STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366114	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Lyndhurst	1575 Brainard Rd Lyndhurst, OH 44124

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on record reviews, observations and interviews, the facility failed to ensure a clean and sanitary environment for Resident #5 and a comfortable mattress in good repair for Resident #61. This affected two residents (#5 and #61) reviewed for a clean, sanitary, and homelike environment. The facility census was 81. Findings include: 1. Review of the medical record for Resident #61 revealed an admitted [DATE]. Diagnoses included quadriplegia, anxiety disorder, contracture right and left hand, reduced mobility, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #61 had intact cognition and required substantial/maximin assistance from staff for bed mobility and was dependent on staff for chair/bed to bed/chair transfers. Interview on 03/24/25 at 11:43 A.M. with Resident #61 stated her bed was uncomfortable, and it sunk in the middle. The resident stated she informed some the aides but did not know their names. Interviews on 03/27/25 at 10:13 A.M. and 04/01/25 at 10:23 A.M. with Certified Nurse Aides (CNAs) #256 and #277 stated the concern with Resident #61's mattress had been going on for about a month. CNA #256 stated Resident #261 complained that she could feel the rails. CNA #256 stated she informed Director of Maintenance (DOM) #266 directly about a month ago. CNA #277 stated she informed the nurse but could not recall the nurse she informed because it had been a while ago. Observation on 03/27/25 at 12:49 P.M. of Resident #61 sitting in a chair in her room next to her bed. At this time, Interview with Resident #61 revealed she was not comfortable in her chair, but they tried to make it comfortable by adding pillows. Resident #61 then pointed to her bed and stated, see. Observation of Resident #61's bed revealed it was made but there was a large dip in the middle of the mattress. Resident #61 stated it had been that way for about a month, and she could not remember who the aides were, but they were aware of the dip. Observation on 03/27/25 at 12:53 P.M. with Nurse Manager (NM) #261 of Resident #61's bed. At this time, Interview with NM #261 verified the large dip in mattress and stated she would get her a new mattress. NM #261 stated the mattress was a regular mattress not an air mattress. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/27/25 at 1:00 P.M. of DOM #266 walking down the hall with a mattress in a plastic covering. Interview at this time with DOM #266 stated he was not sure if he was made aware of her needing a new mattress, and he would have to check the maintenance logs. Reviewed on maintenance logs dated 01/27/25 through 03/28/25 revealed no documented concerns related to Resident #61's mattress. Follow-up interview on 04/01/25 at 8:19 A.M. with DOM #266 verified there were no concerns on the maintenance logs related to Resident #61's mattress. DOM #266 stated 03/27/25 was the first time he was made aware of Resident #61 needing a new mattress. 37096 2. Review of the medical record for Resident #5 revealed an admitted [DATE]. Diagnoses included cerebrovascular disease, dementia, psychotic disturbance, mood disturbance and anxiety, and dysphagia (difficulty swallowing). Review of the MDS assessment dated [DATE] revealed Resident #5 had moderate cognitive impairment and was dependent on staff for personal hygiene and transfers. Observation on 03/24/25 at 11:05 A.M, revealed Resident #5 was lying in bed. The resident had a floor mat to the right side of the bed. The mat was covered with a dried white substance. The carpeted next to the mat had large areas with a dried white substance. Interview 03/24/25 at 11:10 A.M. with Housekeeper #242 verified the dirty floor mat and spillage on the carpet. Housekeeper #242 stated she did not get to clean Resident #5 room today. This deficiency represents non-compliance investigated under Complaint Number OH00163018.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, interview, record review, and review of the facility policy, the facility failed to provide hygiene and grooming as scheduled and as needed for three residents (#13, #28, and #60) of three residents reviewed for hygiene. The facility census was 81. Findings include: 1.Record review for Resident #13 revealed an admitted [DATE]. Diagnosis included cerebral infarction, muscle wasting and atrophy, and muscle weakness. Review of the Modification of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #13 was cognitively intact. Resident #13 had impairment on both sides of the lower extremities, dependent for toileting hygiene, bathing, and substantial/maximal assistants for personal hygiene. Review of the care plan for Resident #13 dated 07/24/24 revealed Resident #13 had an activity of daily living (ADL) self-care performance deficit. Resident #13 requires assistance with ADLs. Interventions included to assist with activities of daily living (i.e.: dressing, grooming, personal hygiene, toileting, bed mobility, transfers, bathing, locomotion, oral care, etc.) and adjust level of assistance and support as needed every shift. Bathing: Check nail length and trim and clean on bath day and as necessary. Record review of the Shower Schedule revealed Resident #13's showers/baths were scheduled on Mondays and Thursdays 7:00 A.M. to 3:00 P.M. Observation on 03/24/25 at 9:55 A.M. revealed Resident #13 was lying in bed. Resident #13's fingernails were long, uneven and embedded with a thick dark substance. Resident #13 revealed she was not getting her showers routinely as scheduled. Observation on 03/25/25 at 3:16 P.M. with Certified Nursing Assistant (CNA) #278 confirmed Resident #13's fingernails were long, uneven and embedded with a thick dark substance. CNA #278 walked away (without offering to assist with nail care) after observing and confirming Resident #13's fingernails. Observation on 03/26/25 at 8:33 A.M. revealed Resident #13 was lying in bed. Resident #13's fingernails were long, uneven and embedded with a thick dark substance. Resident #13 revealed the staff did not offer or assist with cleaning or trimming her nails and went on to say she would like it if they did. Observation on 03/26/25 at 8:38 A.M. with CNA #267 revealed nail care was done on shower days and as needed. CNA #267 confirmed Resident #13's nails continued to be long, uneven and embedded with a thick dark substance. CNA #267 walked away (without offering to assist with nail care) after observing and confirming Resident #13's fingernails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/26/25 at 8:58 A.M. revealed Resident #13 was sitting up in bed feeding herself breakfast. Resident #13's nails continued to be long, uneven and embedded with a thick dark substance. Review of the shower/tub bath/bed bath sheets from 01/01/25 through 03/26/25 revealed there was no bath sheet to confirm Resident #13 received or was offered a shower or bed bath on 01/02/25, 01/16/25, 01/20/25, 01/23/25, 01/27/25, 01/30/25, 02/13/25, 02/20/25, 02/24/25, 02/27/25/03/03/25, 03/06/25, 03/10/25, 03/13/25, 03/17/25, or 03/24/25. Interview on 03/26/25 at 2:41 P.M. with the Administrator confirmed there were no other shower sheets completed for Resident #13. Administrator confirmed when the shower or bath was completed, the shower sheet was also completed to confirm the shower was done. 2. Record review for Resident #60 revealed an admitted [DATE]. Diagnosis included rhabdomyolysis, osteoarthritis, and muscle weakness. Review of the Medicare 5-day MDS assessment dated [DATE] revealed Resident #60 was cognitively intact. Resident #60 had impairment to one side of the upper extremity, was dependent for toileting and required partial/moderate assistants with shower/bathing. Review of the care plan dated 01/14/25 for Resident #60 revealed Resident #60 required staff assistance with activities of daily living related to weakness, impaired mobility, fall, rhabdomyolysis, obesity, and multiple comorbidities. Interventions included to assist with activities of daily living (i.e.: dressing, grooming, personal hygiene, toileting, bed mobility, transfers, bathing, locomotion, oral care, etc.) and adjust level of assistance and support to assist with one to two staff as needed every shift. Review of Shower Schedule for Resident #60 revealed showers were to be completed on Mondays and Thursdays from 11:00 P.M. to 7:00 A.M. Interview on 03/24/25 at 3:53 P.M. with Resident #60 revealed she was not getting baths like she was supposed to. The staff told her she was supposed to get her showers/baths on the night shift, 11:00 P.M. to 7:00 A.M. Resident #60 revealed she felt that was crazy. Usually staff would not even offer her a bath/shower but when they did come in the middle of the night and wake her up, she would tell them it's late so then they would say she refused. Resident #60 revealed she wasn't refusing her showers, she just did not want to have to get them in the middle of the night when she was sleeping. Review of the shower sheets for Resident #60 from 01/31/25 through 03/26/25 revealed on 01/31/25 and 03/04/25 Resident #60 refused her bath. There was no bath sheet to confirm Resident #60 received or was offered a shower or bed bath on 02/07/25, 02/17/25, 02/20/25, 02/24/25, 03/06/25, 03/10/25, 03/17/25, 03/20/25, and 03/24/25. Interview on 03/26/25 at 2:41 P.M. with the Administrator confirmed there were no other shower sheets completed for Resident #60. Administrator confirmed when the shower or bath was completed, the shower sheet was also completed to confirm the shower was done. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the shower sheets/record with Administrator and Unit Manager RN #257 on 03/26/25 at 5:16 P.M. confirmed the shower sheets were not completed to confirm showers were completed as scheduled for Resident #13 and #60. Unit Manager RN #257 revealed if the shower sheets were not completed, that meant the shower/bath was not offered or completed. The shower records would also indicate if the bath/shower was refused. Unit Manager RN #257 revealed she shared her concerns in the past with the previous Director of Nursing (DON) that the showers were not completed as scheduled. Administrator confirmed she was also aware of concerns with Residents showers/baths not completed and the previous DON was working on it. Interview on 03/27/25 at 1:25 P.M. with LPN #304 confirmed there were times residents showers were not being offered or completed and revealed it was because at times there was just not enough time. Interview on 03/27/25 at 3:18 P.M. with CNA #306 stated, Its not that there is not enough time to complete tasks, it's some staff just don't manage their time to do it (showers) so some showers don't get done. Interview on 03/27/25 at 3:24 P.M. with CNA #256 revealed the facility used a lot of agency staff and they just don't do showers. CNA #256 stated, we all know the showers are supposed to get done but agency, they just do what they want., they'll say we did not know we were supposed to do showers even though facility staff would tell them about the facility shower book and schedule. 3. Review of the medical record for Resident #28 revealed an admitted [DATE]. Diagnoses included morbid (severe) obesity due to excess calories, lymphedema, major depressive disorder, generalized anxiety disorder, muscle weakness, and acquired absence of right leg below knee. Review of the Minimum Data Set (MDS) quarterly dated 01/28/25 revealed Resident #28 had intact cognition, was dependent on staff for transfers and toileting hygiene, was frequently incontinent of bladder, and always incontinent of bowel. Interview on 03/24/25 at 12:05 P.M. with Resident #28 revealed a few Fridays ago, he did not get put to bed due to short staffing on the night shift. Resident #28 stated by 5:00 A.M. (on 03/15/25) he still had not been put to bed and had a bowel movement. Resident #28 stated he turned on his call light multiple times, and was told by one aide that she needed to get the other aide because he required a hoyer (mechanical) lift for transfers. Resident #28 stated the aide came back and said that the other aide was on break and the resident would have to wait for assistance. Resident #28 stated when he had the bowel movement he was told by the aide again she had to find the second aide. Resident #28 stated no one came back and he didn't see anybody until the first shift arrived the following morning. Resident #28 stated Certified Nurse Aide (CNA) #256 was one of the four aides that had to clean him up and get him in bed. Resident #28 stated the night shift aide was from agency staffing. Resident #28 stated the incident was very demeaning. Review of Resident #28's progress notes was silent of documentation related to Resident #28 being left up in wheelchair and not being provided with incontinence care all night. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/27/25 at 10:13 A.M. with CNA #256 verified Resident #28 was up all night and soiled when first shift arrived to work. CNA #256 stated two aides and two nurses were scheduled on the unit, but one of the aides could not be found for hours. CNA #256 stated she believed the incident occurred the morning of 03/08/25. CNA #256 stated she had arrived early to work at approximately 6:50 A.M. and Resident #28's call light was on. CNA #256 stated there were a few call lights on when she arrived. CNA #256 started when she got to Resident #28's room she saw him up in his power wheelchair and asked him if he had an appointment. CNA #256 stated he informed her that he had been up all night and had been trying to get into bed since 1:00 A.M. CNA #256 stated he informed her that he was told by the night staff that they would come back. CNA #256 stated Resident #28 was upset and appeared tired. CNA #256 stated Resident #28 usually went to be late. CNA #256 stated the resident requested his call light not be turned off until care was performed, as night staff kept turning off his call light. CNA #256 stated Resident #28 told her that around 1:00 A.M. he had a bowel movement and wanted to get into bed so they could change him. CNA #256 confirmed the resident did have a bowel movement, and recalled it looked like he had been sitting in it for a while at the time care was provided. CNA #256 stated she also observed the resident's urinal was full, and two cups were also full of urine. CNA #256 stated she knew those were his favorite cups. CNA #256 stated she had reported the incident to Registered Nurse (RN) #258 and believed the nurse reported it to someone. CNA #256 stated she was made aware the aide from agency was put on list to not return to the facility. Interviews on 03/27/25 at 11:33 A.M. and 1:11 P.M. with RN #258 via phone verified the incident regarding Resident #28 occurred and stated she was the dayshift nurse for Resident #28 that weekend. RN #258 stated she could not recall the date of the weekend or the day it occurred. RN #258 stated when she came in she went to his room and care was provided immediately. RN #258 stated she assessed him and gave him his morning medications and told him to get some rest. RN #258 stated she reported it to the manager on duty but could not remember who that was. RN #258 stated she was distraught about the incident and Resident #28 was upset but ready to go to bed. RN #258 stated all the aides helped, got him fresh sheets, and he was in bed by 7:15 A.M. RN #258 stated she did not get report from the night nurse until Resident #28 received care. RN #258 stated the night nurse was still there and she was aware of what happened, and she told the night nurse that was unacceptable. RN #258 stated the night nurse did not say what happened on nights and the resident never said to her he felt he was neglected or abused. RN #258 stated she checked on him throughout her shift. RN #258 stated she did not make a note or document in Resident #28's medical record the events of Resident #28's concern. Review of the facility policy titled, Supporting Activities of Daily Living (ADLs) revised March 2018 revealed Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. This deficiency represents non-compliance investigated under Complaint Number OH00163010 and OH00161974.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, interview, medical record review, review of hospice notes, and facility policy review, the facility failed to ensure care and services were provided to facilitate resident preference, comfort and hydration. Actual Harm occurred on 03/24/25 at 10:04 A.M. when Resident #58, a resident who was receiving end-of-life hospice care who staff believed was actively dying, was left alone behind a closed door, thirsty, in severe pain, and unable to call for assistance. Resident #58 was dependent on all aspects of care and unable to call for help, was denied hydration measures, and had minimal pain control for 2 days. This affected one resident (#58) of three residents reviewed for quality of care and treatment. The facility census was 81. Findings include Review of Resident #58's medical record revealed an admitted [DATE]. Medical diagnoses included amyotrophic lateral sclerosis (ALS) (a progressive disease that specifically affects motor neurons responsible for controlling muscle movement, leading to muscle weakness and paralysis), chronic pain syndrome, weakness, lack of coordination, and a need for assistance with personal care. Review of Resident #58's care plan dated 02/22/24 revealed the resident was at risk for altered nutrition/hydration status related to ALS. Interventions included administering medications as ordered, providing total assistance with meals and snacks, encouraging consumption of fluids provided, and monitoring for signs and symptoms of dehydration. An additional care plan focus dated 12/04/24 revealed the resident required hospice care due to end of life processes, with a terminal diagnosis of ALS. Listed interventions included administering medications for comfort prior to activity or care and to keep the resident comfortable to the extent possible. An additional care plan focus dated 02/21/25 revealed Resident #58 was receiving opioid pain medication for pain control. Interventions included administering medication as ordered, assessing pain type, location and characteristics before and after administration of as-needed pain medication, and encourage fluid intake. An additional intervention included to monitor symptoms of a potential overdose including constricted pupils, loss of consciousness, shallow breathing, respiratory depression, limp body, or pale, cold, or clammy skin. Review of the Hospice Skilled Nursing Communication note dated 01/16/25 revealed Resident #58 needed a blow call light (a call light that can be activated by blowing air into a small tube) due to a decreased range of motion to the resident's left hand. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #58's Minimum Data Set (MDS) annual assessment dated [DATE] revealed the resident was cognitively intact. Resident #58 had impairment on both sides of the upper and lower extremities and was dependent on staff for all activities of daily living, including eating. Resident #58's daily preferences, including having snacks available between meals, were listed as very important to her. Resident #58 was noted to have anxiety and depression and received scheduled and as-needed (PRN) pain medication. Resident #58 was noted to receive hospice services and to have a disease that may result in a life expectancy of less than six months. Review of Resident #58's physician's orders revealed an order dated 02/27/25 which stated the resident was admitted to hospice services with a diagnosis of ALS. Review of Resident #58's physician's orders revealed on 03/22/25, all of Resident #58's routine scheduled medications, including Robaxin (a muscle relaxer used to treat painful muscle spasms) 750 milligram (mg) tablet twice daily, Morphine Sulfate Extended Release (ER) (an opioid analgesic used to treat severe pain) 30 mg every eight hours routinely, and Gabapentin (an anticonvulsant and pain adjunct commonly used to treat nerve pain) 900 mg four times daily routinely, were discontinued. Resident #58 had as-needed Morphine Sulfate 20 mg/milliliter (ml) 1 ml ordered as needed for pain related to ALS. There was no documented evidence of a physician order for Resident #58 to have nothing by mouth (NPO) or any orders related to limiting hydration. Review of the Hospice Skilled Nursing Communication note dated 03/22/25, completed by Hospice Registered Nurse (RN) #801, revealed to discontinue all medications, except comfort medications, as Resident #58 was actively transitioning (dying). Review of Resident #58's Medication Administration Record (MAR) for March 2025 reflected all routine medications, including scheduled Robaxin, Morphine Sulfate, and Gabapentin, had been discontinued on 03/22/25. The MAR noted only one as-needed dose of Morphine Sulfate 1 ml had been administered (on 03/23/25 at 6:30 P.M.) since the routine medications had been discontinued. The MAR recorded the effectiveness of the pain medication dose as a U, noting it was unknown if the medication had been effective to treat Resident #58's pain. Review of Resident #58's nursing progress notes revealed a note dated 03/23/25 at 8:01 P.M., authored by RN #323, which revealed Resident #58 remained more alert throughout the shift, discussed with staff and family members. The note stated Resident #58 was able to express her needs. Resident #58 had refused all meals but tolerated sips of fluid well. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Observation on 03/24/25 at 10:04 A.M. revealed the door to Resident #58's room was closed. A sign was posted next to Resident #58's door which stated, please don't close my door unless asked. Upon knocking and opening the door, Resident #58 was observed lying in bed, with both of her arms positioned to her side, and her head lifted off the bed. Her eyes were wide as she looked towards the doorway. Resident #58 repeatedly mouthed the words help me, help me. Resident #58 was observed with tears in her eyes, was able to mouth words clearly, but had no sound projection. Resident #58 stated she was so thirsty and requested a drink. Resident #58's lips were very dry, and her lips stuck together as she mouthed her words. Three Styrofoam cups of water and a half-full bottle of soda was on the resident's bedside table. Resident #58 shared she was unable to move her arms or legs due to ALS. Resident #58 additionally stated that she was unable to use her call light to summon staff assistance, as she also could not move her hands. Further review revealed Resident #58 had a push-button call light next to her left hand. When asked, Resident #57 was unable to move her hand to activate the call light button. Resident #58 continued to mouth help me, help me, and the surveyor exited the room to summon staff assistance. Observation on 03/24/25 at 10:06 A.M. revealed Certified Nursing Assistant (CNA) #265 walked up the hall. CNA #265 was informed Resident #58 requested help and was thirsty. CNA #265 stated she is actively dying; she can't have anything to drink as she was ordered nothing by mouth (NPO). CNA #265 entered Resident #58's room and confirmed there were three cups of water and a half-full bottle of soda on the bedside table and confirmed the sign next to the door. CNA turned to leave Resident #58's room, who mouthed the words don't close, please don't close, referring to the door. CNA #265 confirmed the resident was unable to use her pushed button call light and walked away. The surveyor exited Resident #58's room to find the resident's assigned nurse. A few minutes later, CNA #265 again walked up the hall and stated Resident #58's nurse was on a break, but the Director of Nursing (DON) had stated she could give Resident #58 a drink. CNA #265 shared that her shift started at 7:00 A.M. and she had not yet been into Resident #58's room to provide care nor had she offered the resident anything as she was told Resident #58 was NPO. CNA #265 entered Resident #58's room, where Resident #58 stated she had not had anything to drink since the previous day. Resident #58 stated she had asked staff multiple times, but had been told no, she was not allowed to have anything to drink. Resident #58 additionally stated she had pain everywhere and rated her pain at a 10 on a scale of 1-10, with 10 being the worst pain she could imagine. Interview on 03/24/25 at 10:10 A.M. with RN #262 revealed she was Resident #58's primary nurse. RN #262 was informed Resident #58's pain level was a 10 and her pain was all over. RN #262 stated she had other tasks, including administering another resident's tube feeding, before she could provide any pain medication to Resident #58. Observation on 03/24/25 at 10:13 A.M. revealed RN #262 returned to the surveyor and stated she would address Resident #58's pain. RN #262 revealed Resident #58 was actively dying and was NPO status over the weekend because of her medical diagnosis. RN #262 stated hospice made the Resident #58 NPO status over the weekend as she had been lethargic and it was a bad weekend for the resident. RN #262 confirmed Resident #58 was alert and oriented and revealed she could have pain medications when needed. RN #262 approached the medication card to prepare the resident's dose of pain medication. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Observation on 03/24/25 at 10:37 A.M. revealed Hospice RN #801 walked up the hall. Hospice RN #801 confirmed she was Resident #58's hospice nurse and stated the resident was actively transitioning. Hospice RN #801 confirmed she had visited Resident #58 on 03/22/25, at which time Resident #58 was comatose. Hospice RN #801 discontinued all of Resident #58's routine medications, including all routine pain medications, due to the resident's change in condition. Hospice RN #801 revealed there was never a written order for Resident #58 to be NPO. When asked if she had instructed the staff caring for Resident #58 to treat the resident as NPO, Hospice Nurse #801 repeated there was never a hospice-initiated order for Resident #58 to be NPO. Upon entering Resident #58's room, the door to the resident's room was again observed to be closed. Resident #58 remained in bed alone behind the closed door and unable to use her call light or make any purposeful movement. Further review of Resident #58's medical record revealed no evidence or documentation Resident #58's physician had been notified of Resident #58's decline on 03/22/25 or the staff withholding fluids. Interview on 04/01/25 at 2:43 P.M. with Resident #58 revealed she still had a push button call light she was unable to use. Resident #58 stated she had been receiving some fluids over the last few days and was thankful. Resident #58 stated hospice was still working on getting her a blow call light. During the interview, Resident #58's voice was noted to have sound projection and her voice sounded stronger than during prior interviews on 03/24/25. Interview on 04/02/25 at 11:49 A.M. with the Administrator confirmed she was aware Resident #58 needed a blow call light. The Administrator confirmed staff discussed it, but she did not remember the outcome. Interview on 04/02/25 at 12:35 P.M. with the DON confirmed there was no documentation that Resident #58's physician had been notified of Resident #58's change in condition or the withholding of fluids. The DON revealed the staff were only notifying the contracted hospice provider and stated the resident's physician should be notified with any change in condition, even when the resident was receiving hospice services. Review of the policy Hydration - Clinical Protocol revised September 2017 revealed the staff, with the physician's input, will identify and report to the physician individuals with signs and symptoms (for example, delirium, lethargy, increased thirst) or lab test results that may reflect fluid and electrolyte imbalance. The physician and staff will identify significant risks for subsequent fluid and electrolyte imbalance, to include, for example, individuals who are not eating or drinking well. The physician will manage significant fluid and electrolyte imbalance, and associated risks, appropriately and in a timely manner. The staff will provide supportive measures such as supplemental fluids where indicated. Review of the policy Pain - Clinical Protocol revised March 2018 revealed with input from the resident to the extent possible, the physician and staff will establish goals of pain treatment. The nursing staff assess each individual for pain upon admission to the facility, at quarterly review, whenever there is a significant change in condition, and when there is a new onset of pain or worsening of existing pain. The physician will order pharmacologic interventions to address the individual's pain. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the policy Change in Resident's Condition or Status revised February 2021 revealed the facility promptly notifies the resident's physician when there has been changes in the resident's medical/mental condition and/or status, or there is a need to alter the resident's medical treatment significantly. This deficiency represents non-compliance investigated under Complaint Numbers OH00163018 and OH00162481

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096 Based on record review and interview, the facility failed to apply Resident #179's Automatic Positive Airway Pressure (auto-PAP) machine as ordered. This affected one resident (#179) of four residents reviewed for respiratory care. The facility census was 81. Finding include: Review of Resident #179's medical record revealed an admitted [DATE] with diagnoses including respiratory failure, chronic obstructive pulmonary disease (COPD), obesity, and emphysema. Resident #179 was discharged on [DATE]. Review of the physicians order for February 2025 revealed an order for an auto-PAP (a respiratory machine worn while sleeping which provides positive airway pressure and automatically adjusts in response to measured airway resistance) to be applied every night and as needed for naps. Review of the Treatment Record (TAR) for February 2025 revealed the treatment was signed off on for evening on 02/19/25 and 02/20/25. Review of the nursing assessment dated [DATE] revealed Resident #179 was alert and orientated to person, place and time. The resident was recorded as independent with activities of daily living. Review of the progress note dated 02/11/25 at 11:00 P.M. revealed the Resident #179 had diminished lungs sounds and difficulty breathing. The Nurse Practitioner (NP) ordered to send Resident #179 to the emergency room (ER). A subsequent note dated 02/21/25 at 10:00 A.M. revealed Resident #179 was unresponsive and sent to the ER for further evaluation. Review of the hospital summary dated 02/13/25 revealed the resident had a history of severe COPD, chronic hypercapnic respiratory failure, history of pulmonary embolism, tracheobronchial malacia (a condition where to airway become soft and can collapse during breathing), and had numerous recent hospitalization s for respiratory failure. Review of a Self-Reported Incident (SRI) dated 02/21/25 revealed the facility self-reported an allegation of neglect. The facility Nurse Practitioner (NP) had reported that staff failed to follow treatment order for Resident #179's auto-PAP application. The witness statement for Licensed Practical Nurse (LPN) #351, recorded by the Administrator, stated LPN #351 was interviewed by telephone and was questioned regarding Resident #179's auto-PAP. LPN #351 stated she did not apply the auto-PAP at bedtime on 02/20/25. LPN #351 was unable to give any specific reason why the auto-PAP for Resident #179 was not applied per order other than she had forgotten to apply the resident's auto-PAP. The facility investigated the incident and concluded no neglect had occurred. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/01/25 at 10:28 A.M. with Registered Nurse (RN) #321 revealed she was assigned to Resident #179 the morning of 02/21/25. The resident was up and eating breakfast when she administered her morning medications. Approximately 40 minutes later, RN #321 stated she received a call from Resident #179's daughter who stated she had video-called Resident #179 and stated the resident did not look good. RN #321 assessed Resident #179, who had difficulty breathing. RN #321 applied the resident's auto-PAP and called emergency medical services (EMS) to transfer the resident to the local emergency room (ER) for further treatment. RN #321 did not receive any report from the night nurse that the resident had not had her auto-PAP applied as ordered the night before. Interview on 04/01/25 at 11:24 A.M. with Nurse Practitioner (NP) #352 stated it was reported to her that Resident #179 did not receive her auto-PAP treatment on the night of 02/20/25, and she reported it to the Administrator. Resident #179 was very sick and had horrible lungs. The resident had an extensive medical history, multiple respiratory conditions, and was intubated multiple times prior to admitting to the facility. NP #352 stated not receiving auto-PAP on 02/20/25 had no correlation with the resident being sent to the hospital on 02/21/25. Interview on 04/01/25 at 12:01 P.M. with the Administrator revealed the nurse verified the auto-PAP treatment was not applied overnight on 02/20/25. LPN #351 was an agency nurse was placed on 'do not return' status following the incident. This deficiency represents non-compliance investigated under Complaint Number OH00163179.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, interview, and record review, the facility failed to ensure residents received meals compatible with their likes and dislikes. This affected one resident (Resident #22) and had the potential to affect 76 of 81 residents receiving food from the kitchen as five residents (Resident #17, #35, #44, #52, and #62) received nothing by mouth (NPO). The facility census was 81. Findings include: Record review for Resident #22 revealed an admitted [DATE]. Diagnosis included chronic kidney disease, gout, and type two diabetes mellitus. Review of the Annual Minimum Data Set (MDS) dated [DATE] revealed Resident #22 was cognitively intact. Resident #22's preferences were very important to him. Review of the care plan dated 03/06/25 revealed Resident (#22) is at risk for altered nutritional status related to: Diuretic use, abnormal labs, obesity, therapeutic diet needs, edema and weight changes. Interventions included to provide meals / snacks / fluids based on resident food preferences and physician orders. Review of the physician orders dated 06/04/24 revealed Resident #22's diet order was a two gram low sodium diet, regular texture, regular consistency low sodium diet; double protein/meat portions for nutrition. Review of the facility list of resident diets revealed Resident #17, #35, #44, #52, and #62 received nothing by mouth. Observation on 03/27/25 at 1:19 P.M. of the lunch meal revealed Resident #22 was served corn for his portion of vegetables. Resident #22 did not eat any of his corn. Resident #22 stated, They gave me corn, I told them over and over I don't like corn. Interview on 03/27/25 at 2:26 P.M. with Dietary Tech (DT) #401 confirmed Resident #22 received corn for his vegetable serving at lunch. DT #401 revealed food likes and dislikes were not updated in the new system they recently started. The ordered type and texture was available, but no likes or dislikes were available for any residents. Interview on 03/27/25 at 3:06 P.M. with Dietary Manager (DM) #211 revealed on 03/19/25 the previous contract company removed their software that included the residents food likes and dislikes. The system they had would automatically replace a residents dislikes with an alternate item of equal nutritional value that the resident liked. Since the company took the software on 03/19/25, the facility no longer had the information to include any of the residents food likes and dislikes. DM #211 revealed she had no way to retrieve the information other than to ask the residents again. DM #211 revealed she planned to start that next week.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 observations, interviews, and review of the facility policy and procedures the facility failed to ensure proper storage of food items and failed to maintain a clean and sanitary kitchen and nursing unit refrigerators. This had the potential to affect 76 of 81 residents in the facility as five residents (Resident #17, #35, #44, #52, and #62) received nothing by mouth. The facility census was 81. Findings include: 1. Observation during the initial tour of the kitchen on 03/24/25 from 9:50 A.M. to 10:30 A.M. revealed observation of the walk-in freezer #2 with several boxes of frozen food stored on the floor of the freezer. Dairy walk-in cooler #3 had an opened box of hard boiled eggs in clear plastic bags with one of the clear plastic bags opened and undated, and a clear container with cooked fish with the lid opened. The prep table with the Robocoup had several dried, beige, food splatters and what looked like shredded cheese pieces on table next to the Robocoup. A moderate amount of various food crumbs were observed on bottom shelf of the prep table on the large white plastic tray that had a container labeled salt, a large clear container also had a moderate amount of various food crumbs in it. In the container was a large bottle of imitation vanilla, lemon juice, cooking wine, and corn starch. The oven across of this area was heavily stained and appeared dated. [NAME] #402 stated at this time it was not used due to not working and waiting on a part and stated stains will not come out. Observation of the steamer and the tilt skillet also had various greased on food crumbs. Observation of the fryer, grill, and the cart the grill sat on had a moderate amount of grease on food crumbs. The juice machine observed sitting on a cart that had a large amount of standing water with a moderate amount of various dried juice splashes on the juice machine, the wall on the side and wall behind down to the floor also had various dried splatter. Observation of the dry storage area revealed several boxes of food supply on the floor, some opened, two large containers of onion powder on the floor between the boxes. A clear scoop was stored inside a large white container of sugar. The floor under each rack had various debris including package of cracker, toothpicks, white powder, etc. Interview on 03/24/25 between 9:50 A.M. and 10:30 A.M. with Dietary Manager (DM) #211 confirmed the above findings. DM #211 stated they had a delivery this past Friday and had been trying to get it put away among transitioning to a new company. 2. Observation on 03/25/25 from 4:27 P.M. to 4:37 P.M. during the tour of the nursing unit refrigerators with Diet Technician (DT) #401 revealed on the Reflections memory care unit refrigerator revealed it was heavily soiled with various, dried, sticky spills some red and some cream in color, and strands of hair on the shelf of the inside door. A disposable container of food was observed not labeled or dated. Observation of the first floor CRU nursing unit fridge revealed it was full of various lunch bags, a pizza box, and a paper plate with pizza slices covered by a napkin no label or date. The refrigerator was heavily soiled, there was a large spillage/substance on the bottom of fridge with a folk sitting in it and a large grocery bag with items in it. The freezer portion revealed three empty plastic cups with two of them stacked together, various dried food splatter, an empty plastic bag stuck to bottom in a sticky substance. There was no nursing unit refrigerator on the second floor. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 03/25/25 between 4:27 P.M. to 4:37 P.M. with DT #211 verified the above findings. DT #211 stated both refrigerators contained both staff and resident foods. DT #211 stated the problem was between nursing and housekeeping neither knew who responsibility it was to clean the refrigerators. Review of the diet type report revealed five residents (Resident #17, #35, #44, #52, and #62) who received nothing by mouth. Reviewed policy Sanitation, revised November 2022 revealed the food service area is maintained in a clean and sanitary manner.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096 Based on record review and interview the facility failed to ensure accurate documentation in the medical record. This affected two residents (Resident #42 and #179) of two residents reviewed for accuracy of medical records. The facility census was 81. Findings include: 1. Review of Resident #179's medical record revealed an admitted [DATE] with diagnoses including Respiratory failure, chronic obstructive pulmonary disease (COPD), obesity, and emphysema. Resident #179 was discharged on [DATE]. Review of the physicians order for February 2025 revealed an order for an auto-pap (auto-adjusted positive airway pressure) to apply as needed for naps and every night. Review of the Treatment Record (TAR) for February 2025 revealed the treatment was signed off on for evening on 02/19/25 and 02/20/25. Review of Self-Reported Incident (SRI) 257446 dated 02/21/25 revealed the Nurse Practitioner (NP) reported that staff failed to follow treatment order for Resident #179 auto-pap. The witness statement for Licensed Practical Nurse (LPN) #351 taken by the Administrator per phone stated the LPN #351 was questioned regarding the auto-pap stated she did not apply the auto-pap at bedtime on 02/20/25. LPN #351 was unable to give any specific reason why the auto-pap was not administered. Interview on 04/01/25 at 12:01 P.M. with the Administrator stated the nurse verified the auto-pap treatment was not applied on 02/20/25. LPN #351 was an agency nurse; the incident was reported to the agency and the nurse was put on a do not return status. The Administrator stated she did not know why LPN #351 signed off the treatment as administered. 2. Review of the medical record for Resident #42 revealed an admittance date of 03/06/25. Diagnoses included sepsis, osteomyelitis, heart failure, dementia, and peripheral vascular disease. Review of the comprehensive Minimum Data Set 3.0 dated 03/12/25 revealed the resident had moderate cognitive impairment and was dependent on staff for toileting, transfers and ambulation. The assessment indicated the resident received an antibiotic and antiplatelet. Review of Resident #42's physician orders dated 03/06/25 at 6:13 P.M. revealed an order dated 03/08/25 for Macrobid 100 milligrams, an antibiotic, administered two times a day to treat urinary tract infection. Review of the nursing progress note dated 03/08/25 stated Macrobid oral capsule 100 mg by mouth two a day for Urinary tract infection (URI) was not available. Review of the starter kit replacement form dated 03/08/25 stated Macrobid 100 mg was pulled from the starter kit to be administered but there was no time stating the medication was pulled. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) March 2025 revealed Macrobid 100 mg was documented as not administered and to see nurses note. Interview on 03/31/25 10:50 A.M. with the Director of Nursing (DON) verified the antibiotic was pulled from the starter kit, however, there was no signature of the nurse pulling the medication or time the medication was pulled. The DON stated that the nurse should document in the progress note that the medication was administered. Interview at this time with Registered Nurse (RN) #257, the unit manager, stated the nurse told her that she did not have to document the medication she administered. Review of the policy titled Administering Medication dated April 2019 stated the individual administering the medication records in the resident's record the date and time the medication was administered.

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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** 42011 Based on observation, interview and record review, the facility failed to implement an effective infection control program to include proper use of personal protective equipment for enhanced barrier precautions, hand hygiene, handling of incontinence care supplies, and respiratory equipment storage. This affected Resident #9, #10, #21, #42, #49, and #58 with the potential to affect all 81 residents in the facility. Findings Include: 1. Record review for Resident #21 revealed an admitted [DATE]. Diagnosis included functional quadriplegia, hemiplegia and hemiparesis, and encounter for attention to gastrostomy. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #21 was cognitively intact. Resident #21 had impairment on one side of the upper and lower extremities, was dependent for activities of daily living including bed mobility. Resident #21 had a feeding tube. Review of the care plan for Resident #21 dated 10/08/24 revealed a care plan for enhanced barrier precautions (EBP) infection prevention related to peg tube: use gown and gloves for high-contact resident care including dressing, bathing, showering, transfers, hygiene care, changing linens, changing briefs, assisting with toileting, dressing changes, and care of any device for residents with the following(s): trachs, central lines, tube feeding, catheters and/or wounds. Interventions included apply EBP. Record review of the physician orders for Resident #21 dated 11/16/24 revealed EBP: Use gown and gloves for high-contact resident care including dressing, bathing, showering, transfers, hygiene care, changing linens, changing briefs, assisting with toileting, dressing changes, and care of any device for residents with the following(s): trachs, central lines, tube feeding, catheters and/or wounds. Observation on 03/24/25 at 2:28 P.M. revealed Resident #21 had an EBP sign near her entrance door. PPE was located near the sign. Observation of Certified Nursing Assistant (CNA) #267 turn and reposition Resident #21 from her back to her side while in bed revealed CNA #267 did not don any personal protective equipment (PPE) prior to providing hands on care for Resident #21. CNA #267 verified Resident #21 had a feeding tube intact. After completing care, CNA #267 confirmed she did not wear any PPE while providing hands on care for Resident #21 and revealed Resident #21 was not on EBP. Interview on 03/24/25 at 3:00 P.M. with Director of Nursing (DON) confirmed Resident #21 was on EBP. 2. Record review for Resident #10 revealed an admitted [DATE]. Diagnosis included dysphagia, gastrostomy status, and vascular dementia. Review of the quarterly MDS dated [DATE] revealed Resident #10 was severely cognitively impaired. Resident #10 was dependent for toileting hygiene and personal hygiene. Resident #10 was always incontinent of bowel and bladder. Resident #10 had a feeding tube. (continued on next page)

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	366114	A. Building B. Wing	04/07/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the care plan for Resident #10 dated 09/23/24 revealed EBP Infection Prevention related to peg tube and Contact Isolation for CRE in urine. EBP: Use gown and gloves for high-contact resident care including dressing, bathing, showering, transfers, hygiene care, changing linens, changing briefs, assisting with toileting, dressing changes, and care of any device for residents with the following(s): trach, central lines, tube feeding, catheters and/or wounds. Review of the physician orders for Resident #10 revealed an order dated 03/04/24 for contact isolation for CRE in urine every shift precaution for infinity. Observation on 03/25/25 at 4:26 P.M. of CNA #274 provide incontinence care for Resident #10 revealed CNA #274 donned PPE and entered Resident #10's room. Resident #10 was lying in bed. CNA #274 placed her gloved hand inside the front of Resident #10's brief and revealed she was wet and needed changed. CNA #274 then left Resident #10's room with the isolation gown and gloves on, went to the first linen cart, lifted the cover, looked at the surveyor and removed her gloves, looked inside the cart then replaced the cover. CNA #274 walked down the hall to the second linen cart, removed wash cloths then returned to Resident #10's room with the isolation gown still on and the soiled gloves in her hand. CNA #274 confirmed she left Resident #10's room with soiled gloves and a gown on and touched two clean linen carts with her soiled hands. 3. Record review for Resident #40 revealed an admitted [DATE]. Diagnosis included amyotrophic lateral sclerosis, protein calorie malnutrition, and muscle weakness. Review of the Admission MDS dated [DATE] revealed Resident #40 was cognitively intact. Resident #40 had impairment on both sides of the upper and lower extremities and was dependent for all activities of daily living, Resident #40 was always incontinent of bowel and bladder and Resident #40 had a feeding tube. Review of the care plan for Resident #40 dated 01/21/25 revealed a care plan for EBP: use gown and gloves for high-contact resident care including dressing, bathing, showering, transfers, hygiene care, changing linens, changing briefs, assisting with toileting, dressing changes, and care of any device for residents with the following(s): trachs, central lines, tube feeding, catheters and/or wounds. Interventions included apply EBP. Review of the physician orders for Resident #40 revealed an order dated 03/24/25 for EBP: Use gown and gloves for high-contact resident care including dressing, bathing, showering, transfers, hygiene care, changing linens, changing briefs, assisting with toileting, dressing changes, and care of any device for residents with the following(s): trachs, central lines, tube feeding, catheters and/or wounds. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 03/25/25 at 10:07 A.M. revealed after CNA #451 disposed of soiled linen in the soiled utility room (removed from Resident #10's room), CNA #451 left the soiled utility room, removed her gloves (did not wash her hands) and revealed she was going to change Resident #40. CNA #451 entered Resident #40's room, did not don PPE or wash her hands, spoke with Resident #40 then revealed she needed to get clean linen. CNA #451 left the room, did not wash her hands, went to the linen cart and obtained clean washcloths and towels. CNA #451 returned to Resident #40's room, did not wash her hands or don PPE. CNA #451 confirmed Resident #40 had a feeding tube that was infusing. CNA #451 then went to the bathroom that was shared by Resident #40 and #61. Observation revealed two uncovered wash basins sitting directly on the floor side by side next to the toilet. Observation revealed there was no name or room number on either basin. CNA #451 put on gloves and picked up the wash basin sitting on the floor closest to the toilet. CNA #451 partially filled the basin with water (did not rinse or wash the basin) and sat the basin on Resident #40's bed side table. CNA #451 did not don a gown. CNA #451 then removed Resident #40's brief. Resident #40 had a large bowel movement. A small trash can was sitting next to Resident #40's bed with no trash bag in it. CNA #451 removed Resident #40's soiled brief and placed it in a disposable bag. CNA #451 then provided incontinence care for Resident #40 using the basin of water and multiple wash cloths. CNA #451 disposed of the multiple wash clothes that were soiled with stool in the trash can that had no bag in it. CNA #451 then went to Resident #40's closet, opened the closet door with the same soiled gloves on and obtained a brief and placed the brief on Resident #40. CNA #451 revealed Resident #40's oxygen tubing displaced during care. CNA #451 placed the nasal cannula back in Resident #40's nares and placed the tubing behind her ears. CNA #451 then moved the hair from Resident #40's forehead and face with the same gloves on used to provide incontinent care. CNA #451 confirmed Resident #40's sheet and pad under her were soiled with urine. CNA #451 then went back to Resident #40's closet (with the same gloves on) rummaged in the closet and revealed she did not have what she needed in the closet. CNA #451 then went to the roommate (Resident #61) closet, rummaged in the closet with the same gloves on and revealed she also did not have what she needed. CNA #451 then took off her gloves and grabbed the bag with the soiled brief. CNA #451 did not wash her hands, she exited the room with soiled brief and took it to the soiled linen room. CNA #451 then removed a sheet, gown, and pad from the clean linen cart that was stocked with linen and gowns and handed the supplies to CNA #249. CNA #451 then obtained a disposable trash bag. Both CNA'S returned to Resident #40's room. CNA #451 put on gloves (no gown) and bagged the soiled washcloths and towels that were in the trash can. CNA #451 did not clean the can and still never washed her hands or used hand sanitizer. CNA #249 handed CNA #451 an isolation gown to don. CNA #451 donned the gown but did not tie any of the ties and did not place the gown over her shoulders. CNA #451 and #249 then changed Resident #40's soiled sheets and bed pad and dressed Resident #40. During care CNA #451 isolation gown had fallen down to her mid chest and the sleeves of the gown was down to the elbows. CNA #249 removed her gown and gloves and left the room. CNA #249 did not wash her hands or use hand sanitizer prior to leaving the room. CNA #451 then emptied the basin of water used to wash Resident #40 in the bathroom sink, rinsed the inside of the basin once with plain water and placed the wet basin on top of the other basin on the floor in the bathroom, uncovered. CNA #451 revealed each resident (Resident #40 and #61) had their own wash basin and confirmed neither basin was marked or had any way to identify which basin belonged to which resident. CNA #451 then removed the isolation gown and gloves, did not wash her hands, then exited the room and took the bag with the soiled washcloths to the linen room. CNA #451 then exited the linen room without washing her hands or using hand sanitizer. CNA #451 confirmed she never washed her hands or used hand sanitizer after providing incontinence care for Resident #10 or before, during or after providing incontinence care for Resident #40 and confirmed she never used an isolation gown during incontinence care for Resident #40. After CNA #451 confirmed she never washed her hands or used hand sanitizer at all while providing care, CNA #451 walked away during the interview to answer Resident #10's call light without washing her hands or using hand sanitizer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 03/25/25 at 10:35 A.M. with CNA #249 confirmed she never washed her hands or used hand sanitizer after providing care or prior to leaving Resident #40's room. Interview on 03/25/25 at 1:46 P.M. with the Director of Nursing (DON) revealed when a resident was on EBP/Contact isolation, staff were to don gloves and a gown when providing any hands on care. Staff were required to wash their hands prior to leaving the resident room and were not to wear gloves in the halls. Wash basins were to be cleaned with soap and water after each use, bagged and labeled with the resident identifying information. Wash basins were not shared between residents nor stored on the floor. Review of the facility policy titled, Enhanced Barrier Precautions revised August 2022 revealed EBP are used as an infection prevention and control intervention to reduce the spread of multi drug resistant organisms (MRDO's) to residents. Gloves and gown are applied prior to performing the high contact resident care activity. Examples of high-contact resident care activities requiring the use of gowns and gloves for EPB's include dressing, bathing, showering, transferring, hygiene, changing linens, changing briefs or assisting with toileting, device care or use, or wound care. EBP's are indicated for residents with wounds and or indwelling medical devices regardless of MRDO colonization. EBP's remain in place for the duration of the residents stay or until the resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk. Review of the facility policy titled, Handwashing/Hand Hygiene revised October 2023 revealed the facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Hand hygiene is indicated immediately before touching a resident; before performing an aseptic task; after contact with blood, body fluids, or contaminated surfaces; after touching a resident; after touching a residents environment; before moving from work on a soiled body site to a clean body site; and immediately after glove removal. 37096 4. Review of the medical record for Resident #9 revealed an admittance date of 03/13/23 with diagnoses including spinal injury at T7 through T10, paraplegia, spinal stenosis, hypertension, depression, and heart failure. Review of Resident #9's physician orders for March 2025 revealed morning medications that included Allopurinol 100 milligram (mg), 0.6 mg Colchicine 0.6 mg. Furosemide 40 mg, multivitamin, potassium 20 milliequivalents (meq), vitamin B12, Vyvanse 40 mg, Flomax 0.4. and Gabapentin 800 mg. Observation on 03/26/25 at 7:57 A.M. of medication administration with Registered Nurse (RN) #310 revealed the nurse prepared Resident #9's morning medications and administered the medications. There was no hand sanitizer on the medication cart. RN #310 did not sanitize or wash hands prior to preparing medication Resident #9 medications or after administering the medications. Interview on 03/26/25 at 8:40 A.M. with RN #310 verified she did not sanitize or wash her hand prior to administering medication to Resident #9. 5. Review of the medical record for Resident #58 revealed an admittance date of 02/20/24. Diagnoses included amyotrophic lateral sclerosis, fibromyalgia, chronic pain, and depression and anxiety, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #'58's physician orders for March 2025 revealed morning medications that included Omeprazole 40 mg, and Colace 100 mg. Observation on 03/26/57 at 8:30 A.M. of mediation administration with RN #310 revealed the nurse prepared Resident #58's morning medication and administering the medications. There was no hand sanitizer on the medication cart. RN #310 did not sanitize or wash hands prior to preparing medications or after leaving the room. Interview on 03/26/25 at 8:40 A.M. with RN #310 verified she did not sanitize or wash her hand prior to administering medication to Resident #58. Review of the policy titled Administering Medications, revised April 2019 revealed the staff follows established facility infection control procedures. Such as handwashing or using hand sanitizer antiseptic technique, gloves, and isolation precautions for administration of medication. 6. Review of the medical record for Resident #49 revealed an admittance date of 02/14/25. Diagnoses included heart failure, obesity, obstructive sleep apnea, renal dialysis, pulmonary hypertension, chronic obstructive pulmonary disease (COPD), and acute respiratory failure. Review of the Minimum Data set 3.0 dated 02/21/25 revealed the resident had intact cognition and was receiving oxygen therapy. Review of the physician orders for March 2015 revealed an order for bilevel positive airway pressure (BIPAP) with two liters of oxygen at bedtime for sleep apnea. Observation on 03/24/25 at 11:55 A.M. revealed Resident #49's mask to the BIPAP was laying on the floor. Interview with Resident #49 at this time stated that the aid came in to turn of her call light and knocked the mask off the nightstand. Interview on 03/24/25 at 12:00 P.M. with Registered Nurse #334 verified the mask was not stored in a sanitary manner and stated she would replace the mask for the BIPAP.