STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366171	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cridersville Nursing and Rehab	603 East Main Street Cridersville, OH 45806

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure the physician was notified of a change in condition when the resident had an elevated blood pressure. This affected one (Resident #34) of three reviewed for change in condition. The facility census was 40. Findings include: Review of closed medical record for Resident #42 revealed admission date of 03/20/25. The resident was admitted with diagnoses including chronic obstructive pulmonary disease, atrial fibrillation, bipolar disorder and acute respiratory failure. Review of the plan of care dated 03/27/25 revealed the resident had a plan for altered cardiovascular status related to atrial fibrillation with interventions which included monitor, document, and report to physician ant signs or symptoms of coronary artery disease. Review of the physician's orders revealed an order dated 03/26/25 and placed on hold on 05/04/25, for metoprolol succinate oral capsule extended release 24-hour sprinkle 25 milligrams (mg), to give one capsule by mouth one time a day for blood pressure (bp); hold if systolic bp is less than 90. Review of the Medication Administration Record (MAR) for 05/25 revealed an order for metoprolol succinate oral capsule extended release 24-hour sprinkle 25 milligrams (mg), to give one capsule by mouth one time a day for blood pressure (bp); hold if systolic bp is less than 90. On 05/03/25, the residents bp was documented as 167 systolic and 124 diastolic. The MAR was absent of any further documentation of the residents bp. Review of the vitals tab in the Electronic Medical Record (EMR) revealed Resident #42 blood pressure was 167 systolic and 124 diastolic. The vital tab was absent of any follow up documentation regarding bp. The progress notes for the dates of 05/03/25 and 05/04/25 were absent of documentation of increased bp, or notification to physician and any follow up bp taken. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/07/25 at 11:25 A.M. with the Director of Nursing (DON) verified the resident's vital signs should have been documented in the vitals tab in the EMR. The DON verified the physician was not notified of the blood pressures. The staff will call the doctor if the concern needs immediate attention such as this high blood pressure of 167 systolic and 124 diastolic. Staff can use fax, but this is only for minor concerns. There are on-call doctors and if they do not get back to staff, staff can call the medical director. Review if the facility's policy titled, Change in Condition, dated 04/02/25 revealed the facility shall notify the resident, his or her medical practitioner, and representative of changes in the resident's medical conditions. The nurse supervisor or charge nurse will notify the residents medical practitioner or on-call medical practitioner when there has been a change in resident's condition. The nurse supervisor or charge nurse will record in the resident's medical record information relative to changes in the resident's medical condition or status. This deficiency represents non-compliance investigated under Complaint Number OH00165420.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure a resident's care plan had goals and interventions in place for wound care. This affected one (Resident #45) of three residents reviewed for wound care. The facility census was 40. Findings include: Medical record review for Resident #45 revealed an admission date of 01/17/25. Diagnoses included asthma, Chronic Obstructive Pulmonary Disease (COPD), depression, obesity, cutaneous abscess of left lower limb, cutaneous abscess of right lower limb, abscess of bursa, anxiety, hyperlipidemia, essential primary hypertension, and anemia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #45 was cognitively intact. Review of the wound assessment dated [DATE] revealed Resident #45 had surgical incisions to the right and left hip with a wound vac applied to the left hip. Review of Resident #45's care plan revealed no goals or interventions in place for wounds or the use of a wound vac. Interview on 05/07/25 at 3:15 P.M. with the Director of Nursing (DON) verified Resident #45's care plan did not have goals or interventions in place for wounds or use of a wound vac. This deficiency represents non-compliance investigated under Complaint Number OH00165034.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of a closed medical record, staff interview, policy review, Emergency Medical Services (EMS) run sheet, and review of staff statements, the facility failed to immediately start and continue Cardio-Pulmonary Resuscitation (CPR) until EMS were on scene for one resident (Resident #42) who was identified as a Full Code status and was found unresponsive without vital signs. This resulted in serious life-threatening harm and/or death when Resident #42 did not receive immediate and continuous CPR prior to EMS services arriving at the facility. This affected one (Resident #42) of three residents reviewed for code response. The facility identified 24 residents residing in the facility designated with Full Code status. The facility census was 40. On 05/07/25 at 2:30 P.M., the Administrator and the Director of Nursing (DON) were notified that Immediate Jeopardy began on 05/04/25 at 7:45 A.M. when Resident #42 was found without vital signs Registered Nurse (RN) #164 failed to initiate CPR immediately and stopped CPR prior to the arrival of EMS. Resident #42 expired at the hospital. The Immediate Jeopardy was removed on 05/05/24, when the facility implemented the following corrective actions: • On 05/04/25 at approximately 7:45 A.M., Resident #42 was found without vital signs. • On 05/04/25, the DON completed education on the CPR policy for all licensed nursing staff. • On 05/04/25, the licensed nurse (RN #164) who did not perform continuous CPR on the full code status resident (#42) was removed from the facility and the agency notified of the situation and investigation. • On 05/04/25, the Administrator and DON reviewed the policies and procedures related to code status. There was no revision to the policy made. • On 05/04/25, a Root Cause Analysis was performed using a fishbone diagram for the incident. This was completed by the Regional Director of Operation (RDO) #700, Regional Director of Clinical Operation (RDCO) #200, and the DON. • (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/04/25, disciplinary actions were taken by the facility on the licensed nurse (RN #164) who did not initiate continuous CPR on a full code resident by notifying the board of nursing of the situation through filing a complaint and notifying the staff agency of the situation and marking the nurse as a do not return (DNR) on the facility profile. • On 05/04/25, additional training by the DON or designee was completed on the facility's policy and procedure for initiating CPR. • On 05/04/25, the DON or designee audited all residents advanced directives to the physician's orders and care plan for accuracy and listing in Electronic Medical Records (EMR). Findings are to be reviewed at the monthly Quality Assessment and Assurance (QAA) committee meeting. • On 05/04/25, the DON or designee performed a Code Blue drill with licensed practical nursing staff. Code Blue drills will continue to be completed three times per week for a period of three weeks including off shifts. Findings will be reviewed at the monthly QAA meetings. • On 05/04/25, the DON or designee audited all licensed staff files to verify all licensed staff have an active CPR certification. • On 05/04/25, the crash cart was audited to ensure all items were stocked and functional. Audits will continue for four weeks three times per week. • On 05/04/25, the facility notified the staffing agency of the CPR policy and has it uploaded as a read and sign prior to any staff picking up a shift at the facility through the agency. • On 05/04/25, an ad hoc Quality Assurance Performance and Improvement (QAPI) meeting was conducted to review the plan of correction and abatement including education and audits. Although the Immediate Jeopardy was removed on 05/05/25, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the closed medical record for Resident #42 revealed an admission date of 03/20/25. The resident was admitted with diagnoses including chronic obstructive pulmonary disease, atrial fibrillation, bipolar disorder and acute respiratory failure. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident was independently ambulatory. Review of the physician's orders revealed the resident was a Full Code status indicating all resuscitative measures were to be done if she were to go into cardiac arrest. Review of the plan of care dated 03/27/25 revealed the resident chooses to be a full code. The goal is for CPR to be initiated in any event of arrest. Life sustaining measures will be implemented as needed to honor the resident's wishes. The interventions included the facility will implement CPR and life sustaining measures and the resident's advanced directives will be honored. Review of the nursing progress note dated 05/04/25 at 9:26 A.M. revealed at 8:00 A.M., upon the aide doing rounds, she found Resident #42 blue and unresponsive. Immediately the staff and this nurse, RN #164, ran to check the status of the resident. The resident had no pulse, and staff immediately began 30 compressions per 2 breaths continuously for 20 minutes. The resident remained unresponsive with no pulse. EMS arrived shortly after and began compressions. The DON was notified, and staff also made several attempts to contact the family. Review of Fire Department #1's EMS run report revealed they received the call on 05/04/25 at 8:05 A.M. and arrived at the facility at 8:11 A.M. The patient narrative of the incident was dispatched to location for a [AGE] year-old male, CPR in progress. Arrived on location to find patient on the floor, apneic, and pulseless. No CPR was being done upon arrival. EMS crew began CPR on this patient. Facility aides came into the room and were asked who initially started CPR. They advised the aides had begun CPR, followed by the nurse in charge of the patient's care. The nurse completed one cycle of CPR and made the statement, I am going to call this, and we are going to stop CPR. CPR was not being done on this patient for approximately five minutes prior to EMS arrival on scene. CPR was completed for two cycles and then placed on the LUCAS (automatic chest compression system) device for continuous CPR. Patient was lifted from the ground onto the cot and transported emergently to the hospital. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 05/07/25 at 9:30 A.M. with Certified Nursing Assistant (CNA) #155 revealed the CNA worked on 05/04/25 from 6:00 A.M. to 6:00 P.M. The roommate of Resident #42 came out of the room and stated the resident is not eating and needed CNA #155 to go in and get him up to eat. Upon arrival to the room, the resident was unresponsive and lying on the right side. CNA #155 touched the resident's arm and face to get him to respond. The resident felt warm, so he was turned over onto his back and felt for a pulse. The resident was a bluish color and did not seem to be breathing. CNA #155 ran out of the room and told the agency nurse and other aides she needed help. The aides and nurse went to the room and got the other agency nurse. The nurse, RN #164, went to get the code status of the resident and Licensed Practical Nurse (LPN) #163 brought the crash cart. CNA#161 and CNA#155 lowered the resident to the floor because they did not have a back board on the crash cart. CNA #161 started compressions after knowing the resident was a full code status (unknown how long it was before CPR was initiated) and the agency nurse was doing breaths with a paper towel with a hole in it to cover the mouth due not having a mouthpiece for the Ambu bag. CNA#161 asked RN #164 to take over CPR and she did one round of compressions and stated, There is no pulse, stop CPR. LPN #163 stated she is just an LPN and RN #164 had authority over her. CNA #161 told RN #164, You cannot call a code you are not a doctor. RN #164 told her not to tell her how to do her job. It was about five to seven minutes before the EMS got on scene, and they were livid to find out that staff had stopped CPR. The EMS started CPR immediately upon arrival. Interview on 05/07/25 at 10:06 A.M. with RN #164 revealed she was notified around 7:30 A.M. to 8:00 A.M. Resident #42 was not responsive and went to the room. The resident was cyanotic and had no pulse. RN #164 left the room to check code status and found out the resident was a full code and yelled this down the hall to the nurse aides in the room. CNA #161 and LPN #163 took the crash cart to the room. The oxygen tank on the cart was empty and staff were unable to find any oxygen. A call was made to the DON and 911. RN #164 went to the room and took over CPR compressions. Then after one round, the resident did not have a pulse, was cyanotic and limp. Staff all just stopped doing the CPR, due to being in shock. RN #164 denied telling anyone to stop CPR. The facility made RN #164 write out a report and RN #164 had to leave the job around 11:19 A.M. When asked what they did wrong, the DON said, CPR should have continued until EMS arrived and not stopped. RN #164 agreed they should not have stopped CPR. Interview on 05/07/25 at 10:16 A.M. with CNA #161 revealed CNA #161 was in the hallway when CNA #162 was coming down the hallway saying something was wrong and Resident #42 was not breathing. CNA #161went to Resident #42's room at 7:50 A.M. and RN #164 came into the room and just looked at him and walked away to get the code status. LPN #163 brought down the crash cart and there was not a backboard on it, so staff placed the resident on the floor. At 8:00 A.M., code status was confirmed as full code and staff started CPR. The crash cart had an empty oxygen tank and the Ambu bag did not have a face mask, and no other face mask was found. LPN #163 had to use a paper towel with a hole in it to give breaths. RN #164 came back to the room and was asked to take over CPR. RN #164 was doing compressions as CNA #161went into the hallway to look for EMS. CNA #161 heard RN #164 say, I'm stopping compressions, he is already gone. CNA #162 said, You are not supposed to stop CPR. RN #164 said, Do not tell me how to do my job. When EMS showed up about five to seven minutes later, they asked, What happened, why was CPR stopped? When the DON showed up and had all the staff write up statements, the DON was notified of the crash cart being empty of essential items, and by the time staff left for the day, the crash cart was full of those items. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 05/07/25 at 2:45 P.M. with the Administrator and DON both confirmed Resident #42 was a full code and RN #164 called the code due to the resident having passed away. The Administrator and DON verified RN #164 should not have stopped the CPR. The DON removed RN #164 from the building and placed her on a DNR (do not return) with the agency. The DON, the Administrator, and supervisory staff immediately began in-servicing the nurses on code status of residents as well as beginning an audit of all charts for code status. All of the nurses had been in-serviced regarding code status. The agency was updated on DNR policy and all nurses who picked up a shift will sign before working at the facility. Interview on 05/07/25 at 3:55 P.M. with CNA#162 revealed the food trays came to the hall and Resident #42's tray was delivered to his room. At that time, around 7:30 A.M., Resident #42 was still lying in bed, and the tray was set on the bedside tray table beside the bed. A little bit later (before 8:00 A.M.), CNA#155 yelled she needed help and CNA #162 ran down the hall to Resident #42's room. There was a bruise on the left side of the resident's face and CNA #155 said something was wrong. They both tried to wake up Resident #42 and he did not respond. The resident's pulse was taken and could not be found. CNA #155 stayed in the room as CNA #162 ran to the nurse, RN#164. The nurse was told the resident does not have a pulse and was not breathing. The nurse was just standing there and stated, I do not know the code status. CNA #161 had gone down to the room waiting for a code status, which took around five to seven minutes. She went to the locked hall and got the nurse who grabbed the crash cart and ran to the room while waiting for the code status, but no one was doing CPR. The nurse still did not have the code status and went down to show where it was on the EMR, and she yelled at the staff the resident was a full code. CNA#162 went to the room, and CNA#161 started CPR and LPN #163 looked for a face mask, not present in crash cart and ended up using a paper towel for giving breaths. RN #164 came to the room and watched them doing CPR, when CNA #161 asked to be switched out. RN #164 took over compressions and completed one round, then stopped. RN #164 told all of the staff to stop, and she was calling the code. CNA# 162 said, Once CPR is started, it should not be stopped until the squad gets here. RN #164 stated, He does not have a pulse; he is gone and do not continue CPR. RN #164 also stated, I am a RN and do not tell me what my job is. RN #164 was threatening all staff with write ups if they touched Resident #42 to do any more CPR. He was making gurgling sounds and CNA #162 wanted to continue CPR and didn't because she had no authority. The squad got there after about five to seven minutes and was upset that no one was doing CPR. It was explained RN #164 called the code and she was at the medication cart on the phone. The EMS wanted to know the name of the nurse and stated she cannot call a code and stop CPR. Review of the 911 call from Fire Chief #2, revealed the call came in on 05/04/25 at 8:06 A.M. for Resident #42 who was a full code. When asked are you doing CPR? RN #164 replied, Yes we are. When asked how long have you been doing CPR? RN #164 replied, For about three minutes. Review of the written statement from RN #164 revealed on 05/04/25 she arrived at the facility and shortly after getting report, around 8:00 A.M. the aide informed her that Resident #42 was not responding. Upon arrival to the room, the resident had no pulse, face blue and was not responding. Staff did CPR for 20 minutes. The ambulance was called and were notified. The ambulance arrived five minutes before CPR was stopped. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of CNA #161's statement given on 05/04/25 revealed CNA#155 came running up the front hall and said she thinks something is wrong with a resident. CNAs #161 and #155 went down to Resident #42's room. The resident was on his right side and his face was purple. Then RN #164 came into the room and just looked at the resident. CNA #161 asked for the resident's code status and a crash cart. It took RN #164 seven to 10 minutes to get the code status. CNA #161 and #155 placed Resident #42 on the floor and started the code. LPN #163 came into the room and was looking through the crash cart looking for stuff. The oxygen tanks were empty. LPN #163 was doing the breaths and CNA #161 was doing compressions, which was started at 8:00 A.M. RN #164 came back to the room and was asked to do the compressions. RN #164 started doing compression and CNA #161 was leaving the room to check for the EMS. CNA #161 heard RN #164 stop the code and say he is already gone. Once the EMS showed up, CNA #161 went back to the unit. Review of the statement given by CNA #162 around 8:00 A.M., revealed CNA#155 came to get help because she found Resident #42 not breathing. Resident #42 was lying on his right side, and he had a bruise on the left side of his face. CNAs #155 and #162 immediately got the nurse. Upon getting the nurse, she was trying to find his code status (which took several minutes). CNAs #155 and #161 moved the resident off his bed to the floor. The nurse did not start compressions, CNA#161 started the CPR. CNA#162 went to get the other nurse, LPN #163, who grabbed the crash cart and proceeded to the room. When entering the room, CNA #161 was doing compressions. RN #164 stated she was calling the code. CNA #162 stated, You cannot cancel the code. CNA#162 went to get all the residents away from the door of his room. The squad arrived and wanted to know why CPR was stopped, and CNA #155 told them RN #164 had called the code. The EMS stated she was not allowed to do that, and they started life saving measures again immediately. The EMS stated they needed to report the nurse and wanted to know her name. Review of the statement on 05/04/25 from CNA#155 revealed at approximately 8:00 A.M., a resident came to her and told her his roommate (Resident #42) was not eating and requested that CNA #155 wake him up. When CNA #155 entered the room, Resident #42 was lying in his bed completely covered up with a blanket. The resident was on his right side and the left side of his face was bruised. CNA #155 called his name, shook his arm, tapped his cheek and got no response. CNA #155 ran down the hall and yelled for help. Two aides (CNA #161 and CNA #162) and the two nurses (RN #164 and LPN #163) came to help. CNAs #161 and #155 moved the resident to the floor and CNA #161 started CPR. LPN #163 came in and started doing breaths. RN #164 came to the room with the crash cart. CNA #161 requested for RN #164 to take over compressions. RN #164 did one round of compressions while LPN #163 was doing breaths. RN #164 then stated she was, Calling the code, told staff to stop CPR. From the time CPR was stopped until the EMS arrived was about five minutes. The EMS questioned why CPR was stopped and CNA #155 explained that RN #164 had, Called the code and told staff to stop. RN #164 was the highest authority in the building at the time. The EMS immediately started life saving measures again. The EMS stated that they were reporting RN #164 for stopping CPR. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the statement on 05/04/25 from LPN #163 revealed at 8:00 A.M., the nurse was doing morning medication pass when an aide called the nurse to run down to Resident #42's room. While running to the room, the resident was on the bed, the resident's face was purple, and he was unresponsive. While waiting for RN #164 to get the code status, LPN #163 ran to get the crash cart. After six minutes, RN#164 told staff Resident #42 was a full code. CNA #161 started doing 30 compressions and LPN #163 gave two breaths. LPN #163 heard the bones crack and while giving breaths, she heard gurgling sounds. The crash cart was not properly stocked, no backboard, and the oxygen tank was empty. While doing CPR for twenty minutes, RN #164 told CNA #161 that she is doing compressions now. RN #164 only did one set of compressions and after LPN #163 gave two breaths, RN#164 stopped the code and said, I'm calling it, he is gone. RN #164 stayed in the room and LPN #163 left the room because she was upset with what happened and waited for EMS to arrive. Review of the facility's policy, Cardiopulmonary Resuscitation (CPR), dated 04/28/25 revealed that it is the policy of the facility to adhere to residents' rights to formulate advanced directives. In accordance with these rights, this facility will implement guidelines regarding CPR. This deficiency represents non-compliance investigated under Master Complaint Number OH00165420 and Complaint Numbers OH00165380 and OH00165034.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to complete weekly wound assessments. This affected one (Resident #43) of three residents reviewed for wounds. Additionally, the facility failed to complete wound treatments as ordered. This affected one (Resident #12) of three residents reviewed for wound care. Lastly, the facility failed to ensure a resident made it to a scheduled outside doctor's appointment. This affected one (Resident #12) of three residents reviewed for appointments. The facility census was 40. Findings include: 1. Review of the medical record for Resident #43 revealed an admission date of 10/31/24. Diagnoses included cellulitis of left lower limb, non-pressure chronic ulcer of left foot, muscle weakness, type 2 diabetes, hyperlipidemia, essential primary hypertension, hypomagnesemia, Chronic Obstructive Pulmonary Disease (COPD), adult antisocial behavior, and depression. Review of the Minimum Data Set assessment dated [DATE] revealed Resident #43 was cognitively intact. Review of the care plan with a date initiated of 11/07/24 revealed goals and interventions for wound management. Interventions included wound will be free of signs and symptoms of infection, administer antibiotic therapy as prescribed, encourage resident to elevate legs, and evaluate ulcer characteristics. Review of the weekly wound assessment dated [DATE] revealed Resident #43 had a diabetic ulcer to the left plantar foot measuring 2.0 centimeters (cm) by (x) 2.9 cm x 0.3 cm. Further review of wound assessments revealed no weekly wound assessments with measurements were completed for Resident #43 in March 2025. Review of the progress note dated 03/11/25 revealed podiatry saw Resident #43 outside the facility regarding his wound to foot, indicating the wound was still present in March 2025. Interview on 05/07/25 at 3:14 P.M. with the Director of Nursing (DON) verified there were no weekly wound assessments for Resident #43's wound in March 2025. 2. Review of Resident #12's medical record revealed an admission date of 01/22/25. Diagnoses included superficial frostbite of the right foot, left foot, right hand, and tissue necrosis of the left foot and left hand, homelessness, and cerebral vascular accident. The frostbite resulted in amputation of the right small finger and amputation of all digits on the left hand. Review of Resident #12's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident's cognition was intact. The resident had unhealed surgical wounds. Review of Resident #12's medical record revealed a physician's order dated 12/19/24 to cleanse the right hand with wound cleanser, apply betadine to wound bed of all affected areas, cover with abdominal pad, and wrap with rolled gauze daily and as needed for soiling/dislodgement. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #12's medical record revealed a physician's order dated 12/19/24 to cleanse the left hip with wound cleanser, apply skin prep to peri-wound skin, apply calcium alginate to wound bed, and cover with border foam daily and as needed for soiling/dislodgement. Review of Resident #12's medical record revealed a physician's order dated 12/20/24 to cleanse the left foot with wound cleanser, apply betadine to wound bed of all affected areas, cover with abdominal pad, and wrap with rolled gauze daily and as needed for soiling/dislodgement. Review of Resident #12's medical record revealed a physician's order dated 12/20/24 to cleanse the left hand with wound cleanser, apply betadine to wound bed of all affected areas, cover with abdominal pad, and wrap with rolled gauze daily and as needed for soiling/dislodgement. Review of Resident #12's January 2025's Treatment Administration Record (TAR) revealed the resident's right hand, left foot, left hand, and left hip wound care was failed to be completed on 01/03/25 and 01/06/25. Review of Resident #12's medical record revealed a physician's order dated 02/05/25 to cleanse the left hand with wound cleanser, apply betadine to wound bed of all affected areas, cover with an abdominal pad, and wrap with rolled gauze daily and as needed. Review of Resident #12's TAR dated February 2025 revealed the left-hand dressing change failed to be completed on 02/05/25, 02/05/25, and 02/16/25. Review of Resident #12's medical record revealed a physician's order dated 02/06/25 for the left foot to cleanse the wound with wound cleanser, apply betadine-soaked gauze to wound and between toes, cover with a dry 4 x 4, and wrap with Kerlix daily and as needed for soiling/dislodgement every day shift for wound care initial and date dressing. Document wound appearance with every dressing change. Review of Resident #12's TAR dated February 2025 revealed the left foot wound care failed to be completed on 02/09/25 and 02/13/25. Review of Resident #12's medical record revealed a physician's order dated 02/13/25 revealed to cleanse the right foot with wound cleanser. Apply betadine-soaked gauze to the wound. Cover with an abdominal pad, wrap in Kerlix, and wrap with an elastic wrap daily and as needed for soiling/dislodgement. Review of Resident #12's medical record revealed a physician's order dated 02/13/25 revealed to cleanse the left foot with wound cleanser, apply betadine-soaked gauze to wound and between toes, cover with an abdominal pad or 4 x 4's and wrap with Kerlix daily and as needed for soiling/dislodgement every night shift for wound care. Initial and date dressing. Document wound appearance with every dressing change and as needed for soiling/dislodgement. Initial and date dressing. Document wound appearance with every dressing change. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #12's medical record revealed physician orders dated 02/17/25 to cleanse the left hand with wound cleanser. Apply betadine to the wound bed of all affected areas, cover with an abdominal pad, and wrap with rolled gauze daily and as needed every night shift for wound care. Document wound appearance every dressing change and as need for soiling/dislodgement. Initial and date dressing. Document wound appearance with every dressing change. Review of Resident #12's medical record revealed a physician's order dated 02/17/25 to cleanse the right hand with wound cleanser. Apply skin prep to all affected areas. Leave open to air daily and as needed every night shift for wound care. Initial and date dressing. Document wound appearance with every dressing change and as needed for soiling/dislodgement. Initial and date dressing. Document wound appearance with every dressing change. Review of Resident #12's February 2025 TAR revealed the right hand wound care was failed to be completed on 02/05/25, 02/09/25, and 02/13/25, 02/18/25, and 02/19/25. Review of Resident #12's February 2025 TAR revealed the right foot wound care was failed to be completed on 02/14/35, 02/15/25, 02/16/25, 02/18/25, and 02/19/25. Review of Resident #12's March 2025 TAR revealed left foot treatment failed to be completed on 02/14/25, 02/14/25, 02/15/25, 02/18/25, and 02/19/25. Review of Resident #12's medical record revealed a physician's order dated 03/07/25 for left foot care. Cleanse with in house wound cleanser, pat dry, apply betadine-soaked gauze to surgical incision, cover with 4x4s, Kerlix, and elastic wrap. Change every night shift for wound care. Review of Resident #12's TAR dated March 2025 revealed the resident's left foot wound care failed to be completed on 03/09/25. Review of Resident #12's medical record revealed the record was absent of documentation regarding the missing wound care information. Interview with Resident #12 on 05/08/25 at 11:10 A.M. revealed his wound care failed to be completed timely, especially on the night shift. Interview with the Assistant Director of Nursing (ADON) on 02/13/25 at 9:22 A.M. verified Resident #12's wound care failed to be completed timely as physician ordered. Review of the facility policy titled, Wound Care, reviewed 04/28/25 revealed the purpose of the procedure is to provide guidelines for the care of wounds to promote healing. Verify that there was a physician's order for the procedure. Document that treatment was completed in the electronic medical record. If the resident refused the treatment and the reason(s) why. 3. Review of Resident #12's medical record revealed an admission date of 01/22/25. Diagnosis included superficial frostbite of the right foot, left foot, right hand, and tissue necrosis of the left foot and left hand, homelessness, and cerebral vascular accident. The frostbite resulted in amputation of the right small finger and amputation of all digits on the left hand. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #12's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident's cognition was intact. The resident had unhealed surgical wounds. Review of Resident #12's most recent care plan revealed he was at risk for impaired skin integrity. Review of Resident #12's orthopaedic physician note dated 03/10/25 revealed the resident was seen for post status right small finger amputation and amputation of all digits on the left side. The physician ordered to see the resident in two weeks. An appointment was scheduled for 03/24/25. Interview with the Administrator on 05/08/25 at 10:32 A.M. revealed Resident #12 had missed the appointment on 03/24/25 because the resident called the orthopaedic office and canceled the appointment. Interview with Resident #12 on 05/08/25 at 1:12 P.M. denied canceling any appointments. He stated his wound healing was important. Telephone interview with Nurse #200 at the orthopaedic physician's office on 05/08/25 at 1:27 P.M. revealed Resident #12 was to see the physician on 03/24/25 and he failed to arrive to the appointment. She stated the patient did not call and cancel the appointment. Interview with staff revealed the facility had no policy regarding resident appointments. This represents non-comliance investigated under Complaint Number OH00165034.

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of the outside provider respiratory notes, the facility failed to ensure a Bilevel Positive Airway Pressure (BiPAP) was ordered after a resident returned from the hospital. This resulted in Actual Harm when Resident #34 was admitted to the hospital with an oxygen (O2) level of 38 percent (%) and was admitted to the hospital and placed on a ventilator. This affected one resident (#34) out of three residents reviewed for oxygen. The census was 40. Findings included: Review of the medical record for Resident #34 revealed an admission date of 03/11/25 and re-entry of 04/21/25. The resident was admitted with diagnoses including acute and chronic respiratory failure with hypercapnia, chronic obstructive pulmonary disease (COPD), and anxiety. The resident was discharged on 05/04/25 to the hospital. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The resident was on intermittent O2 therapy and uses a non-invasive mechanical ventilator (BiPAP). Review of the plan of care dated 03/20/25 revealed the resident has potential for alteration in respiratory function related to COPD and respiratory failure. The interventions included for the resident to maintain O2 levels at or greater than 90%, Continuous Positive Airway Pressure (CPAP) or BiPAP therapy for Obstructive Sleep Apnea, resident will adhere to CPAP or BiPAP regimen, educate resident or representative on the importance of CPAP or BiPAP therapy, encourage resident's use of CPAP or BiPAP and to provide BiPAP at pressure of 12 centimeters (cm) of water (H2O) during inhalation (IPAP) and six cm H2O during exhalation (EPAP) (12/6 CM/H2O) pressure with heated humidification at bedtime (hs) 40% bled in. Review of the discharge orders from the hospital dated 04/07/25 revealed an order for BiPAP settings confirmed with attending is 12/6, humification and 40% O2 bled in, to use at night and during any naps. Review of the progress note dated 04/08/25 at 9:02 P.M. revealed the resident had new orders for CPAP given to the Director of Nursing (DON) so respiratory can be contacted. Review of the Advanced Respiratory Services document dated 04/22/25 revealed the recommendation was for four liters per minute of O2 continuous with BiPAP settings of 10/5 decreased in settings. The medication recommendations were made for clarification of BiPAP orders. The additional notes were that the resident states BiPAP is not blowing enough air pressure. The settings were decreased and educated the resident on the change. The respiratory therapist spoke with DON and the NP. Review of the current physician's orders revealed no orders for BiPAP. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) for 04/25 and 05/24 revealed the resident had an order dated 03/13/25 with a discontinue date of 04/07/25 for BiPAP at 12/6 CM/H2O pressure with heated humidification at hs with 40% bled in. The MAR was absent from any order or documentation for BiPAP the months 04/25 and 05/25. Further review of Resident #42's medical record including the Treatment Administration Record (TAR) revealed there was no documentation of the BiPAP being implemented after the hospitalization on 04/07/25. Review of the progress notes dated 05/04/25 at 10:07 A.M. revealed the Certified Nurse Aide (CNA) called for help. The resident was in a wheelchair and was having difficulty breathing. She had just come from smoking, and she was not able to walk to her room and was placed in a wheelchair. She was taken to her room, and this DON placed her on O2 and O2 was at 38%. The resident was groggy but responded to voice commands. She was placed on supplemental O2, and she went up to 60% on six liters per minute (LPM) via nasal cannula (NC). This DON called 911 and Emergency Medical [NAME] (EMS) arrived, and she was assisted to the cart. She was able to follow commands and transfer to cart. Discussed with the EMS's her smoking and her noncompliance with fluid and salt intake. She was transferred to the care of EMS. Sent to hospital for evaluation. The physician was made aware of emergent transfer. Review of the hospital admission documentation dated 05/04/25 revealed the assessment plan as acute hypercapnic respiratory failure, the resident was intubated due to inability to protect airway. The resident's laboratory tests revealed arterial blood gas (ABG) the PH was 7.24 which indicated acidosis (normal 7.35 to 7.45), partial pressure of carbon dioxide indicates hypercapnia (PCO2) 91 (normal is 35 to 45 millimeters of mercury (mmHg), partial pressure of O2 indicating hyperoxia (PO2) 245 (normal is 75 to 100 mmHg) and bicarbonate (HCO3) 39 indicates metabolic alkalosis (normal is 22 to 26 milliequivalents per liter (meq/l)). Interview with DON on 05/07/25 at 3:25 P.M. stated that she felt Resident #42 had been using her BiPAP machine and the staff was putting it on her every night. The DON would not verify the absence of the order in the physician's orders or on the MAR and there were not any progress notes on the use of the BiPAP or refusals by the resident. When the DON was shown the progress note on 04/08/25 which stated resident had new BiPAP order which was given to DON, DON stated she had the respiratory therapist come out and give a note which was dated 04/22/25, which she said was the day the respiratory therapist came to see the resident. The therapist made a recommendation for the BiPAP setting and this did not get put into the physicians order. This was 14 days later after the progress note. Further interview on 05/14/25, when shown the document of the BiPAP document which was taken from the memory card of the machine, the DON verified the BiPAP was not on the night before the resident was taken to the hospital. Interview with the Assistant Director of Nursing (ADON) on 05/07/25 at 3:20 P.M. verified the absence of an order for the use of the BiPAP in physician's orders, the absence of documentation in the MAR and in the progress notes that the BiPAP was being used and or refusals by Resident #42. Interview with the Nurse Practitioner (NP) #175 on 05/07/25 at 3:25 P.M. verified there was not an order in the current physician's orders for the BiPAP settings for Resident #42. Interview on 05/08/25 at 4:50 P.M with the Administrator revealed there is a memory card in the BiPAP machine and they are going to download the information and send it. This will prove the staff were placing the BiPAP machine on at nighttime. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Interview on 05/12/25 at 7:00 A.M. the Administrator verified the respiratory document, which was downloaded from the BIPAP machine, gave the dates of when the resident used the machine. Interview on 05/12/25 at 11:50 A.M. with Respiratory Supervisor #250 revealed the documentation shows the resident was being placed on the BiPAP machine at night. She verified there were six days where she did not have the BiPAP on which were 04/10/25, 04/13/25, 04/14/25 and resident went to the hospital on [DATE] until 04/20/25. The resident then did not have the BiPAP on 05/01/25 and 05/03/25 and left the facility to the hospital on [DATE]. Respiratory Supervisor #250 stated the resident was non-compliant with using the BIPAP but could not provide documentation of the resident refusals. Review of the documentation sent from Respiratory Supervisor #250 revealed Resident #42 was using the BiPAP at nighttime during the dates of 04/07/25 to 05/04/25 and did not have it on for the days of 04/10/25, 04/13/25, 04/15/25, 05/01/25 and 05/03/25. This documentation did not give any reason why the BIPAP was not applied on those missing days and after each time the resident missed two days, she was hospitalized with hypercapnia (a condition where there's an excessive amount of carbon dioxide (CO2) in the bloodstream).

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review, the facility failed to ensure physician orders were followed during medication administration. This affected one resident (#12) of three reviewed for medication administration. The facility census was 40. . Findings included: Review of Resident #12's medical record revealed an admission date of 01/22/25. Diagnoses included superficial frostbite of the right foot, left foot, right hand, and tissue necrosis of the left foot and left hand, homelessness, and cerebral vascular accident. Review of Resident #12's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident's cognition was intact. The resident had a diagnosis of hypertension. Review of Resident #12's care plan revealed the resident had decreased cardiac output. The goal was to have a normal heart rate and rhythm. Interventions included to evaluate the blood pressure, heart rate, character, and rhythm. Review of Resident #12's medical record revealed a physician's order dated 03/05/25 for Metoprolol Tartrate (beta blocker) 50 milligrams (mg). Administer by mouth two times a day for hypertension. Hold for systolic blood pressure under 110 or a heart rate below 60. Review of Resident #12's Medication Administration Record dated May 2025 revealed on 05/01/25 the resident's blood pressure was 104/54 in the evening, and the Metoprolol Tartrate was administered. On 05/03/25 in the morning the resident's blood pressure was 100/71 and his medication was administered. On 05/05/25 in the morning the blood pressure was 100/70, on 05/06/25 in the evening the blood pressure was 109/74 and on 05/07/25 in the evening his blood pressure was 106/52 and the medication was administered each time. Interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 05/12/25 at 9:25 A. M. verified Resident #12's Metoprolol Tartrate was administered beyond the perimeters directed by the physician. Review of Resident #12's medical record revealed he had no negative effects as a result of the medication administration. Review of the facility policy titled, Administering Medications, reviewed 04/28/25 revealed medications must be administered in accordance with the orders, including any required time frames. This deficiency represents non-compliance investigated under Complaint Number OH00165420.