free of liquids and foreign objects, keeping personal items and frequently used items within reach, staff to assist with transfers as needed, and providing non-skid footwear. Review of Resident #48 ' s profile care guide as of 04/04/24 revealed she needed supervision assistance with transfers. The profile care guide did not address Resident #48 ' s assistance needs for applying footwear. Interview on 06/24/24 at 12:21 P.M. with CRCA #141 revealed she had been sitting at the desk in the common area talking to another resident when she saw Resident #48 begin to come out of her room. Resident #48 did not have a walker and did not have shoes on, Resident #48 was wearing regular socks. CRCA #141 reported she did not want Resident #48 to fall so she told her to go put her shoes on. She reported a couple minutes later she heard the resident scream; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	she believed the resident was bending over to get her shoes when she fell . CRCA #141 called the nurse who assessed the resident and sent her out. Interview on 06/24/24 at 3:43 P.M. with the Executive Director (ED) verified that the therapy notes indicated Resident #48 required supervision or touching assistance for picking up an object and a walker for ambulation and transfers. She additionally verified the care plan did not thoroughly address Resident #48 ' s activity of daily living assistance needs. The ED verified Resident #48 ' s plan of care indicated she was at fall risk and required non-skid footwear to prevent falls. Review of the facility policy, Fall Management Program Guidelines, dated 12/31/23, revealed the policy stated, should the resident experience a fall the attending nurse shall complete the Fall Event. This includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episode and a review by the Interdisciplinary Team (IDT) to evaluate thoroughness of the investigation and appropriateness of the interventions. Any orders received from the physician should be noted and carried out. Care plan interventions should be implemented that address the resident ' s risk factors. 2. Review of the medical record for Resident #37 revealed an admitted [DATE] with diagnoses including dementia, depression, diverticulosis, age-related osteoporosis without pathological fracture, repeated falls, mixed-receptive-expressive language. Review of Resident #37's admission assessment dated [DATE] revealed when reviewing her exit seeking or elopement it was noted she had a history of exit seeking, exhibited periods of pacing, agitation or wandering toward the exit, had eloped within the last three and six months, and demonstrated confusion and had the ability to exit campus. Review of Resident #37's physician order dated 11/08/23 revealed an order for a secured or locked unit. Review of Resident #37's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had a severe cognitive impairment. She had wandering that placed her at significant risk of getting to a potentially dangerous place. Review of Resident #37's progress note dated 11/11/23 revealed the nurse was notified that an emergency exit alarm was sounding on the locked unit. Resident #37 was noted standing a few feet from the emergency exit in front of the facility on the sidewalk. The aide reported it took her and three additional aides to get the resident back into the building as she was hitting, kicking, and punching staff. She was escorted back to the day room in the locked unit but continued to attempt to exit. There was no exit seeking event (incident investigation) for this incident. Review of Resident #37's progress note dated 11/12/23 revealed the aide reported the resident was attempting to get out of the facility through the fire emergency door. She was agitated and tearful regarding her late husband, she was able to be redirected back to her room and calmed down. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #37's plan of care dated 11/27/23 revealed they demonstrated exit-seeking behaviors and wandering. Interventions included monitoring for wandering triggers such as need for toileting inactivity, and time of day, encouraging regular family contact or visits with others, provide structured routine to resident's day, resides on legacy lane for safe wandering, assess need for wander guard and apply as appropriate, offer diversional activities as needed, and re-direct resident away from doors/exits as needed. Review of Resident #37's progress note dated 02/01/24 revealed she was having behaviors and exit seeking. She was aware of the code to the main door and was able to unlock it and try to exit the unit. The resident was redirected back to the common area, the resident was to be on continuous watch until the door code was changed. Review of Resident #37 ' s quarterly observation and data collection dated 05/08/24 revealed the resident wandered. There was no exit seeking event for this incident. Review of Resident #37 ' s exit seeking event dated 02/12/24 revealed the resident came out of her room and said she was leaving and her bags were packed. She headed towards the door and was redirected by staff. No wandering alert device was in place and the intervention was to monitor the residents ' patterns. Review of Resident #37's quarterly MDS 3.0 assessment dated [DATE] revealed Resident #37 had intact cognition. Review of Resident #37's progress note dated 05/16/24 revealed she was found to have placed the code into the memory care door and walked out of the unit. Staff caught up with the resident as she was exiting the exterior doors. Resident #37 stated she was going to go home just over the hill. Staff were able to redirect her back to the secured unit. Review of Resident #37 ' s exit seeking event dated 05/16/24 revealed the resident was seen exiting the building but remained on the property. The resident did not have a wandering alert device in place. She had a cognitive memory impairment that affected safety and judgement but had the ability to learn door codes. The immediate measure taken included placement in the secured unit and changing the door codes. Review of the staff education on 05/16/24 revealed the ED sent a message to all employes indicating the code to the memory care unit had been changed. Staff were to ensure residents did not watch them enter the code and they were to remind families of this as well. Attached to the message was a list of staff indicating whether the message was received or not. 28 employees did not acknowledge they received the message and had no read time for the message. Review of Resident #37's interdisciplinary team note dated 05/17/24 revealed they reviewed the incident on 06/12/24 and noted that the exit door codes were changed to ensure resident's safety. Review of Resident #37's plan of care dated 06/12/24 revealed they demonstrated exit-seeking behaviors and wandering. Interventions included monitoring for wandering triggers such as need for toileting inactivity, and time of day, encouraging regular family contact or visits with others, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	provide structured routine to resident's day, resides on legacy lane for safe wandering, assess need for wander guard and apply as appropriate, offer diversional activities as needed, and re-direct resident away from doors/exits as needed. Observation on 06/17/24 through 06/20/24 revealed the code to the memory care unit was the same as listed on the 05/16/24 staff education. The keypad inside the memory care unit had no cover obscuring the numbers. Review of an e-mail on 06/18/24 at 6:16 P.M. from the ED verified the only exit seeking events for Resident #37 were completed on 02/12/24 and 05/16/24. Interview on 06/18/24 at 2:44 P.M. with CRCA #104 verified Resident #37 was able to learn and memorize the code to the memory care unit. Reported the memory care unit code was changed last time and for a while they were not telling family members, but some of the families did know the code. CRMA #104 reported due to Resident #37 ' s elopements she did not say the memory care code out loud anymore. Interview on 06/20/24 at 12:55 P.M. and 3:07 P.M. with the ED verified there was no exit seeking event for the 02/01/24 exit seeking incident. She reported an interview with the prior ED (who was employed at the time of the incident) indicated the intervention for the incident was putting the resident on one on one until the code was changed. She reported the physician or nurse practitioner was not notified of this incident because it was considered baseline behavior for residents on a locked unit. The ED reported following the 05/16/24 incident she implemented changing the code monthly and provided communication to staff that they should not enter the code when the resident is around. The education also included asking staff to inform families to do the same. The ED verified that the staff education did not indicate that all staff read the education. The ED was unable to identify how changing the code monthly would prevent the resident from learning it in the time between the code changing. The ED acknowledged that the care plan called for assessing for a wander guard, however, she stated that it was facility policy to not put wander guards on memory care residents. Review of the policy ' Guideline for Elopement or Missing Residents ' dated 12/31/23, revealed when a resident deemed an elopement risk is observed exiting the campus door the provider and responsible party were to be notified and an exit-seeking event form was to be completed. 3. Review of the medical record for Resident #29 revealed an original admitted on 03/14/19 and a readmitted on 06/16/23. Medical diagnoses included Alzheimer's Disease with early onset, malignant neoplasm of prostate, epilepsy, mixed receptive-expressive language disorder, unsteadiness on feet, repeated falls, and need for assistance with personal care. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #29 had impaired cognition and scored an eight out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #29 used a walker and a manual wheelchair. The resident required substantial assistance from staff with toileting and bathing, moderate assistance from the staff for dressing, bed mobility, and transfers, and supervision or touch assistance with ambulation. There were not any falls reported on the assessment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the progress notes dated from 04/01/24 to 06/21/24 revealed Resident #29 had a witnessed fall on 04/06/24 and hit his head, a witnessed fall on 04/11/24 and hit his head, and a witnessed fall on 04/25/24 and did not hit his head. Review of the Event Report dated 04/06/24 at 2:50 P.M. and completed by Licensed Practical Nurse (LPN) #178 revealed Resident #29 was standing on his bed when had a fall. Resident #29 reported he hit his head. The fall was unwitnessed and neurochecks were initiated. Review of the Event Report dated 04/11/24 at 4:55 P.M. and completed by Registered Nurse (RN) #182 revealed Resident #29 was standing and talking with another resident when he had a fall. The fall was witnessed, and it was reported that Resident #29 hit his head. Neurochecks were initiated. Review of the Event Report dated 04/25/24 at 10:53 A.M. and created by LPN #167 revealed Resident #29 had a fall while attempting to clean himself up in the bathroom and slipped on water he spilled on the floor. Resident #29 denied hitting his head and the resident's roommate denied seeing the resident hit his head. Resident #29 did have an abrasion to his right upper leg/gluteal area. There was no further information provided related to the investigation of the fall. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated April 2024 revealed Resident #29 had an order for to complete neurochecks every four hours for five hours dated 04/06/24. The neurochecks were not completed at 1:45 A.M. or 5:45 A.M. Resident #29 had an order to complete neurochecks every 15 minutes for one hour dated 04/11/24. There was not a neurocheck completed at 6:00 P.M. Resident #29 had an order to complete neurochecks every four hours times five dated 04/11/24. There were not any neurochecks completed at 4:00 A.M., 8:00 A.M., 12:00 P.M., or 4:00 P.M. Interview on 06/24/24 at 3:45 P.M. with the Director of Health Services (DHS) and ED confirmed there was no evidence of a fall investigation being completed in Resident #29's medical record. The DHS and ED also confirmed neurochecks were not completed as ordered as listed above. Review of the facility policy, Fall Management Program Guidelines, dated 12/31/23, revealed the policy stated, should the resident experience a fall the attending nurse shall complete the Fall Event. This includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episode and a review by the Interdisciplinary Team (IDT) to evaluate thoroughness of the investigation and appropriateness of the interventions. Any orders received from the physician should be noted and carried out. Care plan interventions should be implemented that address the resident ' s risk factors.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation, interview and record review, the facility failed to ensure orders were in place for Resident #171 who had a catheter. This affected one resident (#171) of one resident reviewed for catheters. The facility census was 69. Findings include: Review of the medical record for Resident #171 revealed an admitted [DATE] with diagnoses including Parkinsonism, type two diabetes mellitus, chronic kidney disease stage four, anxiety disorder, and Rheumatoid arthritis. Review of Resident #171's physician's orders from 06/05/24 to 06/23/24 revealed no orders related to catheter care. Review of Resident #171's progress note dated 06/05/24 revealed the resident admitted to the facility with a Foley catheter in place. Review of Resident #171's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed severely impaired cognition. The resident had an indwelling catheter. Review of Resident #171's plan of care dated 06/19/24 revealed Resident #171 used a suprapubic catheter or Foley catheter for diagnoses of comfort related to end of life terminal diagnoses of Parkinson's disease. Interventions included leg strap in place to prevent residents catheter from being pulled out, lab work according to physician's orders, maintaining a closed system with urinary bag below the residents bladder and covered, observe tubing and avoid any obstructions, provide assistant with catheter care and change Foley catheter per orders, observe for any signs of complications and recording resident urinary output. Interview on 06/24/24 at 7:50 A.M. with Certified Resident Medication Assistant #104 verified Resident #171 had a catheter but there were no orders in place for this or the care provided and there should have been. Interview on 06/24/24 at 9:44 A.M. with the Executive Director (ED) Verified there had not been orders in place for Resident #171's catheter.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on interview and record review the facility failed to appropriately document, revise, and implement care plans, and appropriately address Resident #35's dementia related behaviors. This affected one (Resident #35) of five residents reviewed for dementia and had the potential to affect all 12 residents on the memory care unit. The facility census was 69. Findings include: Review of the medical record for Resident #35 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, dementia without behavioral disturbance, attention and concentration deficit, Crohn's disease, anxiety disorder, depression, unspecified convulsions, and overactive bladder. Review of Resident #35's physician order dated 02/10/24 to 02/13/24 and from 02/13/24 to 02/24/24 revealed an order for Lorazepam 0.5 mg one time a day as needed. Review of Resident #35's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had a severe cognitive impairment. Wandering was the only behavior indicated in the MDS assessment. Review of Resident #35's progress note dated 02/12/24 revealed Resident #35's daughter stated she wanted to be called anytime her mother refused to do something. Review of Resident #35's progress note dated 02/16/24 revealed the aide reported the resident had been forcing herself onto other residents and had been caught kissing three different residents. The aide attempted to separate residents, however, resident #35 hit staff and spat in their faces. Additionally, Resident #35 would hold onto other resident's hands while staff attempted to separate them. She was not able to be redirected. She continued to kiss other residents despite two staff monitoring the residents. Review of Resident #35's behavior and mood event dated 02/16/24 revealed the resident was experiencing aggressive behavior and inappropriate sexual behavior with multiple residents. No other residents were identified in this incident. This was identified as baseline behavior. Interventions included providing a snack, which was refused, and assisting the resident to different areas. The physician and family of Resident were notified. There was no evidence the resident's that Resident #35 kissed were assessed or that their representatives were notified of the incident. Review of Resident #35's progress note dated 02/16/24 revealed the facility staff met with Resident #35's daughter. It was noted that the resident was known to be friendly with personal space and kissing or fondling others. The family stated to attempt to offer residents snack to assist with behaviors, but not to offer too many snacks. The family voiced that the resident did not participate in activities at the prior facility. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #35's progress note dated 02/19/24 revealed the resident had been wandering around the unit kissing other residents on the lips. She was being redirected without success. Activities were given to Resident #35 for distraction, but she was uninterested and continued to follow other residents around trying to touch and kiss them. Review of Resident #35's medical record revealed there was no further documentation related to the incident on 02/19/24. There was no evidence the family or physician were notified. The residents that Resident #35 was kissing were not identified and there was no evidence their families or physicians were notified. Review of Resident #35's plan of care dated 02/22/24 revealed the resident demonstrated inappropriate behaviors including invading others personal space and sexual behaviors. Interventions included assessing for unmet needs, assisting resident away from other residents as needed, determining cause for inappropriate behavior and referring to physician as needed for intervention, encouraging participating in structured activities as appropriate, and observe for triggers of inappropriate behaviors. Review of Resident #35's progress note dated 02/25/24 revealed the aide reported the resident came into contact with her face when providing peri-care. She was noted to be agitated. The resident was wandering into other resident rooms. Redirectional activity was ineffective. The behaviors were noted to show up after the resident's daughter had gone home for the night. Review of Resident #35's interdisciplinary team notes dated 02/26/24 revealed they reviewed the residents' behaviors on 02/25/24. The intervention was to encourage staff to call her daughter when the resident had increased behaviors and when staff are unable to redirect per the daughter's request. Review of Resident #35's Medication Administration Record (MAR) for February 2024 revealed as needed lorazepam was not administered. Review of Resident #35's progress note dated 03/15/24 revealed she had been 'touching other residents' There was no further documentation in the medical record of what kind of touching the resident was doing or who she was touching. Review of Resident #35's progress note dated 03/23/24 revealed staff reported to Certified Resident Medication Assistant (CRMA) #104 during shift change that a resident-to-resident altercation happened on the previous shift. It was stated that Resident #35 put her hands around another resident's throat (identified as Resident #59). CRMA #104 did skin observation to both residents and noted no areas. There was no evidence the physician or family were notified of the incident. There was no further documentation related to this incident. There was no description of interventions in place or predisposing factors. Review of Resident #35's progress note dated 04/05/24 revealed the resident was noted to make contact with another resident (identified as Resident #5). The residents were separated and head to toe assessments were completed with no injuries noted and family and staff were notified. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #35's behavior and mood events dated 04/05/24 revealed it repeated the information in the progress note. The incident occurred in the common area. There were no non-pharmacological or pharmacological measures taken. No additional information was provided about the type of contact made. There was no description of interventions in place or predisposing factors. Review of Resident #35's progress note dated 04/21/24 at 11:57 A.M. revealed she was noted hitting staff and one resident with her cane prior to lunch with no injury noted to either resident. The other resident denied being hit but told staff that Resident #35 had been swinging her cane at other residents. There was no evidence the daughter was contacted. Review of Resident #35's progress note dated 04/21/24 at 7:35 P.M. revealed an aide reported the resident drew bag her fist and tried to swing and hit another resident. The resident was redirected away from other residents. Review of Resident #35's progress note dated 04/22/24 revealed the resident was sitting at a table playing bingo with other residents. She reached over with her left hand and grabbed Resident #48's right wrist and proceeded to slap her arm. The resident was redirected by staff and assisted to play bingo. No injury was noted to either party. Review of Resident #35's behavior and mood event dated 04/22/24 revealed the resident complained or exhibited anger and the desire to harm others. The physician and family were notified. Review of Resident #35's progress note dated 04/23/24 revealed the resident was started on Lorazepam 0.5 milligrams (mg) three times a day as needed for anxiety and agitation. The family was aware of the new order and in agreement. Nonpharmacological interventions included activities and redirection, there were no pharmacological measures taken. Review of Resident #35's nurse practitioner noted dated 04/23/24 revealed nursing reported increased agitation at times. The residents daughter noted that she had done well with as needed Ativan in the past. As needed Ativan was ordered one time a day as needed for 14 days. Review of Resident #35's physician's order dated 04/23/24 to 05/07/24 revealed an order for Lorazepam 0.5 mg once a day as needed for anxiety and agitation. Review of Resident #35's progress note dated 04/30/24 revealed Resident #35 attempted to bite a staff member and another resident (identified as Resident #37) slapped Resident #35 on her right arm. The resident was assessed, and no redness or bruising was noted and she denied pain. The residents were separated, and the family and physician were notified. Review of Resident #35's MAR for April 2024 revealed as needed Lorazepam was not administered. Review of Resident #35's progress note dated 05/06/24 revealed she was wandering in the dining room on memory care. She became agitated and grabbed another resident's arm, but she let go quickly. She was not easily redirected and grabbed a caregiver by the throat. No injury was noted. The resident exited the dining room and wandered into the hallway. There was no further documentation of the event. The progress note does not indicate who was assessed with no injury noted. There was no evidence the resident's daughter was contacted. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #35's physician order dated 05/09/24 to 07/09/24 revealed an order for Lorazepam once a day as needed for anxiety or agitation. Review of Resident #35's progress note dated 05/16/24 revealed the Executive Director and Director of Health Services met with Resident #35's daughter to review the residents' behaviors. The daughter felt the behaviors happened when the resident is not feeling well, if one on one attention was not provided, and if she was hungry. The walking cane was removed due to inappropriate use of the item. The daughter offered to visit the campus when the resident was noted with agitation and behaviors. The resident was encouraged to participate in programing, daily rhythms, and activities, as well as family style dining. Review of Resident #35's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #35 had a severe cognitive impairment. She experienced delusions. No behaviors during lookback period. She required substantial/maximal assistance with bathing. Review of Resident #35's progress note dated 05/21/24 revealed the resident was combative with staff, she hit two aides with her fist and rammed her walker into another resident (identified as Resident #59) on purpose. Both residents were immediately separated. The resident was removed from the situation and taken back to her room. Review of the medical record revealed there was no further documentation related to the incident. There was no evidence the daughter or physician was notified. There was no description of interventions in place or predisposing factors. Review of Resident #35's Point Of Care responses from 05/18/24 to 05/30/24 revealed Certified Resident Care Assistant (CRCA) #147 reported that on 05/24/24 at 7:36 P.M. the resident was noted to be kissing on other residents. She was redirected and given one-on-one intervention. Review of the medical record revealed no further documentation related to the incident. Review of Resident #35's MAR for May 2024 revealed as needed Lorazepam was not administered. Review of the plan of care revised 06/12/24 revealed Resident #35 demonstrated inappropriate behaviors including invading others personal space and sexual behaviors including kissing, contact or hitting, and inappropriate touching. Interventions included determining cause for inappropriate behavior and referring to physician as needed, encouraging participating in structured activities as appropriate, observe for triggers of inappropriate behaviors and alter environment as needed, assess for unmet needs, and assisting resident away from other residents as needed. Review of the witness statement dated 06/24/24 and provided by the Executive Director (ED) on 06/24/24 at 4:50 P.M. revealed CRCA #147 reported on 05/24/24 Resident #35 was seen kissing Resident #34 while with the resident's personal caregiver at the end of the hall. CRCA #147 immediately separated the residents, and the personal caregiver took Resident #35 on a walk. No injuries were noted to either resident and the incident was reported to the nurse. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/20/24 at 1:04 P.M., 2:10 P.M., and 4:50 P.M. with the ED and Director of Health Services verified the physician and family were not notified of every incident as they should have been. The ED verified the other residents in the resident-to-resident altercations were not always identified. The only residents they were able to identify were Resident #59 on 03/23/24 and 05/21/24, Resident #5 on 04/05/24, Resident #48 on 04/22/24, and Resident #34 on 05/24/24. They reported these interactions both sexual and violent were part of her dementia. The ED verified the care plan was not updated to reflect new or specific interventions for Resident #35's dementia related behaviors. The ED reported their interventions for her behavior were family visits, caregiver in the evening, and activities. They reported the as needed Lorazepam was not being used because the daughter did not want it to be used, however, they verified the daughter had agreed to the order. The ED verified documentation did not thoroughly address what interventions were being used or were in place at the time of each incident. They were unable to identify how they were tracking trends and patterns in Resident #35's behavior. At 4:50 P.M. the ED provided CRCA #147's progress note and verified the incident was not further addressed in the medical record. The facility denied having policies related to dementia care.

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Oaks at Northpointe	3291 Northpointe Drive Zanesville, OH 43701

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review, staff interview, and facility policy review, the facility failed to timely address all pharmacy recommendations. This affected one (Resident #31) of five residents reviewed for medication administration. The census was 69. Findings Include: Resident #31 was admitted to the facility on [DATE]. Her diagnoses were Parkinson's disease, psychosis, hypertensive heart disease, chronic kidney disease (stage III), heart failure, old myocardial infarction, osteoarthritis, syncope and collapse, major depressive disorder, hyperlipidemia, hypomagnesemia, hypokalemia, mild cognitive impairment, anxiety disorder, dysphagia, cognitive communication deficit, and pain in right shoulder. Review of her minimum data set (MDS) assessment, dated 03/31/24, revealed she was cognitively intact. Review of Resident #31 pharmacy recommendation, dated 02/07/24, revealed the pharmacy recommendation that this medication was not recommended to be used for Parkinson's associated dementia. The recommendation was to either consider a trial dose reduction, or if that was going to remain being administered, to document the risk versus benefit consideration. Review of Resident #31 progress note, dated 02/11/24, revealed this progress note was not recorded in the medical record until 04/16/24, which was two months after the recommendation. This was the first document provided in which the nurse practitioner reviewed the pharmacy recommendation. Review of Resident #31 pharmacy recommendation, dated 04/15/24, revealed the pharmacy recommended the review of her use of Olanzapine due to the pharmacy stating the only antipsychotic that should be considered with Parkinson's disease is seroquel, Clozapine, or Nuplazid. They stated if no changes were to be made, provide rationale to support continued use for the patient chart. Review of Resident #31 progress note, dated 04/17/24, revealed it was recorded in the resident's medical records late (dated 05/16/24), which was more than one month after the recommendation was made. This was the first document provided in which the nurse practitioner reviewed the pharmacy recommendation. Interview with Administrator and Director of Health Services (DHS) on 06/24/24 at 2:49 P.M. confirmed the dates and times of the late entry progress notes as to when the pharmacy recommendations were documented as being reviewed by the nurse practitioner. Administrator confirmed the pharmacy recommendation was not reviewed timely. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility Medication Regimen Review procedures, dated January 2018, recommendations are acted upon and documented by the facility personnel and/or the prescriber. Prescriber accepts and acts upon suggestion or rejects and provides an explanation for disagreeing. There was nothing in the policy to specify the timeframe as to when the prescriber is to address/review the pharmacy recommendation.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review, staff interview, and facility policy review, the facility failed to timely address all pharmacy recommendations. This affected one (Resident #31) of five residents reviewed for medication administration. The census was 69. Findings Include: Resident #31 was admitted to the facility on [DATE]. Her diagnoses were Parkinson's disease, psychosis, hypertensive heart disease, chronic kidney disease (stage III), heart failure, old myocardial infarction, osteoarthritis, syncope and collapse, major depressive disorder, hyperlipidemia, hypomagnesemia, hypokalemia, mild cognitive impairment, anxiety disorder, dysphagia, cognitive communication deficit, and pain in right shoulder. Review of her minimum data set (MDS) assessment, dated 03/31/24, revealed she was cognitively intact. Review of Resident #31 progress note, dated 10/11/23, revealed nurse practitioner recorded a visit for medication management and psychiatric evaluation. Within this note, there was no evidence to support any signs of delusions, hallucinations, or psychosis. Review of Resident #31 progress note, dated 10/23/23, revealed Resident #31 was being tested for having a urinary tract infection. Review of Resident #31 progress note, dated 10/24/23, revealed nurse practitioner wrote a note that there were no new mood behaviors or behavioral changes. On 10/26/23, nurse practitioner orders Cipro 250 mg twice daily for a UTI. Review of Resident #31 progress note, dated 11/10/23, revealed the nurse practitioner wrote a note to state that staff told her Resident #31 was having delusions, so she provided a diagnosis of psychosis. Review of Resident #31 pharmacy recommendation, dated 11/22/23, revealed a recommendation to provide proper justification for the use of zyprexa (Olanzapine), which at the time of this recommendation, the order was for Parkinson's, according to the pharmacy recommendation. Review of Resident #31's physician orders, dated 11/10/23 to 03/15/24, revealed she was ordered Olanzapine 2.5 milligrams (mg) for Parkinson's disease. Review of Resident #31's physician orders, dated 03/15/24 to 04/18/24, revealed she was ordered Olanzapine 5 mg for Parkinson's psychosis. Review of Resident #31 physician orders, dated 04/18/24, revealed she was ordered Seroquel 25 mg for Parkinson's hallucinations and delusions. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #31 physician orders, dated 04/18/24 to 04/25/24, revealed she was ordered Seroquel 50 mg for Parkinson's hallucinations and delusions. Review of Resident #31 medical record found no behavioral logs or staff documentation to support behaviors of hallucinations, delusions, or psychosis from 07/01/23 to 11/10/23, when an antipsychotic medication was first prescribed. Interview with State tested Nursing Aide (STNA) #149 and STNA #150 on 06/20/24 at 9:45 A.M. confirmed if a resident has a behavior, it will be documented in the resident's medical records, either in their task section or a progress note. It will also be reported to the nurse was well. Interview with Administrator and Director of Health Services (DHS) on 06/24/24 at 2:49 P.M. revealed the justification for the use of anti-psychotic medication was because the nurse practitioner wrote a progress note on 11/10/23 to add the diagnosis of psychosis based on reported to her from staff that Resident #31 was having delusions. When asked for behavior documentation or other documentation prior to 11/10/23 to support Resident #31 behaviors of delusions or psychosis, they were not able to provide any other supporting documentation.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 41266 Based on observations, staff interview, and facility policy review, the facility failed to ensure pureed food items were an appropriate texture, requiring surveyor intervention. This affected six residents (Residents #6, #9, 11, #16, #49 and #320) who had an ordered pureed diet. The facility census was 69. Findings Include: Observations completed on 06/18/24 from 4:02 P.M. to 4:37 P.M. with Dining Services Assistant (DSA) #123 of pureed swiss steak revealed the facility had six residents on an ordered pureed diet and the cook would be preparing seven servings of swiss steak. DSA #123 washed his hands with soap and water at the sink and donned clean gloves. DSA #123 added seven whole swiss steak patties to the puree blender at 4:06 P. M. At 4:08 P.M., DSA #123 added one cup and one teaspoon of beef base and added 1/4 teaspoon and 1/2 teaspoon of thickener to the swiss steak. DSA #123 stated he tasted the pureed food items prior to serving them to ensure an appropriate smooth texture was reached. At 4:12 P.M., DSA #123 stopped the blender and tasted the pureed swiss steak. DSA #123 proceeded to transfer the pureed swiss steak from the blender into a small silver metal serving container. Interview on 06/18/24 at 4:13 P.M. with DSA #123 confirmed the cook felt the pureed swiss steak was an appropriate texture and he was prepared to serve it to the residents at this time. At 4:15 P.M., this surveyor tasted the pureed swiss steak and found the mixture to be gritty with small bits of fat which required chewing in order to safely swallow it. At 4:16 P.M., observation and interview with the Director of Food Services (DFS) #159 confirmed upon tasting the pureed swiss steak that the steak was not an appropriate texture and required chewing in order to safely swallow it. DFS #159 confirmed the pureed swiss steak would not have been safe to serve to the residents. Review of the facility policy, Pureed Food Guidelines, revised 02/2012, revealed the policy stated, a pureed diet required smooth, homogenous, very cohesive, pudding-like foods that require very little chewing ability. Steps for making pureed foods included cut food into small pieces and then add to food processor to blend. The ideal pureed consistency of foods should resemble that of mashed potatoes or whipped topping.

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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. 41266 Based on observations, staff interviews, and facility policy review, the facility failed to follow appropriate hand hygiene and glove use during dinner meal service. Additionally, the facility failed to ensure prepared food temperatures were taken prior to delivering the foods to be served to the residents who resided on the Memory Care Unit (Residents #5, #18, #34, #35, #37, #42, #43, #48, #51, #59, #60, and #174). This had the potential to affect a total of 68 residents who resided in the facility and received foods from the kitchen. The facility had one resident (Resident #21) on an ordered nothing by mouth (NPO) diet. Findings Include: Observations of food temperatures with [NAME] #123 were attempted on 06/18/24 at 4:55 P.M. The Director of Food Services (DHS) #159 informed this surveyor at that time the steam table located in the kitchen was not working properly and food temperatures would be taken from the steam tables in the dining room areas. DHS #159 instructed Dining Services Assistant (DSA) #123 to escort this surveyor to the locked Memory Care Unit to observe food temperatures there as the food had already been delivered to that unit in a hot box. At 4:58 P.M., Dining Services Assistant (DSA) #123 arrived at the dining room area located in the facility's Assisted Living. This surveyor requested food temperatures be observed of food which were going to be served to nursing home residents. DSA #123 stated, Oh, I don't know where we are supposed to go. At 5:04 P.M., this surveyor entered the locked Memory Care Unit and observed residents were seated at a large dining room table eating dinner meal. Interview on 06/18/24 at 5:06 P.M. with Certified Resident Care Associate (CRCA) #134 revealed the food items were delivered from the kitchen in a hot box. CRCA #134 confirmed food temperatures were not taken by the staff on the unit prior to serving the foods to the residents. CRCA #134 stated, the kitchen does that. At 5:11 P.M., this surveyor returned to the main kitchen. Interview on 06/18/24 at 5:11 P.M. with DHS #159 and Dining Services Assistant (DSA) #123 confirmed the food temperatures of the food items delivered to the Memory Care Unit had not been completed by any of the kitchen staff prior to being delivered to the unit. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observations of dinner meal service in the main dining room on 06/18/24 from 05:19 P.M. to 5:54 P.M. of Dining Services Assistant (DSA) #109 revealed the assistant washed her hands with soap and water at the sink inside the kitchen and donned clean gloves. DSA #109 proceeded out into the main dining room to start dinner meal service from the steam table in the dining room. At 5:21 P.M., DSA #109 placed her gloves hands at her sides, resting them on her pants. DSA #109 did not complete any hand hygiene or change her gloves after touching clothing and continued to serve food to residents. At 5:22 P.M., DSA #109 used the same gloved hands to open a plastic bag of dinner rolls, reached into the bag and removed a dinner roll with the same gloves on and placed on a plate to be served to a resident. DSA #109 continued to use the same gloved hands to remove dinner rolls from the plastic bag and place them on plates to be served to residents until the bag of rolls was emptied. At 5:30 P.M., DSA #109 was observed using the same gloved hands to move a resident's mechanical soft ground swiss steak on the plate. At 5:35 P.M., DSA #109 rested the same gloved hands against her pants again. At 5:40 P.M., a large plastic container was handed to DSA #109 from the kitchen which contained additional dinner rolls and tongs in it. DSA #109 handled the plastic container with the same gloved hands and placed it on top of the steam table. DSA #109 then used the same gloves to reach into the plastic container and removed a dinner roll and placed it on a plate to be served to a resident. DSA #109 did not use the provided tongs to handle the dinner rolls. At 5:53 P.M., DSA #109 was observed while removing clean plates the inside of the plate where foods were plated was being touched with the same gloved hands. DSA #109 did not change gloves or complete any hand hygiene for the duration of the observation. Interview on 06/18/24 at 6:12 P.M. with the Director of Food Services (DHS) #159 and Assistant Director of Food Services (ADFS) #128 confirmed the above observations of DSA #109 during the dinner meal service. Review of the facility policy, Guideline for Handwashing/Hand Hygiene, dated 12/31/23, revealed the policy stated, healthcare workers (HCW) shall use hand hygiene at times such as: before/after preparing/serving meals, drinks, tube feedings, etc. and after removing gloves. All HCW's shall utilize hand hygiene frequently and appropriately. Review of the facility policy, Single-Use Gloves, dated 11/22/17, revealed the policy stated, change gloves whenever an activity or workstation change occurs, or whenever they become contaminated: after touching equipment, after interruptions in food preparation occur, after sneezing,coughing, or touching hair or face. Wash hands before putting on gloves and after discarding gloves. Review of the facility policy, Legacy Family Style Dining Standards, dated 11/07/18, revealed the policy stated, at the designated meal start time, the chef will begin plating and use the following steps: check serving temperatures to ensure food is above 135 degrees Fahrenheit (F). Cover food with plastic wrap and place into Hot Box. Foods are served within ten minutes to ensure food safety and quality standards. The temperatures of the food will be taken in the kitchen and recorded prior to being sent to the legacy unit. The food will be sent to the legacy unit in a temperature-controlled hot box.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on medical record review, staff interview, and facility policy review, the facility failed to keep accurate medical records for two residents (Residents #9 and #48). This affected two residents (Residents #9 and #48) of 21 residents reviewed in the sample. The facility census was 69. Findings include: 1. Review of the closed medical record for Resident #9 revealed an admitted on 02/02/23 and a discharge date of [DATE]. Medical diagnoses included Alzheimer's Disease, Type II Diabetes Mellitus with unspecified complications, mixed receptive-expressive language disorder, difficulty in walking, unsteadiness on feet, generalized weakness, cognitive communication deficit, and need for assistance with personal care. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #9 had impaired cognition and scored three out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #9 required substantial assistance from staff to complete most Activities of Daily Living (ADLs), including bed mobility, transfers, dressing, and toileting. Resident #9 did not have any skin impairments at the time of the assessment. Review of the initial skin assessment dated [DATE] (two days after the area was identified) by former Assistant Director of Health Services (ADHS) #146 of Resident #9's right heel revealed the area was an unstageable deep tissue injury (DTI) on her right heel that measured 4.5 centimeters (cm) long by 4.5 cm wide. The area was closed and purple in color. The periwound was pink and blanchable for a total of 7 cm long by 7 cm wide of discolored skin. A treatment was not indicated in the skin assessment. Review of the progress note dated 04/25/24 at 1:11 A.M. by former ADHS #146 revealed a weekly skin assessment was completed. Resident #9 had a DTI pressure ulcer to her right heel that recently opened. Dressing was removed and a small amount of serosanguinous (thin, watery fluid that is pink in color) drainage was noted. The area was cleansed with wound cleanser. The wound bed measured approximately 3 cm long by 3 cm wide with 20% granulating (new connective tissue) tissue and 80% slough (dead tissue usually cream or yellow in color). There was no odor noted. Wound treatment included cleanse area with wound cleanser or normal saline, pat dry. Apply Solosite gel (used to create a moist wound environment and autolytic debridement of sloughy tissue) to wound bed and cover with an allevyn foam dressing. Change daily and as needed (PRN). The Nurse Practitioner (NP) was aware of the plan of care (POC). Review of the wound observation dated 05/16/24 and completed by former ADHS #146 revealed Resident #9's US pressure ulcer of her right heel was noted to have an area on the right outer ankle connecting to current wound on right heel making the total measurement 4 cm long by 9 cm wide. The area was noted to be 100% eschar tissue. There were irregular wound edges, a light amount to seropurulent drainage, and a pungent odor noted. The wound was noted to be declining. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the wound consult notes dated 05/29/24 at 9:58 A.M. revealed Resident #9 received assessments on two wound areas, the right achilles (heel) and right lateral ankle. The right achilles wound measured 5.4 cm long by 4 cm wide by 0.3 cm deep. The right lateral ankle wound measured 2 cm long by 2.5 cm wide by 0.1 cm deep. The diagnosis was a diabetic ulcer of right heel associated with diabetes mellitus due to underlying condition, with fat layer exposed. There was no additional diagnosis indicated for the right lateral ankle wound. Wounds were debrided at the appointment. Review of the wound observation dated 05/30/24 (after wounds were debrided at wound clinic) and completed by former ADHS #146 revealed Resident #9's right heel wound was classified as an US pressure ulcer (not a diabetic ulcer as the wound center noted). The wound measured 5 cm long by 9 cm wide (does not match measurements from wound center). There was no depth indicated to the wound. A moderate amount of seropurulent drainage and a mildly pungent odor was noted. The wound was noted to be covered by 60% slough tissue and 40% eschar tissue with irregular wound edges. Review of the TAR dated May 2024 revealed Resident #9 had a wound treatment order to cleanse left (not right) heel wound with normal saline or wound cleanser daily. Apply santyl nickel thick to wound bed followed by aquacel, gauze, ABD, roll gauze, tape, and tubifast. Do not tape skin. Change the dressing daily and as needed with a start date on 05/30/24. The treatments were marked as completed on 05/30/24 and 05/31/24. Review of the TAR dated June 2024 revealed Resident #9's wound treatment order indicated for the left heel (not the right heel). The treatments were marked as completed daily until the order was d/c'd on 06/20/24 and re-ordered for the right heel effective 06/20/24. Interviews on 06/20/24 at 11:07 A.M. and 3:22 P.M. with the Director of Health Services (DHS) confirmed the treatment orders for Resident #9's left heel were inaccurate. The DHS confirmed Resident #9 did not have a wound on her left heel and the orders should have indicated wound treatments for Resident #9's right heel wound. 43064 2. Review of the medical record for Resident #48 revealed an admitted [DATE] with diagnoses including dementia, depression, hypertension, disorientation, dysphagia, osteoporosis, and fracture of unspecified part of neck of left femur acquired 04/04/24. Review of Resident #48's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she had severely impaired cognition. Review of Resident #48's medical record revealed there was no incident documented on 04/22/24. Interview on 06/24/24 at 2:10 P.M. with the Executive Director verified that on 04/22/24 there was a resident to resident altercation between Resident #35 and #48 and the incident was not recorded in Resident #48's medical record. Review of the facility policy, Guidelines for Medical Records Clinical Documentation, undated, revealed the policy stated, the campus shall maintain a complete and ongoing resident record on each resident from the time of admission until termination of the resident's stay at the campus. A complete, timely, and accurate medical record is created and maintained for each resident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on observations, medical record review, and interviews the facility failed to have enhanced barrier precautions (EBP) in place for Resident #58, #63, #171, and #371. This affected four (Resident #58, #63, #171, and #371) out of eight residents reviewed for enhanced barrier precautions. Also, the facility failed to follow contact isolation precaution procedures. This affected one (Resident #2) of five residents reviewed for infection control. The census was 69. Findings include: 1. Review of the medical record revealed Resident #58 was admitted on [DATE] with diagnoses that included but not limited to orthopedic aftercare, dysphagia, and an artificial opening status. Review of physician orders dated 05/06/24 revealed Resident #58 had orders for enteral feeding. An observation on 06/18/24 at 2:31 P.M. revealed no evidence of Resident #58 being on EBP. Interview on 06/18/24 at 3:00 P.M. Director of Nursing (DON) verified Resident #58 did not have any EBP signs or personal protective equipment (PPE) in place. A physician order dated 06/18/24 revealed staff were to use EBP by wearing a gown and gloves at the minimum during high-contact care activities for Resident #58. 2. Review of the medical record revealed Resident #63 was admitted on [DATE] with diagnoses that included sepsis, ileus, and disruption of external operation. Interview on 06/18/24 at 2:31 P.M. Licensed Practical Nurse (LPN) #178 verified Resident #63 had a wound vacuum in place. Interview on 06/18/24 at 3:00 P.M. DON verified Resident #63 did not have any EBP signs or PPE in place. 3. Review of the medical record revealed Resident #171 was admitted on [DATE] with diagnoses that included but not limited to Parkinsonism and chronic kidney disease. Interview on 06/18/24 at 2:31 P.M. LPN #178 verified Resident #171 had an indwelling catheter. An observation on 06/18/24 at 2:32 P.M. revealed no evidence of Resident #171 being on EBP. Interview on 06/18/24 at 3:00 P.M. DON verified Resident #171 did not have any EBP signs or PPE in place. A physician order dated 06/18/24 revealed staff were to use EBP by wearing a gown and gloves at the minimum during high-contact care activities for Resident #171. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366051	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks at Northpointe	3291 Northpointe Drive Zanesville, OH 43701

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of the medical record revealed Resident #371 was admitted on [DATE] with diagnoses that included but not limited to spina bifida, osteomyelitis, and sacral wound. Review of physician orders dated 06/12/24 revealed Resident #371 had orders in place for a wound vacuum. An order was also in place for staff to use EBP, which included staff to wear a gown and gloves at the minimum during high-contact care activities for Resident #371. An observation on 06/18/24 at 2:33 P.M. revealed no evidence of Resident #371 being on EBP. Interview on 06/18/24 at 3:00 P.M. DON verified Resident #371 did not have any EBP signs or PPE in place. On 06/18/24 an additional order was put in place for staff to use EBP by wearing a gown and gloves at the minimum during high-contact care activities for Resident #371. 37100 5. Review of the medical record revealed Resident#2 was admitted to the facility on [DATE]. Her diagnoses were pericardial effusion, tachycardia, methicillin resistant staphylococcus aureus (MRSA) infection, interstitial pulmonary disease, hypertensive heart and chronic kidney disease, type II diabetes, chronic kidney disease (stage III), morbid obesity, atherosclerotic heart disease, atherosclerosis of aorta, chronic obstructive pulmonary disease, cardiomyopathy, fibromyalgia, atrial fibrillation, acute kidney failure, hypokalemia, depression, anxiety disorder, osteoarthritis, hypoexia, altered mental status, urinary tract infection, metabolic encephalopathy, dehydration, and enterocolitis. Review of her minimum data set (MDS) assessment dated [DATE], revealed she was cognitively intact. Review of Resident #2 medical records revealed she was placed on contact isolation precautions for Clostridioides difficile (Cdiff) on 05/31/24. Observation on 06/17/24 at approximately 10:30 A.M. revealed Resident #2 had a sign on her door that she was on contact isolation precautions. She also had personal protective equipment (PPE) cabinet outside of her room that had gloves, reusable gowns, masks, and eye protection available for use. There were no bags or other containers in or near the PPE cabinet for those that go into Resident #2 room, to place their used (reusable) gowns. Inside Resident #2 room, there also were no bags, red bags, or bins anywhere for used (reusable) gowns to be placed after staff/visitors were done inside the room. Interview with Resident #2 on 06/17/24 at 10:30 A.M. revealed she is not sure what the staff do with their used gowns after they are done with them. They do not take a bag out of the room after they leave. She doesn't go into the bathroom, so she is not sure if/where the staff leave the used gowns. Interview with Registered Nurse (RN) #184 on 06/17/24 at 10:40 A.M. confirmed there was no disposal bin or red bags in Resident #2 room to dispose of the used cloth/reusable gowns in the resident's room. She confirmed there were no red bags or other containers available in Resident #2 PPE cart as well. She confirmed there should be something in the resident's room to put the used gowns in. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility Guidelines for Contact Precautions, dated 02/28/24, revealed those entering a room will wear a clean, non-sterile, fluid resistant gown when entering the room if it is anticipated clothing will have substantial contact with the resident or environmental surface or when there is likelihood that organisms from blood, urine, stool, or wound drainage may be on surfaces or items in the resident's room. Remove gown, if applied, before leaving resident's room and wash hands immediately with anti-microbial soap or a waterless sanitizing agent. Removal of PPE shall be done so as not to contaminate the individual. Dispose of gown and wash hands. Linen with blood, body fluids, secretions, and excretions will be handled in a manner that prevents skin and mucous membrane contact and contamination of clothing, and that avoids transfer of microorganisms to other residents and staff. Gloves should be worn to empty trash, to gather soiled linen, and to remove trash and linen bags from resident rooms.