STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366149	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williams CO Hillside Country L	09 876 County Rd 16 Bryan, OH 43506

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51513 Based on observation, medical record review and staff interview the facility failed to ensure call lights were within reach and accessible to residents. This affected one (#52) of one resident reviewed for call lights. The facility census was 65. Findings include: Review of the medical record revealed Resident #52 was admitted on [DATE]. Diagnoses included dementia, major depressive disorder and chronic kidney disease. Review of the quarterly Minimum Data Set (MDS) assessment, dated 12/28/24, revealed Resident #52 was frequently incontinent of bowel and bladder, required substantial/maximal staff assistance with toileting and received hospice care. Observation on 02/24/25 at 9:54 A.M. revealed Resident #52 was sitting in a chair in her room, watching television. Further observation revealed the resident's call light was wrapped around side rail of the bed, approximately three feet from the resident, and was not within Resident #52's reach. Interview on 02/24/25 at 9:54 A.M. with Certified Nursing Assistant (CNA) #519 revealed Resident #52 was able to express care needs and utilized the call light for assistance. CNA #519 verified Resident #52's call light was not within the resident's reach and further confirmed call lights should be accessible to residents.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on medical record review, observation and staff interview, the facility failed to ensure privacy curtains were maintained in good repair. This affected two residents (#3 and #29) of two residents reviewed for privacy curtains. The facility census was 65. Findings include: 1. Review of the medical record Resident #3 revealed an admitted [DATE] with diagnoses of cerebral vascular accident (CVA) and Alzheimer's disease. Review of the quarterly Minimum Data Set (MDS) assessment, dated 12/31/24, revealed Resident #3 was cognitively intact. Observation on 02/24/25 at 2:22 P.M. of Resident #3's room revealed the privacy curtain in the semi-private room was in disrepair and ripped at the top. Further observation revealed binder clips were used to hold the curtains together. Concurrent interview with Resident #3's daughter revealed the curtain had been like that the entire time the resident resided in that room, adding she reported it and requested it be repaired. Interview on 02/24/25 at 2:30 P.M. with Hospitality Aide (HA) #507 verified the ripped privacy curtain and verified binder clips were used to hold the curtain together. 2. Review of the medical record for Resident #29 revealed an admitted [DATE] with diagnoses of atrial fibrillation, transient ischemic attack (TIA), and anxiety. Review of the quarterly MDS assessment, dated 01/05/25, revealed Resident #29 was cognitively impaired. Observation on 02/24/25 at 11:23 A.M. of Resident #29's room revealed the resident resided in a semi-private room and the privacy curtain was ripped at the top and hanging onto the floor. Interview on 02/24/25 at 2:31 P.M. with HA #507 verified the privacy curtain in Resident #29's room was ripped at the top and hanging onto the floor. Interview on 02/25/25 at 4:44 P.M. Director of Nursing (DON) revealed the facility did not have a policy for homelike environment.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 47057 Based on review of the facility submitted self-reported incidents (SRI), staff interview and review of the facility policy, the facility failed to ensure thorough investigations were completed. This affected six (#30, #31, #43, #45, #52, and #56) of six residents reviewed for thorough facility investigations. The facility census was 65. Findings include: 1. Review of the facility submitted SRI, created on 11/04/24 at 10:46 A.M., revealed an allegation of physical abuse involving Resident #45 and Resident #30. Review of the corresponding facility investigation revealed no evidence a thorough investigation was completed, including staff interviews, witness statements, like resident interviews/assessments, or any staff education. 2. Review of the facility submitted SRI, created on 11/25/24 at 8:18 A.M., revealed an allegation of physical abuse involving Resident #56 and Resident #43. Review of the corresponding facility investigation revealed no evidence a thorough investigation was completed, including staff interviews, witness statements, like resident interviews/assessments, or any staff education. 3. Review of the facility submitted SRI, created 12/01/24 at 8:55 A.M., revealed an allegation of physical abuse involving Resident #54 and Resident #31. Review of the corresponding facility investigation revealed no evidence a thorough investigation was completed, including staff interviews, witness statements, like resident interviews/assessments, or any staff education. 4. Review of the facility submitted SRI, created 01/17/25 at 9:32 A.M., revealed an allegation of physical abuse involving Resident #31 and Resident #56. Review of the corresponding facility investigation revealed no evidence a thorough investigation was completed, including staff interviews, witness statements, like resident interviews/assessments, or any staff education. Interview on 02/27/25 at 2:03 P.M. with the Administrator verified the facility investigations related to the identified SRIs included no staff interviews, witness statements, like resident interviews/assessments, or evidence of any staff education completed. Interview on 02/27/25 at 2:20 P.M. with the Director of Nursing (DON) confirmed no staff education was completed related to any of the identified SRIs. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled, Abuse and Neglect, revised August 2023, revealed the facility would complete an internal investigation of the incident; have evidence that all alleged violations were thoroughly investigated and document all pertinent information. When a resident to resident abuse was reported, the residents would be removed from the situation and assessments completed, the charge nurse would write a written statement providing all factual events as possible and an investigation would be conducted.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on observation, staff interview and review of the facility policy, the facility failed to ensure medications were not left at the bedside. This affected one (#47) of one resident reviewed for medication storage. The facility identified five (#22, #25, #33, #55, and #56) additional residents who were cognitively impaired and independently mobility residing on the 800-Hall. The facility census was 65. Findings include: Review of the medical record for Resident #47 revealed an admitted [DATE]. Diagnoses included dementia. Review of the annual Minimum Data Set (MDS) assessment, dated 12/17/24, revealed Resident #47 was mildly cognitively impaired. Review of the current physician orders for February 2025 revealed Resident #47 was not prescribed Tums (antacid). Additional review revealed no order for self-administration of medication. Further review of the medical record revealed no evidence Resident #47 had been assessed for self-administration of medication. Observation on 02/24/25 at 2:02 P.M. of Resident #47's room revealed a bottle of Tums at the resident's bedside. A warning label on the Tums bottle read to Keep out of reach. Concurrent interview with Resident #47 revealed her son bought the bottle of Tums for her. Interview on 02/24/25 at 2:14 P.M. with Registered Nurse (RN) #509 verified the bottle of Tums at Resident #47's bedside and confirmed they should not have been there. Interview on 02/26/25 at 2:00 P.M. with the Director of Nursing (DON) revealed five additional residents (#22, #25, #33, #55, #56) resided on the 800-Hall and were cognitively impaired and independently mobile. A follow-up interview on 02/27/25 at 1:17 P.M. with the DON and verified Resident #47 did not have a physician order for Tums until 02/25/25.

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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** 51513 Based on medical record review, staff interview and review of the facility bowel protocol, the facility failed to implement bowel interventions. This affected two (#24 and #52) of two residents reviewed for bowel protocol. The facility census was 65. Findings include: 1. Review of Resident #24's medical record revealed and admitted [DATE]. Diagnoses included dementia, major depressive disorder, myocardial infarction (heart attack) of unspecified site, and weakness. Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/18/25, revealed Resident #24 was cognitively impaired, required substantial/maximal staff assistance with toileting and was frequently incontinent. Review of the care plan, dated 02/06/25, revealed Resident #24 was at risk for constipation due to impaired mobility. Interventions included administer stool softeners and laxatives as ordered, follow facility bowel protocol for bowel management, monitor medications for side effects of constipation and keep the physician informed of any problems. Review of the February 2025 physician orders revealed Resident #24 was ordered Senna oral tablet 8.6 milligrams (mg) one time a day for constipation from 02/01/25 through 02/12/25. On 02/13/25, Senna Plus oral tablet 8.5 mg-50 mg one tablet by mouth one time per day for constipation was added. Additionally, Resident #47 had orders for milk of magnesium oral suspension 400 mg/5 milliliters (ml), 30 ml by mouth daily as needed for constipation and docusate sodium oral capsule 100 mg, give one by mouth as needed for constipation. Further review revealed an order dated 02/24/25 for Dulcolax rectal suppository 10 mg, insert one suppository rectally as needed for constipation. Review of the bowel elimination record from 01/27/25 to 02/25/25 revealed no evidence Resident #24 had a bowel movement from 02/09/25 through 02/12/25 (four days), from 02/14/25 through 02/17/25 (four days) and 02/20/25 through 02/23/25 (four days). Review of the Medication Administration Record (MAR) for February 2025 revealed Resident #47 received no ordered as needed medications for constipation. 2. Review of Resident #52's medical record revealed an admitted [DATE]. Diagnoses included dementia, major depressive disorder, and chronic kidney disease. Review of the quarterly MDS assessment, dated 12/28/24, revealed Resident #54 was cognitively impaired, was frequently incontinent of bowel and bladder, required substantial/maximal staff assistance with toileting and received hospice care. (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 care plan, dated 02/20/25, revealed Resident #52 was at risk for constipation related to decreased mobility. Interventions included to administer stool softeners and laxatives as ordered, follow facility bowel protocol for bowel management, monitor medications for side effects of constipation, and monitor/document/report as needed signs and symptoms of complications related to constipation. Review of the current physicians orders revealed Resident #52 was ordered Miralax oral packet 17 grams (gm), give one packet one time a day, every other day, for constipation. Additionally, Resident #52 had orders for milk of magnesia oral suspension 400 mg/5 ml, give 30 ml by mouth as needed for constipation every other day if no bowel movement in three days and bisacodyl laxative rectal suppository 10 mg, insert one suppository rectally as needed for constipation daily. Review of bowel elimination record from 01/27/25 to 02/25/25 revealed no evidence Resident #52 had a bowel movement from 02/11/25 through 02/14/25 (four days) and 02/16/25 through 02/19/25 (four days). Review of the MAR for February 2025 revealed Resident #52 received no additional ordered as needed medications for constipation. Interview on 02/25/25 at 3:10 P.M. with the Director of Nursing (DON) confirmed there was no evidence Resident #24 had a bowel movement from 02/09/25 through 02/12/25, 02/14/25 through 02/17/25 and 02/20/25 through 02/23/25. Additionally, the DON verified there was no evidence Resident #52 had a bowel movement from 02/11/24 through 02/14/25 and 02/16/25 through 02/19/25. The DON further verified no additional bowel interventions were implemented for Resident #24 and Resident #52. Interview on 02/26/25 at 11:43 A.M. with Licensed Practical Nurse (LPN) #438 revealed the facility bowel protocol included the administration of milk of magnesia and, after three days of no bowel movement, a suppository would be given. LPN #438 stated interventions would be documented on the MAR. Interview on 02/26/25 at 11:46 A.M. with Certified Nurse Aide (CNA) #474 confirmed bowel movements were documented on the bowel elimination record. Review of the facility document titled, Bowel Protocol Per Medial Director, revised 10/30/19, revealed if there was no documentation of a bowel movement in three days, administer bisacodyl suppository 10 mg rectally every other day as needed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on observation, staff interview, medical record review and review of facility policy, the facility failed to ensure non-pasteurized eggs were cooked appropriately. This affected three (#11, #23, and #40) residents who received soft cooked eggs from the kitchen. Additionally, the facility failed to ensure staff practiced proper hand hygiene while providing meal assistance. This affected two (#26 and #49) residents observed during meal service. The facility identified five additional residents (#10, #16, #29, #41, and #58) who required assistance during meals. The facility census was 65. Findings include: 1. Review of the medical record for Resident #11 revealed an admitted [DATE] with a diagnosis of hypertension. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/22/24, revealed Resident #11 had intact cognition and required set-up or clean-up assistance with meals. Further review of the physician order initiated 08/15/23 revealed Resident #11 received a regular diet. Review of the medical record for Resident #23 revealed an admitted [DATE] with a diagnosis of congestive heart failure. Review of the modified annual comprehensive MDS assessment, dated 11/26/24, revealed Resident #23 had intact cognition and required set-up or clean-up assistance with meals. Further review of the physician order initiated 11/23/23 revealed Resident #23 received a regular diet. Review of the medical record for Resident #40 revealed an admitted [DATE] with diagnoses of hypertension and chronic kidney disease. Review of the quarterly MDS assessment, dated 01/27/25, revealed Resident #40 had impaired cognition and required set-up or clean-up assistance with meals. Further review of the physician order initiated 05/13/22 revealed Resident #40 received a regular diet. Observation on 02/24/25 at 8:28 A.M. of the kitchen revealed an 18-count carton of eggs near the griddle. Further observation revealed the egg carton did not indicate the eggs were pasteurized. Concurrent interviews with [NAME] #446 and [NAME] #464 confirmed the facility ran out of pasteurized eggs and the eggs used for the morning meal were unpasteurized. Further interview with [NAME] #446 stated she prepared medium cooked eggs for Resident #11, and soft cooked eggs for Resident #23 and Resident #40. Review of the policy titled, Food Service - Serving Eggs to Residents, revised 05/25/21, revealed pasteurized eggs would be used to prepare soft-cooked, undercooked, or sunny-side up eggs for all residents. 2. Review of the medical record for Resident #26 revealed an admitted [DATE] with diagnoses of Alzheimer's disease, dementia, and depression. Review of the quarterly MDS assessment, dated 12/21/24, revealed Resident #26 had impaired cognition and required set-up or clean-up assistance with meals. Further review of the physician order dated 07/17/24 revealed Resident #26 received a regular diet with soft and bite sized textures. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record for Resident #49 revealed an admitted [DATE] with diagnoses of dementia and chronic pain. Review of the quarterly MDS assessment,t dated 11/21/24, revealed Resident #49 had impaired cognition and required set-up or clean-up assistance for eating. Further review of the physician order dated 02/14/25 revealed Resident #49 received a regular diet with regular textures. Observation during the noon meal service on 02/24/25 at 11:12 A.M. revealed Certified Nursing Assistant (CNA) #458 sitting at a table in the dining room with residents who required cuing and assistance with meals. A bottle of hand sanitizer and a box of disposable gloves were on the table. CNA #458 performed hand hygiene but did not put on disposable gloves before encouraging Resident #26 to eat a cut-up sandwich. CNA #458 picked up the plate and verbally continued to encourage Resident #26 to pick up a piece of sandwich. Resident #26 began to pick up a piece of sandwich, but found it was stuck to another piece, and CNA #458 held the piece of sandwich with her bare hands so Resident #26 could separate the two pieces. Continued observation on 02/24/25 revealed at 11:31 A.M., Resident #29, who was sitting at another table, began calling out. CNA #458 walked over to Resident #29 and attempted to calm him. CNA #458 was not wearing disposable gloves. After CNA #458 was unable to calm Resident #29, she used the telephone to call another staff to remove Resident #29 from the dining room and provide his meal elsewhere. Further observation revealed CNA #458 returned to Resident #29 and again attempted to calm him by touching his arm with one hand while the other hand touched his wheelchair. Continued observation revealed CNA #458 then returned to her chair at the table, did not perform hand hygiene, and picked up silverware and attempted to feed Resident #49. Interview on 02/24/25 at approximately 11:35 A.M. with CNA #458 confirmed she touched Resident #26's sandwich with her bare hand, and further confirmed she touched the telephone, then Resident #29, and did not perform hand hygiene before beginning to assist Resident #49 with eating. CNA #458 confirmed Resident #49 required total assistance with eating. Finally, CNA #458 confirmed she should have donned gloves before touching Resident #26's sandwich and should have sanitized her hands after touching the telephone and Resident #29 before beginning to assist Resident #49 with her meal. Interview on 02/27/25 at 10:00 A.M. with MDS Director #515 revealed Resident #49 had a change in condition mid-February 2025 and was dependent on staff for eating. MDS Director #515 confirmed this was a change from the quarterly MDS assessment completed 11/21/24 when Resident #49 only required set-up assistance. Review of the policy titled Infection Control - Handwashing, revised 03/16/20, revealed no guidance regarding hand hygiene while providing assistance to residents during meals. Review of the policy titled, Food Service - Personal Hygiene, revised 06/27/18, revealed no guidance regarding hand hygiene while providing assistance to residents during meals. Interview on 02/27/25 at 2:50 P.M. with the Director of Nursing (DON) revealed the facility had no policy regarding cleansing hands between residents when providing meal assistance or hand hygiene regarding touching ready-to-eat foods.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41528 Based on observation, staff interview, review of the facility's water management program, review of the Centers for Disease Control (CDC) guidance and review of facility policy, the facility failed to meet the requirements for a Legionella water management program. This had the potential to affect all residents. Additionally, the facility failed to maintain infection control practices during insulin administration. This affected one resident (#18) for administration of insulin. The facility census was 65. Findings include: 1. Interview on 02/27/25 at 9:15 A.M. with Maintenance Director (MD) #486 revealed the facility had eye wash stations and a whirlpool. MD #486 verified the eye wash stations and whirlpool were not flushed to prevent the buildup of bacteria. A follow-up interview on 02/27/25 at 9:30 A.M. with MD #486 verified the facility did not have a risk assessment or flow chart/diagram describing the water systems and offered the blueprint of the building. MD #486 also verified chlorination levels were only tested on ce a week in the facility. Interview on 02/27/25 at 11:53 A.M. with the Administrator confirmed the facility did not meet the requirements for the legionella prevention water management system. Review of the Legionella Prevention Weekly Free Chlorine Log, dated 1/23/23 to 2/24/25, verified chlorination levels were only tested in one room once per week. Review of the Water Plan Operating Report, dated 01/01/24 to 01/31/25, revealed the plant tap/entry point chlorination levels were to be tested daily. Review of the facility policy titled, Legionella Environmental, dated 03/09/20, revealed chlorination levels were checked daily, both in the treatment plant and inside the facility, to ensure disinfection tolerances. In addition, chlorination levels at the furthest point of use were monitored on a weekly basis to ensure residual chlorination was adequate to prevent Legionella growth. Review of the undated CDC guidance titled, Overview of Water Management Programs, revealed water management programs identify hazardous conditions and take steps to minimize the growth and transmission of Legionella and other waterborne pathogens in building water systems. Developing and maintaining a water management program was a multi-step process that required continuous review. Further review revealed the seven key elements of a Legionella water management program were to: Establish a water management program team Describe the building water systems using text and flow diagrams Identify areas where Legionella could grow and spread Decide where to apply and how to monitor control measures (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish interventions when control limits were not met Ensure the program was running as designed and is effective Document and communicate all the activities 47057 2. Review of the medical record for Resident #18 revealed an admitted [DATE] with diagnoses of diabetes mellitus and long term use of insulin. Review of the annual Minimum Data Set (MDS) assessment, dated 11/17/24, revealed Resident #18 was cognitively intact. Review of the February 2025 physician orders for Resident #18 revealed she was prescribed Fiasp FlexTouch subcutaneous solution injector-pen (fast acting insulin) 100 unit/milliliter (ml), inject eight units three times a day. Observation on 02/24/25 at 12:02 P.M. of insulin administration for Resident #18 revealed Registered Nurse (RN) #511 administered the resident's insulin without donning a pair of gloves. Concurrent interview with RN #511 verified she did not don gloves to administering the injectable insulin to Resident #18. Review of the facility policy titled, Bloodborne Pathogen Exposure Control, revised July 2023, revealed the facility established a safety plan for all employees who handle, store, use, process, or dispose of potentially infected blood and blood products. Further review revealed to wear disposable latex or vinyl gloves if handling blood, blood products or body secretions.