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	02/11/2025

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 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** 42015 Based on observation, record review, and interview, the facility failed to ensure residents with non-pressure related skin issues were comprehensively assessed in a routine manner. This affected one resident (Resident #10) of three residents reviewed for non-pressure related skin impairment. The facility census was 53. Findings include: Review of the medical record for Resident #10 revealed an admitted [DATE]. Diagnoses included pain in the right knee, chronic obstructive pulmonary disease (COPD), type two diabetes mellitus with diabetic neuropathy, and peripheral vascular disease. Review of Resident #10's nurse progress note dated 01/03/25 at 11:19 A.M. revealed staff alerted the nurse that the resident has an open area to right lower extremity. The abrasion was to the resident's right shin noted measuring 3.4 centimeters (cm) in length by 10.5 cm in width and 0.1 cm in depth. Resident #10 stated his left heel went across his leg while he was uncrossing his legs. The resident was encouraged to sit with his legs uncrossed. The medical director was notified, and treatment orders were put in place and initiated. Observation on 02/03/25 at 3:20 P.M. revealed Regional Clinical Operations Specialist Registered Nurse #170 dressed Resident #10's wound. The resident was observed to have two small, open ulcers to his lower right leg. Both areas were cleansed with saline, collagen was applied, and an abdominal pad (absorbent dressing) was placed over the wounds, and wrapped with kerlix (a rolled gauze dressing). Review of Resident #10's wound monitoring records revealed on 01/03/25 the facility assessed the wound and described it as one abrasion measuring 3.2 cm in length by 10.5 cm in width, and 0.2 cm in depth. On 01/16/25, the facility assessed the wound again describing it as one abrasion measuring 4.5 cm in length, by 8.5 cm in width and 0.1 cm in depth. Continued review of the resident chart revealed no further wound monitoring was completed after 01/16/25. Review of Resident #10's outside wound healing center assessment dated [DATE] revealed the center classified the wound as a non-pressure chronic ulcer of the right calf with fat later exposed measuring 8.4 cm in length by 4.4 cm in width, and 0.1 cm in depth. The note states the resident underwent debridement at the outside wound center (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Accord Care Community Orrville LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1980 Lynn Drive Orrville, OH 44667	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #10's physicians' order revealed an order dated 01/16/24 for Bactrim DS (an oral antibiotic) 800-160 milligrams (mg) with instructions to give 1 tablet by mouth two times a day for 10 days for wound infection. Interview on 02/05/25 at 1:30 P.M. with Compliance Specialist #206 revealed on 01/03/25, Resident #10 was noted to have an abrasion to his right knee. He was seeing the facilities wound practitioner until 01/16/25 when family requested the resident be seen at an outside wound center. He was also prescribed antibiotics for a wound infection on this date. He was supposed to follow up at the wound center in one week, but due to an acute illness he was unable to go. Compliance Specialist #206 confirmed the facility did not ensure continued wound monitoring was completed after his 01/16/25 wound center visit. This deficiency represents non-compliance investigated under Complaint Numbers OH00161733 and OH00161732.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 42015 Based on observation, interview, review of employee time punch details, review of staffing schedules, policy review, and review of the facility assessment, the facility failed to ensure there was sufficient staff to provide residents with timely care. This had the potential to affect all 53 residents residing in the facility. Findings include: Review of the staffing schedule for 02/03/25 revealed the facility had three Certified Nursing Assistants (CNA) and two Licensed Practical Nurses (LPN) scheduled for the 6:00 A.M. to 6:00 P.M. day shift, with one additional Registered Nurse (RN) scheduled in training. Prior to the shift beginning, one LPN and two CNAs called off, leaving the facility staffed with only one LPN, one RN in training, and one CNA to provide care to 53 residents. Review of the employee time punch details for 02/03/25 revealed CNA #151 clocked out at 6:00 A.M., CNA #103 clocked out 6:15 A.M., and two agency CNAs clocked out at 5:58 A.M. and 6:01 A.M. There were no CNAs present in the facility until Agency CNA #208 clocked in for her shift on 02/03/25 at 6:45 A.M. Observation on 02/03/25 at 10:37 A.M. revealed the facility was separated into four halls with one hall designated as a locked memory care unit. The linen closet on this unit was noted to be locked. There was no evidence of a kardex, care plan, or an activities of daily living (ADL) book on the unit. The facility had several residents on transmission based precautions and signs were noted in the facility indicating they had a COVID-19 outbreak. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Telephone interview on 02/03/25 at 3:52 P.M. with Agency CNA #208 reported she arrived at the facility on 02/03/25 at approximately 6:36 A.M. This was the first time she had worked at the facility. Agency CNA #208 stated, upon arriving for her shift, she walked to the nurse's station and introduced herself. A facility nurse advised her to please report to the memory care unit because they did not have any staff working on that unit. She was told at this time she was the only CNA in the building. She reported to the nurse that she had never worked in the facility before and did not feel comfortable working on the unit by herself. Agency CNA #208 stated she was concerned for her CNA license. She was told by the facility nurse that someone would be coming in soon to assist her. The CNA reported she asked for a report on her patients, but was told the nurse had just arrived and did not have a report to give her. She was told that all the CNAs had left the facility without giving a report or ensuring the next shift had arrived to take over their assignments. Agency CNA# 208 continued that she attempted to find a Kardex or care plan to help assist her with resident care, but she was unable to locate any reference materials. Agency CNA #208 stated when she arrived on the memory care unit around 6:45 A.M., residents were wet, and one resident was covered in bowel movement. She was not provided the code and was unable to access the locked laundry area where clean linens were stored. She reports she used incontinence wipes to clean up the residents the best she could. She stated she had to change one residents incontinence brief while he remained in his recliner due to not having any information on how any of the residents on the unit transferred. Agency CNA #208 continued that at one point, an unnamed dietary staff member brought trays into the memory care unit, but she had no way of knowing how residents transferred, what kind of assistance they needed, or what their diets were. She reported trying to get help on the unit she pushed open the locked door to make it alarm, but no one responded to the alarm for at least 15 minutes. She continued after about 15 minutes she believed someone from therapy responded and helped tell her which residents required assistance with feeding. Agency CNA #208 stated she was not able to provide timely incontinence care nor was able to turn and reposition many of the residents due to being the only one on the unit, having no access to the laundry room, and no care plan information for any of the residents. She went on to say many of the residents were COVID-19 positive, in isolation, and probably needed extra care and services that she was unaware of or unable to provide. Agency CNA #208 stated around 7:45 A.M. a nurse came on the unit. Also, around this time the Administrator arrived at the unit. CNA #208 reported to the Administrator that she did not have the proper supplies to care for the residents on the unit and told him she felt all these residents were unsafe with the staffing levels in the facility. Interview on 02/03/25 at 4:05 P.M. LPN #109 reported she arrived at the facility a little before 6:00 A.M. on 02/03/25. She stated she received a report from an unknown agency nurse. She stated the only people who showed up for work that day was herself and another nurse who was in training. She continued that after getting the shift report she looked around and realized there were no other staff present in the facility except for her and the nurse in training. All of the CNAs scheduled to work did not come in and the night shift CNAs left without coverage. She started around 6:45 A.M., an unnamed Agency CNA arrived at the facility and she asked her to please go to the memory care unit because no one was on the unit. She went on to say she was unable to give her a report or any information regarding the residents on that unit. LPN #109 proceeded to send out a group text to off-duty employees asking for help at the facility. LPN #109 stated, at one point, she thought about calling the paramedics to come into the facility to assist with resident care. She stated that she and the nurse in training were the only staff present to care for all the residents outside of memory care. She stated she answered call lights and provided supervision until 7:30 A.M. when management and additional help arrived. LPN #109 confirmed she felt very unsafe in the situation, and residents went without timely incontinence care and repositioning. She also stated medications were not administered on time that morning. (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 02/03/25 at 4:37 P.M. RN #141 stated she arrived to the facility that morning around 5:54 A.M She reported it was supposed to be her third day in training. She attempted to get a report from an unnamed agency nurse, but was told she had to leave. Another nurse was scheduled for work, but she showed up and then left right away. She reported that she still had a report sheet from the Friday before and had to use that. She stated she was not comfortable taking the assignment. She went on to say that around 6:20 A.M. she had realized that all of the night shift CNA had left the facility, and none of the day shift CNAs had reported to work. stated this left the memory care abandoned and only herself and LPN #109 present in the facility to care for all the residents. RN #141 reported an Agency CNA arrived late and was advised to report to the memory care unit since no one was present on that unit. She confirmed she was unable to give her a report or any information about the residents on that unit since this was only her third day working in the facility. RN #141 confirmed the agency aide expressed concerns regarding resident safety. She went on to say due to the lack of staff, the only care she was able to provide until around 7:30 A.M. was answering call lights and maintaining supervision. RN #141 reported the staffing levels were unsafe due to many residents requiring additional assistance related to the COVID-19 outbreak, no shift-to-shift report having been given, she was not fully trained and was unfamiliar with the computer system, and one hospice resident was actively dying. Around 7:30 A.M. to 8:00 A.M., RN #141 reported additional help arrived at the facility. Telephone interview on 02/04/25 at 11:06 A.M. with CNA #103 reported she was one of the CNAs who worked on 02/02/25 from 6:00 P.M. until 02/03/25 at 6:00 A.M. Se reported the facility staffing is not good and sometimes there are only two CNAs scheduled for the entire building. She reported that on 02/03/25, only one CNA showed up for work briefly. She stated she was unable to stay and work due to a previous engagement and left the facility without ensuring proper coverage. She reported she gave a nurse report and then left shortly after 6:00 A.M. Telephone interview on 02/04/25 at 11:19 A.M. CNA #151 reported she worked in the facility on 02/02/25 from 6:00 P.M. until 02/03/25 at 6:00 A.M. She stated there were no CNAs listed on the schedule to come into work on day shift beginning on 02/03/25 at 6:00 A.M. She stated the facility scheduler had been off work sick. She stated when she left in the morning shortly after 6:00 A.M. only one person had come to work. She stated she had written down the last time she changed her residents on a sheet of paper and left it at the nurse's station without giving it to anyone. She verified she left the facility without ensuring adequate coverage due to a previous commitment. Telephone Interview on 02/04/25 at 1:31 P.M. Agency LPN #210 reported she worked in the facility on 02/02/25 from 6:00 P.M. until 02/03/25 at 6:00 A.M. She reported no CNAs showed up for their shift on 02/03/25. She went on to say all four CNAs that were working with her the night before abandoned their shift without a replacement. Agency LPN #210 went on to say when she left in the morning, the only staff present was an LPN and another nurse who was in training. Telephone interview on 02/4/25 at 1:40 P.M. Agency LPN #211 reported she worked in the facility 02/02/25 from 6:00 P.M. until 02/03/25 at 6:00 A.M. She stated on her shift she had two agency CNAs and two facility CNAs. She estimated all four CNAs left the facility by 6:10 A.M., leaving no CNAs in the facility and the memory care unit completely unattended. She stated she gave the report to the oncoming nurse and at 6:45 A.M. an agency CNA arrived at the facility and was sent to the memory care unit since there was no staff members present in the unit. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 02/04/25 at 10:06 A.M. with Regional Clinical Operation Specialist Registered Nurse (RCOSRN) #170 reported she arrived at work on 02/03/25 at 7:30 A.M., got report from the nurses, and immediately began assisting residents on the memory care unit. She confirmed that due to multiple staff call offs, the facility was understaffed that morning. She stated it is the facility policy that CNAs complete a walk through with the oncoming CNAs and give the oncoming shift a detailed report before leaving the facility. She verified a shift-to-shift report was not completed, and night shift CNAs left the facility without ensuring adequate replacements. She verified that the facility's memory care unit was to be staffed 24 hours a day and confirmed that from 6:10 A.M. until 6:45 A.M. there was no coverage on the unit. RCOSRN #170 stated that the facility kept a care plan for each resident in a binder outside of the memory care unit at the main nurse's station, and verified without receiving a report and being oriented to where this information is stored, Agency CNA #208 would not have had access to any resident information. Interview on 02/04/25 at 1:45 P.M. with the Administrator revealed he was aware of the staffing shortage on the morning of 02/03/25. He reported, due to last-minute staff call-offs, the facility was not staffed adequately. He reported that once he was aware of the situation, facility management arrived at the facility. The Administrator estimated management staff arrived by 7:30 A.M. and assisted with resident care. He reported at a very minimum, the facility can operate with three to four CNAs and two nurses. He went on to state a staff member should always be on the memory care unit at all times. He verified the night shift CNAs should have stayed until a proper replacement arrived and a report was given before leaving the facility. He confirmed he would be providing education to the CNAs who left the facility before ensuring a replacement was present. Review of the facility policy, Staffing revised 10/2027 revealed the facility works to provide sufficient members of staff with skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. Staffing numbers and skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care. Review of the Facility Assessment Tool last updated 01/08/25 regarding direct care staff revealed the facility on an ongoing basis will evaluate the current needs/acuity of residents by facility wing/hall and ensure adequate staffing of licensed staff is provided at all times to meet the needs of the residents at any given time including but not limited to ADL needs are being met, residents have adequate supervision, medications are administered timely, per physician orders and blood sugars are properly monitored. Consideration of the completion of daily staffing is needed, facility administration will be notified immediately and engage the assistance of sister facilities, administration, and agencies as appropriate to ensure significant staffing is achieved. This deficiency represents non-compliance investigated under Master Complaint Number OH00162253.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015 Based on observation, interview, record review and policy review the facility failed to ensure facility staff member donned and doffed the correct personal protective equipment (PPE) when entering and exiting Resident #26's room, who was COVID-19 positive. This had the potential to affect 37 residents (2, #3, #4, #5, #7, #8, #9, #11, #12, #13, #14, #15, #17, #18, #19, #21, #24, #28, #31, #32, #33, #34, #35, #36, #38, #40, #41, #42, #43, #44, #45, #47, #50, #52, #53, #54, and #55) who were not currently infected with COVID-19. The facility census was 53. Findings include: Review of the medical record for Resident #26 revealed an admitted [DATE]. Diagnoses included hypertension, insomnia, anxiety disorder, unspecified dementia, and positive for COVID- 19 on 01/31/25. Review of Resident #26 physicians' orders revealed an order dated 01/31/25 for droplet isolation precautions to be maintained due to COVID positive. All meals and services were to be provided in the room every day and night shift for seven days. Review of the facility infection control log revealed Resident #26 became symptomatic and tested positive for COVID-19 on 01/31/25 and was placed on droplet precautions. Further review revealed 20 residents tested positive for COVID-19 during a facility COVID-19 outbreak between 01/16/25 and 02/02/25. Observation on 2/5/25 at 11:20 A.M. revealed Resident #26's door to her room was open. A sign was posted outside of the resident's door stating she was on droplet precautions. A bin full of PPE was noted to be outside of her door. Observation inside of the room revealed Resident #26 was in her bed and Agency Certified Nursing Assistant (CNA) #200 was standing beside her. Maintenance Director #202 was also present in the room using the bed remote for an additional empty bed that was in the resident room. Agency CNA #200 and Maintenance Director #202 were observed to only have surgical masks on. They did not have the required PPE including gloves, N95 respirator mask, gowns, and face shields. They remained in the room until 11:23 A.M. when they both walked out of the room and used hand sanitizer. Interview on 02/05/25 at 11:23 A.M. with both CNA #200 and Maintenance Director #202 confirmed they did not don and doff proper PPE when entering and exiting Resident #26's room. They both verified she was COVID positive and stated they forgot to don the PPE before entering the room. Additionally, Maintenance Director #202 stated he was only in the room for a couple of minutes. Interview on 02/05/25 at 10:54 A.M. The facility's Director of Nursing (DON) confirmed when staff entered a COVID-19 positive room, staff should wear an N95 respirator mask, gown, gloves, and a face shield. Upon leaving the room staff should clean or disregard the face shield, remove the gown, gloves, and N95 mask and wash their hands or use hand sanitizer. (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the recent facility education completed due to the recent COVID-19 outbreak revealed education for PPE dated 01/07/25, education for cleaning face shields dated 01/07/25, education for Droplet Precautions dated 01/07/25, education titled COVID education dated 01/14/25 had been provided to facility staff. The sign-in sheets revealed STNA #200, and Maintenance Director #202 did not sign that they received the education on any of these topics. Review of the facility's policy, Isolation-Categories of Transmission-Based Precautions revised 10/2022 revealed transmission-based precautions are additional measures used that protect staff, visitors, and other residents from becoming infected. These measures are determined by specific pathogen and how it spreads from person to person. The three types include contact, droplet, and airborne. Droplet precautions are implemented for an individual documented or suspected to be infected with microorganisms transmitted by droplets that can be generated by individual coughing, sneezing talking, or by the performance of procedures such as suctioning. Policy indicated masks are worn when entering the room, gloves, gown, and goggles are worn if there is a risk of spraying respiratory secretions. This deficiency represents non-compliance investigated under Master Complaint Number OH00162253 and Complaint Number OH00162122.

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F 0887 Level of Harm - Actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015 Based on open and closed medical record review, hospital record review, facility policy review, review of Centers for Disease Control (CDC) guidance and interview, the facility failed to ensure residents were administered the Coronavirus (COVID-19) vaccination after receiving education and consenting to the vaccine. This affected four residents (#6, #29, #30, #43) and had the potential to affect 16 additional residents (#3, #4, #8, #12, #13, #16, #17, #24, #28, #32, #34, #35, #40, #42, #52 and #53) who after receiving education and consented to the COVID-19 vaccine, had not yet received the vaccine. The facility census was 53. Actual harm occurred beginning on 01/28/25 when Resident #30, who consented to receiving the COVID-19 vaccine, but never received the vaccine, tested positive for COVID-19 and was subsequently transferred to the emergency room . The resident returned to the facility on [DATE] with orders for continued treatment associated with COVID-19 and pneumonia. However, on 01/31/25 the resident's condition deteriorated with symptoms including shortness of breath, low oxygen saturation and chest pain resulting in the resident again being transferred to the hospital at which time she was admitted for ongoing care related to COVID-19 and treatment of chronic hypercapnic respiratory failure, tachypnea and meeting the hospital sepsis criteria. The resident did not return to the facility after being transferred to the hospital. Findings include: 1. Review of the facility's infection control log revealed 20 residents, Resident #1, #6, #16, #20, #23, #25, #26, #27, #29, #30, #37, #39, #41, #42, #43, #46, #48, #49, #51, and #54 tested positive for COVID-19 during a facility COVID-19 outbreak between 01/16/25 and 02/02/25. Interview on 02/04/25 at 10:06 A.M. with Regional Clinical Operations Specialist #170 revealed she failed to schedule a COVID-19 clinic or order the COVID-19 vaccinations from the pharmacy (in September-October 2024) for residents including Resident #3, #4, #6, #8, #12, #13, #16, #17, #24, #28, #29, #30, #32, #34, #35, #40, #42, #43, #52 and #53 who had previously requested the COVID-19 vaccination. Interview on 02/05/25 at 10:49 A.M. with the Administrator revealed in October 2024 they had placed orders for some of the residents who desired the COVID-19 vaccine to their pharmacy. It was then decided to cancel the orders and to have a COVID-19 vaccine clinic. However, the clinic was never scheduled due to an unknown reason and the residents who requested the COVID-19 vaccine during this time were not administered the vaccine. The Administrator revealed when the facility identified this error, they tried to order the vaccine in January 2025, but it was unavailable and then the facility was in a COVID-19 outbreak. He reported the facility had ordered vaccines to be sent today (02/05/25). (continued on next page)

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F 0887 Level of Harm - Actual harm Residents Affected - Some	Review of the facility COVID policy Coronavirus Disease (COVID-19)- Infection Prevention and Control Measures dated September 2022 revealed infection prevention and control measures that were implemented to address the SARS-CoV-2 pandemic were incorporated into the facility infection prevention and control plan. These measures included identifying and managing ill residents and staff and encouraging all staff, residents, and visitors to remain up to date with all COVID-19 vaccine doses. Review of the Centers for Disease Control (CDC) guidance titled COVID-19 Vaccination for Long-term Care Residents dated 08/30/24, revealed if you live or work in a long-term care (LTC) setting, you can help protect yourself and the people around you by getting your 2024-2025 COVID-19 vaccine. COVID-19 vaccines are the best way to protect yourself from serious illness, hospitalization , and death caused by COVID-19. Older adults and people with certain health conditions are more likely to get very sick from COVID-19. COVID-19 vaccines can help keep you from getting seriously ill if you do get COVID-19. CDC recommends everyone ages [AGE] years and older, including people who live and work in long term care (LTC) settings, get two doses of a 2024 to 2025 COVID-19 vaccine six months apart. People who are moderately or severely immunocompromised should get at least two doses of 2024 to 2025 COVID-19 vaccine six months apart. They may also get more appropriate doses, beyond two doses at least two months apart, after talking to a healthcare provider. People can self-confirm as moderately or severely immunocompromised. This means they do not need documentation to receive a COVID-19 vaccination they are eligible for. While it is recommended to get 2024 to 2025 COVID-19 vaccine doses six months apart, the minimum time is two months apart, which allows flexibility to get the second dose prior to typical COVID-19 surges, travel, life events, and healthcare visits. 2. Review of the closed medical record for Resident #30 revealed an admitted [DATE] and a discharge date of [DATE]. Resident #30 had diagnoses including acute and chronic respiratory failure with hypoxia, diabetes mellitus type two, and morbid obesity due to excess calories. The medical record indicated the resident was transferred to the hospital on 01/31/25 and was never readmitted to the facility. Continued review revealed no evidence the resident had ever received a COVID-19 vaccination while residing in the facility. Review of Resident #30's Resident COVID-19 Vaccination Voluntary Administration or Declination Acknowledgment form, dated 09/20/24, revealed the resident signed consent indicating she wanted the facility to administer her the COVID-19 vaccination. Review of Resident #30's physician's orders revealed (admission) orders dated 09/20/24 for albuterol sulfate inhalation aerosol solution 108 (90 base) micrograms per actuation (mcg/act) with instructions to give two puffs every four hours as needed for wheezing/shortness of breath and continuous oxygen at two liters per minute via nasal cannula. On 09/21/24 the resident was ordered DuoNeb solution 0.5-2.5 (3) milligram (mg)/3 milliliter (ml) once every four hours as needed for shortness of breath and fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act twice daily. The physician's orders further revealed the only order for a COVID-19 vaccine was dated 01/25/25, but it was not signed off as completed in the Medication Administration Record or the Treatment Administration Record. Review of Resident #30's quarterly Minimum Data Set assessment dated [DATE] revealed the resident was cognitively intact. (continued on next page)

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

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F 0887 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #30's nursing progress note dated 01/27/25 at 10:20 P.M. revealed the resident was short of breath and wheezing. Her blood pressure was 114/67, pulse 63, temperature 97.4, respirations 20 and oxygen level was 86 percent on 3 liters per minute. Her as-needed inhaler and aerosol were given. An oxygen saturation recheck was 92 percent and the resident voiced relief. Review of Resident #30's nursing progress note dated 01/28/2025 at 2:45 P.M. and authored by Licensed Practical Nurse (LPN) #159 revealed the resident's symptoms continued to decline. The Medical Director (MD) ordered chest x-rays to be done. When the results came in it showed right basilar airspace disease. The resident was tested for COVID-19 and was positive. The MD wanted the resident sent to the emergency department. The resident was made aware and agreed. The resident's representative was notified, and an ambulance was called to transport. Review of Resident #30's hospital emergency department (ED) notes from 01/28/25 timed 3:30 P.M. revealed the resident presented to the hospital with respiratory symptoms, she reported she had body aches and a headache for about a week. She tested positive for COVID-19 today. She also had a chest x-ray that showed right basilar airspace disease. Per nursing home records, it did not appear the resident was started on any new medications. Reportedly low oxygen level for her at the nursing home so she was transferred to the ED. Review of the plan revealed the hospital would discharge her home (back to the facility) on antibiotics for COVID-19 and superimposed pneumonia. She was given (the antibiotic) Doxycycline. Review of the resident chest x-ray showed patchy bilateral airspace disease and poor inspiratory effect apparently related to viral or bacterial pneumonia. Review of Resident #30's nursing progress note dated 01/28/2025 at 8:45 P.M. and authored by LPN #137 revealed the resident returned to facility via squad, and she was transferred to her bed via squad and staff. The resident was in good spirits. The resident was noted to be hoarse when speaking. Vital signs included blood pressure was 74/49 (hypotensive), pulse 66, respirations 18, temperature 97.3, and oxygen saturation at 95% with oxygen usage. The resident stated she was going to call her husband as soon as she was situated in her bed and let him know she was back and that no further notification needed to be made. Review of Resident #30's physician's orders dated 01/28/25 revealed an order for the antibiotic, Doxycycline Hyclate Oral Capsule with instructions to give 100 milligrams (mg) by mouth two times a day for pneumonia for 10 days. Review of a 01/29/25 physician's orders revealed an order for Paxlovid (300 mg nirmatrelvir with 100 mg ritonavir) oral tablet therapy pack with instructions to give one tablet by mouth two times a day for COVID-19 for five days. Review of the Medication Administration Record (MAR) for Resident #30 revealed the resident received Doxycycline from 01/29/25 to 01/31/25 and received Paxlovid from 01/30/25 to 01/31/25. Review of Resident #30's nursing progress note dated 01/31/25 at 9:52 A.M. and authored by LPN #109 revealed the resident complained of shortness of breath and pain in her chest when coughing. Pulse oximetry was at 84 to 86 (percent) on oxygen (indicating a low saturation). The resident was very congested, currently on Doxycycline and Paxlovid for COVID-19 and pneumonia. The resident stated she felt she needed to be seen. The physician was updated and instructed to send the resident to the emergency room for evaluation. The resident's husband was aware. (continued on next page)

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F 0887 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #30's progress note dated 01/31/25 at 5:42 P.M. revealed emergency room staff reported the resident was placed on a BiPap (a bilevel positive airway pressure machine providing non-invasive positive pressure ventilation) with six liters per minute oxygen and was being transferred to a different hospital (name provided). The note indicated the Director of Nursing (DON) was updated. Review of Resident #30's hospital emergency department notes dated 01/31/25 at 10:26 P.M. revealed the resident's findings were consistent with likely chronic hypercapnic respiratory failure. The patient continued to test positive for COVID-19. From a clinical perspective, on presentation, the patient was tachypneic and did meet sepsis criteria. However, due to secondary concerns for fluid overload status, full sepsis fluids were not given. The patient was covered with antibiotics for possible pneumonia. Additionally, the patient was COVID-19 positive and showed evidence of acute hypoxia. The patient had been getting breathing treatments and was currently on supplemental oxygen. The patient's comorbidities as well as evidence of hypercapnic respiratory failure secondary to COVID-19 warranted admission. Given the patient's respiratory status, it was felt the patient would best be served by being transferred to the main hospital. Interview on 02/05/25 at 10:49 A.M. with the Administrator verified Resident #30, who had consented to receive a COVID-19 vaccine upon admission (in September 2024), had not been provided the vaccine prior to contracting COVID-19 while residing in the facility. The resident subsequently contracted COVID-19 while residing in the facility (in January 2025) requiring in-patient hospital intervention/treatment. The resident did not return to the facility following her transfer to the hospital on 01/31/25 and was permanently discharged from the facility on 02/03/25. On 02/05/25 at 3:36 P.M. an interview with Compliance Specialist #206 revealed the last update she received was that Resident #30 was being transferred from the emergency room to (hospital name) main campus for treatment. On 02/10/25 at 10:17 A.M., information obtained via email from the Administrator revealed Resident #30 had since been transferred to another facility that was in-network. 3. Review of the medical record for Resident #43 revealed an admitted [DATE] with diagnoses including end stage renal disease, COVID-19 and shortness of breath. Review of Resident #43's COVID-19 Vaccination Voluntary Administration or Declination Acknowledgment form, dated 10/06/24, revealed the resident signed consent indicating she wanted the facility to administer her the COVID-19 vaccination. Review of Resident #43's physician's orders since admission revealed she was never ordered the COVID-19 vaccine. Review of the current list of residents who requested the COVID-19 vaccine booster, provided by the facility, revealed Resident #43 wanted the booster. Review of the facility infection control log revealed Resident #43 became symptomatic and tested positive for COVID-19 on 01/24/25. (continued on next page)

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F 0887 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #43's record revealed a health status note dated 01/24/25 at 5:36 A.M. revealed upon administration of morning medications, the writer noted the resident to have congestion. The resident also complained of general malaise and itchy ears. Her lungs were clear to auscultation and vital signs were stable. A COVID-19 test was positive, droplet isolation was implemented, the physician was made aware, and dialysis was cancelled for the day. On 02/05/25 at 11:58 A.M. an interview with Resident #43 revealed the resident had requested (and signed consent) to receive COVID-19 vaccinations following her admission to the facility. The resident denied receiving a COVID-19 vaccine/booster during her stay. During the interview, the resident reported she had tested positive for COVID-19 and had symptoms including congestion, malaise and itchy ears. Interview on 02/05/25 at 10:49 A.M. with the Administrator verified Resident #43, who had consented to receive a COVID-19 vaccine in October 2024, was not provided the vaccine and then subsequently tested positive for COVID-19 while residing in the facility (on 01/24/25). 4. Review of the medical record for Resident #29 revealed an admitted [DATE] with diagnoses including unspecified dementia, dyspnea and cognitive communication deficit. Review of Resident #29's Covid-19 Vaccination Voluntary Administration or Declination Acknowledgment form, dated 07/23/24, revealed the resident signed consent indicating she wanted the facility to administer her the COVID-19 vaccination. Review of Resident #29's immunization tab in the electronic health record revealed the COVID-19 immunization was pending and dated 10/06/24. Review of Resident #29's physician's orders from July to February 2025 revealed the resident was never ordered the COVID-19 vaccine. Review of the facility infection control log revealed Resident #29 became symptomatic and tested positive for COVID-19 on 02/02/25. Review of Resident #29's record revealed a nurse's note dated 02/02/25 at 11:29 A.M. that included the resident complained to staff that she was not feeling well, and she was having a runny nose. A COVID-19 test was administered which was positive. Isolation protocols were put in place, a message was left for the resident's power of attorney, her temperature was 97.7 degrees Fahrenheit (afebrile), no coughing was noted, and her lungs were clear to auscultation but diminished. Interview on 02/05/25 at 10:49 A.M. with the Administrator verified Resident #29, who had consented to receive a COVID-19 vaccine in July 2024, was not provided the vaccine and then subsequently tested positive for COVID-19 while residing in the facility (on 02/02/25). 5. Review of the medical record for Resident #6 revealed an admitted [DATE] with diagnoses included paraplegia, mild intellectual disabilities and severe vascular dementia. Review of Resident #6's COVID-19 Vaccination Voluntary Administration or Declination Acknowledgment form, dated 07/24/24, revealed the resident's Power of Attorney (POA) signed consent for the resident to be administered the COVID-19 vaccination. (continued on next page)

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F 0887 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #6's physician's orders from July 2024 to February 2025 revealed the resident was never ordered the COVID-19 vaccine. Review of the facility infection control log revealed Resident #6 became symptomatic and tested positive for COVID-19 on 01/28/25. Review of Resident #6's record revealed a nurse's note dated 01/27/25 at 3:08 P.M. that included the resident had a cough and general fatigue. A COVID-19 test revealed the resident was positive for COVID-19. Droplet isolation was initiated, and the physician and resident's representative were notified. Interview on 02/05/25 at 10:49 A.M. with the Administrator verified Resident #6, whose POA had consented to receive a COVID-19 vaccine in July 2024, was not provided the vaccine and then subsequently tested positive for COVID-19 while residing in the facility (on 01/28/25). This deficiency represents non-compliance investigated under Master Complaint Number OH00162253 and Complaint Number OH00162122.