STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366123	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accord Care Community Orrville LLC	1980 Lynn Drive Orrville, OH 44667

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39968 Based on medical record review, staff interview, and facility policy review, the facility failed to ensure advanced directives were accurate. This affected one (Resident #108) of one resident reviewed for advanced directives. The census was 55. Findings include: Medical record review revealed Resident #108 was admitted to the facility on [DATE]. Diagnoses included dementia, insomnia, and hypertension. A Brief Interview for Mental Status (BIMS) dated [DATE] revealed a score of ,d+[DATE], which indicated Resident #108 was not cognitively intact. Further review of Resident #108's medical records revealed the hard copy chart included conflicting advanced directives. One advanced directive indicated Full Measures, that required all life saving measures be used. A second advanced directive indicated Do Not Resuscitate - Comfort Care (DNR-CC), that specified Cardio Pulmonary Resuscitation (CPR) was not to be initiated in case of cardiac or respiratory arrest. The DNR-CC was signed by the physician and both forms were dated [DATE]. The electronic medical record indicated Resident #108's advanced directive was DNR-CC. Interview with Licensed Practical Nurse (LPN) #227 and the Administrator on [DATE] between 9:40 A.M. and 9:50 A.M. confirmed there were two different advance directives in the hard chart. They revealed in the case of a resident experiencing a cardiac or respiratory arrest, staff would reference and follow the advance directive in the hard chart. They confirmed the advance directive in the electronic record and the hard copy chart should be the same but for Resident #108, they were conflicting. Review of the facility's Advance Directives policy (revised [DATE]) revealed, Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. The Interdisciplinary Team will review annually with the resident, and/or her representative, her advance directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded on the resident assessment instrument.

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 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** 42011 Based on interview, record review, and review of the facility policy, the facility failed to timely notify Resident #25's Power of Attorney (POA) of an injury of unknown origin. This affected one (Resident #25) of three residents reviewed for resident representative notification. The facility census was 55. Findings include: Record review for Resident #25 revealed a readmitted [DATE]. Diagnoses included age related physical debility, dementia, cognitive communication deficit, Parkinson's disease, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 was rarely or never understood. Resident #25 had impairment on both sides of the upper and lower extremities. Resident #25 was dependent for eating, oral hygiene, toileting, bathing, personal hygiene, bed mobility, chair/bed, bed to chair transfers, and wheelchair mobility. Review of the progress note for Resident #25 dated 09/22/24 timed at 10:53 A.M. completed by Licensed Practical Nurse (LPN) #275 included upon feeding resident in dining room, this nurse noted a bruised raised area two centimeters (cm) in length by 1.2 cm in width by 0.4 cm with open area in center measuring 0.3 cm by 0.3 cm by 0.0 cm. No drainage or odor noted. Also noted, open area right forehead measuring 0.5 cm by 0.3 cm by 0.0 cm. No drainage or odor noted. Location of injury consistent with contact with Hoyer (mechanical lift) bar during transfer. Review of the progress note for Resident #25 dated 09/22/24 timed at 10:59 A.M. revealed Resident POA aware of bruise noted to center forehead. Observation on 10/21/24 at 12:43 P.M. of Resident #25 revealed Resident #25 was sitting up in the dining room. Further observation revealed a large light purple/bluish colored bruise to the center of the forehead. Resident #25 was non-interviewable. Interview on 10/22/24 at 8:56 A.M. with Resident #25's POA/Emergency contact #1 revealed she worked at the facility as a receptionist. While at work, at some point that morning (09/22/24), POA/Emergency contact #1 went to see her mom, her mom had what looked like a lifted goose egg the size of a golf ball cut in half sticking out of her forehead, it was oval shaped up and down just above the bridge of her nose to the hairline. Resident #25's POA/Emergency Contact #1 revealed, Nobody notified me, I noticed it when I came to work, I asked her nurse what happened, she said I don't know, I fed her at breakfast then noticed it. Interview on 10/23/24 at 8:00 A.M. with Licensed Practical Nurse (LPN) #275 revealed she was not aware of Resident #25's bruise to her forehead until she began assisting Resident #25 in the dining room. LPN #275 confirmed Resident #25's POA/Emergency Contact #1 asked her what happened, she was not notified prior. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/24/24 at 11:12 A.M. with State tested Nursing Assistant (STNA) #230 revealed on 09/22/24 she was Resident #25's primary STNA. When she transported Resident #25 to the dining room at around 8:00 A.M. on that day, her and LPN #275 noticed the bruised area on her forehead at that time. Review of the facility policy titled, Change in Resident's Condition or Status revised May 2017 revealed the facility was to promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition and or status. This deficiency represents non-compliance investigated under Complaint Number OH00158226.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on staff interview, medical record review, review of facility reported incidents (FRI) and review of the facility policy, the facility failed to report an injury of unknown origin to the State agency. This affected one (Resident #25) of two residents reviewed for abuse. The facility census was 55. Findings include: Record review for Resident #25 revealed a readmitted [DATE]. Diagnoses included age related physical debility, dementia, cognitive communication deficit, Parkinson's disease, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 was rarely or never understood. Resident #25 had impairment on both sides of the upper and lower extremities. Resident #25 was dependent for eating, oral hygiene, toileting, bathing, personal hygiene, bed mobility, chair/bed, bed to chair transfers, and wheelchair mobility. Review of the care plan dated 04/01/24 revealed Resident #25 had potential impairment to skin integrity related to incontinence, aspirin use, fragile skin (age related). Interventions included to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Review of the physician order dated 09/22/24 for Resident #25 revealed to monitor the bruise to center forehead and leave open to air. Review of the progress note for Resident #25 dated 09/22/24 timed at 10:53 A.M. completed by Licensed Practical Nurse (LPN) #275 revealed upon feeding resident in dining room, this nurse noted a bruised raised area two centimeters (cm) in length by 1.2 cm in width by 0.4 cm with open area in center measuring 0.3 cm by 0.3 cm by 0.0 cm. No drainage or odor noted. Also noted, open area right forehead measuring 0.5 cm by 0.3 cm by 0.0 cm. No drainage or odor noted. Location of injury consistent with contact with Hoyer (mechanical lift) bar during transfer. Review of the FRI's from 09/21/24 through 10/21/24 revealed there was no FRI completed for an injury of unknown origin for Resident #25. Observation on 10/21/24 at 12:43 P.M. of Resident #25 revealed Resident #25 was sitting up in the dining room. Resident #25's bilateral arms were partially contracted. A large light purple/bluish/yellow colored bruise located from below the hairline to above the eyebrows in the center of the forehead was observed. Resident #25 was non-verbal and did not respond to conversation. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/22/24 at 8:56 A.M. with Resident #25's Power of Attorney (POA)/Emergency contact #1 revealed she worked at the facility as a receptionist. Resident #25's POA revealed when she went to work, at some point that morning (09/22/24), she went to see her mom, her mom had what looked like a lifted goose egg the size of a golf ball cut in half sticking out of her forehead, it was oval shaped up and down just above the bridge of her nose to the hairline. Resident #25's POA/Emergency contact #1 noticed it when she came to work and asked her nurse what happened. The nurse said she did not know, she fed her breakfast then noticed it. Resident #25's POA/Emergency contact #1 revealed she left the faciity on [DATE] at around 3:00 P.M. and Resident #25 had no injuries to her forehead at that time. Resident #25's POA/Emergency contact #1 revealed she still did not know how the injury occurred. Interview on 10/22/24 at 3:09 P.M. with Licensed Practical Nurse (LPN) #291 revealed Resident #25 was unable to turn or reposition herself, or even slightly move side to side without assistance. Interview and observation on 10/22/24 at 4:02 P.M. revealed State tested Nurse Aides (STNAs) #230 and #233 transferring Resident #25 from the bed to the chair. The interview and observation revealed inconsistencies with Resident #25 bumping her head during a Hoyer transfer. STNAs #230 and #233 confirmed Resident #25 was unable to move in bed or in the chair without assistance. Observation revealed Resident #25's bed had two half rails, one located on each side of the upper portion of the bed. Observation while Resident #25 was being repositioned in bed to place the Hoyer pad under her by STNAs #230 and #233 revealed the side rail bars lined up to the same height and shape as the bruise on the forehead. Observation with Director of Nursing (DON) on 10/23/24 at 9:38 A.M. of STNA #216 and #230 transfer Resident #25 with a mechanical lift from her chair to her bed revealed no concerns with the transfer. The DON revealed the bar used to lift Resident #25 might have swung sideways and hit her in the head causing the injury of unknown origin. However, observation revealed inconsistencies to location of the injury if the bar were to start swinging. STNA #230 confirmed two STNAs were required to transfer a resident in and out of bed using a mechanical lift but only one STNA was required to turn and reposition Resident #25 in bed including for incontinence care. Observation with the DON while Resident #25 was in bed verified the side rail top bar was the same height as Resident #25's forehead and shape of the bruise lined up with the siderail. The DON confirmed that the injury could have potentially been caused by a staff member turning Resident #25 in bed and hitting her head on the siderail causing the injury to her forehead. Review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating Revised September 2022 revealed all reports of resident abuse (including injury of unknown origin) neglect, exploitation, or theft/misappropriation of resident property would be reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of all investigations would be documented and reported. If resident abuse, including injury of unknown source was suspected, the suspicion must be reported immediately to the Administrator and to other officials according to state law. The Administrator or the individual making the allegation immediately reported his or her suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility; The Ombudsman; The resident's representative; law enforcement officials; the resident's attending physician and the Medical Director. This deficiency represents non-compliance investigated under Complaint Number OH00158226.

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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** 42011 Based on staff interview, medical record review, review of facility investigations, and review of the facility policy, the facility failed to thoroughly investigate an injury of unknown origin for Resident #25. This affected one (Resident #25) of two residents reviewed for abuse. The facility census was 55. Findings include: Record review for Resident #25 revealed a readmitted [DATE]. Diagnoses included age related physical debility, dementia, cognitive communication deficit, Parkinson's disease, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 was rarely or never understood. Resident #25 had impairment on both sides of the upper and lower extremities. Resident #25 was dependent for eating, oral hygiene, toileting, bathing, personal hygiene, bed mobility, chair/bed, bed to chair transfers, and wheelchair mobility. Review of the care plan dated 04/01/24 revealed Resident #25 had potential impairment to skin integrity related to incontinence, aspirin use, fragile skin (age related). Interventions included to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Review of the physician order dated 09/22/24 for Resident #25 revealed to monitor the bruise to center forehead and leave open to air. Review of the physician order dated 01/30/24 revealed an order for a mechanical lift (Hoyer) for transfer with two assistance. Review of the progress note for Resident #25 dated 09/22/24 at 10:53 A.M. completed by Licensed Practical Nurse (LPN) #275 revealed upon feeding resident in dining room, this nurse noted a bruised raised area two centimeters (cm) in length by 1.2 cm in width by 0.4 cm with open area in center measuring 0.3 cm by 0.3 cm by 0.0 cm. No drainage or odor noted. Also noted, open area right forehead measuring 0.5 cm by 0.3 cm by 0.0 cm. No drainage or odor noted. Location of injury consistent with contact with Hoyer bar during transfer. Review of the daily staffing schedule dated 09/21/24 revealed staff worked 12 hour shifts (6:00 A.M. to 6:00 P.M. and 6:00 P.M. to 6:00 A.M.) On 09/21/24 from 6:00 A.M. to 6:00 P.M. LPN #247, LPN #290, State tested Nursing Assistant (STNA) #225, STNA #243, STNA #248, [NAME] #256 and STNA #257 worked the day shift. On 09/21/24 from 6:00 P.M. to 6:00 A.M. (09/22/24) LPN #238, LPN #274, STNA #207, [NAME] #236, STNA #252, and STNA #259 worked the shift. Review of the daily staffing schedule dated 09/22/24 revealed from 6:00 A.M. to 6:00 P.M. LPN #247, LPN #275, STNA #243, STNA #248, STNA #256, and STNA #258 worked from 6:00 A.M. to 6:00 P.M. Review of the Facility Reported Incidents (FRI) from 09/21/24 through 10/21/24 revealed there were no FRI's completed for and injury of unknown origin for Resident #25. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/21/24 at 12:43 P.M. of Resident #25 revealed Resident #25 was sitting up in the dining room. Resident #25's bilateral arms were partially contracted. A large light purple/bluish/yellow colored bruise located from below the hairline to above the eyebrows in the center of the forehead was noted. Resident #25 was non-verbal and did not respond to conversation. Interview on 10/22/24 at 8:56 A.M. with Resident #25's Power of Attorney (POA)/Emergency contact #1 revealed she worked at the facility as a receptionist. When POA/Emergency contact #1 revealed, at some point that morning (09/22/24), she went to see her mom, her mom had what looked like a lifted goose egg the size of a golf ball cut in half sticking out of her forehead, it was oval shaped up and down just above the bridge of her nose to the hairline. Resident #25's POA asked her nurse what happened, she said I don't know, I fed her at breakfast then noticed it. Resident #25's POA/Emergency contact #1 revealed she left the faciity on [DATE] at around 3:00 P.M. and Resident #25 had no injuries to her forehead at that time. Interview on 10/22/24 at 3:09 P.M. with LPN #291 revealed Resident #25 was unable to turn or reposition herself, or even slightly move side to side without assistance. Interview and observation on 10/22/24 at 4:02 P.M. while STNAs #230 and #233 transferred Resident #25 from the bed to the chair revealed inconsistencies with Resident #25 bumping her head during a Hoyer transfer. STNAs #230 and #233 confirmed Resident #25 was unable to move in bed or in the chair without assistance. Observation revealed Resident #25's bed had two half rails, one located on each side of the upper portion of the bed. While Resident #25 was being repositioned in bed to place the Hoyer pad under her by STNAs #230 and #233 revealed the side rail bars lined up to the same height and shape as the bruise on the forehead. Interview on 10/23/24 at 8:00 A.M. with LPN #275 revealed a STNA did not make her aware of the bruise and raised area on Resident #25's forehead prior to going to the dining room for breakfast on 09/22/24. LPN #275 told the DON or Unit Manager #227 (she was unsure which one) about the injury, she did not talk to any other staff about it or initiate an investigation herself as to origin of the injury. LPN #275 thought Unit Manager #227 determined the injury was from the Hoyer. Interview on 10/23/24 at 8:07 A.M. with LPN Unit Manager #227 revealed she did not determine the injury to Resident #25's forehead was from the Hoyer. LPN Unit Manager #227 did not know who made the determination; she did not talk to any staff about it. Interview on 10/23/24 at 8:19 A.M. with the Director of Nursing (DON) revealed one of the aids told her Resident #25 had a bruise on her forehead. The DON looked at the bruise, it was purple dark, so then she looked how Resident #25 transferred. The DON noted the Hoyer bar came close to Resident #25 during the transfer. The DON revealed the daughter said she never saw the Hoyer bar actually touch her mother but it did come close. The DON asked the STNAs on first shift how she transferred, they said with two people. The DON asked if they noticed the Hoyer bar hitting Resident #25 and they said no. The DON educated staff on use of a mechanical lift during transfers. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the investigation on 10/23/24 at 9:20 A.M. for the injury to Resident #25's forehead with the DON, completed by the DON revealed two staff members and Resident #25's POA were interviewed regarding how the injury occurred to Resident #25's forehead. The DON confirmed no other staff or residents were interviewed. The DON revealed an inservice with staff was completed on 09/23/24 on mechanical lift transfers. No other education was provided related to prevention of further injuries for Resident #25. Review of the typed first investigation for Resident #25 dated 09/23/24, untimed, completed by the DON revealed, This writer spoke to (STNA #292) who generally works on A hall at night and she stated that she did not know how the bruise got there, Yes, she transferred with a Hoyer lift. Yes the bars might come close to her but we hold them away. I don't remember seeing a bruise. Review of the typed second investigation for Resident #25 dated 09/23/24, untimed, completed by the DON revealed, This writer spoke with (STNA #230) and she stated that she saw a bruise on (Resident #25) forehead and it wasn't there last time she worked. She was unaware of any event that would have caused the bruise. She also stated that the Hoyer bars do come close to her when she transfers. (STNA #230) generally works on A hall. The DON confirmed no other staff were interviewed regarding the bruise. Review of the daily staff schedule revealed STNA #292 did not work on 09/21/24 or 09/22/24. Observation with the DON on 10/23/24 at 9:38 A.M. of STNA #216 and #230 transferring Resident #25 with a mechanical lift from her chair to her bed revealed no concerns with the transfer. The DON indicated the bar used to lift Resident #25 might have swung sideways hitting her in the head. However, observations during the transfer revealed inconsistencies to location of the injury if the bar were to start swinging. STNA #230 confirmed two STNAs were required to transfer a resident in and out of bed using a mechanical lift but and one STNA was required to turn and reposition Resident #25 in bed including for incontinence care. Observation with the DON while Resident #25 was in bed revealed the side rail top bar was the same height as Resident #25's forehead and the shape of the bruise lined up with the siderail. The DON confirmed that the injury could have potentially been caused by a staff member turning Resident #25 in bed and hitting her head on the siderail causing the injury to her forehead. The DON confirmed no staff reported the injury and staff should report an injury at the time it occurred. Interview on 10/24/24 at 11:12 A.M. with STNA #230 confirmed on 09/22/24 she was Resident #25's primary STNA. When she transported Resident #25 to the dining room at around 8:00 A.M. on that day (09/22/24), her and LPN #275 noticed the bruised area on her forehead at that time. STNA #230 revealed the third shift STNA changed and dressed Resident #25 in the mornings then she would get her up for breakfast by 8:00 A. M.; STNA #230 revealed she never turned the lights on while getting her up, that's why she did not see the area prior to taking her to the dining room. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating Revised September 2022 revealed all reports of resident abuse (including injury of unknown origin) neglect, exploitation, or theft/misappropriation of resident property were to be reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of all investigations were to be documented and reported. If resident abuse, including injury of unknown source was suspected, the suspicion must be reported immediately to the Administrator and to other officials according to state law. The Administrator or the individual making the allegation immediately reported his or her suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility; The Ombudsman; The resident's representative; law enforcement officials; The resident's attending physician and the Medical Director. All allegations were to be thoroughly investigated. The Administrator initiated the investigations. The individual conducting the investigation as a minimum was to interview staff members on all shifts who had contact with the resident during the period of the alleged incident. Interviews other residents to whom the accused employee provided care and services. The investigation was to be documented completely and thoroughly. This deficiency represents non-compliance investigated under Complaint Number OH00158226.

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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** 34297 Based on record review and interview, the facility failed to ensure appropriate treatment was in place for moisture associated dermatitis (MASD) to promote adequate healing. The affected one (Resident #3) of four residents reviewed for skin impairment. Findings include: Review of Resident #3's medical record revealed the resident was admitted on [DATE] with diagnoses including Alzheimer's disease, dementia in other diseases classified elsewhere and diabetes. Resident #3 resided on the secured memory care unit. Review of Resident #3's care plans revealed an intervention dated 08/15/24 to provide incontinence care and apply barrier cream after each incontinent episode. Review of Resident #3's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited a memory impairment and did not have pressure ulcers. Review of Resident #3's physician orders revealed an order to cleanse the intergluteal cleft and bilateral buttocks with soap and water, apply zinc cream two times a day for MASD and as needed after each incontinence was discontinued on 09/21/24 at 10:06 P.M. because the MASD healed. Review of Resident #3's Skin Grid Non-Pressure form dated 09/23/24 revealed the resident had MASD first acquired on 08/18/24 and the area was improving. Resident #3's medical record did not have evidence the zinc MASD treatment was ordered or provided from 09/23/24 to 10/01/24. Review of Resident #3's physician orders revealed an order dated 10/01/24 (discontinued 10/14/24) to cleanse the bilateral buttocks with soap and water, apply zinc cream two times per day and as needed. Review of Resident #3's Skin Grid Non-Pressure form dated 10/14/24 revealed the resident had MASD with a date acquired of 08/18/24. The form indicated the area was improving and continue treatment as ordered. Review of Resident #3's physician orders revealed an order dated 10/14/24 to cleanse the bilateral buttocks/coccyx with soap and water, apply zinc cream two times per day and as needed. Review of Resident #3's medication administration records (MARs) and treatment administration records (TARs) from 08/18/24 to 10/21/24 revealed the ordered treatments were documented as completed. Interview on 10/21/24 at 3:00 P.M. with State tested Nursing Assistant (STNA) #243 confirmed Resident #3 had skin impairment on his bilateral buttocks and she had reported the breakdown to the nurse. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/21/24 at 3:17 P.M. with the Director of Nursing (DON) indicated Resident #3 refused care at times and would refuse to be changed at times. The resident would be approached later in order to provide care. The DON indicated Resident #3 had 4-N-1 Skin Protectant barrier cream in place from 09/23/24 to 10/01/24. Observation on 10/22/24 at 9:55 A.M. with STNA #216 and Licensed Practical Nurse (LPN) Unit Manager (UM) #227 of Resident #3's buttocks revealed redness in the intergluteal cleft with some MASD identified. Interview on 10/22/24 at 10:00 A.M. with LPN UM #227 revealed she was made aware Resident #3's physician order for the treatment to the resident's bilateral buttocks and intergluteal cleft was not in the computer on 10/01/24 and placed the treatment in the electronic health record (EHR) for the resident at that time. Interview on 10/23/24 at 10:42 A.M. with Manufacturer Representative #277 revealed the 4-N-1 skin protectant was a light barrier and not a treatment for MASD. He stated it did not cure MASD but was used to prevent further complications related to incontinence. Review of the undated 4-N-1 Wash Cream manufacturer directions (provided by the facility) indicated the product was a no-rinse skin protectant wash cream that was a gentle alternative to soap and water. The cream cleaned, protected, nourished, and restored even the most delicate skin. Fortified with dimethicone, the cream left behind a moisture barrier to nourish and protect the skin. The cream was ideal for frequent cleansing and incontinence care. Review of the Pressure Ulcers/Skin Breakdown Clinical Protocol revised April 2018 indicated the physician would help identify factors contributing or predisposing residents to skin breakdown and would clarify the status of relevant medical issues. This deficiency represents non-compliance investigated under Complaint Number OH00158226.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on observation, record review and interview, the facility failed to ensure Resident #15 was provided timely incontinence care. This affected one (Resident #15) of two residents reviewed for incontinence care. Findings include: Review of Resident #15's medical record revealed the resident was admitted on [DATE] with diagnoses including diffuse traumatic brain injury with loss of consciousness, other lack of coordination and schizoaffective disorder. Review of Resident #15's care plans revealed a focus dated 07/09/24 indicating the resident was incontinent of bowel and bladder with interventions including to assess resident for burning, pain and distention, monitor for changes in urinary elimination and provide incontinence care, and apply barrier cream after each incontinent episode. Review of Resident #15's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment and was always incontinent of urine and bowel. Review of the undated Nurse Report Sheet for the C hall revealed Resident #15 was to be checked for incontinence and changed. Observation on 10/22/24 at 1:42 P.M. revealed Resident #15 was asleep and sitting in the main common lounge in a wheelchair. A strong odor of urine was in the lounge in the vicinity of Resident #15. The resident had on pants and was sitting on a green chux pad which appeared to have a large urine stain on the pad underneath of the resident. Observation on 10/22/24 at 1:49 P.M. revealed Resident #15 was sitting in the common area. The resident was still sitting on the urine stained chux pad. Observation on 10/22/24 at 2:00 P.M. revealed Medical Records/Activity Director #240 handed Resident #15 a Bingo card for the activity and then walked to other residents. She did not identify the resident had odors or was sitting on a wet chux pad. Interview on 10/22/25 at 2:25 P.M. with State tested Nurse Aide (STNA) #233 revealed Resident #15 was aggressive with her during care and she had last changed the resident after breakfast and before lunch. STNA #233 could not provide an approximate time the incontinence care was provided. Observation on 10/22/24 at 3:05 P.M. revealed STNA #204 completed Resident #15's incontinence care. She confirmed the resident's incontinence brief, pants, chux pad located on the wheelchair and the cushion on the wheelchair were saturated with urine. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Perineal Care policy revised February 2018 indicated the purpose of the procedure was to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. This deficiency represents non-compliance investigated under Complaint Number OH00158226.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on medical record review, observation, staff interview, and review of manufacturer's guidelines, the facility failed to ensure the medication error rate did not exceed five percent (%). Two errors occurred within 30 opportunities for an error rate of 6.67%. This affected one (Residents #13) of four residents reviewed for medication administration. and had the potential to affect an additional 13 residents, (Resident #5, #16, #21, #22, #27, #28, #29, #31, #32, #40, #41, #157, and #158) who received insulin injections. The facility census was 55 residents. Findings include: Record review for Resident #13 revealed an admitted [DATE]. Diagnosis included type two diabetes mellitus with diabetic chronic kidney disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 was moderately cognitively impaired. Resident #13 required set up or clean up assistance with meals and partial moderate assistance with personal hygiene. Resident#13 had a diagnosis of diabetes mellitus. Review of the care plan for Resident #13 dated 12/12/23 revealed Resident #13 was at risk for hypo/hyperglycemic episodes related to insulin dependent diabetes mellitus and required daily and sliding scale insulin. Interventions included to administer insulin as ordered. Review of the physician orders dated 08/28/24 for Resident #13 revealed an order for insulin lispro (one unit dial) 100 units per milliliter (ml) solution pen-injector, inject 20 units subcutaneously (sq) with meals for diabetes mellitus. An additional order dated 06/09/24 included lantus sq solution 100 unit/ml (insulin glargine) inject 40 units sq two times a day for diabetes mellitus. Observation on 10/22/24 at 7:10 A.M. of Licensed Practical Nurse (LPN) #254 preparing the lispro kwikpen 20 units for Resident #13 revealed LPN #254 did not prime the insulin pen injector prior to setting the pen at 20 units. LPN #254 verified she did not prime the insulin pen prior to injecting the medication then continued and injected the lispro insulin. Observation on 10/22/24 at 7:13 A.M. of LPN #254 prepare the lantus solostar 40 units (via insulin pen) for Resident #13 revealed LPN #254 did not prime the insulin pen injector prior to setting the pen at 40 units. LPN #254 verified she did not prime the insulin pen prior to injecting the medication then asked, How do you do that? LPN #254 continued and injected the lantus solostar 40 units without priming the insulin pen. Review of the daily staffing schedule for September/October 2024 revealed LPN #254 worked with residents in all areas of the facility. Interview on 10/22/24 at 11:55 A.M. with the Director of Nursing (DON) confirmed LPN #254 worked in all areas of the facility with all residents. The DON confirmed Resident #5, #16, #21, #22, #27, #28, #29, #31, #32, #40, #41, #157, and #158 also received insulin injections. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the manufacturer's guidelines titled, Use of the Insulin Lispro revised July 2023 included for sq use three ml single-patient-use pen included insulin lispro kwikpen was a disposable single-patient use prefilled pen containing 300 units of insulin lispro. More than one dose could be given from the pen. The guidelines indicated to always use a new needle for each injection. Prime before each injection. Priming the pen meant removing the air from the needle and cartridge that could collect during normal use and ensured that the pen was working correctly. If the pen was not primed before each injection, too much or too little insulin could be administered. Review of the manufacturer's guidelines for use of lantus insulin titled Safely and Effectively revised 11/2018 included, Important Administration Instructions. Always perform the safety test (priming) before each injection. Performing the safety test ensured an accurate dose was administered by ensuring the pen and needle worked properly and removed air bubbles. The guidelines indicated to select a dose of two units by turning the dosage selector. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the inner needle cap and discard it. Hold the pen and needle pointing upwards. Tap the insulin reservoir so any air bubbles rise up towards the needle. Press the injection button all the way in. Check if insulin comes out of the needle tip. You may have to perform the safety test several times before insulin is seen. If no insulin comes out, check for air bubbles and repeat the safety test two more times to remove them. If no insulin comes out, the needle may be blocked, change the needle and try again. If no insulin comes out after changing the needle, your solostar may be damaged. Do not use this solostar. This deficiency represents non-compliance investigated under Complaint Number OH00158226.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 39333 Based on record review, observation, and interview, the facility did not ensure food was served at palatable temperatures. This had the potential to affect 54 residents that received meals from the facility. One resident (Resident #46) out of 55 residents received nothing by mouth. The facility census was 55. Findings include: Interviews during phase one of the annual survey on 10/21/24 from 8:15 A.M. through 5:00 P.M. with Residents #2, #3, #14, #25, #40, and #159 revealed each had complaints the food was cold and/or not palatable. Observation of tray line on 10/22/24 from 11:00 A.M. trough 11:54 A.M. revealed food was above 165 degrees Fahrenheit (F). A test tray was requested as the last resident's food was plated. The food truck left the kitchen at 11:55 A.M. and arrived at the unit at 11:56 A.M. When the last tray on the truck was delivered on 10/22/24 at 12:00 P.M., the test tray was removed from the food truck and placed on a table where food temperatures were taken. Dietary Manager (DM) #208 took the temperature of the food and stated that the temperature for the chicken thigh was 108 degrees F and the peas were 115 degrees F. DM #208 said the food should be hotter. Upon tasting the food it was tepid. The facility was not able to provide a policy regarding what food temperatures should be at point of service. This deficiency represents non-compliance investigated under Complaint Number OH00158226 and OH00158184.

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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** 39333 Based on observation, interview, and record review, the facility failed to provide residents with their preferences during meals. This affected four (#3, #8, #16 and #34) of four residents reviewed for food preferences. The facility census was 55. Findings include: 1. Review of the medical record for Resident #3 revealed the resident was admitted to the facility on [DATE] with diagnoses to include but not limited to dementia, adult failure to thrive, and Alzheimer's disease. Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/03/24, revealed the resident had severely impaired cognition. The resident required partial or moderate assistance for activities of daily living (ADLs). Review of the October 2024 physician orders revealed that Resident #3 was ordered a regular diet with no restrictions and double portions. Review of Resident #3's diet ticket revealed that he disliked orange juice. Observation on 10/22/24 at 7:18 A.M. revealed Resident #3 was sitting up in bed and his breakfast tray had an entree of eggs, sausage casserole with toast, Cheerios, milk, and orange juice. Interview on 10/22/24 at 7:27 A.M. with Dietary Manager (DM) 208 confirmed Resident #3 was served orange juice and his diet ticket indicated a dislike of orange juice. 2. Review of the medical record for Resident #8 revealed the resident was admitted to the facility on [DATE] with diagnoses to include but not limited to depression, anxiety disorder, and schizophrenia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 09/27/24, revealed the resident had intact cognition and required partial or moderate assistance for activities of daily living. Review of the October 2024 physician orders revealed that Resident #8 was ordered a no added salt diet, regular texture, regular consistency of liquids and give fruit for dessert. Review of Resident #8's diet ticket revealed that she was to get fruit for dessert. Observation and interview on 10/22/24 at 11:52 A.M. revealed that Resident #8's tray was plated and placed in the food cart to be delivered. Resident #8's food tray included a piece of cake and no fruit. This was verified by [NAME] #239 at time of observation. 3. Review of the medical record for Resident #16 revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include but not limited to diabetes mellitus, chronic kidney disease, and chronic pulmonary disease. Review of the most recent Minimum Data Set (MDS) assessment, dated 10/03/24, revealed the resident had moderately impaired cognition and required substantial or maximal assistance for activities of daily living. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the October 2024 physician orders revealed that Resident #16 was ordered a consistent carbohydrate, no added salt diet, regular texture, regular consistency of liquids Review of Resident #16's diet ticket revealed that she wanted eight ounces of milk to drink with her meal. Observation and interview on 10/22/24 at 11:52 A.M. revealed that Resident #16's food was plated and placed on the food cart to be delivered. Further observation revealed there was no milk on Resident #16's meal tray. This was verified by [NAME] #239 at time of observation. 4. Review of the medical record for Resident #34 revealed the resident was admitted to the facility on [DATE] with diagnoses to include but not limited to diffuse traumatic brain injury, convulsions, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/01/24, revealed the resident had moderately impaired cognition and required supervision for activities of daily living. Review of the October 2024 physician orders revealed that Resident #34 was ordered a regular diet with no restrictions and double portions. Review of Resident #34's diet ticket revealed the resident wanted eight ounces of milk to drink with his meal. Observation and interview on 10/22/24 at 11:52 A.M. revealed that Resident #34's tray was plated and placed into the food cart to be delivered. There was no milk on Resident #34's tray. This was verified by [NAME] #239 at time of observation. Review of the facility policy dated December 2017 titled, Therapeutic Diets, revealed that diets were prescribed in accordance with resident's goals and preferences. This deficiency represents non-compliance investigated under Complaint Number OH00158226 and OH00158184.