STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366087	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Center, The	100 Vista Drive Lisbon, OH 44432

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on record review, policy review and interview, the facility failed to treat residents in a dignified manner by searching a resident's room without his knowledge and by providing incontinence care to a resident in a common area resulting in a video recording of the resident. This affected two (Residents #13 and #28) of three residents reviewed for dignity. Findings include: 1. During an interview with Resident #13 on 01/06/25 at 12:04 P.M., he stated he did not feel he was treated with dignity or respect because staff had gone into his room without his knowledge or permission and searched his belongings. Review of Resident #13's medical record revealed diagnoses including alcohol abuse and major depressive disorder. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #13 was able to understand others, able to make himself understood, and was cognitively intact with a Brief Interview of Mental Status (BIMS) score of 15 (the maximum score one could get on the assessment). On 01/07/25 at 4:45 P.M., the Administrator stated one of Resident #13's friends provided alcohol to Resident #13. The Administrator verified she had cans of Resident #13's beer in her office awaiting its removal by the friend. The Administrator stated she believed the alcohol was voluntarily given to staff by Resident #13 and denied knowledge of staff searching his room. On 01/08/25 at 4:10 P.M., Licensed Practical Nurse (LPN) #844 stated she was working one day (could not recall the exact date) when Activity Assistant #842 observed Resident #13 arguing with another resident and she overheard Activity Assistant #842 state We aren't having this. as she walked into Resident #13's room. Activity Assistant #842 did not seek Resident #13's permission to enter his room. There was an empty beer container on the bed. Activity Assistant #842 opened Resident #13's closet and removed beer. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/09/25 at 10:45 A.M., Activity Assistant #842 stated she was exiting the activity department office one day (could not recall the exact date), Resident #13 was in the hall cussing and threatening to beat another resident up. Resident #13 appeared to be highly intoxicated and multiple staff kept asking Resident #13 to separate himself from the other resident. Resident #13 left but then returned. The Receptionist was conversing with the Administrator on the phone and the Administrator instructed them to check Resident #13's room and take unauthorized items out of the room. Resident #13 had two empty beer cans on his bed, one full beer can on the bed and a bag on the floor by the closet with two large beer cans. Activity Assistant #842 stated she removed the beer from Resident #13's room and handed it to the nurse. Activity Assistant #842 verified she was unsure if any staff told Resident #13 his room was going to be searched or give him the opportunity to be present during the search. Activity Assistant #842 verified she had also located beer in Resident #13's closet. Resident #13's roommate had separated the residents involved in the altercation and got Resident #13 to leave the area with him. Review of the facility's Alcohol and Illegal Substance Use/Abuse policy (not dated) indicated if the attending physician did not authorize the resident to consume alcoholic beverages, the licensed nurse would receive a physician's order indicating the resident was not permitted to consume alcohol and the reason for the contraindication should be documented. Staff may store the beverages but not distribute them to the resident. The MDS coordinator/designee would develop a plan of care to compliment the resident's physician's orders and it should address any levels of non-compliance with the physician's orders. The resident would be re-educated on the risks and consequences of consuming alcoholic beverages against the orders of the physician. Documentation would be placed in the Social Service section by the social service coordinator regarding the re-education. The resident would be asked to sign an AMA (against medical advice) form as needed. Review of the facility's Room/Personal Space Search policy (not dated) revealed a room search would be conducted if there was a strong reason to suspect a resident had dangerous, toxic, illegal, or unsafe items in their possession. Dangerous objects or potentially dangerous objects were items that might be utilized to inflect harm or injury to self or others. The Administrator or designee would inform the resident and/or resident representative that a room search would be conducted. The resident had the right to be present at the time of the search. 2. Review of Resident #28's medical record revealed diagnoses including Alzheimer's disease, dementia, generalized anxiety disorder, restlessness and agitation. A quarterly MDS dated [DATE] revealed Resident #28 had short and long term memory loss and had moderately impaired cognitive skills for daily decision making, and was always incontinent of bowel and bladder. Review of investigation documentation dated 11/08/24 indicated the Administrator and Activity Director #816 reviewed the camera and observed at approximately 6:02 A.M. observed CNA #873 changed Resident #28 in a broda chair in the common area, removing her brief and clothing, redressing Resident #28 then moving her from the common area. On 12/31/24 at 12:40 P.M., the Administrator verified the incident occurred and the investigation report was accurate regarding Resident #28 being undressed, provided incontinence care and dressed while in the common area. The Administrator stated no other residents were captured in the video footage. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/31/24 at 1:24 P.M., Activity Director #816 stated video surveillance was only available for two weeks. This deficiency represents non-compliance investigated under Complaint Number OH00159892.

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on medical record review, policy review and interview, the facility failed to provide a resident timely access to information in the medical record. This affected one (Resident #10) of four residents interviewed during a resident council meeting. Findings include: Review of Resident #10's medical record revealed diagnoses including chronic osteomyelitis, metabolic encephalopathy, paraplegia, pressure ulcer to the sacrum, depression, and diabetes mellitus type II. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #10 was cognitively intact. On 01/07/25 between 2:06 P.M. and 2:20 P.M., Resident #10 reported he had requested to see his medical record in regard to x-ray results and wound assessments but was told he could not. On 01/09/25 at 3:40 P.M., the Administrator stated she was unaware of any resident requests to view their medical records. On 01/09/25 at 3:50 P.M., Resident #10 stated he could not recall who he had spoken to regarding wanting to review his medical record. Resident #10 gave permission for his name to be shared with the Administrator. The information regarding the allegation by Resident #10 to review his medical record and staff refusing to let him view the requested information was shared with the Administrator directly after the conversation with Resident #10. On 01/13/25 at 1:29 P.M., Resident #10 stated he had still not been provided access to his medical record. Resident #10 indicated he was unsure of the date he originally made the request. On 01/13/25 at 1:32 P.M., Registered Nurse (RN) #900 stated she had not been informed of Resident #10's request to see information from his medical record. On 01/13/25 at 1:35 P.M., the Administrator stated she was unaware if anybody had provided access to Resident #10's medical record after she was informed of the request on 01/09/25. When asked if she had assigned anybody to the task, the Administrator stated staff talked about it but was unable to state who was responsible to ensure the medical record access was provided. Review of the facility's Release of Medical Records policy (last dated 05/2023) revealed a current resident's record was accessible to him/her within 24 hours (excluding weekends and holidays) notice, following an oral or written request. The resident was encouraged to review the record in the presence of the medical director, the resident's attending physician or a representative of the facility. The resident or his/her legal representative could receive a copy of his/her record within two working days after the request had been made.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28701 Based on medical record review and staff interview, the facility failed to ensure advance directives were accurate. This affected one (Resident #1) of 24 residents reviewed for advance directives. The facility census was 49. Findings include: Review of Resident #1's medical record revealed an admitted [DATE] with diagnoses that included intentional self-harm by firearm discharge, traumatic brain injury and vascular dementia. Further review of the medical record including the electronic medical record code status indication, physician's orders and care plan indicated an advance directive of do not resuscitate comfort care arrest (DNRCC-A) (full medical care is implemented until the resident experiences cardiac or respiratory arrest and then comfort measures are initiated). Review of the actual advance directive form for Resident #1, signed by the resident's guardian and physician, indicated the actual advance directive of DNRCC (do not resuscitate comfort care) (comfort measures, no life saving measures) On 01/08/24 at 2:45 P.M. interview with the Director of Nursing verified Resident #1's advance directive form, which indicated a DNRCC, did not match the information contained in the residents electronic and paper medical record which indicated the resident's wishes were to receive care via DNRCC-A.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on record review, interview, and policy review, the facility failed to notify the resident representative of a change in health status. This affected one (Resident #35) of two residents reviewed for notification of change. The facility census was 49. Findings include: Medical record review revealed Resident #35 was admitted to the facility on [DATE] with diagnoses including muscle weakness, cerebral infarction, major depressive disorder, acquired absence of left leg below the knee, and cognitive communication deficit. Review of the 5-Day Minimum Data Set (MDS) 3.0 assessment, dated 12/01/24, revealed a Brief Interview for Mental Status (BIM) score of 15, which indicated intact cognition. The MDS further revealed Resident #35 required staff assistance with activities of daily living (ADLs). Review of the admission record revealed Resident #35's son was listed as the resident's emergency contact and power of attorney. Interview on 12/30/24 at 9:20 A.M. with Ombudsman #950 revealed he had an open case involving Resident #35 who was concerned that her family was not notified when she transferred from the facility for emergency surgery. Review of nursing progress note, dated 11/03/24 at 2:32 P.M., revealed Resident #35 complained of nausea and vomiting earlier in the morning and was administered Zofran which was effective. Later in the shift, the resident complained of severe pain in the right side of her abdomen. The physician was notified, and an order was given to transfer the resident to the emergency room . Further review of the nursing progress notes revealed no family notification was made. Interview with the Director of Nursing (DON) on 01/14/24 at 10:41 A.M. revealed the facility does not notify the emergency contacts of hospital transfers or changes of condition if the resident is their own responsible party. Subsequent interview with the DON on 01/14/24 at 12:14 P.M. revealed the resident was her own responsible party and confirmed Resident #35's power of attorney/emergency contacts were not notified of her transfer to the hospital on 11/03/24. Review of the facility policy titled, Status Change in Resident Condition Notification, undated, revealed the facility will promptly notify the resident, his/her physician, and responsible party of changes in the resident's condition and/or status.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 39969 Based on observations, interview, and record review the facility failed to ensure a clean, sanitary and functional environment. This affected 14 residents (#2, #3, #10, #13, #18, #19, #29, #31, #38, #47, #48, #49, #50, and #144) of 49 residents residing in the facility. The facility census was 49. Findings include: Observation on 12/30/24 at 11:25 A.M. of Residents #29 and #31's bathroom floor revealed a yellow/brown ring around the commode. Observation on 01/06/25 at 11:03 A.M. of Residents #2 and #19's room revealed multiple gouged areas in the bathroom wall, next to the shower, and trash was on the floor. Observation on 01/06/25 at 11:58 A.M. of Residents #47 and #144's room revealed the shower floor had a large, dried dirt stain and dried dirt stains on the bathroom floor and throughout room. Interview at the time of the observation, with Resident #47, revealed the floors were dirty and hadn't been mopped. Interview on 01/06/25 at 2:25 P.M. with Resident #50 revealed the right side bed rail (on their bed) was stuck and doesn't come up. Resident #50 stated it has been that way since she's been at the facility. Observation on 01/6/25 at 3:30 P.M. of Residents #29 and #31's bathroom revealed yellow/brown discoloration remains around floor surrounding commode. Interview on 01/06/25 at 10:51 A.M. with Residents #48 and #49 revealed they had housekeeping concerns. Residents #48 and #49 stated they take trash out and dust but the floors had not been mopped, especially the bathroom floor, in two weeks. Observation at the time of the interview revealed the toilet had bowel movement on the inside back of toilet bowl and the floors in the bathroom and throughout the residents' room were dirty with marks throughout. Observations on 01/07/25 between 11:24 A.M. and 11:38 A.M. of Residents #48 and #49's room and bathroom revealed the floors were still dirty and bowel movement was still in the inside back of the toilet bowl. Observation of Resident #18 and #38 revealed the floors were dirty with dirt stains. Residents #2 and #19 revealed the floors were dirty throughout with dirt stains. Interview at 11:31 A.M. with Resident #19 stated they don't always clean the floor and the last time it was done was couple of days ago, sometime over the weekend. Observation on Residents #10 and #13's room revealed tissues on the floor and a glove near Resident #10's window, by the bed. The floor overall was dirty with dirt stains. The bathroom floor, sink, and walls were dirty and had various stains. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/07/25 from 11:46 A.M. to 12:02 P.M. tour with Resident Assistant (RA) #803 stated she helps out in housekeeping in the nursing home. During tour RA #803 verified the identified findings in Resident's #2, #3, #10, #13, #18, #19, #38, #47, #48, #49, and #144. At 11:55 A.M. the Director of Maintenance (DOM) #804 joined the tour and stated he has had some staffing issues in housekeeping. Observation of Resident #50's bed rail, DOM #804 verified the right side bed rail would not come up. DOM #804 stated he was not aware of it but will get it fixed. Follow up tour on 01/07/25 from 1:41 P.M. to 1:47 P.M. with DOM #804 verified the various holes and walls in disrepair in Residents #2, #19, and #3 rooms. DOM #804 stated the painter was let go and as he was able to get housekeeping staff they had to prioritize. DOM #804 verified the yellowing/brown stain around the toilet of Residents #29 and #31's room and stated it may be stains or it may not be. DOM #804 stated the floors of this room were recently stripped and waxed prior to the residents moving in. Review of policy Housekeeping Policy/Procedure, dated 12/28/13 revealed the facility will be maintained and cleaned to meet a home like environment for our residents. Review of policy Housekeeping Cleaning and Disinfection of Environmental Surfaces, revised 01/11/21 revealed housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a daily basis, when spills occur, and when surfaces are visibly soiled. This deficiency demonstrates non-compliance investigated under Master Complaint Number OH00160455.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on medical record review, review of disciplinary action and investigative reports, policy review and interview, the facility failed to prevent neglect of a resident's physical needs. This affected one (Resident #28) of two residents reviewed for abuse. Findings include: Review of Resident #28's medical record revealed diagnoses including Alzheimer's disease, dementia, generalized anxiety disorder, restlessness and agitation. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had short and long term memory loss and had moderately impaired cognitive skills for daily decision making, and was always incontinent of bowel and bladder. A care plan initiated 03/27/24 revealed Resident #28 had alteration in thought process related to end stage Alzheimer's disease. Goals included for Resident #28's needs to be met on a consistent basis, to be clean, dry and odor free and for Resident #28 to be appropriately dressed. Interventions included providing simple daily routines and assisting with toileting and incontinence care as needed. When the Administrator was asked about a reported incident regarding Resident #28 not being provided incontinence care throughout one shift and staff providing incontinence care in a common area, investigation documentation was provided and revealed the following: Review of the assignment sheet revealed on 10/23/24, Certified Nursing Assistant (CNA) #873 worked with Registered Nurse (RN) #810 and one other aide. A witness statement by (CNA) #836 revealed when day and night shift aides did rounds, CNA #850 indicated she was glad CNA #873 had called off. CNA #850 reported CNA #873 had left Resident #28 up in the chair all night, and only changed her (provided incontinence care) before day shift arrived. CNA #850 told her (CNA #836) she had reported this to the nurse. Because it was first she had knowledge of it, CNA #836 reported it (the incident). An email dated 11/08/24 at 3:11 P.M. from CNA #873 revealed she had not provided care to Resident #28 since 11/01/24 and to her knowledge had never seen Resident #28 spend the night in her chair. The email indicated Resident #28 was changed and dressed in her room. A statement by the Administrator which indicated she and Activity Director #816 reviewed camera footage which revealed Resident #28 was placed in the television room at approximately 2:43 (interview of the Administrator on 12/31/24 at 12:40 P.M. revealed this was 2:43 P.M.) by a visitor. Resident #28 was provided her evening meal in the common area. It was noted Resident #28 did not leave the room the entire night. CNA #873 appeared at approximately 6:02 A.M. and changed Resident #28 in the common area prior to moving her. A notice of Corrective Action form dated 11/12/24 indicated CNA #873 was notified by phone of a written warning regarding poor customer service and instructed CNA #873 to make sure to always treat residents with respect and dignity. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/31/24 at 12:40 P.M., the Administrator stated when she reviewed the facility surveillance footage she noted Resident #28 was taken to the television room at 2:43 P.M. on 10/23/24. Resident #28 received dinner in the television room. No other staff interaction or hands on care was observed until 6:02 A.M. on 10/24/24 when CNA #873 changed Resident #28 in the common area. The Administrator stated when she spoke with CNA #873 she reported she was unaware of Resident #28 being in the chair all night and could not recall who was assigned to provide care for Resident #28. When asked how that would be possible if CNA #873 was making rounds and did not locate Resident #28 in her bed, the Administrator indicated two aides were assigned to a unit and they worked in tandem to provide care. On 12/31/24 at 12:55 P.M., Regional Quality Assurance (QA) nurse #901 stated that generally all incontinent residents should be provided incontinence care at least every two hours but it was individualized such as if a resident did not want disturbed at night. If such a request was made it might be located on the plan of care. The Administrator was present and stated Resident #28 was restless and a fall risk and staff let her sleep when resting. On 12/31/24 at 1:24 P.M., Activity Director #816 verified she watched the video footage with the Administrator. Activity Director #816 stated she saw CNA #873 enter the area three times during her shift before the resident was changed. There was no movement on the camera since 8:00 - 8:30 P.M. Only a side view was available so it was unable to be determined if Resident #28 was sleeping or awake. Activity Director #816 revealed she believed CNA #873's statement about not knowing Resident #28 was sitting in the common area all night was fabricated to avoid disciplinary action. Activity Director #816 verified the incident occurred 10/23/24 but was not reported until 11/07/24. Video footage was only able to be reviewed for the past two weeks (and was no longer available). On 01/02/25 at 11:02 A.M., the Administrator stated she could not answer to the clinical side of things. However, she did not consider lack of hands on care/incontinence care for Resident #28 for such an extended period of time as neglect. RN #810, when interviewed, had indicated Resident #28 was urinating less related to decreased intakes. RN #810 indicated she was unaware Resident #28 had been sitting in a chair in the common area the entire shift. On 01/02/25 at 11:04 A.M., CNA #873 stated she never recalled providing incontinence care to any residents in common areas. CNA #873 verified Resident #28 was incontinent but would sometimes use the restroom after being provided cues. CNA #873 denied Resident #28 ever remained in the common area for extended periods although she would sometimes sit out there when her roommate was disruptive. On 01/02/25 at 2:29 P.M., CNA #850 stated it was not unusual for CNA #873 to wait until the end of the shift to provide incontinence care to residents. Resident #28 was incontinent of bowel and bladder and needed checked and changed every two to three hours. Resident #28 would usually go back to sleep after incontinence care was provided. Review of the facility's Abuse, Neglect and Exploitation of Residents and Misappropriation of Property policy (last dated September 2020 - did not indicate if date reviewed or revised) revealed neglect was identified as unintentionally failing to provide a resident with any treatment, care, goods or service necessary to maintain the health or safety of the resident when the failure results in serious physical harm to the resident. Neglect was also a failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. This deficiency represents non-compliance investigated under Complaint Number OH00159892.

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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** 22653 Based on medical record review, review of disciplinary action/investigative reports, policy review and interview, the facility failed to timely report allegations of possible neglect of a resident's physical needs and failed to report allegations of neglect to the state survey agency. This affected one (Resident #28) of two residents reviewed for abuse. Findings include: Review of Resident #28's medical record revealed diagnoses including Alzheimer's disease, dementia, generalized anxiety disorder, restlessness and agitation. A quarterly MDS dated [DATE] revealed Resident #28 had short and long term memory loss and had moderately impaired cognitive skills for daily decision making, and was always incontinent of bowel and bladder. A care plan initiated 03/27/24 revealed Resident #28 had alteration in thought process related to end stage Alzheimer's disease. Goals included for Resident #28's needs to be met on a consistent basis, to be clean, dry and odor free and for Resident #28 to be appropriately dressed. Interventions included providing simple daily routines and assisting with toileting and incontinence care as needed. When the Administrator was asked about a reported incident regarding Resident #28 not being provided incontinence care throughout one shift and staff providing incontinence care in a common area, investigation documentation was provided and revealed the following: Review of the assignment sheet revealed on 10/23/24, Certified Nursing Assistant (CNA) #873 worked with Registered Nurse (RN) #810 and one other aide. A witness statement by (CNA) #836 revealed when day and night shift aides did rounds, CNA #850 indicated she was glad CNA #873 had called off. CNA #850 reported CNA #873 had left Resident #28 up in the chair all night, and only changed her (provided incontinence care) before day shift arrived. CNA #850 told her (CNA #836) she had reported this to the nurse. Because it was first she had knowledge of it, CNA #836 reported it (the incident). An email dated 11/08/24 at 3:11 P.M. from CNA #873 revealed she had not provided care to Resident #28 since 11/01/24 and to her knowledge had never seen Resident #28 spend the night in her chair. The email indicated Resident #28 was changed and dressed in her room. A statement by the Administrator which indicated she and Activity Director #816 reviewed camera footage which revealed Resident #28 was placed in the television room at approximately 2:43 (interview of the Administrator on 12/31/24 at 12:40 P.M. revealed this was 2:43 P.M.) by a visitor. Resident #28 was provided her evening meal in the common area. It was noted Resident #28 did not leave the room the entire night. CNA #873 appeared at approximately 6:02 A.M. and changed Resident #28 in the common area prior to moving her. A notice of Corrective Action form dated 11/12/24 indicated CNA #873 was notified by phone of a written warning regarding poor customer service and instructed CNA #873 to make sure to always treat residents with respect and dignity. (continued on next page)

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	366087	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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	On 12/31/24 at 12:40 P.M., the Administrator stated when she reviewed the facility surveillance footage she noted Resident #28 was taken to the television room at 2:43 P.M. on 10/23/24. Resident #28 received dinner in the television room. No other staff interaction or hands on care was observed until 6:02 A.M. on 10/24/24 when CNA #873 changed Resident #28 in the common area. The Administrator stated when she spoke with CNA #873 she reported she was unaware of Resident #28 being in the chair all night and could not recall who was assigned to provide care for Resident #28. When asked how that would be possible if CNA #873 was making rounds and did not locate Resident #28 in her bed, the Administrator indicated two aides were assigned to a unit and they worked in tandem to provide care. On 12/31/24 at 1:24 P.M., Activity Director #816 verified she watched the video footage with the Administrator. Activity Director #816 stated she saw CNA #873 enter the area three times during her shift before she was changed. There was no movement on the camera since 8:00 - 8:30 P.M. Only a side view was available so it was unable to be determined if Resident #28 was sleeping or awake. Activity Director #816 revealed she believed CNA #873 statement about not knowing Resident #28 was sitting in the common area all night was fabricated to avoid disciplinary action. Activity Director #816 verified the incident occurred 10/23/24 but was not reported until 11/07/24 . Video footage was only able to be reviewed for the past two weeks. On 01/02/25 at 11:02 A.M., the Administrator stated she could not answer to the clinical side of things. However, she did not consider lack of hands on care/incontinence care for Resident #28 for such an extended period as neglect. Because it was not identified as potential neglect, the allegations were not reported to the state survey agency. Review of the facility's Abuse, Neglect and Exploitation of Residents and Misappropriation of Property policy (last dated September 2020 - did not indicate if date reviewed or revised) revealed neglect was identified as unintentionally failing to provide a resident with any treatment, care, goods or service necessary to maintain the health or safety of the resident when the failure results in serious physical harm to the resident. Neglect was also a failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. All alleged violations concerning abuse, neglect, misappropriation of property and injury of unknown origin were reported immediately to the administrator or designee. Reporting of all allegations not involving abuse or serious bodily injuries must not exceed 24 hours.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on medical record review, review of disciplinary action and investigative reports, policy review and interview, the facility failed to ensure a thorough investigation of allegations of possible neglect was completed. This affected one (Resident #28) of two residents reviewed for abuse. Findings include: Review of Resident #28's medical record revealed diagnoses including Alzheimer's disease, dementia, generalized anxiety disorder, restlessness and agitation. A quarterly MDS dated [DATE] revealed Resident #28 had short and long term memory loss and had moderately impaired cognitive skills for daily decision making, and was always incontinent of bowel and bladder. A care plan initiated 03/27/24 revealed Resident #28 had alteration in thought process related to end stage Alzheimer's disease. Goals included for Resident #28's needs to be met on a consistent basis, to be clean, dry and odor free and for Resident #28 to be appropriately dressed. Interventions included providing simple daily routines and assisting with toileting and incontinence care as needed. When the Administrator was asked about a reported incident regarding Resident #28 not being provided incontinence care throughout one shift and staff providing incontinence care in a common area, investigation documentation was provided and revealed the following: Review of the assignment sheet revealed on 10/23/24, Certified Nursing Assistant (CNA) #873 worked with Registered Nurse (RN) #810 and one other aide. A witness statement by (CNA) #836 revealed when day and night shift aides did rounds, CNA #850 indicated she was glad CNA #873 had called off. CNA #850 reported CNA #873 had left Resident #28 up in the chair all night, and only changed her (provided incontinence care) before day shift arrived. CNA #850 told her (CNA #836) she had reported this to the nurse. Because it was first she had knowledge of it, CNA #836 reported it (the incident). An email dated 11/08/24 at 3:11 P.M. from CNA #873 revealed she had not provided care to Resident #28 since 11/01/24 and to her knowledge had never seen Resident #28 spend the night in her chair. The email indicated Resident #28 was changed and dressed in her room. A statement by the Administrator which indicated she and Activity Director #816 reviewed camera footage which revealed Resident #28 was placed in the television room at approximately 2:43 (interview of the Administrator on 12/31/24 at 12:40 P.M. revealed this was 2:43 P.M.) by a visitor. Resident #28 was provided her evening meal in the common area. It was noted Resident #28 did not leave the room the entire night. CNA #873 appeared at approximately 6:02 A.M. and changed Resident #28 in the common area prior to moving her. A notice of Corrective Action form dated 11/12/24 indicated CNA #873 was notified by phone of a written warning regarding poor customer service and instructed CNA #873 to make sure to always treat residents with respect and dignity. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/31/24 at 12:40 P.M., the Administrator stated when she reviewed the surveillance footage she noted Resident #28 was taken to the television room at 2:43 P.M. on 10/23/24. Resident #28 received dinner in the television room. No other staff interaction or hands on care was observed until 6:02 A.M. when CNA #873 changed Resident #28 in the common area. The Administrator stated when she spoke with CNA #873 she reported she was unaware of Resident #28 being in the chair all night and could not recall who was assigned to provide care for Resident #28. When asked how that would be possible if CNA #873 was making rounds and did not locate Resident #28 in her bed, the Administrator indicated two aides were assigned to a unit and they worked in tandem to provide care. On 12/31/24 at 12:55 P.M., Regional Quality Assurance (QA) nurse #901 stated generally all incontinent residents should be provided incontinence care at least every two hours but it was individualized such as if a resident did not want disturbed at night. If such a request was made it might be located on the plan of care. The Administrator was present and stated Resident #28 was restless and a fall risk and staff let her sleep when resting. On 12/31/24 at 1:24 P.M., Activity Director #816 verified she watched the video footage with the Administrator. Activity Director #816 stated she saw CNA #873 enter the area three times during her shift before she was changed. There was no movement on the camera since 8:00 - 8:30 P.M. Only a side view was available so it was unable to be determined if Resident #28 was sleeping or awake. Activity Director #816 revealed she believed CNA #873 statement about not knowing Resident #28 was sitting in the common area all night was fabricated to avoid disciplinary action. On 12/31/24 at 1:40 P.M., the Administrator revealed she was unable to locate any evidence of the other aide working the night of 10/23/24 or the other aides who originally reported the problem being interviewed as part of the investigation. There was no indication staff were interviewed to inquire if they knew or were concerned Resident #28's needs were not being met why they did not ensure the care was provided. The Administrator indicated the aides assigned to a hall worked in tandem to provide care and were not assigned particular residents to care for. CNA #873 was suspended pending the investigation. No explanation was provided for the lack of action or education with other staff who were present and aware. Review of the facility's Abuse, Neglect and Exploitation of Residents and Misappropriation of Property policy (last dated September 2020 - did not indicate if date reviewed or revised) revealed neglect was identified as unintentionally failing to provide a resident with any treatment, care, goods or service necessary to maintain the health or safety of the resident when the failure results in serious physical harm to the resident. Neglect was also a failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. All alleged violations concerning abuse, neglect, misappropriation of property and injury of unknown origin were reported immediately to the administrator or designee. Reporting of all allegations not involving abuse or serious bodily injuries must not exceed 24 hours. The results of a thorough investigation of the allegation would be reported to the Ohio Department of Health within five working days of the incident.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on medical record review and staff interview, the facility failed to ensure a resident Pre-Admission Screening and Resident Review (PASRR) document accurately indicated all diagnoses. This affected one (Resident #37) of two residents reviewed for PASRR documents. The facility census was 49. Findings Include: Medical record review revealed Resident #37 was admitted to the facility on [DATE] with diagnoses including bipolar disorder, quadriplegia, depressive disorder, obsessive-compulsive disorder, and alcohol abuse. Review of the quarterly Minimum Data Set (MDS) assessment, dated 12/04/24, revealed the resident had intact cognition with diagnoses including depression and manic depression. Review of Resident #37's PASRR document, dated 09/25/24, revealed under Section E, the diagnosis of bipolar disorder and major depression. Review of the resident's diagnoses list revealed obsessive-compulsive disorder, which was not indicated on Section E. Further review of Section E revealed Resident #37's diagnosis of alcohol abuse was not indicated on the PASRR. Interview on 01/09/25 at 4:02 P.M. with Social Services Designee (SSD) #812 confirmed the resident's PASRR document did not indicate the diagnosis of obsessive-compulsive disorder and alcohol abuse. SSD #812 stated that she would make corrections and update Resident #37's PASRR.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on medical record review and interview, the facility failed to ensure residents and/or their representatives were provided with a written summary of the baseline care plan. This affected three (Residents #28, #29, and #97) of ten residents reviewed for baseline care plans. Findings include: 1. Review of Resident #28's medical record revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, dementia, seizures, moderate protein calorie malnutrition, hypertension, generalized anxiety disorder, generalized anxiety disorder, epilepsy, hyperlipidemia, difficulty swallowing, restlessness and agitation. No evidence was located indicating a summary of the baseline care plan was provided to the resident and/or resident representative. On 01/13/25 at 3:40 P.M., the Director of Nursing (DON) provided a form signed by Social Service Designee (SSD) #812 which indicated discharge planning was discussed. The DON verified there was no information indicating Resident #28 and/or her representative provided with a summary of the baseline care plan. 2. Review of Resident #29's medical record reviewed an admitted [DATE]. Diagnoses included spinal stenosis of the lumbar region with neurogenic claudication, muscle wasting and atrophy, need for assistance with personal care, generalized muscle weakness, difficulty walking, moderate protein-calorie malnutrition, chronic pulmonary edema, muscle spasm, hypertension, hypokalemia, hypo-osmolality and hyponatremia, alcohol abuse, anxiety disorder, chronic pain, major depressive disorder, obstructive sleep apnea, osteoarthritis, and cardiomyopathy, An admission Minimum Data Set (MDS) assessment indicated Resident #29 was cognitively intact. No evidence was located indicating a summary of the baseline care plan was provided to Resident #29 and/or his representative. On 01/06/25 at 11:30 A.M., Resident #29 revealed he had not been offered any meetings with the interdisciplinary team to discuss his care/medications and did not believe staff took his input into his care seriously. On 01/13/25 at 3:40 P.M., the DON verified there was no evidence Resident #29 was provided a summary of the baseline care plan. 3. Review of Resident #97's medical record revealed an admitted [DATE]. Diagnoses included osteomyelitis, generalized muscle weakness, moderate protein-calorie malnutrition, type two diabetes mellitus with a foot ulcer, atrial fibrillation, coagulation defect, heart disease, obstructive and reflux uropathy, acute kidney failure, malignant neoplasm of the prostate. No evidence was located indicating a summary of the baseline care plan was provided to Resident #29 and/or his representative. On 01/13/25 at 3:40 P.M., the DON verified there was no evidence Resident #97 was provided a summary of the baseline care plan.

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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** 28701 Based on resident interview, medical record review and staff interview, the facility failed to ensure medication orders for the use of laxatives were transcribed and administered as ordered for Resident #29 and vital signs obtained as ordered for Resident #9. This affected two (Resident #29 and #9) of 20 residents reviewed. The facility census was 49. Findings include: 1. Review of Resident #29's medical record revealed an admitted [DATE] with diagnoses that included spinal stenosis, chronic pulmonary edema and constipation. Review of the Minimum Data Set (MDS) 3.0 admission assessment with a reference date of 12/17/24 indicated the resident had an independent and intact cognition level. Further review of the medical record including physician progress notes revealed on 12/24/24 Resident #29 was evaluated by the physician. Resident #29 had a concern of constipation. The physician ordered the use Milk of Magnesia (laxative) 30 milliliters (ml) daily until a bowel movement, then change to daily as needed. Review of the medication administration record (MAR) revealed on 12/24/24 the physician's order for medication was transcribed as milk of magnesia 30 ml daily as needed, not as daily until a bowel movement, then change to daily as needed. No evidence of the medication being administered daily was noted as indicated by the physician on 12/24/24. A nurse's note on 12/30/24 indicated a change in the medication order and changed to milk of magnesia 30 ml daily. Review of the MAR revealed on 12/30/24 the milk of magnesia was changed to daily and administered daily from 12/30/24 through 01/13/25. Review of Resident #29's bowel movement records revealed a bowel movement on 01/01/25. There was no evidence the milk of magnesia was then changed to as needed as indicated by the physician. Interview with Resident #29 on 01/06/25 at 3:08 P.M. revealed concerns related to constipation and use of laxatives. On 01/14/25 at 12:55 P.M. interview with the Director of Nursing revealed she had discovered the transcription error of the physician's order from 12/24/24 and clarified the order on 12/30/24. She further verified the clarified order was also transcribed incorrectly and did not indicate to change the milk of magnesia 30 ml to as needed after a bowel movement occurs. 33019 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #9 revealed an admitted [DATE] with diagnoses including amyotrophic lateral sclerosis, cerebral palsy, muscle weakness, dysphagia, pressure ulcer of sacrum, and schizophrenia. Review of Resident #9's Care Plan, initiated on 05/03/23, revealed the resident had gastroesophageal reflux disease with the intervention to obtain and monitor vital signs per routine. Review of physician order, dated 09/24/24, revealed the order to obtain vital signs every day shift. Review of a physician order, dated 12/17/24, revealed the order to obtain vital signs every Thursday. Review of the vital sign task log and medication administration record (MAR) revealed there were no vital signs obtained on 12/15/24, 12/16/24, 12/17/24, or 12/19/24. During interview on 01/08/25 at 5:11 P.M., the Director of Nursing (DON) confirmed vital signs are documented in the electronic medical record on the vital sign task log and/or on the MAR. The DON confirmed there was no documented evidence of Resident #9's vital signs having been obtained as ordered by the physician.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on observation, medical record review, policy review, and interview, the facility failed to provide appropriate services after being observed on the floor. This affected one (Resident #26) of three residents reviewed for accidents. Findings include: Review of Resident #26's medical record revealed diagnoses including schizophrenia, muscle wasting and atrophy, parkinsonism, generalized muscle weakness, difficulty walking, need for assistance with personal care, blindness in one eye, and seizures. An annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #26 was usually able to make herself understood and was severely cognitively impaired. Resident #26 had inattention and disorganized thinking which fluctuated. Resident #26 had two or more falls since the prior assessment. A nursing note dated 12/31/24 at 2:42 P.M. indicated Licensed Practical Nurse (LPN) #844 was walking onto the unit when an aide notified her Resident #26 had fallen. When LPN #844 got to Resident #26's room she was already sitting in her wheelchair. On 12/31/24 at 2:26 P.M. Resident #26 was observed sitting on the floor by her bed. Certified Nursing Assistant (CNA) #846 was notified who then informed CNA #837. The two CNAs proceeded to Resident #26's room and placed her in her wheelchair before CNA #837 walked down the hall to notify the nurse. On 12/31/24 at 2:30 P.M., CNA #837 stated she would normally inform the nurse before moving a resident off the floor but Resident #26 would tell staff at times she sat herself on the floor so the CNAs transferred her without having the nurse assess her first. On 01/14/25 at 9:43 A.M., the Director of Nursing (DON) verified if a resident was found on the floor or a fall was witnessed , a nurse should be notified and assess the resident before moving the resident. Review of the facility's Falls Program policy (not dated) revealed the falls committee was to be notified immediately at the time of the fall to determine the resident's condition and to initiate the investigation of the potential root cause of the fall.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on record review and interview the facility failed to ensure consistent communication with dialysis and ensure medications were given per physician order on dialysis days. This affected one resident (#17) of one resident reviewed for dialysis. The facility census was 49. Findings include: Review of the medical record for Resident #17 revealed an admitted [DATE]. Diagnoses included noninfective gastroenteritis and colitis, moderate protein-calorie malnutrition, type 2 diabetes mellitus with diabetic nephropathy, diarrhea, end stage renal disease, hypomagnesemia, and dependence on renal dialysis Review of the admission minimum data set (MDS) assessment dated [DATE] revealed Resident #27 had intact cognition, required setup or clean up help for eating, received a therapeutic diet, and was on dialysis. Review of the physician orders for January 2025 revealed active orders for: Dialysis on Monday, Wednesday and Friday with chair time at 6:00 A.M., Calcium Acetate (phosphate binder) Oral Tablet 667 milligrams (mg) to give two tablets by mouth with meals for phosphorus binder, Diclofenac Sodium External Gel 1 % (Diclofenac Sodium (Topical) to apply to right knee topically in the morning for pain; famotidine Oral Tablet 10 mg (Famotidine) to give 10 mg enterally in the morning for gastroesophageal reflux disease (GERD), Nortriptyline HCl Oral Capsule 50 mg (Nortriptyline HCl) to give 50 mg by mouth two times a day for antidepressant, B-Complex-C Oral Tablet (B Complex w/ C) to give one tablet by mouth in the morning for supplement, Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 mg (Metoprolol Succinate) to give 25 mg by mouth two times a day for beta blocker, Saccharomyces boulardii Oral Capsule 250 mg (Saccharomyces boulardii) to give 250 mg by mouth three times a day for probiotic, Cholecalciferol Oral Tablet (Cholecalciferol) to give 25 micrograms (mcg) by mouth in the morning for supplement, Midodrine HCl Oral Tablet 5 mg (Midodrine HCl) to give five mg by mouth before meals for vasopressor related to atrial fibrillation, Eliquis Oral Tablet 5 MG (Apixaban) to give five mg by mouth two times a day for anticoagulant, Trulicity Subcutaneous Solution Auto-injector 0.75 MG/0.5 ML (Dulaglutide) to inject 0.75 mg subcutaneously in the morning every Wednesday for diabetes Review of the November 2024 medication administrator record (MAR) indicated the medications were not given due to the resident was absent from home or on a leave of absence (LOA) for the following dates: 11/20/24, 11/22/24, 11/24/24, and 11/26/24. Except for the Nortriptyline and Saccharomyces boulardii also included 11/29/24. The Calcium Acetate was noted not given on 11/26/24 and 11/29/24 and the Eliquis on 11/22/24, 11/24/24, 11/26/24, and 11/29/24. Review of the December 2024 MAR revealed the above medications were not given due to the resident was absent from the home/LOA on the following dates: 12/02/24, 12/04/24, 12/06/24, 12/09/24, 12/11/24, 12/16/24, 12/18/24, 12/20/24, 12/22/24, and 12/31/24. The Trulicity only on 12/11/24. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of January 2025 MAR revealed the above medications were not given due to the resident was absent from the home/LOA on the following dates: 01/06/25 and 01/08/25. The Trulicity only on 01/08/25. Review of the plan of care revised 01/06/25 revealed Resident #17 received dialysis on Monday, Wednesday, and Friday with chair time at 6:00 A.M. Interventions included maintain communication with dialysis staff and physician. Interview on 01/08/25 at 1:17 P.M. with Resident #17 revealed at times he doesn't get his morning medications before dialysis and when that happens, he gets them when he returns, he thinks. Resident #17 stated it could also be his afternoon medications. Interview on 01/08/25 at 3:20 P.M. with Registered Nurse (RN) #802 stated morning medication range was between 7:30 A.M. and 10:30 A.M. RN #802 stated Resident #17 he goes out to dialysis by 5:30 A.M. which was technically night shift. And when he returns it just before lunch and outside of the morning range. RN #802 stated most of his morning medications included vitamins and the others he gets later in the day as well. RN #802 stated Resident #17 wasn't getting those medications on dialysis days. RN #802 stated they send paperwork with Resident #17 and verified they don't always send the paperwork back completed with their information. RN #804 stated she knew the facility dietitian communicates with dialysis. Interview on 01/08/25 at 5:22 P.M. with MDS Nurse #805 provided the dialysis communication forms the listed pre-treatment and post-treatment information for Resident #17 dated 11/19/21, 11/24/24, 11/29/24, 12/06/24, and 12/29/24. MDS Nurse #805 verified those were the only communication forms she found and that she would have to call dialysis to get more. MDS Nurse #805 stated they send them, but dialysis does not send them back. Interview on 01/09/25 at 9:53 A.M. with the Director of Nursing (DON) verified the noted morning medications on the MARS for Resident #17. DON stated the time of the scheduled morning medications, Resident #17 has already left for dialysis before the dayshift arrive to work. DON stated there was no order to hold the medications until he returns or to give early, but she would reach out to the physician. Interview on 01/09/25 at 12:29 P.M. with the Interim Registered Dietitian (IRD) #800 stated she didn't see any formal notes indicating communication between the facility RD and dialysis, but she was going to be connecting with dialysis today. IRD #800 stated the RD follow up with dialysis on a as needed basis or per the facility policy. Review of the facility policy titled Dialysis, undated revealed the facility will maintain the safety and health of the resident receiving dialysis services on a routine basis. Residents receiving hemodialysis or peritoneal dialysis will be monitored by the dietitian for nutritional and fluid needs and restrictions. Intake and output will be recorded per the physician's order.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on observations, interview, review of schedules, and record review, the facility failed to ensure there was sufficient staff to provide residents with timely care. This had the potential to affect all 48 residents. Findings include: 1. During confidential interviews of residents and family, concerns were addressed regarding staffing levels. Interviewees did not wish to be identified but concerns addressed included failure of staff to provide timely assistance with three of the residents interviewed revealing wait times for call light response had extended to an hour or more. It was reported this had affected toileting, ability to transfer, medications not being administered on time and incontinence. On 12/30/25 at 6:00 A.M., Certified Nursing Assistant (CNA) #850 stated there had been times where there was one aide. When there was one aide residents who required transfers with mechanical lifts were not able to be transferred as requested. On 12/30/24 at 6:40 A.M., CNA #840 reported from the hours of 11:00 P.M. to 7:00 A.M., employees in the nursing facility were also required to address any needs that arose for the residential care facility residents. On 01/08/25 at 4:10 P.M., Licensed Practical Nurse (LPN) #844 reported she had worked with one aide on a hall in the past. LPN #844 stated she attempted to assist the aide to provide care but medications could not be administered on time. On those occasions when the facility had one aide she noticed residents might be asked if they wanted a shower but were not encouraged to take one. 2. During the resident council meeting on 01/07/25 between 2:06 P.M. and 2:20 P.M. with three additional residents who were not previously included in the interviews addressed under example #1, residents reported there was insufficient staff to provide the care needed without residents waiting a long time. 3. Interview of a CNA who wished to remain anonymous on 01/07/24 revealed she had worked as the lone full duty nursing assistant even though one time there was a light duty aide who could not provide assistance with lifting. Even if there was one nursing assistant, that person was expected to cover the attached Resident Care Facility residents' needs also if there was no Resident Assistant on duty. The 100 hall had ten residents who required two assists when care was provided. Some of the nurses would try to assist but showers were not consistently able to be provided. Sometimes bathing consisted of wiping armpits and perineal areas. The facility hired staff but they did not consistently stay. 4. On 01/08/25 at 1:50 P.M., CNA #828 revealed she had never worked with less than two aides on the 100 hall but it would not be possible to provide care residents needed. Residents tried to be understanding. Sometimes the ability to provide resident care was dependent on residents' expectations on any given day. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. On 01/09/25 at 9:39 A.M., the call light in room [ROOM NUMBER] was observed to be activated. No staff were in the room. Resident #2 was observed sitting in the wheelchair and stated she was waiting for assistance to use the bathroom. Resident #2 reported since she started using a mechanical lift it had been a wait time up to one to two hours for sufficient staff to be available to assist with toileting and it had lead to incontinence. On 01/09/25 at 9:49 A.M., Activity Assistant #814 reported to two aides providing assistance to Resident #10 that she was answer the call light in room [ROOM NUMBER]. An unidentified housekeeper had been observed walking past the call light without responding and one other unidentified staff member walked past room [ROOM NUMBER] twice without inquiring if she could provide assistance. On 01/09/25 at 9:50 A.M., Resident #2's call light was turned off then Activity Assistant #814 proceeded to do activity related duties. A call light in room [ROOM NUMBER] was activated at approximately the same time Resident #2's call light was turned off. At 9:53 A.M., Activity Assistant #814 reported to staff in Resident #10's room about Resident #2's request. On 01/09/25 at 9:58 A.M., two certified nursing assistants exited Resident #10's room. An unidentified staff member reported to them that the resident in room [ROOM NUMBER] was requesting assistance from one of the aides. One of the aides (backs turned toward surveyor) requested the staff member informed the resident in room [ROOM NUMBER] they had two other residents to lie down then they would be with him. The unidentified staff member then stated she thought the resident in room [ROOM NUMBER] wanted his machine turned off. CNA #828 referred the staff member to the nurse stating she was the one who would have to turn off the machine. The unidentified staff member responded she did not know but he had requested a nursing assistant and walked down the hall. Meanwhile, Resident #1 who had been in the common lounge area on the 100 hall yelled out (had been periodically doing so throughout the observation). One of the CNAs was overheard asking Resident #1 if she wanted to lie down and she responded affirmatively. The CNA responded they would be with her in a few minutes then entered room [ROOM NUMBER] with the mechanical lift. On 01/09/25 at 10:07 A.M. Resident #2 was overheard calling out when she saw LPN #838 in the hall. LPN #838 asked what Resident #2 needed. Resident reported she had been waiting on the aides. Her call light had been turned off by another staff member and she had been told both aides were busy with another resident. LPN #838 responded she would get the aides to assist her. On 01/09/25 at 10:09 A.M. two CNAs exited room [ROOM NUMBER] with the mechanical lift and assisted Resident #1 to her room with the mechanical lift. While in the hall, Resident #1 reported she would also like to have her teeth brushed. At that time in call light in room [ROOM NUMBER] remained on and call lights in rooms [ROOM NUMBERS] had been activated. Resident #129 was moving around in the bed and cursing. On 01/09/25 at 10:14 A.M., Resident #2 had once again reactivated her call light. On 01/09/15 at 10:15 A.M., LPN #838 responded to Resident #2's call light. Resident #2 was overheard repeating she needed aides. LPN #838 responded the aides were in the next room and she would inform them. At 10:17 A.M. LPN #838 responded to the call light in room [ROOM NUMBER]. At 10:21 A.M., LPN #838 responded to the call light in room [ROOM NUMBER] and turned it off stating she would tell the girls. LPN #838 the proceeded to room [ROOM NUMBER] and told the aides the resident in room [ROOM NUMBER] wanted to get up. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/09/25 at 10:22 A.M., one of the aides exited room [ROOM NUMBER] with the left then the second aide exited the room. LPN #838 informed the aides the order she turned off the call lights was room [ROOM NUMBER] (Resident #2's room), room [ROOM NUMBER], and room [ROOM NUMBER]. LPN #838 indicated the resident from room [ROOM NUMBER] was in the bathroom doing his morning routine so he would probably not need assistance for a while. One of the aides proceeded to room [ROOM NUMBER]. It was not observed where the second aide went but at 10:30 A.M. the second aide was observed walking down the residential care facility hall. At 10:31 A.M., one of the aides exited room [ROOM NUMBER]. At 10:35 A.M., one of the aides was in room [ROOM NUMBER]. The other aide obtained the mechanical lift at 10:36 A.M. and stopped by room [ROOM NUMBER] to ask if the other aide could help her with Resident #2. Both aides were in Resident #2's room at 10:37 A.M. to provide assistance. On 01/09/25 at 10:20 A.M., LPN #838 stated it was often busier than it was that morning, acknowledging the wait times for Resident #2 were probably correct. On 01/09/25 at 4:20 P.M., Regional Director of Operations #905 stated she would generally consider toileting should occur within 20 minutes of a request but it varied her resident. Observations would shared regarding Resident #2 having waited a minimum of 58 minutes for toileting assistance and she agreed it was not the number of staff that mattered but the timeliness and quality of the care. Review of the Facility assessment dated [DATE] revealed staffing was based on resident population and acuity. The staffing plan was based on the facility assessment, along with facility-based and community based risk assessments to inform staffing decisions to ensure that there were a sufficient number of staff to care for the residents' needs. 6. During an interview with Ombudsman #950 on 12/30/24 at 9:20 A.M., it was reported during previous visits to the facility he had observed call lights taking over an hour for response, especially on the 100 hall where many residents need two assists. This had been discussed with the Administrator and she was asked to review staff levels. This deficiency represents non-compliance investigated under Master Complaint Number OH00160455 and Complaint Number OH00159892.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 28701 Based on employee personnel file review, policy review and staff interview, the facility failed to ensure employees had performance evaluations completed at 90 days and annually. This occurred with four certified nursing assistants (CNA) personnel files reviewed (#807, #816, #850, #873) and had the potential to affect all 49 residents residing in the facility. Findings include: Review of staff personnel files with Human Resources (HR) #877 on 01/14/25 at 9:40 A.M. revealed the following concerns: CNA #807 was hired on 09/24/00 and did not have an annual performance evaluation completed for 2024. CNA #816 was hired on 05/31/18 and did not have an annual performance evaluation completed for 2024; CNA #850 was hired on 04/04/24 and did not have a 90 day performance evaluation completed; CNA #873 was hired on 05/03/24 and did not have a 90 day performance evaluation completed. On 01/14/25 at 9:45 A.M. interview with HR #877 verified CNA #807, CNA #816, CNA #850 and CNA #873 did not have the required performance evaluations completed as required. Review of the facility policy titled Performance Evaluations, dated 01/10 indicated employee must receive a 90-day evaluation and an annual evaluation on or before their anniversary date.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 22653 Based on observation and interview, the facility failed to post required nursing staffing information. This had the potential to affect all 48 residents. Findings include: On 12/30/24 at 6:35 A.M., the facility's staffing information from 12/25/24 was observed posted near the kitchen. There were no additional forms posted behind it or elsewhere. On 12/30/25 at 6:35 A.M., Activity Director #816 verified the staff posting was dated 12/25/24 with no additional postings available. On 12/30/24 at 8:30 A.M., Activity Director #816 provided a notebook she stated was found in the staff break room and stated the nurse who was responsible for posting the forms was unaware of where the information was to be posted as she was covering for another staff member. Activity Director #816 acknowledged residents and visitors did not have access to the break room to obtain the information.

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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** 33019 Based on record review and interview, the facility failed to ensure pharmacy recommendations were addressed by the physician. This affected two (Resident #38 and Resident #10) of five residents reviewed for unnecessary medications. The facility census was 49. Findings include: 1. Review of the medical record revealed Resident #38 was admitted to the facility on [DATE] with diagnoses including cerebral ischemia, muscle weakness, diabetes mellitus, chronic obstructive pulmonary disease, and peripheral vascular disease. Review of the Minimum Data Set (MDS) 3.0 quarterly assessment, dated 12/10/24, revealed a Brief Interview for Mental Status (BIMS) assessment could not be completed. The resident was dependent on staff for physical assistance with activities of daily living (ADL)s. Review of the Monthly Regimen Review (MRR), dated 06/25/24, revealed the pharmacist recommended the intervention to rinse the resident's mouth with water after the use of her corticosteroid inhaler Advair to prevent thrush from developing. The physician did not address or sign the pharmacy recommendation. Review of the Monthly Regimen Review (MRR), dated July 2024, revealed the pharmacist advised the physician that the resident was receiving Meloxicam (non-steroidal antiinflammatory medication for pain) 15 milligrams (mg) twice daily. The pharmacist recommendation was to use the lowest effective dose for the shortest duration of time. The physician did not address or sign the pharmacy recommendation. Interview on 01/13/25 at 4:05 P.M., with the Director of Nursing (DON) confirmed there was no evidence of the physician addressing Resident #38's pharmacy recommendations for June or July 2024. 28701 2. Review of Resident #10's medical record revealed an admitted [DATE] with diagnoses that included chronic osteomyelitis, paraplegia, pressure ulcer to sacrum and diabetes mellitus. Resident #10's medications were reviewed monthly by a pharmacist. Review of the pharmacy recommendations on 01/25/24, 02/20/24 and 03/14/25 revealed the pharmacist requested a clarification for pain medication use due to Percocet (opioid analgesic pain medication) being used for minor pain. There was no evidence the pharmacist recommendation was addressed by the physician. On 01/13/24 at 4:12 P.M., interview with the Director of Nursing verified the physician did not address the pharmacist's recommendations. (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 the facility policy Medication Regiment Review and Reporting dated 09/08 revealed the consultant pharmacist reviews the medication regimen of each resident at least monthly. Findings and recommendations are communicated to those with authority and/or responsibility to implement the recommendations and responded to in an appropriate and timely fashion.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on medical record review, interview and policy review , the facility failed to obtain a laboratory sample/test in a timely manner or as ordered. This affected one (Resident #37) of two residents reviewed for isolation and one (Resident #9) of five residents reviewed for unnecessary medications. Findings include: Review of Resident #37's medical record revealed diagnoses of enterocolitis due to clostridium difficile (diagnosis list indicated a date of 08/27/24), need for assistance with personal care, bipolar disorder, quadriplegia, and obsessive-compulsive disorder. A nursing note dated 12/19/24 at 1:49 P.M. indicated Resident #37 complained of severe diarrhea which had an odor to it. The physician was contacted and an order was received to obtain a stool specimen to rule out clostridium difficile (a very contagious bowel infection). A nursing note dated 12/19/24 at 3:51 P.M. indicated a stool specimen was collected. A nursing note dated 12/21/24 at 7:58 A.M. indicated a stool sample was to be collected and sent via (the contracted lab) in a sterile plain specimen cup on the next lab day. A laboratory report indicated a stool sample was collected on 12/27/24. On 12/28/24, the laboratory specimen was determined to be positive for c diff and reported. A nursing note dated 12/29/24 at 10:50 A.M. indicated Resident #37 tested positive for c diff. New orders were received for vancomycin (antibiotic) 125 milligrams (mg) four times a day for ten days. Resident #37 was notified. On 12/30/24, an order was written for contact isolation precautions with all services being provided in his room for c diff infection. The care plan did not address current isolation/antibiotic use. During an interview on 01/07/25 at 4:55 P.M., Registered Nurse (RN) #900 verified the order to obtain the stool sample to test for c diff was written 12/19/24. RN #900 provided a lab report indicating a specimen was obtained 12/19/24 and received by the lab 12/20/24. The specimen was not obtained in the correct container. The nurses were notified of this on 12/21/24. Instructions revealed the stool sample could be sent the next lab day. RN #900 indicated lab days were usually Mondays, Wednesdays and Fridays. An official lab report on 12/23/24 indicated an incorrect specimen was sent. RN #900 stated she was unable to explain why a new sample was not obtained until 12/27/24 as bowel records revealed Resident #37 had a large loose bowel movement on 12/23/24, 12/24/24 and 12/25/24. 2. Review of the medical record for Resident #9 revealed an admitted [DATE] with diagnoses including amyotrophic lateral sclerosis, cerebral palsy, muscle weakness, dysphagia, pressure ulcer of sacrum, and schizophrenia. Review of Resident #9's Care Plan, initiated on 04/10/24, revealed the intervention to monitor labs as ordered and to inform the physician of abnormal labs. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a laboratory report, dated 10/14/24, revealed a comprehensive metabolic panel laboratory test was ordered and the test could not be obtained due to the resident being unwilling and combative. Review of a nursing progress note, dated 10/14/24 at 6:24 P.M., revealed labs were unable to be obtained due to the resident being combative. The physician was notified, and the labs were rescheduled for Wednesday, 10/16/24. During interview on 01/09/25 at 11:40 A.M., the Director of Nursing (DON) confirmed the resident refused lab testing on 10/14/24, the physician was notified and re-ordered the labs for 10/16/24; however, there is no documented evidence of a laboratory order for 10/16/24 or of a resident refusal. Review of the facility policy titled, Lab Draws, undated, revealed the health care facilities of Continuing Healthcare Solutions will implement lab orders as written and maintain written standards and practice guidelines regarding physician ordered lab draws. The nurse accepting the order will enter the ordered lab into the lab computer to communicate the order draw requirements with the lab.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 39969 Based on observation, interview, test tray, packaging label review, portion chart review and policy review the facility failed to ensure the menu and menu spreadsheet were followed to ensure accurate portions and food items were served. This had the potential to affect all residents. The facility census was 49. Findings include: Review of the menu for 01/08/25 revealed sauce with meatballs, rigatoni pasta, and Italian blend mixed vegetables. Review of the menu diet spreadsheet revealed: Regular diet: three each meatballs, four ounce (oz) spoodle of rigatoni and Italian vegetables Mechanical soft diet: #8 scoop of ground meatballs, 1/2 cup of carrots Pureed diet: three #30 scoop (black handle provide one ounce each) for pureed meatballs and #8 scoop (gray handle provide four ounces) for the pureed pasta Observation of tray line on 01/08/25 at 11:48 A.M. revealed Dietary [NAME] (DC) #801 observed to plate three meatballs for the regular diet using a black slotted spoon. DC #801 used the same black slotted spoon to serve the mechanical soft meatballs and serve the Italian blend mixed vegetables for the mechanical soft diet. No carrots were observed on the tray line. Observation on 01/08/24 at 12:34 P.M. of the test tray with Dietary Manager (DM) #806 of the regular diet meatballs and rigatoni revealed two meatballs. DM #806 verified there were only two meatballs and stated the recipe called for two but verified the menu diet spread sheet called for three meatballs. Observation on 01/08/25 at 12:40 P.M. revealed last meal cart (dining room) being pushed out of kitchen. Observation of tray line at the end of service with DC #801 revealed the black slotted spoon did not indicate a serving size and was used to serve the meatballs and mechanical soft meatballs. DC #801 verified and stated she did not know what the serving size was for the black slotted spoon. At this time DM #806 came verified she was unable to say what serving size the black slotted spoon provided. Further observation of tray line revealed a blue handled scoop in the pureed pasta and a red handled scoop in the pureed meatballs. DM #806 stated the blue handled scoop was a #16 and the red handled scoop was a #24. DM #806 verified the serving utensils for the mechanical soft meatballs, pureed meatballs, and pureed pasta were not the correct servings. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 01/08/24 at 12:48 P.M. with DC #801 and DM #806 revealed DC #801 only provided one serving each for the pureed pasta and pureed vegetables. DM #806 stated the recipe for the regular meatballs were for homemade meatballs and it called for two meatballs for the serving size. DM #806 stated the meatballs used for the meal were frozen. DM #806 verified the packaging label for the frozen meatballs called for three meatballs for a serving and the menu diet spreadsheets also indicated three meatballs. DC #801 and DM #806 both stated they had carrots available and verified carrots were not prepared or served for the mechanical soft diet. Review of the portion control chart revealed the #30 scoop (black handle) provided one oz serving. The #24 scoop (blue handle) provided one 1/3 oz serving. The #8 scoop (gray handle) provided four oz serving. Review of the packaging label for the cooked, frozen meatballs revealed a serving was three meatballs. Review of the facility policy titled Portion Control, undated revealed individuals will receive the appropriate portions of food as outlined on the menu. Control at the point of service is necessary to assure that accurate portion sizes are served. Review of the facility policy titled Accuracy and Quality of Tray Line Service, undated revealed the director of food and nutrition services or designee will be responsible for assuring that all foods needed for meal assembly are present at the appropriate time. The meal will be checked against the therapeutic diet spread sheet to assure that foods are served as listed on the menu.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 22653 Based on observation, review of a dietary department snack list, and interview, the facility failed to ensure snacks were provided at bedtime. This affected Residents #6, #9, #10, #14, #18, #25, and #37 but had the potential to affect all 48 residents residing in the facility. Findings include: During a resident council meeting on 01/07/25 between 2:06 P.M. and 2:20 P.M. Residents #10, #14, #18, and #25 indicated bedtime snacks were not offered. If snacks were requested, staff would tell them none were available. On 01/08/25 at 12:48 P.M., Dietary Manager (DM) #806 stated upon admission she interviewed residents to determine if they wanted a snack then a label was made for them. If a resident changed their mind about wanting snacks it was the responsibility of the residents or nursing staff to ensure the dietary department was aware. Review of the snack labels revealed Resident #10 was to receive milk for bedtime snack. Residents #14 and #18 did not have a label for a snack. Resident #25 was to receive a plain peanut butter sandwich. On 01/08/25 at 4:27 P.M., Dietary Aide #815 stated in addition to snacks that were sent for specific residents each unit received an extra eight to 10 snacks at night. Dietary Aide #815 stated he assumed aides were passing the snacks. Sometimes snacks were returned to the kitchen the following morning. On 01/09/25 at 12:05 P.M., a tray sitting on the 100 hall nursing stated revealed three snacks with labels dated 01/08/24 at bedtime. The snacks were unopened. There was no documentation of refusal of the snacks. Among the snacks was a peanut butter sandwich for Resident #9, a peanut butter and jelly sandwich for Resident #6 and a pack of peanut butter and cheese crackers for Resident #37. On 01/09/25 at 12:37 P.M., Licensed Practical Nurse (LPN) #838 stated she was unaware if or where intake of bedtime snacks was recorded. Residents did not receive snacks on day shift. On 01/09/25 at approximately 2:35 P.M., Dietary Manager #806 stated staff did not always inform her if a resident refused a snack. Sometimes the snacks were returned to the kitchen with no documentation as to why they were not consumed. Interview on 01/09/25 at 1:52 P.M., Resident #37 stated that he has never been offered snacks and would like to be offered one in the evening. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/09/25 at 3:55 P.M., Activity Director #816 (had been covering as a dietary manager until DM #806 was recently hired) stated there was no documentation of whether residents had snacks offered and if they accepted or refused them. Activity Director #816, Dietary Manager #806 and the Administrator were all present. No explanation was provided regarding discrepancies in what residents reported and the information provided by staff. Activity Director #816 stated in addition to the residents who received snacks labeled specifically per their request, additional snacks were provided in the event another resident wanted a snack. None of the three staff members were working when the snacks were delivered to the units and could not state with certainty that they were offered/provided.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39969 Based on observation, interview, and review of the facility policy and procedure the facility failed to maintain the ice machine in a clean and sanitary manner. This had to potential to affect all residents except one resident (#36) who had a physician order for no fluids. The facility census was 49. Findings include: Observation during the tour of the kitchen on 01/06/25 from 9:17 A.M. to 9:30 A.M. with Dietary Manager (DM) #806 revealed the ice machine located outside of kitchen, on the outside of each side of the ice machine was a moderate amount of a white substance running down each side. Interview on 01/06/24 between 9:17 A.M. and 9:30 A.M., with DM #806 verified the white substance and stated when they place the water softener it will help eliminate that substance. DM #806 stated she believed the ice machine was cleaned monthly. Review of the facility policy titled Food Safety: Ice, undated revealed ice machines and containers will be cleaned and sanitized on a regular basis.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 33019 Based on record review and interview, the facility failed to ensure medical records were complete and contained documentation regarding medication administration, catheter care, a fall, a dietary upgrade, activities of daily living, restorative care, and the refusal of a dental extraction. This affected six (Resident #9, #13, #97, #26, #1, and #10) of 23 records reviewed for documentation. The facility census was 49. Findings include: 1. Review of the medical record for Resident #9 revealed an admitted [DATE] with diagnoses including amyotrophic lateral sclerosis, cerebral palsy, muscle weakness, dysphagia, pressure ulcer of sacrum, and schizophrenia. Review of the Care Plan, initiated on 04/25/22, revealed the resident received antipsychotic medication for schizophrenia with interventions including to administer medications as ordered. Review of Physician Order, dated 03/28/24 revealed the order for Aristada 882 milligrams (mg)/3.2 milliliters (ml) to be injected intramuscularly (IM) monthly on the first day of the month. Review of Resident #9's Medication Administration Record (MAR) dated August, September, and October 2024, revealed no documentation of the administration of Aristada 882 mg/3.2 ml IM. Interview on 01/09/25 at 11:40 A.M. with the Director of Nursing (DON) confirmed there was no documentation on Resident #9's MARs for August, September, and October 2024. The DON further confirmed the nurse failed to document properly in the medical record. 22653 2. Review of Resident #13's medical record revealed diagnoses including chronic obstructive pulmonary disease, moderate protein-calorie malnutrition, congestive heart failure, adult failure to thrive, cerebral infarction and alcohol abuse. A physician progress note dated 11/07/24 at 8:41 P.M. indicated Resident #13 complained of a migraine headache. Resident #13 stated he got the migraines about four times per month. The migraines typically resolved after a day or two with Tylenol and ibuprofen but this one had lasted one week. Occasionally the migraines were associated with photophobia (an abnormal intolerance to light) and nausea. The physician started sumatriptan (imitrex) (migraine medication) 50 milligrams (mg) at the onset of a migraine and may repeat two hours later with a maximum dose of 100 mg a day. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #13 was cognitively intact. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/06/25 at 11:58 A.M., Resident #13 stated the facility ran out of his migraine medication and his migraines were so bad it made him sick. On 01/07/25 at 2:49 P.M., Resident #13 stated the migraines were getting out of control. On 01/06/25 at 2:48 P.M., Licensed Practical Nurse (LPN) #838 stated she had called pharmacy and Resident #13 could only be provided nine sumatriptan over a 30 day period due to insurance. The prescription was last filled 12/15/24. Usually if it was an insurance issue nursing services received a notice and nursing could speak to manager about covering the cost. LPN #838 stated she had not seen a notice regarding Resident #13's sumatriptan. Review of the December 2024 and January 2025 Medication Administration Records (MAR) revealed one dose of imitrex was administered on 12/15/24 (unknown if this was from prior supply but was the day the new supply was sent from pharmacy). Including 12/15/24, staff had documented administration eight times. The last dose was documented as given 01/05/25 at 11:29 A.M. After identifying the discrepancy between the number of imitrex delivered and the number administered, along with interviews regarding imitrex not being available, the Administrator was notified on 01/08/25. On 01/08/25 at 1:25 P.M., the Administrator provided an email from LPN #826 stating she had administered a dose of imitrex on 01/02/25 at 3:00 P.M. The Administrator stated LPN #826 had failed to document the administration of the imitrex on the MAR. 3. Review of Resident #26's medical record revealed diagnoses including schizophrenia, muscle wasting and atrophy, secondary parkinsonism, generalized muscle weakness, difficulty walking, blindness in one eye and seizures. An annual MDS revealed Resident #26 was severely cognitively impaired. Resident #26 had two or more falls since the prior assessment. While reviewing fall investigations, it was identified two falls were not documented in the medical record. The date/time of the falls not recorded in the medical record was a fall on 10/23/24 at 11:30 P.M. and a fall on 11/06/24 at 2:19 P.M. On 01/14/25 at 10:43 A.M., the Director of Nursing (DON) provided documentation of the falls on 10/23/24 and 11/06/24, stating the falls were documented under the clinical tab of the electronic health record. The DON verified the information was not part of the medical record. 4. Review of Resident #97's medical record revealed diagnoses included cognitive communication deficit, need for assistance with personal care, malignant neoplasm of the prostate and obstructive and reflux uropathy. A physician order dated 12/27/24 revealed use of a 16 French (refers to the diameter of the catheter) catheter with a 30 cubic centimeter (cc) balloon. A urology consult dated 01/07/25 revealed an 18 French coude catheter (A coude catheter is a type of catheter with a curved tip. The bent tip allows the catheter to bypass obstructions and navigate spaces that a straight catheter, which has a completely straight tip, may have trouble with.) with a 10 cc balloon had been inserted. On 01/13/25 an order was written for a 18 French catheter with a 30 cc balloon with documentation to change the catheter as necessary. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/13/25 at 12:15 A.M., Registered Nurse (RN) #900 stated she would have to check the order for the foley to determine it was different that what the urology office had inserted. RN #900 stated she had noticed there was a change in the diameter of the catheter from previous orders but had to check to determine why the amount of saline to be inserted into the balloon of the catheter differed. At 1:32 P.M., RN #900 verified after consulting with the physician the order for the catheter should have read 18 French with 10 cc so she wrote a new order. It was drawn to RN #900's attention the urologist had placed a coude catheter and the order was not written for a coude catheter. RN #900 stated she had not clarified that. RN #900 stated it was generally the urologist office that inserted/changed Resident #97's catheter but there was an order for facility staff to change it as necessary so it would be important to know why a coude catheter was inserted by the urology office and to determine if the facility had any available if needed. On 01/14/25 at 11:55 A.M., RN #900 stated she did clarify the catheter orders and a 18 French coude catheter with a five cc balloon was ordered. 28701 5. Interview with Resident #1's representative on 01/06/25 at 5:49 P.M. revealed the resident is sometimes not clean. Review of Resident #1's medical record revealed an admitted [DATE] with diagnoses that included intentional self-harm by firearm, traumatic brain injury, quadriplegia and contractures. Further review of the medical record including Minimum Data Set (MDS) 3.0 quarterly assessment with a reference date of 11/21/24 indicated Resident #1 had a moderately impaired cognition level and was dependent upon staff for Activities of Daily Living (ADL). Review of care plans for Resident #1 revealed the resident requires staff assistance with ADLs including toileting, hygiene including oral hygiene and personal hygiene. Review of the Certified Nurse Assistant (CNA) Tasks including ADL assistance provided for the prior 30 days revealed no documented evidence of ADL assistance provided for oral hygiene, personal hygiene or toileting assistance provided on 12/12/24 day shift, 12/13/24 day and night shift, 12/14/24 day shift, 12/15/24 day shift, 12/16/24 day shift, 12/17/24 day and night shift, 12/18/24 day and night shift, 12/19/24 day shift, 12/20/24 day shift, 12/21/24 day and night shift, 12/22/24 day and night shift, 12/23/24 day shift, 12/25/25 day and night shift, 12/26/24 day shift, 12/27/24 day shift, 12/28/24 day shift, 12/29/24 day shift, 12/30/24 day and night shift, 12/31/24 day shift, 01/01/25 day and night shift, 01/02/25 day and night shift, 01/03/25 day shift, 01/04/25 day shift, 01/05/25 day shift, 01/06/25 day and night shift, 01/07/25 day shift and 01/08/25 day shift. On 01/08/25 at 2:45 P.M. interview with the Director of Nursing verified the facility had a lack of documentation to prove ADLs provided by staff to Resident #1. 6. Interview with Resident #1's representative on 01/06/25 at 5:49 P.M. revealed staff had not addressed a concern regarding the resident's present puree diet use. Review of Resident #1's medical record revealed an admitted [DATE] with diagnoses that included intentional self-harm by firearm, traumatic brain injury, quadriplegia and contractures. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the medical record including MDS 3.0 quarterly assessment with a reference date of 11/21/24 indicated Resident #1 had a moderately impaired cognition level and was dependent upon staff for ADLs. Review of Resident #1's physician's orders revealed on 05/26/24 the resident was placed on hospice services for a terminal prognosis related to senile degeneration of the brain. Further physician's orders revealed the use of a puree diet on 06/03/24 and a trial of a mechanical soft diet per hospice recommendations on 08/13/24 to 08/19/24. Review of the medical record found a progress note on 08/16/24 which indicated facility staff spoke with Resident #1's representative and gave update on trial diet. No other documentation regarding the trial diet was found within the medical record including nursing note and/or nutrition notes to indicate the status of the trial diet. Review of Resident #1's speech therapy services revealed services provided from 08/22/23 to 09/18/23. No evidence of any services provided during diet upgrade trial from 08/13/24 to 08/19/24. On 01/09/25 at 8:37 A.M. Speech Language Pathologist (SLP) #870 revealed Resident #1 was not evaluated by speech therapy for a trial diet due to being on hospice services and has not had any speech therapy services since mid 2023. On 01/09/25 at 11:25 A.M. interview with Licensed Practical Nurse (LPN) #838 revealed Resident #1 had a decline in condition last year, was placed on hospice services and a puree diet. LPN #838 added that the resident had a trial diet to upgrade back to a mechanical soft, but failed the trial diet. On 01/13/25 at 11:45 A.M. interview with the facility administrator verified a lack of documentation related to progress, status and outcome of the trial diet. 7. Interview with Resident #1's representative on 01/06/25 at 5:49 P.M. revealed Resident #1 has not had splints utilized for contractures. Review of Resident #1's medical record revealed an admitted [DATE] with diagnoses that included intentional self-harm by firearm, traumatic brain injury, quadriplegia and contractures. Further review of the medical record including MDS 3.0 quarterly assessment with a reference date of 11/21/24 indicated Resident #1 had a moderately impaired cognition level and limited range of motion to bilateral upper and lower extremities. Physician's orders revealed the use of bilateral upper arm resting hand splints up to eight hours daily as tolerated, left upper extremity palm roll and right upper arm resting hand splint up to eight hours overnight as tolerated. Review of Resident #1's care plans revealed a restorative/maintenance plan for splint/brace use five to seven days per week for 15-30 minutes. Care plans also indicated refusal of use by Resident #1. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record including Treatment Administration Record (TAR) and Certified Nurse Aide (CNA) tasks revealed no evidence of documentation for use or refusal of splints. On 01/09/25 at 10:15 A.M. interview with the Director of Nursing revealed Resident #1 refused to wear any splints/braces for her contractures. The Director of Nursing verified there was no documentation to reflect the use or refusal of the splints as ordered by the physician. 8. On 01/16/25 at 11:43 A.M. interview with Resident #10 revealed he had several broken teeth that had not been extracted by the dentist. Review of Resident #10's medical record an admitted [DATE] with diagnoses that included chronic osteomyelitis, paraplegia, pressure ulcer to the sacrum and diabetes mellitus. Review of the Minimum Data Set (MDS) 3.0 quarterly assessment with a reference date of 12/02/24 revealed Resident #10 had an independent and intact cognition level. Review of dental visits revealed on 04/30/24 Resident #10 was evaluated by the facility contracted dental provider who recommended extraction of teeth 21, 22, 23, 24 and 25. No further dental visits or evidence of extraction was found. Review of Resident #10's progress notes revealed no evidence of any follow up related to the dental recommendations of teeth extraction on 04/30/24. On 01/13/25 at 2:55 P.M. interview with Social Services Designee (SSD) #812 revealed the facility dental contractor recommended dental extractions. She further indicated dental extractions are completed outside the facility at a community dentist. At the time of the recommendation for dental extraction Resident #10 was asked by the facility transportation staff which dentist he wanted to go to and the resident refused to go outside of the facility for the appointment and declined the consultation. SSD #812 verified there was no documentation in the medical record indicating Resident #10's refusal and declination of the consultation.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 22653 Based on review of staffing schedules and time sheets and interview, the facility failed to submit accurate data related to direct care staff to the Centers for Medicare and Medicaid Services (CMS) from July 2024 through September 2024. This had the potential to affect all 48 residents. Findings include: On 12/30/24 at 6:40 A.M., Certified Nursing Assistant (CNA) #840 reported the Residential Care Facility (RCF) hall had no separate staff between the hours of 11:00 P.M. to 7:00 A.M. On 12/30/24 at 6:45 A.M., Registered Nurse (RN) #819 stated there was no separate staff for the RCF form 11:00 P.M. to 7:00 A.M. Nursing facility staff cover the RCF during those hours with two nurses splitting the hall. Nursing assistants attended to personal needs of the residents of the RCF. Review of schedules for the RCF from July 2024 through September 2024 revealed there were no RCF staff scheduled from 11:00 P.M. to 7:00 A.M. There were 34 other shifts in which the RCF schedule did not reflect separate staff on the RCF. On 12/31/24 at 9:30 A.M., staffing and scheduling was discussed with Human Resources (HR) manager #906 and the Administrator revealed throughout every day the nurses from the nursing facility were also assigned 1/2 of the RCF residents. During the times when there was no resident aide to care for residents in the RCF, the nursing facility residents were assigned to cover. Payroll records were used to submit staffing information to CMS. All hours direct care staff worked were submitted to CMS for evaluation of the staffing. There was no subtraction of hours worked in the RCF.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on observations, record review, review of census sheets, policy review and interview, the facility failed to implement isolation protocol for a resident with clostridium difficile and failed to position catheters in a manner to decrease the possibility of urinary tract infections. This had the potential to affect all 48 residents. Finding include: 1. On 12/30/24 at 10:19 A.M., Resident #37 gave permission for a surveyor to enter his room. After entering the room, Resident #37 reported to the surveyor he had tested positive for clostridium difficile. No signs were posted regarding Resident #37 being on isolation. On 12/30/24 at 10:25 A.M., Activity Assistant #842 carried mail into Resident #37's room without donning personal protective equipment (PPE). Upon exiting Resident #37's room, Activity Assistant #842 stated she was aware Resident #37 had c diff and verified there was no signs for isolation posted. Activity Assistant #842 stated she did not need to wear PPE for residents with c diff when she was delivering mail. On 12/30/24 at 11:38 A.M., two signs were posted on Resident #37's door. One indicated providers and staff were required to don gloves and gown before entering the room and remove them before exiting the room. The second sign for special contact precautions indicated hand sanitizer was not to be used to cleanse hands. Hands were required to be washed with soap and water. On 12/31/24 at 8:40 A.M., Certified Nursing Assistant (CNA) #846 verified she had entered Resident #37's room to remove his meal tray but had not donned gloves and a gown. The tray was carried to the meal cart and placed on it. No hand hygiene was performed. CNA #846 was interviewed at that time and stated she did not wear PPE when just entering the room unless providing direct care and she had only obtained his tray. After addressing hand hygiene, CNA 846 used alcohol based hand sanitizer to clean her hands. Review of Resident #37's medical record revealed diagnoses of enterocolitis due to clostridium difficile (diagnosis list indicated a date of 08/27/24), need for assistance with personal care, bipolar disorder, quadriplegia, and obsessive-compulsive disorder. A nursing note dated 12/19/24 at 1:49 P.M. indicated Resident #37 complained of severe diarrhea which had an odor to it. The physician was contacted and an order was received to obtain a stool specimen to rule out clostridium difficile. A laboratory report indicated a stool sample was collected on 12/27/24. On 12/28/24, the laboratory specimen was determined to be positive for c diff and reported. A nursing note dated 12/29/24 at 10:50 A.M. indicated Resident #37 tested positive for c diff. New orders were received for vancomycin (antibiotic) 125 milligrams (mg) four times a day for ten days. Resident #37 was notified. On 12/30/24, an order was written for contact isolation precautions with all services being provided in his room for c diff infection. The care plan did not address current isolation/antibiotic use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/08/24 at 11:08 A.M., Certified Nursing Assistant (CNA) #836 and CNA #828 were observed providing perineal care to Resident #37 and transferring Resident #37 into a chair with a mechanical lift they had taken into the room prior to providing care. On 01/08/25 at 1:50 P.M., CNA #828 stated the mechanical lift used to transfer Resident #37 was shared among other residents. CNA #828 stated bleach wipes were used to disinfect the lift after it was used to transfer Resident #37. On 01/08/25 at 2:05 P.M., while looking through Resident #37's isolation cart no wipes were found. Maintenance director #804 verified there were no wipes in the cart then went to another isolation cart and stated staff use the sanicloth wipes. While reviewing the information regarding what the sanicloth wipes were effective against, Maintenance Director #804 stated clostridium difficile was not listed. Maintenance Director #804 left and returned with a spray bottle of bleach cleaner which indicated it was effective against c diff stating it was what housekeeping used to clean rooms of residents with c-diff but could not state definitively what aides or nurses were supposed to use for shared equipment before removing it from Resident #37's room. CNA #828 was passing through the area and stated there were no bleach wipes in the cart when they finished transferring Resident #37 so she used the sanicloth wipes. Maintenance Director #804 provided a canister of bleach wipes which indicated it was effective against c diff. On 01/08/24 at 6:00 P.M., due to their being no order for isolation for Resident #37 prior to 12/30/24, the Director of Nursing searched through what the Administrator referred to as a communication board from 12/19/24 through 12/30/24 in the surveyor's presence and verified she was unable to locate any evidence of when Resident #37 was placed in isolation after symptoms of c diff were exhibited on 12/19/24. Review of the facility's C diff policy (not dated) indicated a physician's order would be obtained to initiate isolation precautions if a resident was identified to have active c diff or the resident had three or more loose stools, unrelated to laxative or other known source, in a 24 hour period. Signage should be placed on the resident door, directing staff and visitors to speak with a nurse before entering. Designated equipment items were to be maintained in the resident's room throughout the duration of the isolation precautions. Bleach wipes or 1/10% bleach solution were to be kept in a dirty utility closest to the resident's room to clean any other equipment that could not be designated such as a hoyer lift. Hands should be washed with soap and water as opposed to utilizing hand sanitizers in caring for residents with known C diff as standard sanitizers did not kill the spores. If disposable trays and utensils were not utilized trays were to be bagged and sanitized. 2. Review of Resident #97's medical record revealed diagnoses included osteomyelitis, type two diabetes mellitus with a foot ulcer, obstructive and reflux uropathy, and UTI. An admission assessment dated [DATE] revealed Resident #97 had a urinary catheter with cloudy urine. On 01/06/25 at 12:30 P.M., Resident #97 was sitting in the 100 hall dining/ common area. The urinary catheter tubing was on the floor. Staff were present in the room. At 12:33 P.M. staff approached Resident #97 to wipe ketchup off his face. Catheter tubing remained on the floor. At 2:40 P.M., Resident #97 was propelling himself in the wheelchair with the catheter bag cover and catheter tubing dragging on the floor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366087	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Center, The	100 Vista Drive Lisbon, OH 44432

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/06/25 at 2:48 P.M. the observation was shared with Licensed Practical Nurse (LPN) #838 who acknowledged she would have to fix it. Review of the facility's Foley Catheter Care policy (not dated) instructed staff to position the foley catheter bag below the level of the bladder and to keep the bag and tubing off of the floor at all times. 28701 3. Review of Resident #10's medical record an admitted [DATE] with diagnoses that included chronic osteomyelitis, paraplegia, pressure ulcer to the sacrum and diabetes mellitus. Review of the Minimum Data Set (MDS) 3.0 quarterly assessment with a reference date of 12/02/24 revealed Resident #10 had an independent and intact cognition level and utilized an indwelling urinary catheter. Observation on 01/13/25 at 9:31 A.M. revealed Resident #10 asleep in bed with a urinary catheter drainage bag and tubing lying on the floor next to the bed. Review of the undated facility policy titled Foley Catheter Care revealed staff are to keep the urinary drainage bag and tubing off of the floor at all times. On 01/13/25 at 10:15 A.M. Certified Nurse Aide (CNA) #853 verified Resident #10's urinary drainage bag and tubing were lying on the floor.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on medical record review, review of the infection control log, interview, and policy review the facility failed to ensure the appropriate use of antibiotics. This affected two (Resident #9 and Resident #10) of five residents reviewed for unnecessary medications. Finding include: 1. Review of the medical record for Resident #9 revealed an admitted [DATE] with diagnoses including amyotrophic lateral sclerosis, cerebral palsy, muscle weakness, dysphagia, pressure ulcer of sacrum, and schizophrenia. Review of Resident #9's urinalysis (UA), dated 01/04/25, revealed the urine color was turbid with trace protein, 4+ leukocytes, white blood cells greater than 50 (high power field) HPF, and bacteria too numerous to count. The UA indicated a culture and sensitivity (C&S) was pending as the UA met criteria. Further review of the medical record revealed no evidence of the UA culture and sensitivity result/report. Review of the Infection Control Log, dated January 2025, revealed the resident was ordered Cefdinir 300 milligrams (mg) for a UTI, with a start date of 01/05/25. There was no evidence of an assessment to determine if the antibiotic was appropriate and met criteria. Review of Resident #9's physician order, dated 01/05/25, revealed the order to administer Cefdinir 300 mg via PEG tube two times a day for urine infection for seven days. Review of the January 2025 Medication Administration Record (MAR) revealed the resident was started on Cefdinir 300 mg on 01/05/25. Review of a nursing progress note, dated 01/09/25 at 7:32 P.M., revealed the nurse reached out to physician regarding the initiation of the antibiotic without the urinalysis culture and sensitivity result. The physician stated he knew the C&S was pending, but per the UA result, he wanted to place the resident on the antibiotic and to continue the antibiotic until the results were received. Interview on 01/09/25 at 9:31 A.M., Infection Preventionist/Assistant Director of Nursing (ADON) #900 confirmed the UA culture had not yet been received from the laboratory. The ADON stated that she utilized McGeer Criteria to determine if an antibiotic is appropriate, however, this had not been completed for Resident #9. Interview on 01/09/25 at 9:49 A.M., the Director of Nursing (DON) confirmed there was no UA C&S report in Resident #9's medical record and this report would typically be received from the laboratory within 48 hours. The DON confirmed there was not an appropriate follow-up since the UA was collected on 01/04/25 and antibiotic stewardship was not followed. 28701 2. Review of Resident #10's medical record an admitted [DATE] with diagnoses that included chronic osteomyelitis, paraplegia, pressure ulcer to the sacrum and diabetes mellitus. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) 3.0 quarterly assessment with a reference date of 12/02/24 revealed Resident #10 had an independent and intact cognition level and utilized an indwelling urinary catheter. Review of Resident #10's physician orders revealed on 06/06/24 to 06/20/24 the use of ciprofloxacin (antibiotic) 750 milligrams (mg) twice daily for a wound infection. Further review of the medical record revealed no evidence of any assessment completed to determine the appropriate indication for use of the antibiotic. On 01/14/25 at 8:50 A.M. interview with Registered Nurse (RN) #900 verified no assessment was completed to determine the appropriate use and indication for the antibiotic. Review of the facility policy titled, Antibiotic Stewardship, dated January 2020, revealed it is the purpose was to assure antibiotics are used only when truly needed and utilizing the correct antibiotic for each infection. Each facility will designate an infection control preventionist who will be responsible for the following including to track, record, and analyze infections related to residents, staff, volunteers, and visitors.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on record review, staff interview, and policy review, the facility failed to provide documented evidence of refusals of pneumococcal and influenza immunizations. This affected two (Resident #9 and Resident #38) of five residents reviewed for immunizations. Findings include: 1. Review of the medical record for Resident #9 revealed an admitted [DATE] with diagnoses including amyotrophic lateral sclerosis, cerebral palsy, muscle weakness, dysphagia, pressure ulcer of sacrum, and schizophrenia. Review of Resident #9's immunization report revealed the resident refused a Pneumovax immunization, however, there was no refusal/declination form signed by the resident/responsible party. 2. Review of the medical record for Resident #38 revealed an admitted [DATE] with diagnoses including cerebral ischemia, muscle weakness, diabetes mellitus, chronic obstructive pulmonary disease, and peripheral vascular disease. Review of Resident #38's immunization report revealed the resident refused a pneumococcal immunization, however, there was no refusal/declination form signed by the resident/responsible party. Interview on 01/14/25 at 3:26 P.M., Assistant Director of Nursing (ADON)/Infection Preventionist #900 confirmed there was evidence of a completed/signed pneumococcal immunization declination form for Resident #9 nor Resident #38. Review of the facility's policy titled, Influenza, Pneumococcal, Shingles, and COVID-19 Immunizations, undated, revealed each resident will be offered the influenza and pneumococcal vaccine upon admission and the influenza and pneumococcal consent/declination form will be completed at this time.