| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366141 | A. Building<br>B. Wing | 09/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Louisville Gardens Care Center | 4466 Lynnhaven Avenue NE<br>Louisville, OH 44641 |

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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 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to ensure care conferences were completed at least quarterly for Residents #5, #21, and #27, and the facility failed to ensure care plan accuracy regarding incontinence care for Resident #40 and an updated care plan to reflect Resident #51's fall. This finding affected three (Residents #5, #21, #27) of three residents reviewed for care conferences and two (Residents #51 and #40) of 25 residents reviewed for care planning. The facility census was 53. Findings include:<br><br>1. Review of the medical record for Resident #27 revealed in admission date of 12/02/24 24. Diagnoses included cognitive communication deficit, depression, muscle weakness, anxiety, insomnia and diabetes.<br><br>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #27 was cognitively intact. She required setup help for eating and partial to moderate assistance for oral hygiene, toileting, showering, dressing, and hygiene.<br><br>Interview on 09/02/25 at 9:47 A.M. with Resident #27 revealed she did not get invited to care conferences. Review of the social service notes dated 12/04/24 through 09/04/25 revealed the resident had a 72-hour meeting on 12/04/24 to discuss care needs, and a care conference was scheduled for 07/22/25. There was no documented evidence this meeting occurred.<br><br>Interview on 09/04/25 at 12:53 P.M. with the Administrator confirmed there were no formal care conferences for Resident #27 because the social service designee (SSD) was in regular contact with Resident #27's son; however, she identified the necessity for a care conference in which the resident would be included.<br><br>2. Review of the medical record for Resident #40 revealed an admission date of 04/04/25. Diagnoses included cognitive communication deficit, dementia, anxiety, depression, elevated blood pressure, chronic obstructive pulmonary disease, and hyperlipidemia.<br><br>Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #40 was cognitively intact. She required setup help for eating, oral hygiene, toileting, personal hygiene and substantial or maximum assistance for showering. She was always continent of bowel and bladder.<br><br>(continued on next page) |



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

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the care plan dated 07/03/25 revealed Resident #40 was at risk for developing complications secondary to bowel incontinence. Interventions included checking the resident every two hours and assisting with toileting as needed, observing for patterns of incontinence and initiating a toileting schedule if necessary and providing a bedside commode. Resident #40 was also at risk for bladder incontinence and had an indwelling urinary catheter. Interventions included cleaning the peri area with each incontinent episode, ensuring the resident had an unobstructed path to the bathroom, ensuring her call light was within reach and monitoring, documenting and reporting possible causes for incontinence.<br><br>Interview on 09/03/25 at 3:05 P.M. with Resident #40 revealed she did not need help to go to the bathroom; she used the bathroom on her own and did not wear an incontinence brief. She also revealed she never had accidents of either bowel or bladder.<br><br>Interview on 09/03/25 at 3:08 P.M. with Licensed Practical Nurse (LPN) #539 revealed she had no knowledge of Resident #40 ever having a catheter and confirmed she was continent of both bowel and bladder.<br><br>Interview on 09/04/25 at 9:16 A.M. with the Director of Nursing (DON) confirmed Resident #40 had never had a catheter, and she could not explain why her care plan identified her as incontinent of both bowel and bladder when she was in fact continent.<br><br>Review of the facility policy titled Care Plans, Comprehensive Perso-Centered revealed care plan interventions were chosen after gathering data and careful consideration of the relationship between the resident's problems and their causes and relevant clinical decision making. Assessments were ongoing and care plans would be revised as conditions changed. The interdisciplinary team would review and update the care plan when there was a significant change in the resident's condition or at least quarterly in conjunction with their required quarterly MDS assessment.<br><br>3. Review of the medical record for Resident #51 revealed an admission date of 02/24/25 with diagnoses including hypertensive heart disease with heart failure, anxiety, major depressive disorder, morbid obesity, obstructive sleep apnea, chronic pain, restless leg syndrome, and generalized muscle weakness. Further review of the medical record revealed diagnoses were added in June 2025, including unstable burst fracture of the second lumbar vertebrae, fusion of lumbar and thoracic region of the spine, urinary retention, thrombocytopenia, type II diabetes mellitus, and lymphedema.<br><br>Review of the care plan initiated on 02/27/25 revealed Resident #51 was at increased risk for falls related to deconditioning, gait and balance problems, age-related debility, and use of a straight cane for mobility. Interventions included encouraging Resident #51 to use the call light for assistance as needed, provide physical therapy evaluation or treatment as ordered or as needed, keep the floors clean from spills and/or clutter, and provide adequate, glare-free lighting. Further review of the care plan revealed the last intervention was added on 02/28/25 for therapy to evaluate Resident #51 for appropriate assistive devices for ambulation. There were no care plan updates indicating Resident #51 sustained a fall with major injury or any revision of the fall care plan focus or intervention section after the fall (sustained on 05/20/25).<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the quarterly MDS 3.0 assessment completed on 06/06/25 revealed Resident #51 had intact cognition, used a walker as a mobility device, and needed supervision or touching assistance for transfers from the chair to the bed. Further review of the MDS revealed Resident #51 sustained one fall with major injury since facility admission or re-entry.<br><br>Review of the progress notes revealed a note dated 06/10/25 at 5:36 P.M. indicating Resident #51 requested to go to the emergency department due to an increase in back pain. Review of the hospital discharge paperwork revealed Resident #51 was admitted to the hospital for increased back pain since a fall at the facility. The hospital paperwork further revealed Resident #51 had magnetic resonance imaging (MRI) of the spine on 06/12/25 which revealed a burst fracture of the second lumbar spine (L2 fracture) which required surgery.<br><br>Interview on 09/02/25 at 11:25 A.M. with Resident #51 revealed her L2 vertebra exploded when she fell at the facility in May 2025. Resident #51 further revealed she had immediate back pain that worsened over time, and the fracture was not found until a few weeks later, but was attributed to the fall.<br><br>Review of the fall investigation with the DON on 09/03/25 at 1:40 P.M. revealed the immediate interventions post fall included to educate Resident #51 to use the call light, do a therapy evaluation, and declutter the room. The DON further confirmed the care plan had these interventions in place at the time of the fall.<br><br>Interview on 09/03/25 at 2:53 P.M. with the DON confirmed that when the facility learned Resident #51 had a major injury related to the fall sustained on 05/20/25 (which required an acute care inpatient stay and surgery), the fall care plan was not updated upon Resident #51's return to the facility.<br><br>Review of the policy titled Care Plans, Comprehensive Person-Centered, last updated in March 2022, revealed care plans were to be revised or updated as changes occurred, when the desired outcome was not met, and after inpatient hospitalizations.<br><br>Review of the policy titled Falls and Fall Risk, last revised December 2007, revealed that if a resident fell, despite the initial interventions put into place, staff were to implement additional or different interventions or indicate why new approaches were not implemented.<br><br>4. Review of Resident #5's medical record revealed the resident was admitted on [DATE] with diagnoses including Parkinson's disease, bipolar disorder and unspecified dementia.<br><br>Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #5 exhibited intact cognition.<br><br>Review of Resident #5's medical record revealed the resident was her own responsible party and she had a guardian of person.<br><br>Review of Resident #5's medical record revealed a care conference was held for the resident on 04/24/25. The medical record did not have evidence care conferences were held for the fourth quarter 2024, the first quarter 2025 or the third quarter 2025.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 09/04/25 at 9:00 A.M. with SSD #566 confirmed the above findings.<br><br>Review of the Comprehensive Person-Centered Care Plans policy, revised 03/2022, revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident. The interdisciplinary team reviews and updates the care plan at least quarterly, in conjunction with the required quarterly MDS assessment.<br><br>5. Review of Resident #21's medical record revealed an admission date of 04/02/25 with diagnoses including schizoaffective disorder bipolar type, paranoid schizophrenia, anxiety, psychosis, diabetes mellitus type II, asthma, chronic pain, and non-Hodgkin lymphoma.<br><br>Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #21 was cognitively intact and required minimal assistance with activities of daily living.<br><br>Interview on 09/02/25 at 11:50 A.M. with Resident #21 revealed they did not get invited to care conferences.<br><br>Record review revealed a social services progress note for an initial care conference on 04/17/25, with no other care conferences documented.<br><br>Interview on 09/04/25 at 10:18 A.M. with SSD #566 confirmed a care conference was not completed for the third quarter of 2025.<br><br>Review of the facility policy titled Care Plans, Comprehensive Perso-Centered revealed care plan interventions were chosen after gathering data and careful consideration of the relationship between the resident's problems and their causes and relevant clinical decision making. Assessments were ongoing and care plans would be revised as conditions changed. The interdisciplinary team would review and update the care plan when there was a significant change in the resident's condition or at least quarterly in conjunction with their required quarterly MDS assessment. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews and facility policy review, the facility failed to ensure residents received showers as scheduled. This finding affected seven residents (Residents #6, #14, #21, #27, #31, #47 and #48) of seven residents reviewed for activities of daily living (ADL) and had the potential to affect 30 additional residents (Residents #3, #5, #7, #8, #9, #11, #12, #13, #18, #20, #25, #28, #29, #30, #32, #33, #35, #36, #37, #39, #40, #42, #43, #44, #45, #46, #51, #52, #58 and #59) the facility identified as requiring extensive assistance or totally dependent on staff assistance for showers. The facility census was 53. Findings include:<br>1. Review of Resident #14's medical record revealed the resident was readmitted to the facility on [DATE] with diagnoses including unspecified dementia, urinary incontinence and emphysema.<br><br>Review of Resident #14's ADL self-care care plan revealed an intervention dated 05/23/25 indicating the resident's usual performance was partial/moderate assist with showers.<br><br>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #14 exhibited intact cognition.<br><br>Review of the shower schedules revealed Resident #14 was scheduled for showers on Tuesdays and Fridays on the 6:00 A.M. to 6:00 P.M. shift.<br><br>Review of Resident #14's shower documentation from 08/02/25 to 09/02/25 revealed the resident received showers on 08/07/25, 08/12/25, 08/15/25, 08/19/25, 08/28/25 and 08/30/25. Resident #14 did not receive showers as scheduled on 08/01/25, 08/05/25 and 08/22/25.<br><br>Interview on 09/03/25 at 9:15 A.M. with Licensed Practical Nurse (LPN) #536 confirmed Resident #14 did not receive showers as scheduled.<br><br>Review of the Shower/Tub Bath policy, revised 10/2010, revealed the purposes of the procedure was to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.<br><br>2. Review of the medical record for Resident #6 revealed an admission date of 08/02/25. Diagnoses included systemic lupus erythematosus (an autoimmune disease), muscle weakness, adult failure to thrive, and dysphagia (difficulty swallowing).<br><br>Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #6 was cognitively intact and was dependent on staff for all care needs.<br><br>Review of the activity assessment dated [DATE] revealed it was somewhat important for Resident #6 to choose between a tub bath, shower, bed bath, or sponge bath.<br><br>Review of the care plan dated 08/04/25 revealed Resident #6 has a self-care deficit related to disease process. Interventions included the resident was dependent for shower care, dressing, and bed mobility.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the shower schedule revealed Resident #6 was scheduled to receive a shower on Wednesdays and Saturdays.<br><br>Review of the shower sheets for 08/2025 revealed Resident #6 received a bed bath on 08/08/25, a shower on 08/13/25, a shower on 08/16/25, 08/20/25, and a shower on 08/23/25.<br><br>Interview on 09/04/25 1:44 P.M. with the Administrator confirmed she was aware the facility had not been consistently providing showers to residents.<br><br>3. Review of the medical record for Resident #21 revealed an admission date of 04/02/25. Diagnoses including schizoaffective disorder bipolar type, paranoid schizophrenia, anxiety, psychosis, diabetes mellitus type II, asthma, chronic pain, and non-Hodgkin lymphoma.<br><br>Review of the care plan dated 05/07/25 revealed Resident #21 had a self-care deficit related to disease process. Interventions include avoid scrubbing and pat dry sensitive skin, set up and supervision from staff for showering, and showering two times a week and as needed.<br><br>Review of the activity assessment dated [DATE] revealed it was very important for Resident #21 to choose between a tub bath, shower, bed bath, or sponge bath<br><br>Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #21 was cognitively intact and required minimal assistance with ADL.<br><br>Review of the shower schedule revealed Resident #21 was scheduled to receive a shower on Tuesdays and Saturdays.<br><br>Review of the shower sheets for 08/2025 revealed Resident #21 had a shower on 08/02/25, a shower on 08/10/25, a shower on 08/12/25, a shower on 08/16/25, a shower on 08/19/25, a shower on 08/23/25, and a shower on 08/31/25.<br><br>Interview on 09/02/25 at 11:45 A.M. with Resident #21 revealed she did not always get showers twice a week.<br><br>Interview on 09/04/25 1:44 P.M. with the Administrator confirmed she was aware the facility had not been consistently providing showers to residents.<br><br>4. Review of the medical record for Resident #48 revealed an admission date of 01/02/18. Diagnoses included aphasia (a communication disorder), dysphagia (a swallowing disorder), cognitive communication deficit, hemiplegia (paralysis on one side of the body), hemiparesis (one sided muscle weakness), and muscle contracture.<br><br>Review of the activity assessment dated [DATE] revealed it was very important for Resident #48 to choose between a tub bath, shower, bed bath, or sponge bath.<br><br>Review of Resident #48's care plan dated 06/12/25 revealed a self-care deficit related to disease process. Interventions included extensive one-person assistance for showering, showering twice a week, and showering as needed.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #48 was cognitively intact and required maximal assistance for showering.<br><br>Review of the shower schedule revealed Resident #48 was scheduled to receive a shower on Mondays. (His preference was one to two showers a week).<br><br>Review of the shower sheets for 08/2025 revealed Resident #48 had a shower on 08/04/25, refused a shower on 08/07/25 due to a dental appointment, a shower on 08/08/25, a shower on 08/11/25, refused a shower on 08/14/25, a shower on 08/21/25, and refused a shower on 08/25/25 due to not feeling well. There was no documented evidence Resident #48 was offered a bed bath or shower on a different day or time after the refusal of the showers except for the refusal on 08/07/25.<br><br>Interview on 09/03/25 at 9:54 A.M. with Resident #48 revealed they don't always get twice weekly showers.<br><br>Interview on 09/03/25 at 1:31 P.M. with LPN #538 verified showers aren't always being completed twice weekly.<br><br>Interview on 09/04/25 at 11:25 A.M. with Certified Nurses Aid (CNA) #590 verified they weren't able to get all assigned showers completed on 09/03/25.<br><br>Interview on 09/04/25 1:44 PM. with the Administrator confirmed she was aware the facility had not been consistently providing showers for residents.<br><br>Review of the Shower/Tub Bath policy, revised 10/2010, revealed the purposes of the procedure were to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.<br><br>5. Review of the medical record for Resident #27 revealed in admission date of 12/02/24. Diagnoses included cognitive communication deficit, depression, muscle weakness, anxiety, insomnia, and diabetes.<br><br>Review of the comprehensive MDS 3.0 assessment dated [DATE] revealed it was very important for Resident #27 to choose between a tub bath, shower, bed bath or sponge bath.<br><br>Review of the care plan dated 07/08/25 revealed Resident #27 had an ADL performance deficit due to musculoskeletal impairment. Interventions included providing a sponge bath, a full bath or shower could not be tolerated and avoiding scrubbing the skin.<br><br>Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #27 was cognitively intact. She required set-up help for eating and partial to moderate assistance for oral hygiene, toileting showering dressing and hygiene.<br><br>Interview on 09/02/25 at 9:47 A.M. with Resident #27 revealed she did not always get showers at least twice weekly.<br><br>Review of the shower schedule revealed Resident #27 was scheduled to receive showers on Sundays and Fridays.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the shower sheets for August 2025 revealed Resident #27 received a shower on 08/08/25, 08/14/25, 08/17/25 and 08/26/25. She received a bed bath after refusing a shower on 08/22/25.<br><br>Interview on 09/04/25 1:44 P.M. with the Administrator confirmed she was aware the facility had not been consistently providing showers to residents.<br><br>6. Review of the medical record for Resident #31 revealed an admission date of 01/19/23. Diagnoses included Multiple Sclerosis, muscle weakness, heart disease, left hip prosthesis, anxiety, and cervical disc degeneration.<br><br>Review of the comprehensive MDS 3.0 assessment dated [DATE] revealed it was very important for Resident #31 to choose between a tub bath, shower, bed bath or sponge bath.<br><br>Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #31 was cognitively intact. She required set-up assistance for eating and oral hygiene, partial to moderate assistance for dressing and hygiene and substantial to maximum assistance for showering<br><br>Review of the care plan dated 07/03/25 revealed Resident #31 needed assistance with showers. Interventions included the residents' preference for showers on Tuesdays and Friday evenings between 2:00 P.M. and 8:00 P.M., asking the resident their bathing preference quarterly and as needed, filling out shower sheets upon completing a resident shower or bath and notifying the charge nurse of shower or bath refusals.<br><br>Review of the shower schedule revealed Resident #31 was scheduled to receive showers on Tuesdays and Fridays.<br><br>Review of the nursing note dated 08/19/25 at 10:25 P.M. revealed Resident #31 refused a shower due to chronic pain; the shower was rescheduled for 8/20/25.<br><br>Review of the shower sheets for August 2025 revealed Resident #31 received a shower on 08/05/25, 08/13/25, 08/20/25 and 08/29/25. She refused a shower on 08/08/25 and 08/19/25. There was no documented evidence Resident #31 was offered a bed bath or shower on a different day or time after the refusal of the showers.<br><br>Interview on 09/02/25 at 10:28 A.M. with Resident #31 revealed she didn't get showers like she wanted because the facility no longer had a shower aide.<br><br>Interview on 09/04/25 1:44 P.M. with the Administrator confirmed she was aware the facility had not been consistently providing showers to residents.<br><br>7. Review of the medical record for Resident #47 revealed an admission date of 08/22/23. Diagnoses included schizoaffective disorder, diabetes, muscle weakness, asthma, and post-traumatic stress disorder.<br><br>Review of the comprehensive MDS 3.0 assessment dated [DATE] revealed it was very important for Resident #47 to choose between a tub bath, shower, bed bath or sponge bath.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the care plan dated 06/30/25 profile Resident #47 had an ADL self-care performance deficit due to the disease process. Interventions included two staff members assisting the resident with a shower twice per week, offering a bed bath if a shower was refused and filling out the shower sheet upon completion of the shower or bed bath, notifying the nurse if the resident refuses.<br><br>Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #47 was cognitively intact. She was totally dependent on staff for all ADL.<br><br>Review of the shower schedule revealed Resident #47 was scheduled to receive showers on Sundays and Wednesdays.<br><br>Review of the shower sheets for August 2025 revealed Resident #47 revealed she received a shower on 08/24/25 and a bed bath on 08/10/25. She refused a shower on 08/13/25, 08/17/25, 08/20/25 and 08/27/25. There was no documented evidence Resident #47 was offered a bed bath or shower on a different day or time after the refusal of the showers.<br><br>Interview on 09/02/25 at 10:39 A.M. with Resident #47 revealed she did not get showers because the facility no longer had a shower aide.<br><br>Interview on 09/04/25 at 7:50 A.M. with CNA #508 revealed she was often not able to get all showers completed each day.<br><br>Interview on 09/04/25 1:44 P.M. with the Administrator confirmed she was aware the facility had not been consistently providing showers to residents.<br><br>Review of the facility policy titled Shower/Tub Bath, dated 2001, revealed the facility would document the date and time the shower or bath was performed and the name of the individual assisting the resident with the shower or bath. If the resident refused, the reasons why and the interventions taken would be documented as well.<br><br>This deficiency represents noncompliance investigated under Complaint Number 1395034 (OH00167579). |

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| | 366141 | A. Building<br>B. Wing | 09/04/2025 |

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| Louisville Gardens Care Center | 4466 Lynnhaven Avenue NE<br>Louisville, OH 44641 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of pharmacy invoices, interview and facility policy review, the facility failed to ensure Resident #16's skin treatments were implemented as ordered and Resident #1's dialysis medications were available for resident use. This finding affected one resident (Resident #16) of three residents reviewed for pressure ulcers and general skin conditions and one resident (Resident #1) of one resident reviewed for dialysis services. The facility census was 53. Findings include:1. Review of the medical record revealed Resident #16 was admitted on [DATE] with diagnoses including dementia, cognitive communication deficit, and muscle weakness.<br><br>Review of the wound grid dated 06/18/25 revealed Resident #16 had a left buttock Stage II pressure ulcer (partial-thickness loss of skin, affecting only the epidermis and dermis layers, which appears as a shallow open wound or a serum-filled blister) which measured zero cm (centimeters) length, zero cm width and zero cm depth which improved with delayed wound closure and 70% (percent) epithelial and 30% granulation tissue with attached intact scarring.<br><br>Review of Resident #16's physician's orders dated 06/18/25 revealed an order dated 06/18/25 to apply Skin Prep (creates a protective film) to the left sacrum and cover with a bordered dressing every Monday, Wednesday and Friday for preventative measures.<br><br>Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #16 exhibited intact cognition.<br><br>Interview on 09/03/25 at 1:42 P.M. with Licensed Practical Nurse (LPN) #536 confirmed Resident #16's left sacrum Stage II pressure wound healed on 06/22/25, and the facility put treatments in place to prevent the area from reopening.<br><br>Observation on 09/03/25 at 2:25 P.M. with Nurse Practitioner (NP) #850 and LPN #536 of Resident #16's left sacrum wound care revealed LPN #536 washed both hands, put on gloves, removed the existing dressing to the left sacrum which was dated 08/28/25, removed the gloves, washed the hands, replaced the gloves and completed the wound care as ordered.<br><br>Interview on 09/03/25 at 2:30 P.M. with LPN #536 confirmed Resident #16's left sacrum dressing should have been changed on 09/01/25 per the physician's order, and LPN #851 documented on the treatment administration record (TAR) dated 09/01/25 that Resident #16's left sacrum wound care was completed. LPN #536 also confirmed LPN #539 documented on 09/02/25 that Resident #16's left sacrum wound care was completed in error.<br><br>Interview on 09/03/25 at 3:09 P.M. with LPN #539 revealed the nurse had documented Resident #16's left sacrum wound care was completed on 09/02/25 in error and the nurse thought the documentation was to confirm the dressing was intact.<br><br>Review of the Pressure Ulcers/Injuries Overview policy, revised 07/2017, revealed the purpose of the procedure was to provide information regarding clinical identification of pressure ulcers/injuries and associated risk factors.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Review of the medical record for Resident #1 revealed an admission date of 05/19/25 with diagnoses including end stage renal disease, unspecified protein-calorie malnutrition, paroxysmal atrial fibrillation, major depressive disorder, essential (primary) hypertension, ventricular tachycardia, type II diabetes mellitus, diabetic neuropathy, acquired absence of right leg below knee, acquired absence of the left leg below the knee, and dependence on renal dialysis.<br><br>Review of the quarterly MDS 3.0 assessment completed on 07/17/25 revealed Resident #1 had intact cognition and end stage renal disease. Further review of the MDS revealed Resident #1 received dialysis.<br><br>Review of the care plan dated 05/21/25 through 10/15/25 revealed Resident #1 was at risk for malnutrition due to obesity, blood pressure problems, wounds, unspecified protein-calorie malnutrition, and end stage renal disease with dialysis. Interventions included providing all dietary interventions and medications as prescribed.<br><br>Review of the orders revealed an order dated 06/26/25 for Resident #1 to begin at 6:00 A.M. on 06/27/25 to take sevelamer hydrochloride (HCL) 800 milligram (mg) tablets, two tablets by mouth before meals as a potassium binder. Further review of the order revealed instructions for staff to call the number listed on the paper in the chart and provide the identification (I.D.) number to reorder the sevelamer.<br><br>Review of the July 2025 medication administration record (MAR) revealed the ordered sevelamer to be taken before meals not given 07/01/25 through 07/05/25 at 6:00 A.M., 11:00 A.M., or 4:00 P.M., 07/06/25 at 6:00 A.M. or 11:00 A.M., 07/07/25 at 6:00 A.M., 11:00 A.M., or 4:00 P.M., 07/08/25 at 4:00 P.M., or 07/09/25 at 6:00 A.M., 11:00 A.M., or 4:00 P.M.<br><br>Review of the progress notes from 07/05/25 through 07/31/25 revealed the following linked electronic MAR (eMAR) notes when the sevelamer was not given:<br><br>07/05/25 at 6:26 A.M. pending dialysis providing<br><br>07/05/25 at 9:36 A.M. Unavailable<br><br>07/05/25 at 10:32 A.M. medication was unavailable and awaiting delivery from dialysis. The note also indicated the physician was aware.<br><br>07/05/25 at 3:50 P.M. medication was unavailable, and the physician was aware.<br><br>07/06/25 at 9:49 A.M., 10:33 A.M., and 4:18 P.M. notes revealed the medication was unavailable<br><br>07/07/25 at 5:18 A.M. and 4:42 P.M. the notes indicated the medication was on order and pharmacy was to send it.<br><br>07/08/25 at 7:56 A.M. and 4:31 P.M. the notes indicated the medication was not in the medication cart.<br><br>07/09/25 at 5:09 A.M. and 4:52 P.M. revealed the medication was not in the cart.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 07/09/25 at 12:01 P.M. the note revealed the nurse spoke with the pharmacy, verified medication was sent, and would arrive at the facility in three to five days. The note further revealed the physician was notified.<br><br>The notes further revealed Resident #1 was transferred to the hospital at 9:00 P.M. and remained hospitalized until 07/12/25 at 11:30 A.M.<br><br>Review of the August 2025 MAR revealed sevelamer was not given on 08/08/25 at 11:00 A.M. or 4:00 P.M., 08/09/25 at 6:00 A.M., 08/13/25 at 4:00 P.M., 08/15/25 at 4:00 P.M., 08/24/25 at 4:00 P.M., 08/25/25 at 6:00 A.M., 11:00 A.M., or 4:00 P.M., 08/26/25 at 6:00 A.M. and 11:00 A.M., or 4:00 P.M., 08/27/25 at 6:00 A.M. or 11:00 A.M., 08/28/25 at 6:00 A.M., 11:00 A.M., or 4:00 P.M., 08/29/25 at 6:00 A.M., 11:00 A.M., or 4:00 P.M., 08/30/25 at 11:00 A.M. or 4:00 P.M., and 08/31/25 at 6:00 A.M., 11:00 A.M., or 4:00 P.M.<br><br>Review of the progress notes from 08/01/25 through 08/31/25 revealed the following linked eMAR notes:<br><br>08/08/25 at 4:14 P.M. revealed the medication was not available.<br><br>08/09/25 at 5:32 A.M. revealed the medication was on order from the pharmacy, and the nurse practitioner was aware.<br><br>08/15/25 at 4:57 P.M. revealed the medication was not available and reordered.<br><br>08/24/25 at 4:08 P.M. revealed the medication was not available and on order.<br><br>08/25/25 at 5:13 A.M. and 5:01 P.M. and 08/26/25 at 5:10 A.M. revealed the medication was not available.<br><br>08/26/25 at 10:10 A.M. revealed the pharmacy rejected the medication and it would not be delivered.<br><br>08/26/25 at 1:50 P.M. revealed the medication was no available.<br><br>08/27/25 at 5:21 A.M. and 6:26 P.M. revealed the medication was not available and further revealed a call was placed to the dialysis center.<br><br>08/28/25 at 5:15 A.M. and 10:58 A.M. revealed the medication was on order.<br><br>08/29/25 at 6:39 A.M. revealed the medication was on order.<br><br>08/30/25 at 10:27 A.M. and 3:57 P.M. revealed the medication was not available.<br><br>08/31/25 at 5:05 A.M., 12:07 P.M., and 3:56 P.M. revealed the medication was not available.<br><br>Review of the September 2025 MAR revealed Resident #1 did not receive the ordered sevelamer on 09/01/25 at 6:00 A.M., 11:00 A.M., or 4:00 P.M. or on 09/02/25 at 6:00 A.M.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the progress notes from 09/01/25 through 09/04/25 revealed the following linked eMAR notes:<br><br>09/01/25 at 5:09 A.M. and 4:14 P.M. revealed the medication was not available, and notes for the lunch dose revealed Resident #1 was at dialysis.<br><br>09/02/25 at 5:25 A.M. revealed the medication was not available<br><br>Interview with Resident #1 on 09/02/2025 at 9:02 A.M. revealed he had not been getting his phosphorus binder, the sevelamer, for at least a week or more. The dialysis physician had told him it was taken care of, and nobody was able to explain why he still did not have the medication.<br><br>Interview on 09/04/2025 at 10:12 A.M. with Resident #1 confirmed he received the sevelamer the last two days, but there were gaps when he did not receive the medication for several days at a time. Resident #1 further revealed when not taking the medication, he felt nauseous and would often experience diarrhea, with more prominent symptoms after meals.<br><br>Interview on 09/04/2025 at 10:16 AM with Licensed Practical Nurse (LPN) #589 confirmed she thought the pharmacy had not been sending the sevelamer, but then another nurse had told her it had to be special ordered. During the interview, LPN #589 also reported once the medication was ordered, it seemed to take a long time before it was delivered. Review of the medication bottle at the time of the interview revealed the medication came from Health [NAME] Pharmacy in Lakeland, Florida.<br><br>Interview on 09/04/2025 at 1:35 PM with the Director of Nursing (DON) verified the dates the sevelamer was reordered included 07/08/25 and 08/27/25. During the interview, the DON was unable to confirm the date the medication was received by the facility, stating the medication went directly to the resident, and the facility did not have a process to record receipt of medications from this particular pharmacy.<br><br>Review of the prescription reorder information form revealed sevelamer was reordered on 07/08/25 and 08/27/25.<br><br>Review of the shipping invoice from Health [NAME] Pharmacy revealed the sevelamer was last shipped to the facility, to the attention of the DON, on 08/27/25. The facility did not have the shipping invoice for previous sevelamer orders.<br><br>Review of the policy titled Medication Orders and Receipt Record, last revised April 2007, revealed the charge nurse was to maintain medication order and receipt records and that medications were to be ordered in advance based on the pharmacy's required lead time.<br><br>This deficiency represents noncompliance investigated under Master Complaint Number 2600257 and Complaint Number 1395034 (OH00167579). |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observations, payroll-based journal review, facility assessment review, policy review and interview, the facility failed to ensure adequate staffing to meet resident needs. This had the potential to affect all residents residing within the facility. The facility census was 53. Findings include: 1. Review of the Facility Assessment Tool updated 08/11/25 revealed the staffing included seven nurses per day; ten certified nursing assistants (CNAs) per day; two other nursing personnel; one dietitian, seven food and nutrition services staff, and one respiratory care services staff. The facility provides adequate staffing to meet needed residents' daily needs, preferences, and routines to help each resident attain or maintain the highest practicable physical, mental, and psychosocial well-being. This includes services of a registered nurse (RN) for at least (8) consecutive hours a day, seven days a week and a designated licensed nurse to serve as a charge nurse on each tour of duty as well as adequate staffing on each shift to ensure that the resident's needs and services were met by registered and licensed nursing staff, certified/state tested nursing assistants, and other support services that include but were not limited to dietary, activities/recreational, social, therapy and environmental.<br><br>Review of the second quarter (2025) PBJ revealed the facility had a one-star rating.<br><br>Review of resident records revealed Residents #6, #14, #21, #27, #31, #47 and #48 did not receive showers as scheduled.<br><br>Interview on 09/02/25 at 9:13 A.M. with Licensed Practical Nurse (LPN) #539 confirmed there were not enough staff at times, and showers, as well as appointments, were always an issue.<br><br>Interview on 09/02/25 at 9:16 A.M. with CNA #506 revealed there used to be a shower aide, and the facility took the shower aide away. CNA #506 stated she could not complete showers timely due to lack of staffing.<br><br>Interview on 09/02/25 at 10:38 A.M. with Resident #49 revealed she had to wait 30 to 40 minutes for a call light response depending on the day.<br><br>Interview on 09/02/25 at 10:41 A.M. with Resident #47 revealed the call light was not answered timely due to lack of staffing.<br><br>Interview on 09/02/25 at 10:45 A.M. with Resident #25 revealed there were not enough staff, and she regularly had to wait 90 minutes for care.<br><br>Interview on 09/02/25 at 11:47 A.M. with Resident #21 revealed there was not enough staff for timely resident care.<br><br>Review of the Staffing policy, dated 03/09/22, revealed the facility was to provide adequate staffing to meet the care and services the resident population required. Under the heading titled Policy Interpretation and Implementation revealed the following: section one of the policy noted the facility provided staffing to ensure resident care needs and services were met by licensed nursing staff, and section two noted that CNAs were available to meet needed resident care and services.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 2. Observation on 09/02/25 at 4:35 P.M. revealed two call lights were on upon arrival to the 400-unit, including Resident #1's call light and Resident #60's call light. The nurse was in hall at the medication cart preparing medications, talking loudly and giggling (nobody else was near the medication cart). No aides were observed on the unit.<br><br>Observation on 09/02/25 revealed the meal cart arrived and was left in hall by nursing station at 4:40 P.M.<br><br>Observation of Resident #42's call light on 09/02/25 at 4:50 P.M. revealed it was triggered while RN #585 was in the resident's room administering medications. RN #585 exited the room a few minutes later, leaving the call light on. After exiting the room, RN #585 was heard asking another staff member walking briefly through the hall with a clipboard if there was an aide assigned to the unit, adding that the meals needed passed and there were three call lights that needed answered. That staff member responded that they did not know. RN #585 was then observed entering the secured memory care unit, leaving the meals undelivered and three call lights unanswered.<br><br>Observation on 09/02/25 from 5:00 P.M. to 5:08 P.M. revealed CNA #502 exited the secured memory care unit and began passing meal trays and responding to call lights. Response to the call light were as follows:<br><br>Resident #42's call light was answered at 5:03 P.M. (13 minutes).<br><br>Resident #1's call light was answered at 5:06 P.M. (after 31 minutes observed).<br><br>Resident #60's call light was answered at 5:08 P.M. (after 33 minutes observed).<br><br>Observations further revealed the last dinner tray was delivered at 5:08 P.M. (28 min. to get trays passed after arriving on the unit).<br><br>Interview on 09/02/25 at 5:10 P.M. with CNA #502 confirmed she was not the assigned aide for the 400 unit and did not know where the aide was but was instructed by the nurse to deliver trays and respond to call lights.<br><br>Interview on 09/02/25 at 5:14 P.M. with RN #585 acknowledged Resident #1 and #60 had their call lights on when the surveyor entered the hall and confirmed she was not made aware that there was no aide for the unit. During the interview, RN #585 only became aware there was no aide when she got to the end of the hall near the nurses' station and saw that call lights remained unanswered and the meal trays remained undelivered. She requested the memory care aide pass trays and answer call lights while she passed medications and monitored the dining on the memory care unit.<br><br>Interview on 09/02/25 at 5:22 P.M. with the Director of Nursing (DON) confirmed there should have been an aide scheduled for the 400 unit and was unaware that no aide was there. As far as expectations for timely response to call lights, the DON responded it depends on whether meal trays were being passed or what else was going on at the time, but call lights should not go unanswered for longer than 30 minutes.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Interview on 09/03/25 at 9:50 A.M. with CNA #567 revealed concerns getting assistance for two person tasks, stating the nurse working the unit on 09/02/25 (LPN #586) did not sign any of the shower sheets upon CNA #567's request and refused to assist with the transfer and toileting of Resident #23. CNA #567 reported the inability to have the aide from memory care assist because the unit should not be left unattended and had to get a nurse from another unit to come help with Resident #23's care. During the interview, CNA #567 reported that the aide that was scheduled at 3:00 P.M. on 09/01/25 and on 09/02/25 did not show up and had been a no-call, no-show several times. CNA #567 further reported informing the scheduler there was no aide to relieve her and later received a text message thanking her for staying and then telling CNA #567 that she was good to go home. CNA #567 confirmed leaving the facility with only one nurse working on the 400 unit and no aide on the afternoon shift of 09/02/25.<br><br>Interview on 09/03/25 5:10 P.M. interview with Resident #1 confirmed he had placed his call light on just before dinner on 09/02/25, and it remained unanswered for greater than 30 minutes. By the time someone came in the room with his dinner tray, he had forgotten why he activated the light on in the first place (during the interview, Resident #1 recalled he had some bleeding from his backside he thought he should report to someone).<br><br>Review of the policy titled Answering the Call Light, last revised March 2021, revealed staff were to provide a timely response to resident's requests and needs. The policy further revealed that if staff were able to perform the requested task, it should be completed within five minutes of knowledge of what they needed/requested.<br><br>This deficient practice represents noncompliance investigated under Complaint Number 1395034 (OH00167579). |