STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366190	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Manor	51999 Guirino Drive St Clairsville, OH 43950

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on observation, interview and policy review, the facility failed to ensure resident dignity was maintained during use of indwelling urinary catheters for three residents (#6, #12, and #22) and when dining for five residents (#3, #19, #21, #44 and #46). This affected eight residents (#3, #6, #12, #19, #21, #22, #44, and #46). The census was 51. Findings include: 1. Review of Resident #12's medical record revealed a 10/16/19 admission with diagnoses including Parkinson disease, end stage renal disease, Tourette's disorder, schizoaffective disorder, rheumatoid arthritis, neuromuscular dysfunction of bladder, benign prostatic hyperplasia with lower urinary tract symptoms, and moderate intellectual disability. Review of the 06/26/24 quarterly Minimum Data Set Assessment (MDS) included the resident was moderately impaired for daily decision making, had an indwelling catheter and upper and lower extremity impairment on both sides. Observation on 08/05/24 at 1:12 P.M. revealed the resident had a urinary drainage bag hanging on the side of the bed facing the door. [NAME] urine was visible in the bag and tubing. Interview on 08/06/24 at 10:28 A.M. with Registered Nurses #522 and #528 verified Resident #12's urinary drainage bag was not in a protective cover and was visible to other residents and visitors. 2. Review of Resident #22's medical record revealed a 03/09/24 admission with diagnoses including encounter for fitting and adjustment of urinary device, pressure ulcer of right lower back, encounter for palliative care, retention of urine, cerebral infarction, dementia, osteomyelitis of vertebra, need for assistance with personal care, and anxiety. Review of a Significant Change MDS dated [DATE] for initiation of hospice care included the resident was severely impaired for daily decision making, dependent for personal hygiene, dependent on rolling in bed, had bilateral lower leg functional impairment, and had a Stage IV pressure ulcer (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location). (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/05/24 at 11:20 A.M. revealed the resident had an indwelling catheter bag hanging on the side of the bed facing the door. The clear amber urine was visible in the tubing and bag. It was not covered for privacy and to maintain dignity, visible to anyone when they walked through the door to the room. Interview on 08/06/24 at 10:41 A.M. with Registered Nurses #522 and #528 verified Resident #22's urinary catheter tubing and bag was not covered and was visible to other residents and visitors. 3. Review of Resident #6's medical record revealed an admission on 05/11/23 with diagnoses including flaccid neuropathic bladder, retention of urine, history of urinary tract infections, and urinary incontinence. Review of the 07/21/24 Quarterly MDS revealed the resident was moderately impaired for daily decision making, functional impairment in both lower extremities, used a walker and a wheelchair, dependent for rolling left to right, and lying to sitting, has an indwelling catheter, at risk for pressure ulcer and has one vascular ulcer and had highly impaired hearing with the use of a hearing aide. Observation on 08/05/24 at 11:49 A.M. revealed the resident was in a low bed, with a mat to left side of bed on the floor. A television on and utilized a custom wheelchair. She had an indwelling urinary catheter with the bag hanging on the side of the bed. The catheter bag not covered, there was white sediment in the tubing and bag. Interview on 08/06/24 at 10:28 A.M. with Registered Nurses #522 and #528 verified Resident #6's catheter and tubing was not in a protective covering and did not provide dignity to the resident as it was visible to others. 28704 4. On 08/05/24 at 11:27 A.M., State tested Nurse Aide (STNA) #105 and STNA #108 were observed applying cloth clothing protectors to Resident #3, #19, #21, #44 and #46 without asking if the residents' wanted to wear one. On 08/07/24 between 7:22 A.M. and 8:50 A.M., observations of the secured unit morning meal revealed State tested Nurse Aide (STNA) #244 was putting clothing protectors on residents including Resident #21, #40 and #44. The cloth clothing protectors extended from the neck to the resident's lap and attached around the neck with velcro. STNA #244 did not ask the residents if they preferred to wear a clothing protector or not. At 8:10 A.M., the breakfast tray cart arrived and STNA #108 and #244 began distributing the meal trays to residents. The breakfast meal was served on orange cafeteria-style serving tray and the dishes remained on the serving trays during the course of the meal. STNA #108 and STNA #244 were observed during the meal intermittently having personal conversations between each other about what they were going to be doing later including shopping and selling personal property. The residents were not involved in the above conversations. During the course of the meal, STNA #244 was also observed standing while assisting and/or feeding Resident #21 and #44 during the meal. On 08/07/24 at 8:50 A.M., interview with STNA #244 verified the above. On 08/12/24 at 2:45 P.M., interview with the Director of Nursing verified residents were to be offered the choice to wear a clothing protector. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy: Quality of Life-Dignity (revised January 2024) included demeaning practices and standards of care that compromise dignity were prohibited. Staff shall promote dignity including to assist residents as needed by helping the resident to keep urinary catheter bags covered.

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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** 28704 Based on observation, medical record review, policy review and interview, the facility failed to ensure accommodations of resident needs was met when call lights were not readily accessible to residents. This affected one resident (#26) of two residents reviewed for communication-sensory. The facility identified two residents being blind (#3, #26). In addition, based on observation, medical record review, policy review and interview, the facility failed to provide residents with appropriate table heights on the secured unit during meals. This affected one resident(#21) of 14 residents on the secured unit. The census was 51. Findings include: 1. Medical record review revealed Resident #26 was admitted on [DATE] with diagnoses including diabetes mellitus, unspecified macular degeneration and need for assistance with personal care. Review of the care plan: Highly Impaired Visual Function related to Macular Degeneration revised 04/22/24 revealed interventions including to arrange room and things in order to promote independence. Review of the care plan: Communication Problem dated 04/01/24 revealed Resident #26's call light was to be within reach to ensure/provide a safe environment. On 08/05/24 at 8:46 A.M., observation during initial tour revealed Resident #26 was in her room sitting in a wheelchair. The wheelchair was positioned near the door leading to the hallway. Resident #26 stated she had macular degeneration, was unable to see anything and asked the surveyor if she could find her call light and give it to her. The call light was observed looped over the bedside table positioned across the room next to the window. At the time of the observation, the surveyor stepped into the hallway and State tested Nurse Aide #114 was informed of the resident's request. STNA #114 verified Resident #26's call light was not within reach and she used her call light to alert staff that she needed help. Review of the policy: Quality of Life - Dignity (revised January 2024) revealed staff was to keep the resident informed and oriented to their environment. 2. Medical record review revealed Resident #21 was admitted on [DATE] with diagnoses including non-traumatic brain dysfunction, Alzheimer's disease, and history of pneumonia. On 08/05/24 at 12:01 P.M., observation revealed State tested Nurse Aide (STNA) #105 and #108 distributed the lunch meals to residents on the secured unit. After distribution, STNA #108 sat at one of the dining room tables to assist Resident #21 and Resident #46 who were both seated in specialty tilt wheelchairs. The table height reached Resident #21's chin and this remained throughout the meal. STNA #108 was cueing Resident #21 to eat as the wheelchair was positioned low to the ground which positioned her at chin height with the table. STNA #105 and STNA #108 did not intervene or reposition either resident during the meal observation. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/07/24 at 8:07 A.M., Resident #21's breakfast was delivered and placed on the dining room table. The resident remained in a low wheelchair at the table, the food was covered and not within the resident's reach as she was positioned along the side of the table and not in front of the table with her legs under the table. STNA #112 and STNA #244 were observed in the dining room assisting residents but did not intervene or reposition Resident #21 to the front of the table with her legs under the table during the meal. On 08/07/24 at 8:50 A.M., interview with STNA #244 verified Resident #21 was not positioned at the table properly and stated if Resident #21 was positioned in front of the table, she grabs everything off the table and will spill or throw it. On 08/07/24 at 10:47 A.M., interview with the Director of Nursing verified residents should be upright, properly positioned and at an appropriate table height during meals. Review of the policy: Quality of Life - Dignity revised January 2024 revealed each resident shall be cared for in a manner that promotes and enhances quality of life. dignity, respect and individuality.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, policy review and interview, the facility failed to ensure resident information remained private. This affected one resident (#6) during a random observation. The census was 51. Findings include: Medical record review revealed Resident #6 was admitted on [DATE] with diagnoses including diabetes mellitus and depression. On 08/05/24 at 12:15 P.M., observation of the main nurses station revealed two medication carts behind the desk. One of the two medication carts computer screen was open revealing the electronic medical record for Resident #6. The screen included a picture of the resident, the resident's date of birth, physician name and medications. There was no staff observed at the nurses station. On 08/05/24 at 12:18 P.M., interview with Registered Nurse #528 verified the electronic medical record was visible and open exposing personal resident health information. This deficiency represents non-compliance investigated under Complaint Number OH00155816.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, policy review and interview, the facility failed to ensure residents were free from restraints. This affected two residents (#21 and #46) of three residents reviewed for restraints. The facility did not identify any residents having restraints. The census was 51. Findings include: 1. Medical record review revealed Resident #21 was admitted on [DATE] with diagnoses including non-traumatic brain dysfunction, Alzheimer's disease, pneumonia, thyroid disorder, arthritis, hip fracture, psychotic disorder, and unsteadiness on feet. Review of the annual Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #21 was severely impaired for daily decision-making, and did not use restraints, chair alarms or a chair to prevent rising. Review of the Full Year Therapy Screen dated 2024 revealed on 02/27/24, 05/16/24 and 08/08/24 Resident #21 was dependent for wheelchair mobility and walking was not attempted due to medical condition/safety. Review of the electronic Physician Orders dated August 2024 revealed no orders for restraints or a chair alarm for Resident #21. Review of Resident #21's care plan: Impaired Self positioning and mobility revised 12/05/23 revealed the resident was unsteady on her feet, would not be able to get out of the recliner or tilt-in-space independently but had freedom of movement. The goal dated through 11/14/24 was for her not to experience any restriction of movement in her tilt-in-space wheelchair. Interventions included to ensure good body alignment, anticipate and meet needs, evaluate device use per protocol, observe resident response to/and effectiveness of positioning device with use, postural supports as ordered, and refer to therapy as needed. Observations on 08/05/24 at 9:09 A.M. and 11:50 A.M., on 08/06/24 at 2:23 P.M., on 08/07/24 at 7:00 A.M. and on 08/08/24 at 10:00 A.M., Resident #21 was seated in a reclined specialty wheelchair with the seat dropped with no leg rests. The resident's legs and feet were observed dangling in the air approximately 16 inches off the floor without any support. The resident was observed at times fidgeting, attempting to push against the wheelchair/furniture and in an attempt to sit upward and then would recline back against the backrest. An activated chair alarm was also observed attached to the back of the wheelchair on 08/05/24 and 08/06/24. Observation on 08/06/24 at 1:53 P.M. revealed Resident #21 was observed in a reclined, tilted specialty wheelchair with the back of the seat dropped and her knees bent toward her chest with no leg rests or support. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/06/24 at 1:55 P.M., interview with State tested Nurse Aide (STNA) #100 revealed Resident #21's wheelchair seat was lowered in the back to recline the resident to keep her legs elevated and feet off the floor. STNA #100 stated the resident was a high fall risk and when the wheelchair was in an upright position, the resident tries to self-propel and stand-up causing her to fall. STNA #100 verified the resident was unable to get out of the specialty chair when it was tilted. STNA #100 also verified chair alarms are used to alert staff of when residents at risk for falls are attempting to get up. The resident could not remove the sensor alarm and when the resident would raise up it would emit a sound. On 08/08/24 at 10:38 A.M., interview with the Director of Nursing (DON) verified the wheelchair seat should not be dropped to lower the resident to the point in which she cannot get up out of the chair or self propel as this would be considered a restraint. 2. Medical record review revealed Resident #46 was admitted on [DATE] from the community with diagnoses including non-Alzheimer's dementia, anxiety, major depressive disorder and diabetes mellitus type 2. Review of the Nursing Admission Evaluation dated 02/27/24 revealed Resident #46 required supervision with bed mobility, transfers, mobility and hygiene; had no balance concerns and was oriented to person and place. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #46 was severely impaired for daily decision-making, did not have functional limitations in range of motion, required partial/moderate assistance to perform sit to stand and walk 10 feet. Walking 50 feet with two turns and the ability to walk 150 feet was not attempted due to medical condition or safety concerns. Review of the Comprehensive Nursing Note 1.1 dated 07/18/24 indicated Resident #46 releases seatbelt frequently when in wheelchair but not observed at this time. Review of the Progress Note dated 07/09/24 revealed the resident had been severely unsteady on feet and gait, was unable to maintain a standing position independently and was sitting on couch and kept rolling body forward and unable to sit up independently. Cognition severely impaired causing resident to be unaware of safety precautions, unaware of need for assist, unable to use assuasive devices, and multiple falls in the past few days. Resident #46 attempts to ambulate; however, walks into walls, doors, and falling related to unsteady gait. Physician was notified and specialized tilt wheelchair with alarmed seatbelt was ordered. Resident was able to remove seatbelt and stood up from wheelchair; however, unsteady. Wheelchair and seat belt did not inhibit resident's self mobility, range of motion, able to propel self in wheelchair or sit up in chair. Review of the electronic Physician Orders dated 07/09/24 revealed a self-releasing seat belt while in wheelchair was ordered and on 08/06/24 a pressure sensitive alarm at all times except while in wheelchair was ordered. Review of the care plan: Potential for Complications related to Self-Releasing Seat Belt while in Wheelchair dated 07/09/24 revealed Resident #46 was able to release the seat belt on her own. Interventions included to ensure as needed that the resident was able to release the seatbelt on her own. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan: Risk for falls revised 07/10/24 revealed pressure alarm at all times except in wheelchair to alert staff of self rising and as a gentle reminder to seek assistance. Review of the Occupational Therapy (OT) Discharge Summary dated 07/23/24 revealed goals met on 07/23/24 included the resident will demonstrate improved seating/positioning while in wheelchair indicating appropriate wheelchair fit with adequate supports and sufficient fall prevention measures. On 07/09/24 the resident was trialing a tilt/recline wheelchair with self-releasing seat belt secondary to falls, OT to address seating/positioning. At the time of OT discharge on 07/23/24 the resident can self release with cues or occasionally not needing cues. Observations on 08/05/24 at 9:09 A.M. and 11:45 A.M. revealed Resident #46 was sitting in a specialized wheelchair with a seat belt secured around the resident's waist. The chair was not observed at a 90 degree angle and a chair pressure alarm was observed attached to the back of the wheelchair. Resident #46 was observed trying to get out of chair by grasping table and placing feet with gripper socks on floor, twisting her body sideways and positioning her legs over the arm rest of the wheelchair. On 08/06/24 at 11:50 A.M., 1:53 P.M. and 2:23 P.M., and on 08/07/24 at 7:00 A.M., and 08/08/24 at 10:00 A.M., observations revealed Resident #46 would be fidgeting in the chair, attempting to push against the wheelchair/furniture in an attempt to sit upward and then would recline back against the backrest. An activated chair alarm was also observed attached to the back of the wheelchair on 08/05/24 and 08/06/24. On 08/07/24 at 6:31 P.M., interview with State tested Nurse Aide #102 verified Resident #21 and #46 cannot get out of their specialized wheelchairs by themselves when the wheelchairs are tilted/reclined. On 08/08/24 at 10:24 A.M., interview with Licensed Practical Nurse (LPN) #544 verified Resident #21's wheelchair seat should not be dropped to the point to where the resident's feet cannot touch the floor. At the time of the interview, LPN #544 was observing Resident #21 who was seated in the living area of the unit. LPN #544 stated the resident was capable to self-propel if her feet were on the floor and verified the resident appeared uncomfortable as the resident was lifting and extending her legs outward. LPN #544 verified the wheelchair seat being dropped kept her from self-propelling and getting out of the chair and that it would be considered a restraint. During the interview and observation of Resident #21, LPN #544 was observed walking over to STNA #112 and they positioned Resident #21's wheelchair to an upright position . At that time, Resident #21's feet were able to reach the floor and she was observed to be able to self-propel in the wheelchair. On 08/12/24 between 12:48 P.M. and 1:22 P.M., observation revealed Resident #46 ambulated 708 feet with a front wheeled walker with Physical Therapy Assistant (PTA) #700 and Certified Occupational Therapy Assistant (COTA) #701. Resident #46 was assisted back to her wheelchair for a rest period by PTA #700 who reattached the velcro alarming seatbelt. At 1:25 P.M., interview with PTA #700 stated the resident was able to release the seatbelt and it was requested that she ask Resident #46 if she could release the seatbelt. PTA #700 asked Resident #46 to release the velcro alarming seatbelt and the resident was unable to do so upon command three times. The surveyor asked the resident to release the seatbelt and the resident was unable to do so upon command three times. COTA #701 stated she could try and she asked Resident #46 to release the seatbelt and the resident was unable to release the seatbelt upon command. Interview with PTA #700 and COTA #701 at the time of the observation verified the resident was unable to release the alarming seatbelt upon command after seven requests and the velcro seat belt was restraining the resident at that time. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/12/24 at 2:45 P.M., interview with the DON verified Resident #21 and Resident #46's wheelchairs were considered restraints and Resident #46's inability to release the seat belt upon command was also a restraint. Review of the policy: Restraints (revised January 2024) revealed the resident had a right to be free from any physical or chemical restraint imposed for purposes of discipline and/or convenience. Restraints shall only be used as required to treat residents' medical symptoms. The purpose was to control movement to protect the resident in an emergency to permit medical treatment, control behavior to prevent the resident injuring himself or others and to improve the resident's mobility and independent function. Procedure included the decision to apply physical restraints was to be based on the assessment of each resident's capabilities and less restrictive alternatives were used whenever possible. The use of restraints will be justified through the care planning process and restraint enabler form. Restraints were to be removed at meal times and rest period as able to allow for restraint free time frames. The facility will provide the resident or resident's representative with appropriate information, obtain consent forms and a physician order. If the resident is able to remove the restraint independently it will not be considered a restraint rather a safety device. Review of the policy: Pressure Alarms (dated January 2024) revealed pressure alarms were used to alert staff of resident self-rising and as a gently reminder to have resident call for assistance. Procedures included to obtain an order, apply the pressure alarm as ordered i.e. while in bed, while in chair, at all times; replace pressure pad as directed by manufacturer guidelines, always test and check the battery before use, and battery checks every shift.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on medical record review, observation, and interview, the facility failed to ensure the comprehensive assessments were accurate related to alarms, falls and psychotropic medications. This affected one resident (#46) of 18 residents reviewed for comprehensive assessments. The census was 51. Findings include: Medical record review revealed Resident #46 was admitted on [DATE] from the community with diagnoses including non-Alzheimer's dementia, anxiety, major depressive disorder and diabetes mellitus type 2. Review of the electronic Physician Orders dated July 2024 revealed resident was ordered a self-releasing seat belt and a pressure sensitive alarm at all times except while in wheelchair. The resident also received a PRN (as needed) Haldol (antipsychotic) 1 milligram on 07/04/24 for anxiety. a. Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #46 was severely impaired for daily decision-making and sustained one fall with no injury . Review of the Fall Investigation dated 06/13/24 revealed Resident #46 had an unwitnessed fall on 06/13/24 resulting in an abrasion. b. Review of the quarterly MDS assessment dated [DATE] revealed Resident #46 sustained two or more falls with no injuries, used a bed alarm daily and no other alarms, and no restraints. Review of the Fall Investigations dated 07/06/24, 07/08/24, 07/10/24 and 07/17/24 revealed the resident had a total of five falls and two of the four falls resulted in an abrasion and a skin tear. On 08/05/24 at 9:05 A.M., observation revealed Resident #46 was in a specialty tilt in space wheelchair with an alarmed, self-releasing seat belt and a pressure sensitive alarm to wheelchair. c. Review of the quarterly MDS assessment dated [DATE] revealed Resident #46 received antipsychotic medications on a routine basis only. Review of the electronic Medication Administration Record dated July 2024 revealed the resident was administered PRN Haldol 1 milligram (mg) on 07/04/24 and began receiving Rexulti 0.5 mg on 07/11/24. On 08/12/24 at 12:39 P.M., interview with the Director of Nursing verified the above findings and MDS assessment errors.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Manor	51999 Guirino Drive St Clairsville, OH 43950

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on medical record review and interview, the facility failed to ensure residents were provided a written summary of the baseline care plan. This affected one resident (#106) of 18 residents reviewed for care planning. Findings include: During an interview on 08/05/24 at 9:51 A.M., Resident #106 stated she did not recall receiving a summary of her baseline care plan. Review of Resident #106's medical record revealed an admitted [DATE]. Diagnoses included muscle wasting and atrophy, hypokalemia, pain, age-related physical debility, hypothyroidism, cervical disc degeneration, right artificial knee joint, bilateral hearing loss, angina pectoris, depression, hypertension, hyperlipidemia, osteoarthritis, thyroid disorder, squamous cell carcinoma of skin, and anxiety disorder. Review of the baseline care plan dated 07/20/24 revealed there was an area at the bottom of the second page for a resident or representative to sign indicating they received a copy of the resident's medication list and a copy of the baseline care plan. Instead of a signature there was a note written to indicate the baseline care plan was reviewed verbally with Resident #106. On 08/06/24 at 3:00 P.M., during interview, Registered Nurse (RN) #522 verified the facility did not provide residents/responsible parties with written summaries of the baseline care plans.

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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** 28704 Based on medical record review and interview, the facility failed to develop and implement care plans to maintain a resident's highest practicable well-being. This affected one resident (#46) of 18 residents reviewed for care plans. The census was 51. Findings include: Medical record review revealed Resident #46 was admitted on [DATE] with diagnoses including non-Alzheimer's type dementia, anxiety, breast cancer and arthritis. a. Review of the admission Fall Risk assessment dated [DATE] revealed Resident #46 was at moderate risk for falls. Further review revealed no evidence a care plan was developed between 03/04/24 and 06/05/24 to prevent falls. Review of the Nursing Notes dated 06/05/24 revealed Resident #46 had sustained a fall. This was the first documented fall for the resident. b. Review of the admitting History and Physical dated 02/06/24 and the electronic Diagnosis List revealed Resident #46 had health conditions/diagnoses including diabetes mellitus, breast cancer, arthritis, constipation and hypertension. Review of the electronic Physician Orders dated August 2024 revealed as needed (PRN) medications included dulcolax suppository 10 milligrams (mg) PRN for constipation, milk of magnesia 2400 mg per 30 milliliters PRN for constipation, fleets enema PRN for constipation, and extra strength Tylenol 500 (mg) PRN for pain. Review of the medical record revealed no comprehensive care plan had been developed related to diabetes mellitus (DM), pain, constipation or hypertension (HTN). c. Review of the Physician Progress Notes dated 03/11/24 revealed nurse practitioner (NP) #601 evaluated Resident #46 due to increased anxiety and confusion. NP #601's impression was generalized anxiety disorder and dementia with behaviors and her plan included to start Exelon 4.6 milligrams every 24 hours topically for cognition. Review of the Health Status Note dated 03/11/24 revealed Resident #46's daughter informed the nurse that the resident had been on Rivastigmine previously, and it had a negative effect on Resident #46 including worsening behaviors. NP #601 was notified and ordered to discontinue the medication. Exelon was listed as an allergy at that time. Review of the electronic Physician Orders dated August 2024 revealed Resident #46 was allergic to Exelon. There was no comprehensive care plan developed for the known allergy to Exelon. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/14/24 at 2:37 P.M., interview with Licensed Practical Nurse (LPN) #544 verified care plans had not been developed as indicated above for Resident #46 including falls, medication allergies, pain, HTN or DM. LPN #544 stated the constipation care plan was discontinued on 08/13/24 after pharmacy recommendations to discontinue even though additional PRN orders to treat constipation were in place. LPN #544 stated she does not develop a care plan unless the resident is receiving a medication, even if they have a medical diagnosis of the condition.

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F 0657 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on medical record review and interview, the facility failed to ensure comprehensive care plans were revised. This affected four residents (#15, #21, #44 and #46) of 18 residents sampled. The census was 51. Findings include: 1. Medical record review revealed Resident #46 was admitted on [DATE] with diagnoses including non-Alzheimer's type dementia, anxiety, breast cancer and arthritis. Review of the care plan: No Nutritional Triggers at present dated 03/05/24 revealed interventions included to honor preferences, provide diet as ordered, record intakes every meal and weight per policy. The physician was to be notified of a significant weight change. The care plan had not been revised to reflect the resident's weight loss. Review of the Weight Change Note dated 07/30/24 revealed Dietitian #532 notified Resident #46's physician of a 13 pound (#) (12.1%) weight loss in a month; 18.2# (16.2%) weight loss in three months and a 16.6# (15%) weight loss in five months. Current weight was 94# with a BMI of 18.4 indicating borderline underweight. Resident meal intakes was fair, weight loss noted, receiving 60 ml nutritional supplements twice a day (since 07/09/24) and new order to start mighty shakes three times a day. Review of the note revealed no evidence the dietitian was notified of the restraint use or psychotropic medications. There was no evidence the Nutritional Triggers care plan had been revised regarding Resident #46's weight loss or implementation of supplements. On 08/12/24 at 11:09 A.M., interview with the Director of Nursing (DON) verified Resident #46's nutrition care plan was not revised. 2. Medical record review revealed Resident #21 was admitted on [DATE] with diagnoses including cataracts, glaucoma or macular degeneration, non-traumatic brain dysfunction, Alzheimer's disease, hypertension, pneumonia, thyroid disorder, arthritis, hip fracture and psychotic disorder. Review of the annual Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #21 was rarely/never understood, unclear speech, severely impaired for daily decision-making, had moderate difficulty hearing with no hearing aid and adequate vision with corrective lenses. Activities daily preferences discussed with family and assessed not to be important to have books, newspapers and magazines or keep up with news. Very important to listen to music she likes, be around animals, doing things with groups of people, fresh air when weather is good and to do your favorite activities. The resident was receiving hospice services and had less than six months life expectancy. On 08/06/24 at 2:23 P.M., observation revealed staff turned television (TV) on for Resident #21 to watch the Olympics. The resident was not wearing any glasses. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident Participation Sheet for Daily Programs and Independent Activities dated June, July, August 2024 revealed Resident #21 participated in activities including exercise/groups, religious, manicures, mail, music, pets, visitors, arts/crafts, games, party, current events, reads/writes, walks/wheels, listens/watches TV, and visits others. Review of the care plan: Preferred social programs and activities dated 11/02/2020 revealed Resident #21's preferred activities included socials, parties picnics, holiday gatherings, musical programs, large games such as Yahtzee-bowling, volleyball-noodle exercise-tossing & batting games, group discussions, relaxing/napping, having snacks in between her meals, outdoor programs with supervision and assistance as needed and weather permitting, reminiscing groups, pet visits-especially dogs, children visits, and bird watching from her window or patio during her stay here at this facility. One activity goal included independent activities of choice such as: bird watching out her window or on the patio, likes to people watch, Television viewing-on occasion, independent prayer-Methodist by faith, napping/relaxing, having snacks in between her meals-chocolate-cheese balls, beauty shop visits-as needed or interested, manicures, reading her mail that she gets often, and listening to the radio and television in the common areas during her stay here at this facility. Review of the interventions revealed no revisions had been made since 11/02/24. On 08/12/24 at 3:35 P.M., interview with the DON verified Resident #21's activity care plan had not been revised since 2020 including being admitted to hospice services and her glasses have been missing for an unknown amount of time since at least May 2024. 3. Medical record review revealed Resident #44 was admitted on [DATE] with diagnoses including diabetes mellitus, muscular dystrophy, dementia, vitamin D deficiency and hypothyroidism. Review of the Weights revealed Resident #44 weighed 151# on 11/30/23 and the resident's weight was 129. 2# on 07/25/24 indicating a weight loss of 14.4%. Review of the quarterly Nutritional Sheet dated dated 04/23/24 revealed Resident #44 had a decreased appetite. Mighty shakes are provided three times a day at meals and accepted well. The resident had a 12#/8.2% weight loss within two months since 02/20/24. Review of the Quarterly Nutrition Note dated 07/16/24 revealed Resident #44 had a 16.2#/11% weight loss within six months. Review of the electronic Physician Orders dated August 2024 revealed a nutritional supplement 60 milliliters twice a day was started on 07/02/24. Review of the Task List dated March 2024 revealed mighty shakes three times a day was administered starting 03/26/24. Review of Resident #44's care plan: Leaves greater than 25% of meals dated 10/27/23 revealed no evidence it had been revised to reflect the resident's significant weight loss or interventions implemented. On 08/14/24 at 10:13 A.M., interview with the DON verified the nutrition care plan was not revised to reflect the resident's significant weight loss or interventions implemented. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	26706 4. Review of Resident #15's medical record revealed an admission on 10/26/23 with diagnoses including age related debility, herpes viral infection, need for assistance with personal care, mixed incontinence, muscle weakness, Alzheimer's disease, congenital hiatal hernia, disorder of the kidney an ureters, history of urinary tract infections, dementia, repeated falls, anorexia, hyperlipidemia, hypothyroidism, depression, difficulty walking, and gastroesophageal reflux disease. Admission orders included Macrobid Oral Capsule 100 milligrams (mg) daily for personal history of urinary tract infections. A 11/04/23 Bladder and Bowel Incontinence plan of care related to activity intolerance, Alzheimer's, dementia, chronic history of urinary tract infection, impaired mobility, inability to communicate needs, and loss of peritoneal tone. On Macrobid therapy for chronic urinary tract infections. Pharmacist review in November 2023 included a recommendation to change Macrodantin to Trimethroprim due to poor renal function. Trimethroprim Oral Tablet 100 mg was ordered 11/17/23 and the Macrobid was discontinued. The 11/04/23 Bowel and Bladder plan of care identified Macrobid as the current antibiotic used for chronic urinary tract infections. Review of the 07/31/24 Quarterly Minimum Data Set Assessment included the resident was severely impaired for daily decision making, received antidepressants and antibiotics, always incontinent of urine and was frequently incontinent of stool. Interview on 08/14/24 at 11:37 A.M. with the Director of Nursing verified the care plan still has Macrobid as the long term antibiotic when it was changed in November 2023 to Trimethroprim.

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, policy review and interview, the facility failed to ensure proper positioning of residents during meals on the secured unit. This affected three residents (#21, #25 and #46) of 14 residents on the secured unit. The census was 51. Findings include Medical record review revealed Resident #46 was admitted on [DATE] with diagnoses including non-Alzheimer's type dementia. Medical record review revealed Resident #21 was admitted on [DATE] with diagnoses including non-traumatic brain dysfunction, Alzheimer's disease and history of pneumonia. Medical record review revealed Resident #25 was admitted on [DATE] with diagnoses including non-traumatic brain dysfunction and non-Alzheimer's type dementia. Observations of meal service on the secured unit revealed the following: a. On 08/05/24 at 12:01 P.M., observation revealed State tested Nurse Aide (STNA) #105 and #108 distributed the lunch meals to residents on the secured unit. After distribution, STNA #108 sat at one of the dining room tables to assist Resident #21 and Resident #46 who were both seated in specialty tilt wheelchairs at 60 degree to 75 degree angles at the table. The table height reached Resident #21's chin and this remained throughout the meal. Resident #46 was being fed by STNA #108 who was also cueing Resident #21 to eat. Resident #21's wheelchair was positioned low to the ground which positioned her at chin height with the table. STNA #105 and STNA #108 did not intervene or reposition either resident during the meal observation. b. On 08/07/24 at 7:00 A.M., Resident #21 was observed sitting in a low wheelchair and the seat was in the dropped positioned. A chair alarm was attached to the wheelchair and the resident's feet and legs were dangling straight down from the edge of the seat due to there were no leg rests attached to the wheelchair. c. On 08/07/24 at 8:07 A.M., Resident #21's breakfast was delivered and placed on the dining room table. The resident remained in a low wheelchair at the table, the food was covered and not within the resident's reach as she was positioned along the side of the table and not in front of the table with her legs under the table. STNA #112 and STNA #244 were observed in the dining room assisting residents but did not intervene or reposition Resident #21 to the front of the table with her legs under the table during the meal. On 08/07/24 at 8:50 A.M., interview with STNA #244 verified Resident #21 was not positioned at the table properly and stated if Resident #21 was positioned in front of the table in her wheelchair, she would grab everything off the table and will spill or throw it. On 08/07/24 at 10:47 A.M., interview with the Director of Nursing verified residents should be upright, properly positioned and at an appropriate table height during meals. (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/08/24 at 8:24 A.M., observation revealed Resident #25 was in the dining room in a specialty wheelchair in a semi-reclined position and was being fed by STNA #112. Review of the policy: Quality of Life - Dignity (revised January 2024) revealed each resident shall be cared for in a manner that promotes and enhances quality of life. dignity, respect and individuality.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on observation, record review, policy review, and interview, the facility failed to ensure dependent residents received nail and oral care. This affected two residents (#22 and #49) of two residents reviewed for activities of daily living. Findings include: 1. Review of Resident #22's medical record revealed a 03/09/24 admission with diagnoses including encounter for fitting and adjustment of urinary device, pressure ulcer of right lower back, encounter for palliative care, retention of urine, cerebral infarction, dementia, osteomyelitis of vertebra, need for assistance with personal care, and anxiety. Review of a Significant Change Minimum Data Set (MDS) dated [DATE] for initiation of hospice care included the resident was severely impaired for daily decision making, dependent for personal hygiene, dependent on rolling in bed, had bilateral lower leg functional impairment, and had a Stage IV pressure ulcer (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location). Review revealed a physician order 06/20/24 included inspect nails weekly and trim as needed, every dayshift. Observation on 08/05/24 at 11:20 A.M. revealed the resident was in bed, had fingernails bilaterally with debris embedded under the nails. Observation on 08/06/24 at 8:56 A.M. revealed the resident was in bed on her left side. Her fingernails on both hands were long with dirt under the nail beds. All the fingernails on the left hand including the thumb and two fingers on right hand had brown debris under the nail beds. Several of the nails were long. Review of the nail care policy reviewed 01/2024 included it must be performed and document. Review of TASK in the electronic aide documentation included a task since 03/09/23 was to inspect nails weekly and trim as needed. Review of the last 30 days included the aides were documenting yes daily that they were inspecting nails and trimming. However, the nails were not trimmed and clean. The resident was also under hospice care. The resident received aide services five days a week. Review of the aide documentation last submitted to the facility 07/31/24 included nail care was part of the routine duties. Interview on 08/06/24 at 6:24 P.M. with Registered Nurse #522 verified the resident's fingernails had embedded debris under them. Further verified, there was an odor noted when her hands were opened up for inspection. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #49's medical record revealed a 06/19/24 admission with diagnoses including protein calorie malnutrition, cognitive communication deficit, delusional disorders, tremor, edema, need for assistance with personal care, lack of coordination and anxiety. Physician orders 06/19/24 included to inspect nails weekly and trim as needed every dayshift. Review of the Admission 06/26/24 MDS included the resident was moderately impaired for daily decision making, moderate assist for personal hygiene, set up for oral hygiene, was on antipsychotic, anti-anxiety, antidepressant, and anti-platelet. Plans of care plan included a 06/26/24 plan for deficit in functional abilities/completing activities of daily living related to balance/mobility/range of motion impairments. Impaired cognition/confusion/poor decision making, Needs substantial/maximum assist with toileting hygiene. Needs partial/moderate assist with showers, dressing, personal hygiene, sit-stand, chair/tub/toilet transfers, and ambulating. Needs touching/supervision to roll left-right, sit-lying, lying-sit, and propel self in wheelchair. Needs set up/clean up with toileting hygiene. Observation on 08/05/24 at 11:02 A.M. revealed the resident was in a low bed, floor mat to left of bed, she said her mouth was dry, water on overbed table out of reach, bruising noted to right hand, and left thumb nail was dirty. Observation on 08/06/24 at 8:48 A.M. revealed the resident was in a low bed, call bell in reach, and mat to floor. The resident's fingernails on her right hand had debris under the nail beds. Her teeth had white around the gums and between teeth. Interview on 08/06/24 at 5:18 P.M. with State tested Nurse Aide (STNA) #202 included she had been taking care of the resident since 6:00 A.M. She revealed they gave her a bed bath this morning ad changed her. When asked about the resident's teeth and fingernails, STNA #202 stated she did not brush the resident's teeth this morning or provide nail care. She verified there was debris under the nails of the resident's right hand.

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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** 22653 Based on observation, medical record review, and interview, the facility failed to implement physician orders for tubigrips (tubular bandages that provide light to moderate compression) to address edema. This affected one resident (#27) of 24 residents screened for edema (swelling). Findings include: Review of Resident #27's medical record revealed diagnoses including edema, hypertension, and type two diabetes mellitus. Resident #27 had a physician order dated 04/12/24 to apply tubigrips to both legs to be worn at all times except during hygiene as tolerated. An annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #27 was cognitively intact. Documentation on the electronic task bar indicated Resident #27 had tubigrips worn on 08/05/24 at 5:59 A. M. and refused on 08/05/24 at 9:47 A.M. Observation of Resident #27 on 08/05/24 at 3:35 P.M. revealed both of Resident #27's feet were swollen. Resident #27 stated she used to wear compression stockings but did not know where they were. Resident #27 had no compression stockings or tubigrips on. Resident #27 stated she elevated her feet at night while sitting in the recliner. A subsequent observation on 08/06/24 at 9:20 A.M. revealed Resident #27's feet remained swollen. No tubigrips were observed. On 08/06/24 at 9:40 A.M., State tested Nursing Assistant (STNA) #200 entered Resident #27's room asking if she could put the things on her legs. STNA #200 exited Resident #27's room in less than one minute and verified she had been unable to locate any tubi-grips in Resident #27's room. STNA #200 stated sometimes tubigrips were not returned from laundry. STNA #200 stated she would go to the nursing station because there were always tubigrips there. On 08/07/24 at 9:45 A.M., STNA #200 was interviewed regarding documentation of Resident #27 refusing tubigrips on 08/05/24 as she had not been observed providing care on Resident #27's unit that day. STNA #200 verified she was not working on Resident #27's unit on 08/05/24 and she did not offer to apply her tubigrips that day. STNA #200 stated she had a good relationship with Resident #27 and could generally get her to do whatever she requested.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, missing item log review, policy review and interview, the facility failed to ensure visual appliances i.e. eyeglasses were readily available for resident use. This affected one resident (#21) of two resident reviewed for communication-sensory. The census was 51. Findings include: Medical record review revealed Resident #21 was admitted on [DATE] with diagnoses including cataracts, glaucoma or macular degeneration, non-traumatic brain dysfunction and Alzheimer's disease. Review of the care plan: Communication Problem dated 10/26/20 revealed Resident #21 vision was adequate as she will name things across the room, has glasses that she chooses not to wear at all times but staff was to encourage her to wear her glasses. Review of the Eye Care evaluation dated 01/17/24 revealed resident with severe cataracts, hyperopia and presbyopia (refractive errors that cause blurry close-up vision) in both eyes. Resident declined new prescription glasses and spectacle prescription for right and left eye was provided. Review of the annual Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #21 was severely impaired for daily decision-making and had adequate vision with corrective lenses. Review of the Missing Item Log dated 2024 revealed no evidence Resident #21's glasses were broken or missing. Resident #21 was observed not wearing eyeglasses on 08/05/24 at 9:09 A.M. and 3:56 P.M., on 08/06/24 at 1:53 P.M., on 08/06/24 at 2:23 P.M., on 08/06/24 at 2:43 P.M., on 08/07/24 at 7:00 A.M., and on 08/08/24 at 8:48 A.M On 08/08/24 at 8:48 A.M., observed Resident #21 up in wheelchair and she was not wearing glasses. Interview with Activities Director #594 at the time of the observation stated Resident #21 had a pair of glasses; but they broke during a fall and had not had a pair since. Activity Director #594 verified the resident activities included watching television and reading. Observation with Activity Director #594 of Resident #21's room revealed no evidence of a pair of prescription glasses. Activity Director #594 verified the resident liked to read but she did not know if she could read without her glasses. Picture books and novels were observed readily available in the resident's room and there was no evidence of a prescription pair of eyeglasses. Activity Director #594 found a pair of unlabeled, non-prescription reader glasses at the nursing station and placed them on the resident. On 08/08/24 at 8:50 A.M., interview with State tested Nurse Aide #112 stated she was unaware of any prescription glasses for Resident #21. (continued on next page)

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	366190	A. Building B. Wing	08/16/2024

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Belmont Manor	51999 Guirino Drive St Clairsville, OH 43950

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/08/24 at 9:55 A.M. and 10:05 A.M., interview with the Director of Nursing (DON) states the resident was seen by the eye doctor in January 2024 and did not need a new prescription pair of glasses but was not aware that the resident's glasses were missing or she would have called for a replacement. The DON stated the resident's glasses must have been lost between 05/22/24 and 08/08/24 because she had them at the time of the comprehensive assessment. The DON verified the vision assessment did indicate prescription glasses were needed for Resident #21. Review of the policy: Ancillary Services (dated January 2024) revealed facility will offer ancillary services including ophthalmology and residents/family can decline an utilize personal choices for these services. Dental will make visits schedules annually or by treatment plan as written. Ophthalmology will make visit schedules annually or by treatment plan as written. If resident presents with any emergency type needs, the emergency services department for ancillary services, as listed above will be contacted to make appointment for visit.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 26706 Based on observation, record review and interview, the facility failed to ensure pressure relieving measures were in place as ordered. This affected one resident (#34) of three residents reviewed for pressure ulcers. Findings include: Review of Resident #34's medical record revealed a 06/27/24 admission with diagnoses including pressure induced deep tissue damage of sacral region, systemic lupus erythematosus, age related osteoporosis with current pathological fracture, urinary incontinence, fracture of neck of right femur, joint replacement surgery, anemia, type 2 diabetes with polyneuropathy,, hyperglycemia,, vitamin D deficiency, depression, paroxysmal vertigo of right ear, hypertension, atrial fibrillation, peripheral vascular disease, panlobular emphysema, gastroesophageal reflux disease, duodenal ulcer, constipation, lack of coordination, repeated falls, cognitive communication deficit, fracture of one right rib, need for assistance with personal care, artificial left hip joint and cerebral infarction. The resident had a fall on 07/10/24 with fracture of right hip. The resident was readmitted from the hospital 07/15/24 with a suspected deep tissue injury (SDTI) (Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister), pressure ulcer to the sacrum 5 centimeters (cm), x 7cm x unable to determine depth. The pressure ulcer plan of care included an intervention dated 07/19/24 to encourage to float heels while in bed. Review of the 07/22/24 five day MDS included the resident was independent for daily decision making, had no behaviors, risk of pressure ulcers, one unstageable pressure ulcer, surgical wound, pressure reducing bed and chair, turning and repositioning, needs partial assist of one for bathing, toileting, dressing, walking, and uses a walker and wheelchair. The resident had no upper extremity functional impairment, and had bilateral lower extremity functional impairment. The resident was dependent for rolling in bed, sit to lying, lying to sitting and dependent for sitting to standing. A 07/28/24 Health Status Note included the discovery of a SDTI to left heel 6cm x 5.5 cm purple/maroon in color. Area intact and slightly mushy. Some complaints of discomfort to the area when being assessed. A 08/01/24 left heel assessment included the pressure ulcer was 5.3 cm x 6 cm x unable to determine SDTI, blood blister. Observation on 08/05/24 at 1:31 P.M. revealed Registered Nurse (RN) #528 and State tested Nurse Aide (STNA) #104 were applying hand sanitizer leaving the residents room after putting her into bed. The surveyor entered the room as the staff was exiting. Resident #34 stated her left heel is killing her. The resident's left heel was not floating off a pillow. Resident #34's heel was resting on a pillow not floating off the pillow. The resident had slipper socks on. The resident was verbally prompted to reposition her foot. She was unable to move her foot enough to reposition. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	STNA #222 was in the hall and was alerted Resident #34 needed assistance. On 08/05/24 at 1:36 P.M. STNA #222 verified the resident's heel was resting on the pillow not floating off the pillow as ordered. This deficiency represents non-compliance investigated under Complaint Number OH00155816.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on observation, record review, policy and interview, the facility failed to ensure restorative services were initiated, assessed, reviewed and revised if needed. This affected three residents (#12, #21, and #46) of four residents reviewed for positioning, mobility and limited range of motion. Findings include: 1. Review of Resident #12's medical record revealed a 10/16/19 admission with diagnoses including Parkinson disease, end stage renal disease, Tourette's disorder, schizoaffective disorder, rheumatoid arthritis, neuromuscular dysfunction of bladder, benign prostatic hyperplasia with lower urinary tract symptoms, and moderate intellectual disability. The resident had a plan of care initiated 04/28/22 for impaired self performance of bed mobility, Related to rheumatoid arthritis, Parkinson;s disease, age related osteoporosis, osteoarthritis, and dementia with behavioral disturbance. Interventions included 01/20/23 assistance with placement of soft palm guard to both hands at ALL times EXCEPT for meals & hygiene. Explain what you are going to do prior to program. Provide gentle passive range of motion (ROM) to upper extremity, after/before splint is removed/applied. Cleanse affected area of skin and dry thoroughly. Inspect skin for redness, irritation. Bed mobility program initiated 06/29/23 six to seven days per week at least 15 minutes per day, once a day. Prompt and assist to participate, once a day with two persons assist and frequent verbal cue for technique, encouragement, stay on task. Encourage resident to roll from one side of bed to the other reaching arm across to grab opposite side of bed for support. If program is initially refused, offer again at a later time that shift. Praise for efforts and success and provide encouragement through the entire program. Watch for fatigue and provide rest periods as needed. Active Assist ROM to bilateral upper extremities initiated 10/25/23. Do three sets, 10 reps daily, at least 15 minutes per day 6/7 days per week. Assist as needed and cue for proper technique and to stay on task. If program is initially refused, offer again at a later time that shift. Praise for efforts and success and provide encouragement through the entire program. Watch for fatigue and provide rest periods as needed. Active assist ROM to bilateral lower extremities initiated 06/13/24. Do three sets, 10 reps daily, at least 15 minutes per day six to seven days per week. Assist as needed and cue for proper technique and to stay on task. If program is initially refused, offer again at a later time that shift. Praise for efforts and success and provide encouragement through the entire program. Watch for fatigue and provide rest periods as needed. Review of the 06/26/24 quarterly Minimum Data Set Assessment (MDS) included the resident was moderately impaired for daily decision making, had an indwelling catheter and upper and lower extremity impairment on both sides. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/05/24 at 1:12 P.M. revealed the resident was in bed with his eyes closed. Noted to have bilateral hand and wrist contractions without splints in place. Review of the aide TASK electronic documentation revealed the restorative programs were being signed off daily as completed with an occasional refusal. Review of restorative notes revealed the last note was 03/22/24. The restorative note included resident was current with restorative for bed mobility, range of motion extremities and bilateral palm guard placement. Transferred via Hoyer lift. Dependent with functional abilities and activities of daily living. Totally incontinent, able to feed self, dwelling catheter remains in place for abnormal muscular dysfunction of bladder. Goals are for patient to participate in care as able, not suffered decline in range of motion, and urinary tract infections. The restorative note did not address how the resident was tolerating and participating in the restorative programs. The note did not include whether the programs needed increased or decreased related to response. The note did not show the programs were being monitored to determine advancing as appropriate or decline. The facility was completing quarterly therapy screens and quarterly mobility screens but was not assessing each restorative program to determine continued appropriateness. Review of the restorative nursing services policy (reviewed 01/2024) included residents will receive nursing care as needed to help promote optimal, safety and independence. Restorative goals and objectives are individualized, resident centered and are outlined in the resident plan of care. The policy did not include conducting quarterly updates. Interview on 08/05/24 at 6:57 P.M. with Registered Nurse (RN) #522 verified the resident did not have palm guards on as ordered. She looked in the resident's room for the palm guards and found a left palm guard in the drawer and none for the right hand. Interview on 08/08/24 at 4:22 P.M. with Licensed Practical Nurse (LPN) #544 revealed she does not complete quarterly assessments of the restorative programs. Licensed Practical Nurse #544 included therapy screens and mobility assessments were competed to assess a decline in abilities. The restorative programs were not individually addressed. 28704 2. Medical record review revealed Resident #21 was admitted on [DATE] with diagnoses including non-traumatic brain dysfunction, Alzheimer's disease, arthritis, hip fracture, psychotic disorder, and unsteadiness on feet. Review of the Restorative Nursing programs revealed the following: a. Active ROM (range of motion) to upper extremities dated 10/29/20 revealed to complete one set of 10 reps daily for 15 minutes at least six to seven days per week. b. Active ROM to lower extremities dated 06/06/23 revealed to complete one set of 20 reps daily for 15 minutes at least six to seven days per week. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the annual Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #21 was severely impaired for daily decision-making and had functional limitations of bilateral upper and lower extremities. Review of the electronic Task Documentation dated May, June and July 2024 revealed the restorative programs were provided for 15 minutes. There was no evidence in the medical record if cues were provided, if the resident was able to complete without rest periods, quarterly evaluations or evidence the program had been revised since the programs were initiated. Review of the care plan: At Risk for Impaired Functional ROM dated 10/29/2020 with goals to maintain or have no decline through 11/14/24. The programs written included Active ROM to bilateral upper and lower extremities once a day, one set of 10 repetitions for 15 minutes six to seven days a week with interventions included to reassess quarterly. 3. Medical record review revealed Resident #46 was admitted on [DATE] with diagnoses including non-Alzheimer's type dementia, anxiety and arthritis. Review of the Nursing Admission Evaluation dated 02/27/24 revealed the resident required supervision with bed mobility, transfers, mobility and personal hygiene. The resident had no balance concerns, was oriented to person and place, and continent of bowel and bladder. Review of the Physical Therapy (PT) Discharge Summary dated 03/27/24 revealed Resident #46 was discharged independent with transfer with no verbal cues, ambulating 350 feet independently using hand held assist on level surfaces and independent with bed mobility. Discharge recommendations included established/trained restorative programs for ambulation and transfers. The patient was currently able to walk in corridor, balance was steady and with restorative nursing program the patient will be able to walk in corridor with assist of none and balance stable by allowing her to take her time and encourage participation. The patient was currently able to perform stand pivot transfers with a restorative nursing program. The patient will be able to stand and pivot independently by performing the following restorative nursing interventions and document any change in abilities. Prognosis was good with consistent staff follow through. Outcome risks including lacks insight into condition and risk factors and PT/caregiver agreeable to PT plan of care and goals. Review of Licensed Practical Nurse (LPN) #544 Restorative Note dated 03/28/24 revealed Resident #46 was discharged from therapies as maximum potential was reached. The resident ambulates independently throughout the facility. Referred to restorative for ROM to extremities. There was no documentation as to why ambulation or transfer programs were not implemented as recommended. Review of the PT Discharge Summary dated 07/03/24 revealed Resident #46's baseline on 05/24/24 was 75 feet with partial/moderate assistance with ambulation, static standing was fair-/poor+, partial/moderate assistance to perform bed mobility with 50% verbal cues, and partial/moderate assistance with transfers. At the time of discharge on 07/03/24 the resident was ambulating 300 feet with supervision or touching assistance. Discharge Recommendations included restorative ambulation and transfer programs. Prognosis was good with consistent staff follow-through. Decline in mental, emotional or behavioral status in past three months and currently reports exhaustion. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the record revealed no evidence a restorative nursing ambulation or transfer program was written or implemented between 03/27/24 and 05/24/24 or between 07/03/24 and 08/07/24 as recommended by PT. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #46 was severely impaired for daily decision-making, required extensive assistance with transfers, bed mobility of two persons, and had no functional limitations of upper or lower extremities. The resident did not receive restorative ambulation or transfer programs and had received therapy between 05/24/24 and 07/03/24. Review of the care plan: Potential for Impaired ROM revised 03/28/24 revealed to complete active assist ROM to upper extremities and reassess quarterly and as needed. On 08/08/24 at 3:08 P.M., interview with LPN #544 stated she was the facility restorative nurse and recently found out that she was not completing restorative notes as required. LPN #544 verified she had not been evaluating the restorative programs, including Resident #21 and #46, for declines or improvements, the programs had not been changed or evaluated for effectiveness. On 08/08/24 at 5:21 P.M., reviewed the PT Discharge Summary dated 03/27/24 and 07/03/24 with LPN #544. LPN #544 stated when a resident was discharged from therapy services recommendations were reviewed, discussed and individualized to each resident as needed. LPN #544 stated Resident #46 was independent in ambulation, walked around everywhere and she felt the resident did not need a restorative program for ambulation or transfers; therefore, a program was not initiated as recommended. LPN #544 reviewed the record and verified there was no consistent staff follow through as recommended and no evidence as to when the resident started to decline in ambulation/mobility or transfers until a therapy screened the resident for a MDS assessment. LPN #544 also stated the resident was having behaviors and medication changes and that was the focus of her care. On 08/08/24 at 5:50 P.M., interview with the Director of Nursing (DON) and LPN #544 verified Resident #46 had declined twice in ambulation and transfers requiring physical therapy to restore her to her previous level of functioning. Once the resident had met maximum potential, therapy discharged the resident with recommendations for nursing restorative programs; however, the restorative therapy referral did not match what was written in the therapy discharge recommendations. The DON acknowledged therapy recommendations were made with no evidence of implementation and no documentation as to why the therapy recommendations were not implemented. On 08/12/24 between 12:48 P.M. and 1:22 P.M., observation revealed Resident #46 ambulated 708 feet with a front wheeled walker with Physical Therapy Assistant (PTA) #700 and Certified Occupational Therapy Assistant (COTA) #701. On 08/12/24 at 11:49 A.M., interview with LPN #544 verified Resident #46 had not received restorative ambulation and the record included a care plan to increased Assistance with an intervention for ambulation six to seven days but stated this was an auto-populated intervention and was not implemented or accurate. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy: Restorative Nursing Services (revised January 2024) revealed residents will receive restorative nursing care as needed to help promote optimal safety and independence. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services. Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehab care. Restorative goals and objectives are individualized and resident-centered, and outlined in the plan of care.

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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** 28704 Based on observation, medical record review, fall investigation review, policy review and interview, the facility failed to implement interventions and complete accurate investigations to prevent further falls. This affected one resident (#46) of three residents reviewed for accidents. The census was 51. Findings include: Medical record review revealed Resident #46 was admitted on [DATE] with diagnoses including non-Alzheimer's type dementia, anxiety and arthritis. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #46 was severely impaired for daily decision-making and had one fall without injury since the last assessment. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #46 was severely impaired for daily decision-making, required extensive assistance with transfers, bed mobility of two persons, had two or more falls with no injury, had received therapy services and did not use any alarms or restraints. Review of the admission Fall Risk assessment dated [DATE] revealed Resident #46 was at moderate risk for falls. Review of the Nursing Notes revealed Resident #46 had sustained a fall on 06/05/24. There was no fall care plan prior to this date. Review of the Fall Investigations revealed the following: a. Dated 07/06/24, the resident tripped and fell when ambulating into another resident's room. Review of the record revealed no evidence of the fall resulting in two abrasions. The investigation did not indicate what interventions were in place at the time of the fall, no immediate intervention was implemented, the resident's klonopin (anxiolytic) was ordered to be increased and neurological checks were not completed per policy. b. Dated 07/08/24 at 6:30 A.M., the resident followed a hospice aide into another resident room pacing quickly, tripped over hoyer lift and fell to floor. No immediate or new intervention was implemented. c. Dated 07/08/24 at 6:45 P.M., the resident was ambulating on the unit, stumbled over her own feet, fell to her buttocks and hit the back of her head on the floor. The fall investigation did not indicate the resident had received an anxiolytic at 4:30 P.M. or that the resident had sustained a fall earlier that day and neurological checks were not completed per facility policy. d. Dated 07/10/24 at 5:15 P.M., resident was found laying on floor by wheelchair with seatbelt unfastened. No immediate fall intervention was implemented to prevent further falls, the investigation was inaccurate for PRN (as needed) medications administered prior to the fall and neurological checks were not complete per facility policy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/06/24 at 2:23 P.M., observation revealed Resident #46 was seated in a specialized tilt wheelchair with the seat dropped wearing an alarming velcro seatbelt and chair alarm activated. Review of the medical record revealed no evidence Resident #46 had a fall care plan developed until after her first fall on 06/05/24. Once a fall care plan was developed, it was not implemented as written. On 08/12/24 at 11:49 A.M., interview with the Director of Nursing verified the above. Review of the Policy: Fall (revised January 2024) included to implement immediate intervention to prevent further falls if applicable and update the plan of care. The assessment actions will be thoroughly documented in the medical report. Neurological assessments will be done for seven days post fall for resident with known head injury or impaired cognition resident who had an unwitnessed fall and all assessment to be completed upon admission, quarterly and after each fall.

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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. 26706 Based on observation, record review, policy review, and interview, the facility failed to ensure treatment and care was provided as ordered for a resident with a history of urinary tract infections and urinary catheter. This affected one resident (#6) of one resident reviewed for urinary catheter. Findings include: Review of Resident #6's medical record revealed an admission on 05/11/23 with diagnoses including flaccid neuropathic bladder, neurogenic bladder, retention of urine, history of urinary tract infections, urinary incontinence, atherosclerosis of native arteries of right leg with ulceration of heel and midfoot, peripheral vascular disease and type 2 diabetes. The resident had a positive urinary tract infection from Escherichia Coli >100,000 on 05/18/23 and was treated with Keflex. A positive urinary tract infection from Escherichia Coli on 12/12/23 was treated with Levoquin. The resident returned from the hospital on 12/27/23 with an indwelling urinary catheter due to retention and urinary tract infection. A plan of care for catheters revealed the catheter places the resident at risk for urinary tract infection. A readmission physician order and intervention included catheter care daily and every shift. A 01/08/24 urine culture showed no growth. A 02/05/24 urinary tract infection was treated with Rocephin for Proteus Mirabillis. The resident had a 03/13/24 appointment with an infectious disease specialist due to recurrent urinary tract infections. The physician recommended topical estrogen 1 gram intravaginally two to three times a week, perineal hygiene, avoid fecal contamination, urology evaluation and reassessment of need for chronic indwelling catheter. She did not recommend antibiotic prophylaxis at this time to avoid selection for multi drug resistant organisms. Urine cultures should be obtained from a newly placed catheter, with a follow up in three months. There was no evidence of the resident having a reevaluation with the urologist to reassess the need for an indwelling catheter. There was no evidence of the topical estrogen 1 gram intravaginally two to three times a week being administered despite the recommendation and nurse note indicating it was ordered. The resident was started on Augmentin 03/16/24 for a urinary tract infection with enterococcus faecalis and klebsiella oxytoca. A 03/27/24 urinalysis resulted in Candida Glabrata treated with Diflucan. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Manor	51999 Guirino Drive St Clairsville, OH 43950

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow up visit 06/12/24 with the infectious disease specialist included a recommendation to start topical estrogen Vagifem 10 micrograms (mcg), 1 tab intravaginally daily for two weeks followed by twice weekly for three months. Recommending only sending urine culture when symptomatic, and follow up with urology. There was no evidence of a follow up visit with the urologist as recommended. Review of the 07/21/24 Quarterly Minimum Data Set Assessment revealed the resident was moderately impaired for daily decision making, functional impairment in both lower extremities, used a walker and a wheelchair, dependent for rolling left to right, and lying to sitting, has an indwelling catheter, at risk for pressure ulcer and has one vascular ulcer. The facility staff worked 12 hour shifts 6:00 A.M. to 6:00 P.M. and 6:00 P.M.-6:00 A.M. Review of the Task in the aide electronic documentation revealed the resident did not received foley catheter care every shift as ordered. In the last 30 days catheter care was provided once a day not once a shift on 07/12/24, 07/15/24, 07/18/24, 07/24/24, and 08/04/24. On 08/04/24 urine was obtained for a urinalysis. There was no evidence of the urine being obtained from a clean foley per infectious disease specialist recommendation. Review of the treatment sheet revealed the foley was last changed 07/23/24. The 08/04/24 urinalysis result was mixed commensal flora. The resident was on ceftriaxone for pneumonia at the time and no other treatment was ordered. Observation on 08/05/24 at 11:49 A.M. revealed the resident was in a low bed. She had an indwelling urinary catheter with the bag hanging on the side of the bed. The catheter bag was not covered, there was white sediment in the tubing and bag. Review of the facility policy and procedure for Catheter Care (last reviewed 01/2024) included catheter care will be performed by the nurse aid every shift. Interview on 08/08/24 at 10:20 A.M. with Registered Nurse (RN) #522 verified the resident did not have a follow up visit with the urologist. The facility has since called and scheduled an appointment in September 2024. There was no topical estrogen intravaginally administered as recommended after the March consult with the infectious disease specialist. RN #522 verified catheter care was not signed off each shift as ordered. RN #522 verified there was no supporting evidence of the urine collected on 08/04/24 being collected from a clean foley catheter as ordered. This deficiency represents non-compliance investigated under Complaint Number OH00155816.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on medical record review, observation and interview, the facility failed to ensure a resident with a significant weight loss received medications, supplements and routine meals. This affected one resident (#46) of two residents reviewed for nutrition. The census was 51. Findings include: Medical record review revealed Resident #46 was admitted on [DATE] with diagnoses including non-Alzheimer's dementia, anxiety, major depressive disorder, breast cancer and diabetes mellitus type 2. The resident's admission weight was 110.6 pounds (#). Review of the Nutritional Sheet Version 1.5 revealed: -dated 03/04/24 revealed resident weight 110.6# with a BMI of 21.6 indicating a healthy weight. Tolerating diet with intakes averaging 86% with no chewing or swallowing difficulties. Dietitian to follow and address nutrition concerns as appropriate. -dated 06/13/24 revealed resident weight 112.2# with a BMI of 21.9 indicating a healthy weight. , no significant weight loss. Tolerating diet with intakes averaging 65% with no chewing or swallowing difficulties. RD to follow and address nutrition concerns as appropriate. -dated 07/09/24 revealed Resident #46 weighed 107#, was alert and able to feed self, and had no chewing or swallowing difficulty. Has had a 4.6% weight loss in one month but not considered significant. May benefit from a nutritional supplement to promote kcal intake and weight maintenance. Recommended 60 milliliters of nutritional supplement twice a day. Review of the Physician Progress Note dated 06/11/24 revealed Nurse Practitioner (NP) #601 ordered to start Remeron (antidepressant) 15 milligrams at bedtime for sleep and mood and resident's daughter agreed. Review of the drug manufacturer guidelines revealed side effects included increased appetite. There was no evidence Remeron was transcribed or started on 06/11/24 as ordered. Review of the Weight Change Note dated 07/30/24 revealed Dietitian #532 notified Resident #46's physician of a 13# (12.1%) weight loss in a month; 18.2# (16.2%) weight loss in three months and a 16.6# (15%) weight loss in five months. Current weight was 94# with a BMI of 18.4 indicating borderline underweight. Resident meal intake was fair, weight loss noted, receiving 60ml nutritional supplements twice a day (since 07/09/24) and new order to start mighty shakes three times a day. Review of the note revealed no evidence the dietitian was notified of the restraint use or psychotropic medications. Review of the care plan: No Nutritional Triggers at present dated 03/05/24 revealed interventions included to honor preferences, provide diet as ordered, record intakes every meal and weight per policy. The physician was to be notified of a significant weight change. The care plan had not been revised to reflect the resident's weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/07/24 between 7:22 A.M. and 8:50 A.M. and on 08/08/24 at 8:21 A.M., observation of the breakfast meal revealed Resident #46 was sleeping on the couch in the main lobby area. The resident continued to sleep through the morning meal and staff did not offer the resident a nutritional supplement or alternative meal. On 08/08/24 at 11:55 A.M., interview with State tested Nurse Aide (STNA) #112 verified Resident #46 had been sleeping all morning and had not eaten breakfast, was not offered a substitute or ordered supplements. On 08/08/24 at 12:05 P.M., observation revealed STNA #100 and STNA #112 staff assisted Resident #46 up to the specialty wheelchair and pushed her up to the dining room table with her seatbelt attached. Resident #46 stated she was a little hungry and was observed eating and drinking independently her lunch meal including chips, a sub sandwich, macaroni salad and juice independently. On 08/12/24 at 9:53 A.M., interview with NP #601 verified Remeron had been ordered but not started, a common side effect of Remeron was an increase in appetite and this could have helped Resident #46's meal intakes. On 08/12/24 at 10:55 A.M., interview with the Director of Nursing (DON) stated the documentation regarding the Remeron was not clearly written and verified it indicated the resident's daughter agreed to the new orders and it should have been started. On 08/12/24 at 11:09 A.M., interview with the DON verified the nutrition care plan was not revised. On 08/12/24 at 11:49 A.M., interview with the DON verified Resident #46 had a recent significant weight loss and during the survey the resident had slept through two meals. The DON stated when she spoke to the staff they told her that they normally would have warmed up the breakfast tray for the resident when she woke up but they did not because the surveyor was on the unit. On 08/14/24 at 10:46 A.M., interview with the DON verified the meal percents and nutritional supplements were documented as refused because the resident slept through the meal. The DON stated staff should have provided a meal, nutritional supplement or substantial snack once the resident was awake.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on medical record review, medication guide review,policy review, and staff interview, the facility failed to provide monitoring for side effects with the use of a psychoactive medication. This affected one resident (#46) of three residents reviewed for unnecessary medications. Findings Include: Medical record review revealed Resident #46 was admitted on [DATE] from the community with diagnoses including dementia, anxiety, major depressive disorder and diabetes mellitus type 2. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #46 was severely impaired for daily decision-making with diagnoses including diabetes mellitus. Review of the electronic Physician Orders dated 07/10/24 revealed to start Rexulti (antipsychotic) 0.5 milligrams one tablet daily. Review of the July and August 2024 Medication Administration Record revealed Resident #46 had received Rexulti daily since 07/11/24. Review of the medical record revealed no baseline AIMS (Abnormal Involuntary Movement Scale) assessment or monitoring of blood glucose had been completed since Resident #46 started Rexulti. Review of the Medication Guide: Rexulti (revised May 2024) revealed Rexulti may cause serious side effects including uncontrolled body movements (tardive dyskinesia) and problems with your metabolism such as high blood sugar (hyperglycemia) and diabetes. Increases in blood sugar can happen in some people who take Rexulti. Extremely high blood sugar can lead to coma or death. Your healthcare provider should check your blood sugar before you start, or soon after you start Rexulti and then regularly during long term treatment with Rexulti. On 08/12/24 at 11:10 A.M., interview with the Director of Nursing (DON) verified Resident #46 had a diagnosis of diabetes mellitus and was not receiving routine monitoring of her blood glucose as recommended with the use of Rexulti. On 08/12/24 at 11:42 A.M., interview with the DON verified there was no AIMS completed upon initiation of Rexulti. Stated the pharmacist identified this as well and the nurse is doing one now. On 08/12/24 at 11:49 A.M., interview with Licensed Practical Nurse (LPN) #544 verified she did not complete an AIMS assessment as required for Resident #46 prior to taking Rexulti. Review of the Policy: Psychoactive Medication (revised January 2024) revealed psychoactive medication shall not be used only for inappropriate reasons and if these drugs are being used or going to be used in treating a resident, the Abnormal Involuntary Movement Scale (AIMS) will be done by a nurse initially and then every three months.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on record review and interview, the facility failed to ensure an as needed antianxiety medication had a 14 day stop date, and an antipsychotic medication had behaviors documented and an indication for use. This affected two residents (#22 and #46) of five residents reviewed for unnecessary medication. The facility census was 51. Findings include: 1. Review of Resident #22's medical record revealed a 03/09/24 admission with diagnoses including encounter for fitting and adjustment of urinary device, pressure ulcer of right lower back, encounter for palliative care, retention of urine, cerebral infarction, dementia, osteomyelitis of vertebra, need for assistance with personal care, and anxiety. Review of a Significant Change MDS dated [DATE] for initiation of hospice care included the resident was severely impaired for daily decision making, dependent for personal hygiene, dependent on rolling in bed, had bilateral lower leg functional impairment, and had a Stage IV pressure ulcer (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location). The resident received opioids. A hospice order dated 07/03/24 included ativan 0.5 milligrams (mg) one tablet every four hours as needed for anxiety, terminal and restlessness. There was no stop date ordered. Review of the facility Psychoactive Medication policy (reviewed 01/2024) included residents cannot be given psychoactive drugs on an as needed basis. Psychoactive medication could be used as needed if the resident is already on a routine dosage given regularly. As needed usage would be for acute episodes of inappropriate behavior with the behavior documented on behavior data collection. If a resident is on a psychoactive agent ONLY on a PRN basis the physician will be asked to (gradually, if need be) discontinue the PRN psychoactive drug. The policy did not include a 14 day limit for PRN psychotropic medication's. Interview on 08/09/24 at 2:29 P.M. with the Director of Nursing (DON) verified hospice ordered an antianxiety medication as needed without a stop date. The DON verified more than 14 days had passed since the date the medication was ordered. 28704 2. Medical record review revealed Resident #46 was admitted on [DATE] from the community with diagnoses including dementia, anxiety, major depressive disorder and diabetes mellitus type 2. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Review of the Progress Note dated 07/04/24 revealed Resident #46 was extremely agitated, very emotional, had been nonstop walking back and forth in the unit. Resident #46 was so tired but would not stop long enough to relax and was stumbling because she was so exhausted. Nurse Practitioner (NP) #601 was notified and ordered to increase Klonopin to three times a day and also gave an order for a one-time dose of Haldol 1 milligram (mg) which the resident took without difficulty. Review of the electronic Medication Administration Record (MAR) dated July 2024 revealed PRN (as needed) Xanax (anxiolytic) 0.25 (mg) every four hours as needed was administered on 07/04/24 at 11:17 A. M. that was documented as being effective. No other dose of Xanax PRN was administered on 07/04/24. Further review of the July 2024 MAR revealed a one-time dose of Haloperidol 1 (mg) was administered on 07/04/24 at 5:45 P.M. for anxiety. The resident was not receiving a routine antipsychotic medication as of 07/04/24. Review of the nurse practitioner (NP) #601's Physician's Progress Notes dated 07/05/24 revealed Resident #46 was seen for a follow-up after recent medication changes and a one-time order given for Haldol on 07/04/24. NP #601 stated the resident had slept last night, and was currently calm, oriented to person only and very confused. On 08/12/24 between 9:40 A.M. and 9:53 A.M., interview with NP #601 stated Resident #46 has been seen multiple times since admission for challenging behaviors and exit seeking prior to residing on the secured unit. NP #601 stated when staff called her regarding the resident's increased behaviors on 07/04/24 they did not tell her the Xanax was effective earlier in the day. Staff stated the resident needed something else as she was highly agitated but she was not aware the resident had received a dose of Xanax at 11:16 A.M. and that it was documented as effective. NP #601 stated she would not have ordered a PRN antipsychotic knowing the resident could have received another dose of the Xanax. NP #601 verified there should be documentation of behaviors prior to the administration of PRN anxiolytic's and the record should accurately reflect the residents condition. b. Review of the June 2024 monthly electronic Physician Orders revealed PRN medications included Vistaril 50 (mg) every four hours PRN for anxiety. Review of the July 2024 monthly electronic Physician Orders revealed PRN medications included Xanax 0. 25 (mg) every four hours PRN for anxiety. Review of the medical record including the electronic MAR revealed Resident #46 was administered the following PRN anxiolytic's without behavior documentation: On 06/02/24 at 9:30 P.M., administered PRN Vistaril 50 (mg). On 06/11/24 at 11:00 P.M., administered PRN Vistaril 50 (mg). On 07/24/24 at 1:23 P.M., administered PRN Xanax 0.25 (mg). Review of the care plan: Behavior Problem related to dementia revised 07/04/24 revealed interventions included to monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations and document the behavior and potential causes. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/12/24 at 10:55 A.M., interview with the Director of Nursing (DON) stated behavior documentation was documented in the Progress Notes and on the MAR. The DON verified there was no behavior documentation for the above PRN anxiolytic's in the medical record. On 08/12/24 at 11:42 A.M., interview with the DON verified there was no AIMS completed upon initiation of Rexulti. On 08/12/24 at 11:49 A.M., interview with Licensed Practical Nurse (LPN) #544 verified she did not complete an AIMS assessment as required for Resident #46. Review of the policy: Psychoactive Medication (revised January 2024) revealed psychoactive medication shall not be used only for inappropriate reasons such as : wandering, crying out or uncooperative behavior. If the resident is displaying behaviors, document the specific behavior in nurses' notes or behavioral monitoring tool and behaviors on data collection tool when the resident is given PRN psychoactive medication. If these drugs are being used or going to be used in treating a resident, the Abnormal Involuntary Movement Scale (AIMS) will be done by a nurse initially. Document the behavioral interventions tried in the nurses' notes. Residents cannot be given psychoactive drugs on an as needed basis. Psychoactive could be used PRN if the resident is already on a routine dosage given regularly. Such PRN usage would be for acute episodes of inappropriate behavior.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 26706 Based on observation, test tray, and interview, the facility failed to ensure food was pureed to the correct consistency. This affected four residents (#14, #17, #22 and #23) who receive a pureed diet. The facility census was 51. Findings include: Observation of the pureed process took place on 08/07/24 at 4:31 P.M. with Dietary #570. Dietary #570 pureed barbeque chicken, rice pilaf and mixed vegetables following the recipe and under sanitary conditions. After pureeing each food type she placed them in plastic containers, covered each with foil and placed them on the steam table to serve for the supper meal. Dietary #570 did not taste the chicken, rice or vegetables for texture after they were pureed. On 08/07/24 at 4:45 P.M. the surveyor completed a test tray. The chicken was tasted for consistency. It was fibrous and not pureed to a creamy consistency. The rice was smooth and the correct consistency. When the vegetables were tasted, there was visible bits of green and orange vegetables. It was visible the vegetables were not fully blended. To taste, the vegetables were in pieces, lumpy, not a smooth consistency. Dietary #570 verified at the time of the tasting the chicken and vegetables were not pureed to a smooth consistency. Review of the facility Pureed Diet policy (reviewed 06/18/17) included those with swallowing difficulties require modified texture to reduce the risk of aspiration or choking. The use of a pureed diet may reduce this risk and improve a resident's ability to consume adequate nutrition. Pureed food should be smooth and lump free, and served at a pudding or mashed potato consistency. Pureed soups and other liquids may be served thin if the resident does not require thickened liquids.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 26706 Based on observation, record review, policy review and interview, the facility failed to ensure sanitary kitchen practices. This had the potential to affect all the individuals in the facility except for Resident #9 who did not receive nutrition from the kitchen. The facility census was 51. Findings include: 1. Observation of the kitchen [DATE] at 8:26 A.M. of Dietary #572 revealed she was washing dishes. Interview at the time of the observation revealed Dietary #572 thought the facility had a high temperature dishwasher. There were dishes that have been run through the dishwasher on the draining board. Dietary #576 did not know if they had a high or low temperature dishwasher. The surveyor noticed the facility had a low temperature chemical dishwasher. Dietary #572 was asked if she could test the sanitation in the dishwasher. Dietary #572 said she does not usually test the dishwasher, and stated Dietary #588 does the testing. Dietary #572 found a container of chlorine strips on the top of the dishwasher. She removed a strip opened the dishwasher and swished a strip around in the water. She checked the strip against the grid on the container and it measured 100 parts per million. Observation of the container of strips revealed they had expired in [DATE]. The instructions included to dip strip in water and remove. Dishwasher #572 had agitated the strip in the water. Observation of a storage cabinet revealed an additional container of chlorine strip that expired in [DATE] and a container that had expired in 2021. The facility had no strips that had not expired. Observation of the dishwasher temperature during the wash and rinse cycle revealed the gauge had a clouded covering making it difficult to read the gauge. Dishwasher #572 said she was guessing the temperature gauge was reading 120 degrees Fahrenheit. Review of the [DATE] dishwasher temperature log revealed on [DATE] there was no water temperature or sanitation level documented for breakfast. There was no lunch dishwasher water temperature or sanitation level recorded for [DATE]. Review of the undated Dishwashing policy included dishwasher temperature will be 120 Fahrenheit or greater. The policy did not address chemicals or sanitation level. Review of the Dishwasher Parts Per Million (PPM) and Temperature Log included the range of PPM was to be 50 PPM minimum and 200 maximum. Dishwasher #572 verified during the observations and interview, the dishwasher temperature and sanitation level had not been obtained that morning before starting breakfast dishes. She verified she did not know if they had a high or low temperature dishwasher. Further verified the chlorine strips had expired and she was unsure of the testing technique. Dietary #572 verified the water temperature gauge was clouded and difficult to read. 2. Observation [DATE] at 8:42 A.M. revealed the deep fryer oil was covered with debris. There were white/yellow flakes of food covering the oil. When the build up of debris floating on the oil was separated the oil appeared black. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview at the time of the observation with Dietary #588 included the debris on the oil was tater tots. Dietary #588 said the oil turns black when they cook onion rings in the oil. Dietary #588 included maintenance cleans the oil every Friday. Review of the deep fryer cleaning log revealed the last time the oil was filtered was on [DATE]. The last time the deep fryer oil was changed was [DATE], over a month since the oil had been changed. Review of the Deep Fryer Cleaning log for 2024 revealed oil was changed twice in January and not filtered. The oil was changed twice in February and not filtered. In March the oil was filtered twice and changed once. In April the oil was filtered twice and changed once. In May the oil was changed twice and filtered once. In June the oil was changed once and filtered once. The oil was changed on [DATE] and not changed again until [DATE] going a month between change. Review of a [DATE] Procedure for Cleaning Deep Fryer included -Deep fryer is to be emptied and cleaned every other week, according to policy, with fresh fryer oil added after this cleaning. -Deep fryer oil is strained of debris weekly and fresh oil added as needed. Deep fryer should be kept clean by wiping it down as needed. Interview on [DATE] at 10:24 A.M. with Maintenance #556 revealed the oil was to be changed every other week and filtered on opposite weeks. He thought they only used the fryer on Friday but the deep fryer should be addressed weekly. Maintenance #556 said he gets to it when he can. When he is on vacation no one does anything. The deep fryer oil waits for him. Maintenance #556 verified the oil was not changed or filtered weekly. 3. Observation of the walk-in refrigerator [DATE] at 8:51 A.M. with Dietary #588 revealed macaroni salad made on [DATE] was to be discarded on [DATE] was still stored in the refrigerator. Review of the facilities Leftover Food policy dated [DATE] included foods may be stored up to seven days for reserving and then discarded. Dietary #588 verified at the time of the observation the macaroni was not discarded on [DATE] per policy. 4. Observation of the ice maker in the hall outside the kitchen [DATE] at 9:01 A.M. revealed the scoop was on top of a clear three drawer bin. The top of the plastic bin was soiled with brown. The top drawer had two silver metal scoops in it. There were visible hairs at the bottom of the drawer. The second and third drawers were empty, but had debris on the bottom. Interview with Dietary #588 at the time of the observation revealed the scoop holder broke. The one she ordered was not the correct size and she ordered another. She verified the ice scoop was on the soiled top of the bin. was not contained to keep it clean.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366190	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Manor	51999 Guirino Drive St Clairsville, OH 43950

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on record review and interview, the facility failed to ensure an accurate medical record. This affected two residents (#22 and #46) of 19 residents reviewed. The facility census was 51. Findings include: 1. Review of Resident #22's medical record revealed a 03/09/24 admission with diagnoses including encounter for fitting and adjustment of urinary device, pressure ulcer of right lower back, encounter for palliative care, retention of urine, cerebral infarction, dementia, osteomyelitis of vertebra, need for assistance with personal care, and anxiety. Review of a Significant Change MDS dated [DATE] for initiation of hospice care included the resident was severely impaired for daily decision making, dependent for personal hygiene, dependent on rolling in bed, had bilateral lower leg functional impairment, and had a Stage IV pressure ulcer (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location). There was a 03/25/24 pressure ulcer grid for a sacral ulcer measuring 0.5 centimeter (cm) x 0.5 cm x 0.1 cm when a sacral ulcer reopened. The grid identified the ulcer as a Stage 1 pressure ulcer (the earliest stage of a pressure ulcer). Intact skin with persistent erythema (redness) of a localized area, usually over an area of bony prominence. Non-blanchable erythema that remains red instead of blanching (blanching describes the lightening of the skin with pressure, and then darkening again when the pressure is released). Observable differences in the affected area may include one of the following characteristics: changes in temperature to cool or warm, induration (hardening of tissues), edema (tissue swelling), burning, pain, itchiness, blue or purple color in people who have dark skin. Review of a 08/01/24 pressure ulcer skin grid for the left thigh revealed a 1.5 centimeter (cm) X 2.0 cm X 0.1 cm Suspected Deep Tissue Injury (SDTI) (intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister). Interview on 08/09/24 at 6:22 P.M. with Registered Nurse (RN) #522 verified the entry was an error. A SDTI would not have depth. There should have been no depth with the measurement not a depth of 0.1 cm., 0.1 cm was written in error. Further verified it was an error calling the pressure ulcer a Stage 1 when there was depth of 0.1 cm. A Stage 1 pressure ulcer would not have a depth. 28704 2. Medical record review revealed Resident #46 was admitted on [DATE] with diagnoses including non-Alzheimer's type dementia and anxiety. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nursing Admission Evaluation dated 02/27/24 revealed Resident #46 had no known allergies. Review of the Physician Progress Notes dated 03/11/24 revealed nurse practitioner (NP) #601 evaluated Resident #46 due to increased anxiety and confusion. NP #601's impression was generalized anxiety disorder and dementia with behaviors and her plan included to start Exelon 4.6 milligrams every 24 hours topically for cognition. Review of the Health Status Note dated 03/11/24 revealed Resident #46's daughter informed the nurse that the resident had been on Rivastigmine previously, and it had a negative effect on Resident #46 including worsening behaviors. When it was stopped, the resident became calm and much improved without it. NP #601 was notified and ordered to discontinue the medication. Exelon was listed as an allergy at that time. Review of the electronic Physician Orders dated August 2024 revealed Resident #46 was allergic to Exelon. Review of Resident #46's hard chart revealed a sticker on the outside front cover listing NKA (no known allergies). On 08/12/24 at 4:43 P.M., interview with the Director of Nursing verified Resident #46's hard chart front cover Allergy label was not accurate.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 22653 Based on medical record review and interview, the facility failed to ensure antibiotic orders were reviewed with the resident's attending physician when there was inadequate information to support the presence of an infection and an antibiotic was not in daily use without consultation with a specialist. This affected two residents (#9 and #15) of 24 residents screened for infections. Findings include: 1. Review of Resident #9's medical record revealed diagnoses including calculus of the kidney and kidney cyst. A nursing note dated 04/30/24 at 12:40 P.M. indicated Resident #9 complained of pain in the testes area and pain while urinating. An order was received to send Resident #9 to the emergency room (ER) for evaluation. The physician was notified Resident #9 had bright red intermittent blood coming from his penis. A progress note dated 04/30/24 at 2:04 P.M. indicated Resident #9 was being transported to the ER. A nursing note dated 05/01/24 at 1:30 A.M. revealed Resident #9 returned from the ER with orders for Cefdinir (antibiotic) to be administered twice a day for seven days for a urinary tract infection (UTI). Review of Resident #9's infection report revealed a urinalysis was completed in the hospital and an antibiotic was ordered. The form indicated information was reviewed by the Infection Preventionist on 05/02/24 and by the Infection Control and Quality Assurance committees (undated). Information was included in the surveillance data, antibiotic stewardship data and reviewed by the medical director (date of review not documented). Attached to the infection report was a form to determine if McGeer criteria for UTI was met. The form indicated both criteria for symptoms and microbiologic criteria were required to be met. The symptom criteria was met with acute pain or tenderness of the tests and gross blood in the urine. The microbiologic criteria differed based on whether the sample was obtained via a voided urine sample or an in and out catheter. If a voided urine sample was obtained 100000 or greater colony forming units per milliliter (cfu/ml) of no more than two species of organisms met criteria. If an in and out catheter was used to obtain the sample 100 or more cfu/ml of any organism in a specimen was required. Laboratory results were not received from the hospital until 05/11/24 after Resident #9 had finished the course of antibiotics. The source of the urine was not specified. Results revealed 50000 cfu/ml of candida albicans (microorganism) was identified. There was no sensitivity panel to ensure the isolated microorganism was sensitive to the ordered antibiotic. Review of the May 2024 infection control log indicated Resident #9 met criteria of an urinary tract infection. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/07/24 at 9:24 A.M., the Director of Nursing (DON) verified before the facility determined if criteria for the UTI was met they were unable to state with certainty the urine was obtained via a straight catheterization. The DON verified there was different criteria for voided and catheterized samples, stating the facility assumed it was a sample obtained by catheterization related to Resident #9's incontinence. The DON verified the culture results were not available until after the course of antibiotics was completed. The lack of documentation regarding any efforts to contact the hospital for quicker results or to consult with the physician to ensure the appropriate antibiotic was ordered or if he wished to await culture results was discussed. The DON stated the facility had a difficult time getting the laboratory to send results but no further information was available. 26706 2. Review of Resident #15's medical record revealed an admission on 10/26/23 with diagnoses including age related debility, herpes viral infection, need for assistance with personal care, mixed incontinence, muscle weakness, Alzheimer's disease, congenital hiatal hernia, disorder of the kidney an ureters, history of urinary tract infections, dementia, repeated falls, anorexia, hyperlipidemia, hypothyroidism, depression, difficulty walking, and gastroesophageal reflux disease. Admission orders included Macrobid Oral Capsule 100 milligrams (mg) daily for personal history of urinary tract infections. Pharmacist review in November 2023 included a recommendation to change Macrodantin to Trimethroprim due to poor renal function. Trimethoprim Oral Tablet 100 mg was ordered 11/17/23 and the Macrobid was discontinued. Review of the 07/31/24 Quarterly Minimum Data Set Assessment included the resident was severely impaired for daily decision making, received antidepressants and antibiotics, always incontinent of urine and was frequently incontinent of stool. Review of the record revealed no evidence of the resident consulting with a urologist or infectious disease specialist to determine the need for a daily preventative antibiotic. Interview on 08/14/24 at 11:14 A.M. with the Director of Nursing (DON) revealed the resident was admitted with a history of urinary tract infections. A 10/26/23 admission summary included the primary care physician in the community started her on Macrobid daily prior to admission and it was effective for prevention. The facility physician reviewed and agreed with Macrobid for long term treatment/prevention of chronic urinary tract infections. The DON verified there was no evidence of the resident seeing a urologist or infectious disease specialist related to chronic urinary tract infections. The DON verified the resident takes antibiotics daily. This deficiency represents non-compliance investigated under Complaint Number OH00155816.