STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366199	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Lane Gardens Rehab & Nursing Ctr	7820 Pleasantville Road Pleasantville, OH 43148

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47985 Based on record review, observation, and interviews, the facility failed to ensure residents were treated with dignity and clothed per their preference. This affected one resident (#59) of two residents reviewed for dignity. The facility census was 77. Findings include: Record review revealed Resident #59 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, pneumonia, respiratory failure with hypoxia, and anorexia. Review of a care plan dated 05/22/24 revealed Resident #59 had an activity of daily living (ADL) self-care performance deficit and interventions included allowing sufficient time for dressing and undressing, needs maximum assistance with upper extremity dressing and dependent assistance for lower extremity dressing and putting on or taking off footwear. Review of a Personal Belonging Inventory assessment completed on 05/22/24 at 6:51 A.M. revealed Resident #59 had one shirt, one pair of pants, colostomy equipment, two cell phones and a cell phone charger. Review of an admission minimum data set completed on 05/30/24 revealed Resident #59's cognition was intact, he required maximum assistance from staff for upper body dressing and was dependent on staff for lower body dressing and applying footwear. Interview on 06/25/24 at 10:17 A.M. revealed Resident #59 was wearing a hospital gown, but he would rather not. Resident #59 stated the facility does change the hospital gown but does not change him into clothes. Resident #59 stated the hospital gown was thin and did not provide much warmth. Resident #59 had multiple blankets at the time of the observation trying to get warm. Interview on 06/26/24 at 2:14 P.M. with Activities Director (AD) #433 revealed the facility does have extra clothes as well as a lost and found. AD #433 was not sure if Resident #59 had been offered additional clothing to wear. Interview on 06/27/24 at 8:10 A.M. with Resident #59 revealed he was cold and still did not have clothing besides hospital gowns. Resident #59 stated he is freezing. (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 - Few	Interview on 06/27/24 at 8:11 A.M. with State tested Nursing Assistant (STNA) #102 confirmed Resident #59 was wearing a hospital gown and would prefer to wear sweatpants from the lost and found. Resident #59 stated to STNA #102 he was freezing.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review, interview and facility policy review, the facility failed to ensure one residents (#68) was able to utilize her power wheelchair. This affected one of two residents reviewed for dignity. Findings Include: 1. Review of the medical record for Resident #68 revealed an initial admitted [DATE] with the diagnoses including chronic obstructive pulmonary disease (COPD), asthma, severe morbid obesity, cerebrovascular accident (CVA) with left sided hemiplegia, protein calorie malnutrition, atrial fibrillation, major depressive disorder, gastro-esophageal disorder, hypertension, hyperlipidemia, cannabis use, obstructive sleep apnea, anxiety disorder, diabetes mellitus, anemia, nicotine dependence, cardiac arrhythmia and pain in limb. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident had functional limitations in range of motion to one side of the upper and lower extremities. Review of the Occupational Therapy (OT) recertification, progress report and update therapy dated 05/17/24 to 07/15/24 revealed no goal for working with the resident on power wheelchair (PW) safety. Review of the resident's progress note dated 06/06/24 at 3:18 P.M. revealed the resident was relocated to a manual chair. The entry noted the Administrator and Human Resources (HR) were made aware. Review of the resident's power wheelchair (PW) or scooter safety skills assessment supplement dated 06/06/24 revealed the resident ran into another resident due to being late for smoking break. The resident was deemed to have failed several areas of the assessment. The assessment indicated OT and Physical Therapy (PT) would continue to address safety. On 06/24/24 at 12:58 P.M., interview with Resident #68 revealed she was grounded from her PW for the past month. Resident #68 reported she had been incontinent and it took the staff over 30 minutes to answer her call light which made her late for the scheduled smoking break. Resident #68 revealed the unknown State tested Nursing Assistant (STNA) would not permit her to participate in the smoking break due to being late. Resident #68 revealed when a resident was coming in the door she was going out so she could smoke and she bumped the resident. On 06/26/24 at 4:16 P.M., interview with the Administrator revealed Resident #68 was removed from the resident and she was placed into a manual wheelchair due to running over two residents. The Administrator said the last incident occurred about three weeks ago when a resident was coming into the facility and she was going out to smoke. She revealed instead of Resident #68 waiting on the other resident to come in she ran over the resident. On 06/27/24 at 10:20 A.M., interview with Licensed Practical Nurse (LPN) #330 revealed the facility had planned on allowing the resident back into the PW upon discharge. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/27/24 at 10:25 A.M., interview with Occupational Therapy Assistant (OTA) #500 revealed therapy was working on wheelchair safety with the resident as she had three incidents involving hitting other residents with her PW. On 07/01/24 at 2:01 P.M., interview with OTA #500 verified the resident had not received any rehabilitation services related to PW safety prior to 06/27/24 when the surveyor requested the evaluation and daily notes for review. She revealed the resident has refused to work with the therapy staff on wheelchair safety this date but had no documented evidence of the resident's refusals. 07/01/24 at 2:05 P.M., interview with Resident #68 revealed the resident had received range of motion (ROM) services to her left upper and lower extremities but had not been offered to participate in wheelchair safety in her PW. She revealed she would participate with therapy as long as she was able to go out and smoke on time or the aides would not allow her to smoke. Resident #68 revealed she would work with Physical Therapy Assistant (PTA) #501. The resident revealed she had not been in her power chair since they grounded me from my chair. On 07/01/24 at 2:16 P.M., interview with PTA #501 revealed she had worked with the resident on stretching of her left upper and lower extremities this date however she refused to get out of bed to work on wheelchair safety. PTA #501 was informed the resident would participate in wheelchair safety in the PW. PTA #501 revealed she would try to get to her before she leaves but it may not be today. PTA #501 revealed if the resident refuses they don't document the refusal and move the resident to another day. PTA #501 revealed she had no documented evidence the resident refused services for PW safety. PTA #501 said the resident has a way of manipulating the situation in her favor and if we give the wheelchair back she won't learn from it. The PTA verified the resident had a difficult time propelling herself with one arm and leg in the manual wheelchair and the facility had not made any modifications to the manual wheelchair to ensure the resident had less difficulty propelling the wheelchair.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review, policy review, and interview, the facility failed to ensure a physician, resident, or the resident's guardian were notified of changes in services and treatment. This affected one resident (#9) of one resident reviewed for hospice services. The facility census was 77. Findings include: Record review revealed Resident #9 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, alcoholic liver disease, unspecified psychosis not due to a substance or known physiological condition, hypertension, anemia, hyperlipidemia, schizoaffective disorder, major depression, adult failure to thrive, insomnia, and diverticulosis of large intestine without perforation or abscess without bleeding. An additional diagnosis of unspecified severe protein-calorie malnutrition was added on 09/13/21. Review of a care conference sheet dated 01/04/24 revealed Resident #9, her guardian via phone, Activities Director, Social Services Director, Dietary Manager, and another staff member were present. The sheet revealed Resident #9 was still on a pureed diet and the facility was having trouble getting her to eat, discussed her degenerative tongue issue, reviewed her weight, and the resident's guardian wanted to know if or when hospice should step in and discussed potential of comfort foods. No further information was documented in the medical record as a follow-up to this care conference. Review of a social services note dated 03/14/24 at 2:05 P.M. by Social Services Assistant (SSA) #123 revealed Resident #9's guardian gave permission to get a hospice consult due to weight loss with no preference for hospice provider. A referral was sent and an additional note at 2:09 P.M. revealed SSA #123 was awaiting a response regarding hospice consult from the hospice provider. Review of a progress note dated 03/22/24 at 7:16 P.M. by Registered Nurse (RN) #389 revealed Resident #9 was admitted to Hospice for severe protein calorie malnutrition, routine level of care, continue DNRCC (do not resuscitate-comfort care), and continue all current medications. Review of written orders dated 03/22/24 revealed Resident #9 was admitted to Hospice for severe protein calorie malnutrition, routine level of care, and to continue all current orders. Hospice services were discontinued on 03/24/24 with no evidence of notification to the physician, resident or guardian at that time. In addition, there was no evidence of follow-up to resolve why services were discontinued at this time. Interview on 06/25/24 at 2:31 P.M. with Registered Nurse (RN) #223 revealed in January 2024, Resident #9's guardian had requested hospice but services were terminated due to a clerical issue with the paperwork involving her last name. RN #223 stated Resident #9 had not been receiving hospice services for weeks and she was told her legal guardian had not contacted hospice to start services. Interview on 06/26/24 at 4:11 P.M. with Resident #9's legal guardian revealed she was unaware resident was no longer receiving hospice services. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/27/24 at 1:02 P.M. with Medical Director (MD) #115 revealed he did not recall resident and was not aware of hospice discharge without looking at the computer. Interview on 06/27/24 at 1:40 P.M. with Resident #9's guardian revealed she had been in contact with hospice to sign new paperwork and re-admit. Guardian stated the facility had still not been in contact with her. Interview on 06/27/24 at 4:04 P.M. with Certified Nurse Practitioner (CNP) #503 revealed she did not believe the facility notified her when Resident #9 was discontinued from hospice services. Interview on 07/02/24 at 8:06 A.M. with SSA #123 revealed she had been attempting to get referrals out to hospice services prior to March and has since attempted to contact Resident #9's guardian without success. SSA #123 confirmed there was no documented evidence of her attempting to contact hospice or Resident #9's guardian, aside from the care conference note on 04/09/24. SSA #123 stated she is working on getting better at documentation. Review of a policy titled Change in a resident's Condition or Status (dated 03/25/24) revealed the facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition and/or status. Unless otherwise instructed by the resident, a nurse with notify the resident's representative when the resident is involved in any accident or incident that results in injury including injuries of unknown source, a significant change in resident's physical, mental, or psychosocial status, there is a need to change the resident's room assignment, a decision has been made to discharge the resident from the facility, or it is necessary to transfer the resident to a hospital/treatment center. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on record review and interviews, the facility failed to follow up on one resident's (#68) report of missing personal items. This affected one of one resident reviewed for personal property. Findings Include: Review of the medical record for Resident #68 revealed an initial admitted [DATE] with the diagnoses including chronic obstructive pulmonary disease (COPD), asthma, severe morbid obesity, cerebrovascular accident (CVA) with left sided hemiplegia, protein calorie malnutrition, atrial fibrillation, major depressive disorder, gastro-esophageal disorder, hypertension, hyperlipidemia, cannabis use, obstructive sleep apnea, anxiety disorder, diabetes mellitus, anemia, nicotine dependence, cardiac arrhythmia and pain in limb. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. On 06/24/24 at 1:04 P.M., interview with Resident #68 revealed she had an engagement ring and wedding band stolen from her drawer, Resident #68 revealed she had reported the missing items to the Administrator. On 06/26/24 at 4:16 P.M interview with the Administrator revealed the Resident #68 had reported an engagement ring missing however had not reported the wedding band missing. The Administrator revealed Resident #68 was not sure if the ring was taken home but would find out. The Administrator revealed Resident #68 had reported the missing ring three to four weeks ago. The Administrator verified she had not followed up with Resident #68 regarding the missing ring. On 06/26/24 at 4:43 P.M., interview with the Administrator revealed she spoke with the Resident #68 and the resident's rings were not taken home. The Administrator revealed she began an investigation and started a self-reported incident.

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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** 32654 Based on observation, record review, interview and facility policy review the facility failed to ensure two residents, who were dependent on staff, were provided shaving of facial hair and nail care. This affected two residents (#59 and #62) of five residents reviewed for activities of daily living (ADL). Findings Include: 1. Review of the medical record for Resident #62 revealed an initial admitted cerebrovascular accident with right sided hemiplegia, aphasia, dysphagia, diabetes mellitus, protein calorie malnutrition, congestive heart failure, anemia, obstructive and reflux uropathy, hyperlipidemia, major depressive disorder, hypertension, insomnia, chronic pain syndrome, dry eye syndrome and gastro-esophageal reflux disease. Review of the plan of care dated 04/08/24 revealed the resident was at risk for declines/fluctuations in activities of living (ADL) related to present condition, CVA with hemiplegia, aphasia, dysphagia, congestive heart failure, noted limitations to one upper and lower extremity, transferred via Hoyer lift, uses motorized wheelchair with assist, feeds self after tray set-up dependent for all other ADL. Interventions included dependent on staff for bathing and grooming. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the resident's monthly physician orders identified no orders related to ADL. On 06/24/24 at 4:07 P.M., observation of Resident #62 revealed his nails were long, jagged and dirty with a brown substance under them. Further review revealed the resident had an unkempt beard. On 06/25/24 at 1:38 P.M., observation of Resident #62 revealed the resident's nails remained long, jagged and dirty with a brown substance under them. Further observation and interview with the resident revealed Resident #62 had an unkempt beard. Resident #62 revealed he normally doesn't wear a beard however the staff does not provide shaving. On 06/26/24 at 1:45 P.M., observation of Resident #62 revealed the resident's nails remained long, jagged and dirty with a brown substance under them. Further observation and interview with the resident revealed Resident #62 had an unkempt beard. On 06/26/24 at 1:48 P.M., interview with Licensed Practical Nurse (LPN) #440 verified the resident's nails were long, jagged and dirty with a brown substance under them. Additionally LPN #440 verified the resident had a long beard. Review of the facility policy titled, Care of Fingernails/Toenails, dated 10/10 revealed nail care includes daily cleaning and regular trimming. 47985 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review revealed Resident #59 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, pneumonia, respiratory failure with hypoxia, and anorexia. Review of a care plan dated 05/22/24 revealed Resident #59 had an activity of daily living (ADL) self-care performance deficit and interventions included bathing/showering: check nail length and trim and clean on bath day and as necessary. Review of a shower sheet dated 05/29/24 revealed Resident #59's nails were not clipped. Review of an admission minimum data set completed on 05/30/24 revealed Resident #59's cognition was intact, he required maximum assistance with completing personal hygiene. Review of shower sheets dated 06/07/24, 06/14/24, and 06/17/24 revealed Resident #59 refused his shower due to not wanting to be cold but did not indicate if he was offered to have his nails trimmed. Review of a shower sheet dated 06/24/24 revealed Resident #59's shower was not completed. Interview on 06/25/24 at 9:38 A.M. revealed Resident #59's nails were longer than he preferred. Observation revealed his nails were approximately a quarter of an inch long, uneven and dirty. Interview on 06/27/24 at 8:10 A.M. with Resident #59 revealed his nails had not been trimmed and his preference was to have them trimmed. Interview on 06/27/24 at 8:11 A.M. with State tested Nursing Assistant (STNA) #102 confirmed Resident #59's fingernails were long, uneven and dirty. Review of a policy titled Care of Fingernails/Toenails dated 10/2010 revealed nail care includes daily cleaning and regular trimming.

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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** 32654 Based on observation, record review and interview, the facility failed to implement a treatment to and monitor an abrasion behind Resident #79's right ear. This affected one of one resident (#79) reviewed for skin conditions. Findings Include: Review of the medical record for Resident #79 revealed an initial admitted [DATE] with the diagnoses including but not limited to chronic obstructive respiratory failure (COPD), acute and chronic respiratory failure with hypoxia, severe protein calorie malnutrition, emphysema, anemia, metabolic encephalopathy, anxiety disorder, major depressive disorder, hyperlipidemia, bipolar disorder, sleep disorder, mood disorder, suicidal ideations, poisoning by drugs, medicaments and biological substances intentional self harm, nicotine dependence, palliative care and overactive bladder. Review of the incident report dated 05/17/24 at 1:10 P.M. revealed the nurse was notified the resident was outside in her wheelchair and fell forward out of her wheelchair. The Administrator was in front of the resident and prevented her from completely falling out of her chair and hitting a parked car. The resident's knees touched the ground. The resident stated her wheelchair went down the front ramp and she couldn't stop it. The resident was assessed after incident and an irritation was noted behind the resident's right ear from the resident's oxygen tubing stretching during incident. The resident was on safety awareness and voiced understanding. The Certified Nurse Practitioner (CNP) was notified of the irritation and will monitor for any additional adverse effects. Review of the medical record revealed no documented evidence the facility assessed, monitored or implemented a treatment for the irritation behind the resident's right ear. Review of the weekly skin assessment dated [DATE] revealed the resident had a scab behind her right ear. Review of the medical record revealed no assessment, monitoring or treatment implemented for the scabbed area found behind the resident's ear on 05/30/24. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the plan of care dated 06/11/24 revealed the resident was noted to have an abrasion to the back of his right ear. Interventions included observe/report/document for s/s of infection including redness, warmth, edema, treatment as ordered, notify physician of ineffectiveness, weekly monitoring for measurements and wound bed assessment and wound physician as indicated. Review of the weekly wound observation tool dated 06/11/24 revealed the resident was found to have an abrasion behind her right ear on 06/06/24. The facility classified the wound as an abrasion measuring 2.5 centimeters (cm) by 1.0 cm and describes as being 100% scabbed with scant amount of exudate. The facility implemented the treatment of skin prep. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed no initial assessment of the abrasion on 06/06/24 or implementation of a treatment. Review of the plan of care dated 06/11/24 revealed the resident was noted to have an abrasion to the back of his right ear. Interventions included observe/report/document for signs/symptoms of infection including redness, warmth, edema, treatment as ordered, notify physician of ineffectiveness, weekly monitoring for measurements and wound bed assessment and wound physician as indicated. Review of the weekly wound observation tool dated 06/18/24 revealed the abrasion behind her right ear measured 2.5 cm by 1.0 cm and described as 100% epithelial tissue. The facility determined the wound was improving. The facility implemented the treatment Exuderm and change every three days. Review of the weekly wound observation tool dated 06/25/24 revealed abrasion behind her right ear measured 1.5 cm by 0.9 cm by 0.1 cm and described as sallow pink tissue. The facility determined the wound was improving. The facility implemented the treatment cleanse with normal saline, apply zinc oxide and leave open to air daily and as needed. On 06/25/24 at 3:53 P.M., interview with the Administrator revealed the facility was applying skin prep, a foam dressing and Exuderm behind the resident's ear for prevention. She revealed there was an incident report for the resident when the abrasion occurred behind the resident's ear. On 06/26/24 at 9:06 A.M., interview with the Administrator verified there was no initial assessment, monitoring or implementation of a treatment for the abrasion behind Resident #79's right ear.

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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** 41271 Based on medical record review, observation, and staff interview, the facility failed to ensure residents had physician orders for safety/fall interventions including the use of a perimeter mattress. This affected one resident (#38), of the five residents reviewed for fall interventions. Findings include: Review of the medical record for Resident #38 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, primary generalized osteoarthritis, chronic pain, and alcohol inducted persisting dementia. Review of Resident #38's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 03 out of 15 indicating a severely impaired cognition for daily decision making abilities. Noted to be free from any bilateral upper or lower extremity impairment and required the use of a wheelchair for mobility. Resident #38 required partial to moderate assistance for bed mobility and substantial to maximal assistance for transfers. Review of Resident #38's plan of care revealed plan for fall interventions but an indication for the use of a perimeter mattress was not included. Review of Resident #38's physician orders revealed no current order for the use of a perimeter mattress. Observation on 06/27/24 at 10:25 A.M. of Resident #38 along with Unit Manager (UM) #440 revealed resident sitting on the side of his bed. The bed was lowered to the floor and a fall mat was on the left side of the bed while the right side of the bed was up against the wall. Resident #38's mattress was noted to have sides that raised higher than the mattress itself. Interview on 06/27/24 at 10:30 A.M. with UM #440 verified Resident #38's current bed was noted to be a perimeter mattress and was used to help define edges for residents who are able to turn themselves in bed and move around, when residents are in bed and rolling, they can feel the edge of the mattress and note that it goes up and this is to let them know they are getting close to the edge of the bed so they don't roll out. This type of special mattress requires a physician order for use. It is not used to try and keep residents in bed. UM #440 verified Resident #38 did not have an current order for this type of mattress nor was this resident care planned for the use of a perimeter mattress.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review and interview, the facility failed to implement a physician ordered dressing change to bilateral nephrostomy tubes (a tube that drains urine from your kidney into a bag) upon readmission to the facility. This affected one resident (#27) of two residents reviewed urinary tract infection. Findings Included: Review of the medical record for Resident #27 revealed an initial admitted [DATE] with the latest readmission of 06/20/24 with diagnoses including congestive heart failure, acute and chronic respiratory failure with hypoxia, diabetes mellitus, chronic obstructive pulmonary disease, (COPD), severe morbid obesity, hyperlipidemia, hypertension, obstructive sleep apnea, lymphedema, major depressive disorder, gastro-esophageal reflux disease, constipation, bacteremia, urinary tract infection, disorder of kidney and ureter, anemia, chronic kidney disease, stage three, artificial openings of urinary tract status, presence of urogenital implants, hydronephrosis with renal and ureteral calculous obstruction, seasonal allergic rhinitis and migraine. Review of the resident's five day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident has no cognitive deficit. The resident was dependent for toileting and transfers. Review of the resident's acute care hospital discharge summary dated 06/20/24 revealed an order to cleanse the bilateral nephrostomy tubes with antibacterial soap and water, pat dry and cover with a dry dressing every other day. Review of the plan of care dated 06/24/24 revealed the resident required enhanced barrier precautions (EBP) related to wound for intravenous (IV) and bilateral nephrostomy tubes. Interventions included EBP signage on door and gloves and gowns for high contact resident care. Review of the plan of care dated 06/20/24 revealed the resident returned from the hospital with bilateral nephrostomy tubes in place, at risk for complications and will maintain until next physician visit. Interventions included call physician if develops sudden increase drainage with discomfort, blood in/around tubes, fever greater than 101, persistent blood in urine, nausea/vomiting, cloudy urine or strong odor or becomes dislodged/broke or leaks, cover nephrostomy tubes and keep dry for 14 days then may shower and allow water to run over them, empty nephrostomy tube bags often and when 2/3 full, follow up with urology on 07/15/24 and flush per physician order and as needed and notify the physician of any complications. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's monthly physician orders for June 2024 identified orders dated 06/21/24 call and schedule bilateral nephrostomy tube change in two to three months, 06/23/24 cover nephrostomy tube drain dressing with plastic wrap before showering, do not submerge in water, must cover for 14 days if site is healed may shower without it, empty drain bag as often as needed and when it is about two thirds full, do not rinse bag and replace if it's leaking or bag or tubing gets damaged, monitor drainage from nephrostomy tube twice daily empty when two thirds full, EBP related to indwelling medical device and IV during high contact resident care activities and 06/24/24 may flush nephrostomy tubes with 10 milliliters (ML) of normal saline (NS) every 12 hours as needed, 06/26/24 clean around nephrostomy tube drain with clean cloth and NS making sure it is completely dry, apply dry T-drain drain dressing around drain tube place tape every other day and as needed. Review of the resident's July 2024 Treatment Administration Record (TAR) revealed the first documented treatment to the bilateral nephrostomy tubes was on 06/24/24. On 06/24/24 at 12:28 P.M., observation of Resident #27 revealed bilateral nephrostomy tubes collection bags laying on the resident's lap with clear yellow urine. On 06/27/24 at 11:50 A.M., Resident #27 refused to allow the observation of the dressing change to the bilateral nephrostomy tubes. 07/01/24 at 11:10 AM interview with Licensed Practical Nurse (LPN) #330 verified the physician ordered treatment was not implemented upon readmission and the treatment was not administered for four days following the readmission to the facility.

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on observation, medical record review, facility policy and procedure reviews and interviews, the facility failed to ensure Resident #9, who was identified as nutritional risk, was provided a comprehensive and individualized nutritional plan to include monitoring of nutritional status, physician notification of diet changes and discharge from hospice services, and implementation of nutritional interventions to prevent weight loss and honor the resident's right for food preferences. This resulted in Immediate Jeopardy and serious life-threatening harm beginning on 08/01/23 related to malnutrition/weight loss for Resident #9, who experienced a 9.47 percent weight loss in three months from 07/25/23 (92.9 pounds) to 10/31/23 (84.1 pounds), and a 12.91 percent weight loss in five months from 01/16/24 (85.2 pounds) to 06/02/24 (74.2 pounds) with a total weight loss of 22.38 percent of her body weight (a 19.8 pound weight loss) and a severely low body-mass index of 13.6 due to the facility's failure to address the resident's refusal to consume pureed foods, obtain hospice services/offer in-house palliative care or order comfort foods, negatively impacting the resident's psychosocial well-being due to not being able to participate in food related activities and evidence of continued weight loss. The resident was identified and/or observed during the survey to request money to obtain food from the facility vending machine and obtain food of regular consistency on her own to consume indicating she was hungry. This affected one resident (#9) of three residents reviewed for weight loss. The facility census was 77. On 06/27/24 at 5:18 P.M., the Administrator, Regional Director of Operations (RDO) and Regional Nurse were notified Immediate Jeopardy began on 08/01/23 when Resident #9's orders were changed from a regular diet with regular textures to regular diet with pureed textures which the resident refused to accept. Prior to and following this change in diet order the resident sustained a 9.47 percent (%) /8.8-pound weight loss in three months and continued to progressively lose weight, with another significant weight loss of 12. 91% over five months resulting in admission to Hospice services on 03/22/24 with an admitting diagnosis of severe protein calorie malnutrition. On 03/24/24, hospice services and comfort foods were discontinued related to a clerical error which the facility failed to notify Registered Dietician (RD) #352, Certified Nurse Practitioner (CNP) #502, physician, or Resident #9's legal guardian of. The facility failed to follow-up with hospice and the resident's guardian or offer in-house palliative care and comfort foods until hospice services could be re-established. Additionally, the RD was not familiar with the facility policy related to comfort foods. The Immediate Jeopardy was removed on 06/27/24 when the facility implemented the following corrective actions: On 06/27/24 at 5:45 P.M., the RDO and Regional Director of Clinical Services (RDCS) educated the facility Administrator on the Weight Assessment Interdisciplinary Interventions policy and Resident Dietary Preferences. On 06/27/24 at 6:00 P.M., an emergency Quality Assurance Performance Improvement (QAPI) meeting was held with department heads including Dietary Manager #150, Unit Managers #440 and #330, Human Resource Director #200, Social Service Assistant #123, MDS Coordinator #101, Business Office Manager #108, Director of nursing (DON) and Medical Director (MD) #115 via telephone to discuss notification of Immediate Jeopardy and initiation of abatement plan for corrective action. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/27/24 at 6:00 P.M., Transitions Hospice' Regional Care Coordinator #500 had communications with Resident #9 and her guardian to sign new consents to enter hospice care. On 06/27/24 at 6:23 P.M., the facility Administrator contacted Resident #9's guardian to discuss Resident #9's wishes for comfort/pleasure foods due to Resident #9 disliking pureed food. A dietary waiver was emailed to Resident #9's guardian after a telephone conversation to obtain a signed dietary waiver. On 06/27/24 at 6:31 P.M., the facility Administrator received a signed dietary waiver via email to change Resident #9's recommended diet to comfort foods. On 06/27/24 at 7:24 P.M., Unit Manager #330 notified facility CNP #502 of new signed waiver for Resident #9 and a new order was received for comfort foods on 06/27/24. On 06/27/24 at 7:28 P.M., the Administrator provided education to RD #352 regarding updates to the Weight Assessment Interdisciplinary Interventions Policy and Resident Dietary Preferences. On 06/27/24 at 7:29 P.M., notification was made to Resident #9's guardian by Administrator of Resident #9's new orders. On 06/27/24 at 8:34 P.M., Resident #9 and her guardian were notified of diet changes. On 06/27/24 at 8:40 P.M., Unit Manager #440 notified the dietary department of the resident's diet change, and a diet slip was completed for Resident #9 to receive comfort food items. On 06/27/24 at 8:45 P.M., Administrator developed an action plan for residents who voiced concerns regarding their diet type. The plan included for the interdisciplinary team (IDT) to meet with the resident(s) and guardian(s) to discuss diet concerns and changes per preference the resident may desire. The IDT would notify Speech and Occupational therapies for a need to screen resident to identify any physical conditions that may be causing the resident's refusal of diet. On 06/27/24 at 9 P.M., Resident #9's care plan was updated by Unit Manager #330 to reflect changes to Resident #9's diet to regular/comfort food. On 06/27/24 at 9:10 P.M., the facility policy for Weight Assessment and Interdisciplinary Intervention was updated by RDCS. On 06/27/24 at 10 P.M., education was completed by the Administrator to the facility department heads via phone message per group chat. Employees responded back they received and read education which was documented by the Administrator with the date and time on an employee roster. A total of 103 staff members were notified of the education. Education included the updated policy for Weight Assessment and Interdisciplinary Interventions as well as resident preferences for diet. On 06/27/24 at 10:30 P.M., the Administrator completed education to the facility staff on updated policy for Weight Assessments and Interdisciplinary Interventions as well as resident preferences for diet. 21 Licensed Practical Nurses (LPN) and six Registered Nurses (RN) were educated at this time. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/27/24 at 10:40 P.M. Administrator, UM #440 and UM #330 assessed 76 residents for weight loss and identified nine additional residents with weight loss (Residents #51, #34, #65, #81, #28, #1, #57, #56 and #40) to ensure their weight loss was not due to psychosocial issues from dislike of their current diets. Interviews with identified residents provided no concerns with their current diets. If a resident was not interviewable, a legal representative was called. Care conference sheets were completed for the identified residents (#1, #9, #28, #34, #40, #51, #56, #57, #65 and #81) and conferences were completed in person or via phone. On 06/27/24 at 10:50 P.M., care conferences were completed with residents or guardians to review weights, diets and preferences to ensure residents' psychosocial status is maintained. Care conferences were completed by Unit Managers #330 and #440, RDO, and Director of Business Development. On 06/27/24 at 10:55 P.M., the Administrator implemented a plan to complete weekly audits for all residents for weight loss. This audit would be completed three times per week for two weeks, two times a week for two weeks, then weekly for four weeks. Any new residents with weight loss identified by the RD would be added to the audit list. Residents would be reviewed in QAPI for further need of monitoring or enhancement. Although the Immediate Jeopardy was removed on 06/27/24, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Review of Resident #9's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, alcoholic liver disease, unspecified psychosis not due to a substance or known physiological condition, hypertension, anemia, hyperlipidemia, schizoaffective disorder, major depression, adult failure to thrive, insomnia, and diverticulosis of large intestine without perforation or abscess without bleeding. An additional diagnosis of unspecified severe protein-calorie malnutrition was added on 09/13/21. Review of a Dietary Review completed on 06/08/23 by the RD revealed Resident #9 did not have a therapeutic diet order, received house shakes twice daily, had no swallowing concerns, no weight loss, a Body Mass Index (BMI) of less than 19, intakes met 26-75% of estimated needs, and the resident was independent for eating after set-up. Review of a progress note dated 07/02/23 at 5:39 P.M. by Registered Nurse (RN) #223 revealed Resident #9 was going to other resident's rooms using feet to knock at doors trying to get snacks and money from residents and was redirected. Review of Resident #9's weight records revealed the resident's weight on 07/25/23 was 92.9 pounds. Review of a nursing note dated 07/26/23 at 11:42 A.M. by Licensed Practical Nurse (LPN) #227 revealed Resident #9 received a new diet order for mechanical soft foods and thin liquids. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a progress note dated 07/26/23 at 11:52 A.M. by Speech Therapist (ST) #321 revealed Resident #9's guardian was informed of Resident #9's new onset of choking and coughing with meals. Updated regarding new diet order with potential to downgrade to pureed if coughing continued. Record review revealed on 08/01/23 the resident's weight was 92.1 lbs. Review of a modified barium swallow study completed on 08/01/23 revealed Resident #9 exhibited intermittent pre-spill into the pharynx during the oral phase and displayed up to a two second swallow delay, intermittent flash penetration with thin liquids, and decreased epiglottic inversion with moderate vallecular residue with reflexive swallows able to clear in the pharyngeal phase. Recommendations included pureed diet, crushed medications or liquids medications, and noted the resident would benefit from speech therapy. Review of Speech Therapy information revealed the following: Review of a Speech Therapy (ST) Evaluation and Treatment plan revealed Resident #9 received services from 07/26/23 through 09/26/23. Review of a ST note dated 08/02/23 by ST #321 revealed Resident #9 stated she will not eat pureed food and declined to participate in therapy on this date. Review of a ST note dated 08/29/23 by ST #321 revealed staff requested allowance of cheese puffs to pureed diet due to very poor intake and weight loss. Review of the ST note dated 09/07/23 by ST #321 revealed staff reported concerns over poor intake of pureed food and risk for weight loss with request for soft food items such as beefaroni. Resident #9 did not like pureed diet. There was no documented evidence facility staff requests for Resident #9 to receive cheese puffs or soft food items such as beefaroni were addressed and these food additions implemented. Review of the physician's orders revealed Resident #9 had a diet order dated 08/01/23 for a regular diet with pureed textures, thin liquids, ice cream with lunch and dinner, and super cereal for breakfast. Review of a dietary note dated 08/08/23 at 12:34 P.M. by RD #352 revealed Resident #9's diet was downgraded to pureed on 08/01/23 and as a result, her by mouth intake had decreased. RD #352 stated Resident #9 received house shake twice daily with good intakes. Recommendations included offer milkshakes once or twice daily. Record review revealed on 08/15/23 the resident's weight was 90.2 lbs. On 09/10/23 the resident's weight was 92 lbs. On 09/19/23 the resident weighed 89.9 lbs. and on 09/26/23 she weighed 88.2 pounds. Review of a dietary note dated 09/26/23 at 9:48 A.M. by RD #352 revealed Resident #9 had an insignificant weight loss of 3.8 pounds, continued with poor appetite with 38% of meals consumed on average. Further weight loss was expected with poor appetite and refusal of supplements. Record review revealed no new interventions or changes made at this time. On 10/02/23 the resident weighed 88.6 lbs. which was noted to be a 4.3 pound weight loss from the weight of 92.9 lbs. on 07/25/23. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a quarterly Minimum Data Set (MDS) completed on 10/04/23 revealed Resident #9 had moderate cognitive impairment, no behaviors, required supervision for eating, had no signs of a swallowing disorder, had no significant weight loss, and received a mechanically altered diet. On 10/31/23 the resident weighed 84.1 lbs. On 11/01/23 the resident weighed 84.3 lbs. and on 11/06/23 she weighed 84.5 lbs., indicating a weight loss of 4.63% from 10/02/23 through 11/06/23. Review of a dietary note dated 11/07/23 at 11:16 A.M. by RD #352 revealed Resident #9 had a significant weight loss of 7.5 pounds in 60 days, 7.6 pounds in 90 days, and 8.5 pounds in 120 days, appetite remains poor, and Resident #9 was being noncompliant with diet order. Recommendations included adding ice cream with lunch. Review of a progress note dated 11/08/23 at 1:13 P.M. by LPN #227 revealed Resident #9 received a new order for speech therapy (ST) to evaluate and treat up to three times a week for three weeks for dysphagia management. Resident #9 and guardian aware of new order. Review of ST information revealed the following: Review of ST Evaluation and Treatment revealed Resident #9 received ST from 11/08/23 through 11/29/23. Review of a ST note dated 11/13/23 by ST #321 revealed extensive education was provided to Resident #9 regarding rationale for pureed diet. Review of a ST note dated 11/20/23 by ST #321 revealed Resident #9 was highly agitated and wanted a sandwich. There was no evidence the resident's right to consume foods other than pureed was considered or further pursued at this time. On 11/14/23 the resident weighed 85 lbs., on 11/20/23 she weighed 83 lbs., on 11/27/23 she weighed 84.2 lbs. and on 12/01/23 she weighed 82.4 lbs., indicating a weight loss of 3.06% from 11/08/23 through 12/01/23. Review of a progress note dated 12/06/23 at 1:34 P.M. by LPN #227 revealed Resident #9 had a new order for a dietary consult for low protein. Resident #9 and guardian were aware of new order. Record review revealed on 12/11/23 the resident weighed 84.4 lbs. Review of a nutrition note dated 12/12/23 at 10:19 A.M. by RD #352 revealed Resident #9's BMI was 15.4 and considered to be severely underweight. Resident #9 continued to receive a regular diet with pureed texture, fortified foods, and appetite was varying from 0-100% meals consumed on average. Resident #9 frequently refuses ONS (oral nutritional supplement) to aid in meeting nutritional needs and is a picky eater, does not like pureed diet, occasionally is noncompliant with diet texture. No new recommendations and the note indicated will monitor as needed. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a care plan dated 12/12/23 revealed Resident #9 had potential for behavior problems related to dementia, mood disorder, depression, psychosis, calls staff derogatory names, can be both physically and verbally aggressive towards staff, raises her voice at times, will refuse ADL care such as bathing, changing clothes and oral care; taking peers personal belongings for herself; going into rooms of others uninvited; confabulating stories about staff/residents; will attempt to assist other residents with ADLs; 07/31/23 asking other residents for money; 08/15/23 asking other residents for food/etc. since downgrade of her diet; 08/28/23 attempting to get ice herself from ice bucket; and 12/12/23 will often refuse medications. Interventions included redirecting Resident #9 when she asks others for money/snacks and reminding her she cannot ask others for food that is not on her diet. On 12/18/23 the resident weighed 81.8 lbs. which reflected an 11.1 pound weight loss since the weight on 07/25/23 of 92.9 lbs. Review of a nutrition note dated 12/19/23 at 11:09 A.M. by RD #352 revealed Resident #9 triggered for a significant weight loss of 2.6 pounds times one week, appetite was varying and overall poor with 0-50% of meals consumed on average. Record review revealed no new interventions or changes made at that time. On 12/28/23 the resident weighed 82.6 lbs., and on 01/01/24 the resident weighed 81.4 lbs. Review of a nutrition note dated 01/02/24 at 10:34 A.M. by RD #352 revealed Resident #9 triggered for a 7.2 lb. weight loss in 90 days and 11.6 lb. weight loss in 180 days. Resident #9 had a poor appetite with 0-75% of meals consumed on average with two meals consumed a day. No new interventions or recommendations were made at this time. Review of a quarterly MDS completed on 01/03/24 revealed Resident #9 had moderately impaired cognition, no behaviors, required supervision for eating, no signs of a swallowing disorder, had a weight loss of either five percent in the last month or loss of ten percent or more in the last six months and was not on a prescribed weight-loss regimen, and had a mechanically altered diet. Review of a Dietary Review completed on 01/04/24 revealed Resident #9 received a mechanically altered diet, house supplement twice daily, had no swallowing concerns, had a weight loss of five percent or more in the last month or loss of ten percent or more in the last six months without a prescribed weight-loss regimen, had a BMI of less than 19, intakes met 26-75% of needs, and was independent for eating after setup. Record review revealed no new interventions or recommendations were made at this time. Review of a care conference sheet dated 01/04/24 revealed Resident #9, her guardian via phone, Activities Director, Social Services Director, Dietary Manager, and another staff member were present. The sheet revealed Resident #9 was still on a pureed diet and the facility was having trouble getting her to eat, discussed her degenerative tongue issue, reviewed her weight, and the resident's guardian wanted to know if or when hospice should step in and discussed potential of comfort foods. However, no further information was documented in the chart as a follow-up to this care conference. On 01/15/24 the resident weighed 81.3 lbs., and on 01/16/24 the resident weighed 85.2 pounds. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a nutrition note dated 01/16/24 at 11:52 A.M. by RD #352 revealed Resident #9 triggered for a significant weight loss of 11.6 pounds in 180 days. The note indicated to continue nutrition plan of care and will follow up as needed. No new interventions or recommendations were implemented at this time. On 02/08/24 the resident weighed 71 lbs., indicating a weight loss of 16.67% from previous weight of 85.2 lbs. on 01/16/24. Review of a nutrition note dated 02/12/24 at 10:14 A.M. by RD #352 revealed Resident #9 triggered for a significant weight loss of 10.4 pounds in 30 days, 13.3 pounds in 90 days, and 21.1 pounds in 180 days. No changes in diet or appetite documented, and RD #352 requested a re-weight to verify weight loss. Record review revealed no new interventions or recommendations were implemented at this time. On 02/20/24 the resident weighed 76.2 lbs. Review of a nutrition note dated 02/27/24 at 10:22 A.M. by RD #352 revealed Resident #9 triggered for a weight gain of 5.2 pounds in 12 days, a weight loss of 9 pounds in 30 days, loss of 8 pounds in 90 days and 15.9 pounds in 180 days, with a question of the accuracy of weight taken on 02/08/24. No new interventions were noted at this time. On 03/04/24 the resident weighed 74.2 lbs., and on 03/11/24 the resident weighed 74.6 lbs. Review of a nutrition note dated 03/12/24 at 10:33 A.M. revealed Resident #9 triggered for a significant weight loss of 1.8 pounds in seven days with a recommendation to increase ice cream to twice daily (with lunch and dinner) and add pudding as a snack. Review of a social services note dated 03/14/24 at 2:05 P.M. by Social Services Assistant (SSA) #123 revealed Resident #9's guardian gave permission to get a hospice consult due to weight loss with no preference for hospice provider. A referral was sent and an additional note at 2:09 P.M. revealed SSA #123 was awaiting a response regarding hospice consult from the hospice provider. Review of a progress note dated 03/15/24 at 11:38 A.M. by previous DON #160 revealed a referral was sent to a different hospice provider and the social worker was to come to facility at noon for intake paperwork. An additional note at 2:39 P.M. revealed hospice representative was present and received paperwork. Review of a progress note dated 03/15/24 at 2:47 P.M. by previous DON #160 revealed Resident #9's weights were reviewed for one, three and six months with a 10% weight loss noted in six months. Review of the progress note revealed no additional information related to the root cause of the weight loss and/or any new interventions to prevent additional weight loss/promote weight gain. Review of a progress note dated 03/18/24 at 3:47 P.M. by previous DON #160 revealed the facility was awaiting paperwork from the hospice provider. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a progress note dated 03/22/24 at 7:16 P.M. by RN #389 revealed Resident #9 was admitted to Hospice for severe protein calorie malnutrition, routine level of care, continue DNRCC (do not resuscitate-comfort care), and continue all current medications. The resident's diet plan was for comfort foods and a liberalized diet at this time. Review of written orders dated 03/22/24 revealed Resident #9 admitted to Hospice for severe protein calorie malnutrition/routine level of care. There was no documented evidence Resident #9 ever received a liberalized diet or comfort foods. Review of Resident #9's medical record revealed no documented evidence of a physician order to discontinue hospice services. However, medical record review revealed staff progress notes that identified Hospice services were discontinued on 03/24/24 for Resident #9 with no evidence of notification to the physician, resident or guardian at that time. In addition, there was no evidence of follow-up to resolve why services were discontinued at this time. On 03/25/24 the resident weighed 74.6 lbs. Review of a nutrition note dated 03/26/24 at 2:05 P.M. by RD #352 revealed Resident #9 recently admitted to hospice care, overall goal was for comfort and quality of life with hospice. The note did not include any additional information related to comfort foods/liberalized diet at this time. The note also failed to identify that although hospice services had recently been initiated, they were not being provided as of this time. Review of a Nutritional Assessment Review completed by the RD on 03/26/24 revealed Resident #9's BMI was 13.6 and her goal weight was 110 lbs., she did not have swallowing issues, and her overall goal was for comfort and quality of life with hospice, expect decline in weight, skin integrity, and intakes as disease state progress. Recommendations included discontinuing weekly weights order due to hospice, consider discontinuing monthly weights due to hospice and monitor as needed. Review of a significant change MDS completed on 04/03/24 revealed Resident #9 had moderately impaired cognition, had no behaviors, required set-up help for eating, had no signs of a swallowing condition, had a weight loss of five percent or more in the last month or loss of ten percent or more in the last six months and was not on a prescribed weight-loss regimen, received a mechanically altered diet, and received hospice care. Review of a Dietary Review completed on 04/05/24 revealed Resident #9 received a mechanically altered diet, house supplement twice daily, had no swallowing issues, had a weight loss of five percent or more in the last month or loss of ten percent or more in last six months without a prescribed weight loss regimen, had a BMI of less than 19, intakes met 26-75% of estimated needs, and was independent for eating after set-up. Record review revealed no evidence of the resident receiving any type of comfort foods/liberalized diet at this time. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a social services note dated 04/09/24 at 2 P.M. by SSA #123 revealed a quarterly care conference was held with Resident #9, her guardian did not answer, and she would follow up as soon as guardian called back. Review of the care conference sheet revealed no additional information. There was no indication the resident's nutritional status, weight loss, diet order or hospice were discussed. On 04/16/24 the resident weighed 76 lbs. Review of a dietary note dated 04/16/24 at 10:40 A.M. by RD #352 revealed Resident #9 had a significant weight loss of 12.6 pounds in 180 days, she remained with varying appetite. At the time of this note, the RD documented the resident's overall rate of weight loss had slowed with a goal of comfort and quality of life with hospice. Review of a care plan dated 04/18/24 revealed Resident #9 was at risk for fluctuations in activity of daily living (ADL) ability related to current condition, diagnosis of psychosis, dementia, schizophrenia, on noted the resident was on hospice services at this time. The care plan also reflected the resident had communication problems and may need tasks explained. On 05/07/24 the resident weighed 74.8 lbs. Review of a dietary note dated 05/14/24 at 10:24 A.M. by RD #352 revealed no new recommendations regarding weight loss. Review of a dietary care plan dated 06/04/24 revealed Resident #9 was at risk for impaired nutritional status due to diagnoses including chronic obstructive pulmonary disease, anemia, hyperlipidemia, depression, ETOH abuse, hypertension, cataract, malnutrition. Underweight BMI and history of refusal of supplements, refuses to be weighed at times, need for mood-altering medications that may alter weight/appetite, and consistent weight loss in facility. On 03/25/24 the resident had been identified to have a significant weight loss in six months. Interventions included monitor intakes, monitor labs, monitor skin integrity, provide supplements as ordered, provide diet as ordered, provide medications as ordered, if meal was refused offer an alternative from the always available menu. On 06/02/24 the resident weighed 74.2 lbs. Review of a nutrition note on 06/11/24 at 11:38 A.M. by RD #352 revealed Resident #9 had a goal to clarify fortified foods. Fortified foods order discontinued and new order for super potatoes or super cereal once a day. Interview on 06/24/24 at 4:07 P.M. with Resident #9 revealed she refused to eat the facility food because they puree it. During the interview, Resident #9 was observed to have a bag of cool ranch Doritos and was observed to smash the chips into smaller pieces before eating them. No coughing was noted. Observation on 06/25/24 at 2:27 P.M. revealed Resident #9 had a pudding cup for a snack, and as she finished the pudding, she was scraping the sides clean trying to get as much of the pudding as she could from the cup to consume it. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/25/24 at 2:31 P.M. with RN #223 revealed Resident #9 received mighty shakes as a supplement. RN #223 stated in January 2024, Resident #9's guardian had begun requesting hospice services, but services were stopped due to a clerical issue with the paperwork. RN #223 could not recall when hospice stopped but stated it had been weeks (since hospice stopped) and she was told Resident #9's guardian had not contacted hospice to resume services. RN #223 stated Resident #9 would eat but because she received pureed food she refuses to eat. RN #223 stated a paper was signed by Resident #9's guardian so that she could eat comfort foods (liberalized diet) and when she was on hospice services, she could eat whatever she wanted. RN #223 stated staff were told residents could only have comfort food if they received hospice services. RN #223 stated Resident #9 did have trouble swallowing, sometimes she was fine and sometimes she would cough. RN #223 stated Resident #9 had not been receiving any type of palliative care in house while awaiting readmission to hospice services. RN #223 stated Resident #9 has always been small but has had a weight loss. RN #223 stated Resident #9 mostly just eats mighty shakes, pudding, Jell-O and some pureed fruits. Interview on 06/26/24 at 4:11 P.M. with Resident #9's guardian revealed she was not aware Resident #9 was not receiving hospice services. The guardian stated there had been challenges with weight loss but stated Resident #9 was supposed to have been taken off the pureed diet and given whatever she wanted to eat. During the interview, Resident #9's guardian revealed she was aware Resident #9 buys food from the vending machine with her monthly allowance. Interview on 06/26/24 at 4:44 P.M. with Hospice Receptionist (HR) #111 revealed Resident #9 admitted to hospice on 03/22/24 and was discharged on [DATE]. An additional hospice evaluation was completed on 04/01/24 but she was not readmitted at that time. No additional information was provided. Interview on 06/26/24 at 4:54 P.M. with the Hospice Administrator revealed Resident #9's paperwork had a different last name listed than her medical card, so she was discharged from services. Interview on 06/26/24 at 4:58 P.M. with the Administrator, the RDO, and the ROCS revealed Resident #9 was to receive a house shake twice daily but confirmed even with this supplement she had not regained any of the weight she lost. The ROCS stated she believed Resident #9's weight was stable, and revealed the facility does not have paperwork for a comfort food diet being in place for Resident #9. The ROCS revealed hospice was offered in house but not palliative care because she was not sure Resident #9's primary care provider would offer palliative care. The Administrator revealed the hospice company had attempted to contact Resident #9's guardian about the paperwork and confirmed apart from one attempt at a care conference on 04/09/24, no one from the facility had reached out the Resident #9's guardian regarding comfort care, palliative care, or hospice care as it pertained to the resident's ability to consume foods other than pureed foods which the resident was refusing. Interview on 06/26/24 at 6:33 P.M. with the Administrator confirmed Resident #9's care conference notes, nursing progress notes, dietary notes, care plan listed hospice, and a hospice order entered by RN #389 as noted above. Observation on 06/27/24 at 10:35 A.M. revealed Resident #9 was following the surveyor demanding money to purchase food from the vending machine. Observation on 06/27/24 at 11:40 A.M., revealed Resident #9 was following surveyor and calling her name demanding money to purchase food out of the vending machine. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 06/27/24 at 12:10 P.M., revealed Resident #9 was sitting in the office asking staff and surveyor for money to purchase food items from the vending machine. Interview on 06/27/24 at 1:02 P.M. with Medical Director (MD), who was also Resident #9's primary care physician, revealed he was not familiar with Resident #9, and he would not be able to answer questions regarding Resident #9 until he had access to a computer. No additional information was provided from the medical director during the survey. Interview on 06/27/24 at 1:09 P.M. with Resident #9 revealed for dinner she had pureed chicken, but she did not want it and put it back because she does not eat that pureed s**t. Resident #9 was observed to have two packs of [NAME] Link's jerky which she [TRUNCATED]

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on medical record review, interview, and facility policy review, the facility failed to ensure three residents (#9, #68, and #79) were seen by a physician as required every 30 days for the first 90 days then every sixty thereafter. This affected three of 23 sampled residents. Findings Include: 1. Review of the medical record for Resident #68 revealed an initial admitted [DATE] with the diagnoses including chronic obstructive pulmonary disease (COPD), asthma, severe morbid obesity, cerebrovascular accident (CVA) with left sided hemiplegia, protein calorie malnutrition, atrial fibrillation, major depressive disorder, gastro-esophageal disorder, hypertension, hyperlipidemia, cannabis use, obstructive sleep apnea, anxiety disorder, diabetes mellitus, anemia, nicotine dependence, cardiac arrhythmia and pain in limb. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the medical record revealed Resident #68 was admitted on [DATE] and was seen by Former Medical Director (FMD) #502 on 07/14/23 for an initial history and physical (H&P). Further review of the medical record revealed the resident was not seen by a physician again until 05/14/24 when the facility's current Medical Director (MD) #115 examined the resident. Additionally, MD #115 failed to alternate visits with the designee to see the resident every 60 days. On 07/02/24 at 3:45 P.M., interview with Licensed Practical Nurse (LPN) #440 verified Resident #68 was not seen by a physician and/or designee every thirty days for the first 90 days then every 60 days thereafter. 2. Review of the medical record for Resident #79 revealed an initial admitted [DATE] with the diagnoses including but not limited to chronic obstructive respiratory failure (COPD), acute and chronic respiratory failure with hypoxia, severe protein calorie malnutrition, emphysema, anemia, metabolic encephalopathy, anxiety disorder, major depressive disorder, hyperlipidemia, bipolar disorder, sleep disorder, mood disorder, suicidal ideations, poisoning by drugs, medicaments and biological substances intentional self harm, nicotine dependence, palliative care and overactive bladder. Review of the resident's quarterly change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident has no cognitive deficit. Review of the medical record revealed Resident #79 was admitted on [DATE] and was seen by Former Medical Director #502 on 01/24/24 for an initial history and physical (H&P). Further review of the medical record revealed the resident was not seen by a physician again until 05/14/24 when the facility's current Medical Director #115 examined the resident. Additionally, MD #115 failed to alternate visits with the designee to see the resident every 60 days. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/02/24 at 3:45 P.M., interview with Licensed Practical Nurse (LPN) #440 verified the resident was not seen by a physician and/or designee every thirty days for the first 90 days then every 60 days thereafter. 3. Record review revealed Resident #9 admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, alcoholic liver disease, unspecified psychosis not due to a substance or known physiological condition, hypertension, anemia, hyperlipidemia, schizoaffective disorder, major depression, adult failure to thrive, insomnia, and diverticulosis of large intestine without perforation or abscess without bleeding. An additional diagnosis of unspecified severe protein-calorie malnutrition was added on 09/13/21. Review of a physician note dated 03/11/23 revealed Resident #9 was seen by Medical Director #115 for a one month follow up. Resident #9 was not seen again by the physician until 05/14/24. Additionally, MD #115 failed to alternate visits with the designee to see the resident every 60 days. On 07/02/24 at 3:45 P.M., interview with Licensed Practical Nurse (LPN) #440 verified the resident was not seen by a physician and/or designee every thirty days for the first 90 days then every 60 days thereafter. Review of the facility policy titled, Attending Physician Responsibilities, (dated 08/14) revealed the primary practitioners responsible for providing medical services and coordinating the healthcare of each resident in the facility. Each attending physician will be responsible for accepting responsibility for initial and subsequent resident care. The attending physician will visit at least every 30 days for the first 90 days after admission and then at least every 60 days thereafter. After the first 90 days a Nurse Practitioner or other ,midlevel practitioner under the physician's supervision can make alternate scheduled visits unless otherwise restricted by regulations.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review and interview, the facility failed to ensure resident's received medically-related social services to maintain the highest practicable psychosocial well-being. This affected one resident (#9) of one resident reviewed for receiving social services. The facility census was 77. Findings include: Record review revealed Resident #9 admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, alcoholic liver disease, unspecified psychosis not due to a substance or known physiological condition, hypertension, anemia, hyperlipidemia, schizoaffective disorder, major depression, adult failure to thrive, insomnia, and diverticulosis of large intestine without perforation or abscess without bleeding. An additional diagnosis of unspecified severe protein-calorie malnutrition was added on 09/13/21. Review of a care conference sheet dated 01/04/24 revealed Resident #9, her guardian via phone, Activities Director, Social Services Director, Dietary Manager, and another staff member were present. The sheet revealed Resident #9 was still on a pureed diet and the facility was having trouble getting her to eat, discussed her degenerative tongue issue, reviewed her weight, and the resident's guardian wanted to know if or when hospice should step in and discussed potential of comfort foods. No further information was documented in the medical record as a follow-up to this care conference. Review of a social services note dated 03/14/24 at 2:05 P.M. by Social Services Assistant (SSA) #123 revealed Resident #9's guardian gave permission to get a hospice consult due to weight loss with no preference for hospice provider. A referral was sent and an additional note at 2:09 P.M. revealed SSA #123 was awaiting a response regarding hospice consult from the hospice provider. Review of a care conference dated 04/09/24 revealed SSA #123 attempted to contact Resident #9's guardian for a care conference. No additional social services notes were identified relating to attaining hospice services or advocacy for Resident #9 to receive additional nutrition. Interview on 06/25/24 at 2:31 P.M. with Registered Nurse (RN) #223 revealed in January 2024, Resident #9's guardian had requested hospice but services were terminated due to a clerical issue with the paperwork involving her last name. RN #223 stated Resident #9 had not been receiving hospice services for weeks and she was told her legal guardian had not contacted hospice to start services. Interview on 06/26/24 at 4:11 P.M. with Resident #9's legal guardian revealed she was unaware resident was no longer receiving hospice services. Interview on 06/27/24 at 1:40 P.M. with Resident #9's guardian revealed she had been in contact with hospice to sign new paperwork and re-admit. Guardian stated the facility had still not been in contact with her. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/27/24 at 5:56 P.M. with RN #223 and #389 revealed they asked facility management each week to call and get hospice re-established with no results. Interview on 07/02/24 at 7:37 A.M. with Administrator revealed the Social Services Director (SSD) is in charge of coordinating hospice services. Administrator revealed Social Services Assistant (SSA) #123 was the previous SSD but things weren't getting done so she took the assistant position. Administrator stated hospice services are being monitored more closely now. Administrator stated the hospice company did not notify the facility Resident #9 had enrolled in services but did notify them when she was discontinued from services. Interview on 07/02/24 at 7:47 A.M. with SSD #200 revealed she took over the position in late April or early May (2024) and does have previous experience as a social worker in a nursing facility. SSD #200 stated she did not know Resident #9 had actually signed up for hospice because everything on the facility's end stated pending. SSD #200 stated since she took over the position, she has been trying to get the department moving in the right direction which has been a struggle. SSD #200 stated one call for a follow up to hospice services being discontinued was not sufficient, but she is working on building a better relationship with all the hospice providers the facility works with. SSD #200 stated she does not have many communications with the hospice company providing services to Resident #9, but she is trying to rectify the situation. SSD #200 stated she planned on reaching out to arrange a conference and establish a better relationship with the hospice company. Interview on 07/02/24 at 8:06 A.M. with SSA #123 revealed she had been attempting to get referrals out to hospice services prior to March (2024) and has since attempted to contact Resident #9's guardian without success. SSA #123 confirmed there was no documented evidence of her attempting to contact hospice or Resident #9's guardian, aside from the care conference note on 04/09/24. SSA #123 stated she is working on getting better at documentation. SSA #123 stated she usually communicates with hospice companies via telephone. SSA #123 confirmed one or two residents currently receive hospice from the provider for Resident #9. SSA #123 stated hospice is invited to care conferences and additionally hospice will talk to unit managers. SSA #123 confirmed it was her responsibility to coordinate hospice services. SSA #123 stated in her role as a social worker, she should advocate for resident rights. SSA #123 stated she was unsure how to answer if she should have advocated for Resident #9 to receive additional services or nutrition to cultivate a higher psychosocial well-being and decrease behaviors. SSA #123 stated she was involved in morning meetings and afternoon meetings for the clinical staff and she had stated additional interventions were needed to get Resident #9 to eat her food or something along those lines. SSA #123 stated Resident #9 was not enjoying pureed foods. When asked if palliative care was offered in lieu of hospice services until the clerical issue was resolved, SSA #123 was unable to distinguish between palliative care and hospice care. SSA #123 stated she was new to the role and did not learn much in orientation about resources available to residents or an orientation in general. SSA #123 stated she learned as she went and she was in the process of learning the difference between hospice and palliative care. SSA #123 stated she was aware hospice had additional staff come in the facility but she was drawing a blank on other services. SSA #123 stated in regards to Resident #9, there is not much encouragement can do because once she has her mind set she doesn't change it. SSA #123 stated any time she spoke with Resident #9, the concerns were always food related.

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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** 47985 Based on record review and interview, the facility failed to ensure as needed pain medication had parameters in place. This affected one resident (#59) of two residents reviewed for pain. The facility census was 77. Findings include: Record review revealed Resident #59 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, pneumonia, respiratory failure with hypoxia, and anorexia. Review of orders revealed Resident #59 had an order in place starting on 05/22/24 for Acetaminophen oral tablet 325 milligrams (mg) give two tablets by mouth every six hours as needed for mild pain. The resident had an order starting on 06/26/24 for oxycodone oral tablet 15 mg give one tablet by mouth every eight hours as needed for pain. The resident had an order starting on 06/27/24 for oxycodone oral tablet five mg give three tablets by mouth every eight hours as needed for pain. There were no parameters for pain medication administration. Review of an admission minimum data set completed on 05/30/24 revealed Resident #59's cognition was intact, he had occasional pain, and shortness of breath when lying flat. Interview on 07/02/24 at 7:22 A.M. with the Administrator confirmed there were no parameters in place for the administration of acetaminophen or oxycodone.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 32654 Based on observation and interview, the facility failed to ensure medications were stored in a locked compartment. This affected one resident (#1) of 77 residents in the facility. Findings Include: On 06/27/24 at 2:28 P.M., during a search of Resident #1's room for her right wrist brace, a clear plastic cup of pudding was found with chunks of a crushed white pill in them by State tested Nursing Assistant (STNA) #116 on top of Resident #1's dresser. On 06/27/24 at 2:43 P.M., interview with Registered Nurse (RN) #223 revealed Resident #1's medications are administered whole and not crushed. RN #223 revealed she was unsure where the cup of medication came from and what the medication was. On 06/27/24 at 2:55 P.M., interview with Licensed Practical Nurse (LPN) #111 verified the white chunks in the clear plastic cup containing pudding was a white pill (narcotic) and was not stored in a locked compartment.

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Country Lane Gardens Rehab & Nursing Ctr	7820 Pleasantville Road Pleasantville, OH 43148

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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** 32654 Based on medical record review and interview the facility failed to ensure accurate and complete medical records in the area of nutritional supplement intake. This affected one resident (#79) of three residents reviewed for weight loss. Findings Include: Review of the medical record for Resident #79 revealed an initial admitted [DATE] with the diagnoses including but not limited to chronic obstructive respiratory failure (COPD), acute and chronic respiratory failure with hypoxia, severe protein calorie malnutrition, emphysema, anemia, metabolic encephalopathy, anxiety disorder, major depressive disorder, hyperlipidemia, bipolar disorder, sleep disorder, mood disorder, suicidal ideations, poisoning by drugs, medicaments and biological substances intentional self harm, nicotine dependence, palliative care and overactive bladder. Review of the plan of care dated 01/30/24 revealed the resident had nutritional problem or potential nutritional problem related to mechanically altered diet, history of thickened liquids, malnutrition, emphysema, COPD, hypertension, bipolar disorder, low BMI, history of wounds, on mood altering medications, weight gain history, need for hospice care, expect decline in weight, skin integrity and by mouth intakes as disease state progress. Interventions included administer medications as ordered and monitor/document for side effects and effectiveness, provide and serve supplements as ordered, provide and serve diet as ordered, monitor intake and record every meal and Registered Dietician (RD) to evaluate and make diet change recommendations as needed. Review of the resident's quarterly change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The resident had no known weight loss and her weight was coded as 103 pounds. Review of the monthly physician orders for June 2024 identified orders dated 05/15/24 house supplement 120 milliliters (ml) by mouth twice daily and frozen nutritional treat daily with lunch. Review of the resident's May and June 2024 Medication Administration Record (MAR) revealed no documented evidence the facility recorded the percentage of the house supplement and frozen nutritional treat consumed. On 06/26/24 at 10:33 A.M. interview with Licensed Practical Nurse (LPN) #330 verified the facility was not recording the percentage of the house supplement and frozen nutritional treat consumed.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review and interview, the facility failed to ensure a communication process was in place with a hospice company resulting in Resident #9 having a delay in hospice services. This affected one resident (#9) of one resident reviewed for hospice. The facility census was 77. Findings include: Record review revealed Resident #9 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, alcoholic liver disease, unspecified psychosis not due to a substance or known physiological condition, hypertension, anemia, hyperlipidemia, schizoaffective disorder, major depression, adult failure to thrive, insomnia, and diverticulosis of large intestine without perforation or abscess without bleeding. An additional diagnosis of unspecified severe protein-calorie malnutrition was added on 09/13/21. Review of a care conference sheet dated 01/04/24 revealed Resident #9, her guardian via phone, Activities Director, Social Services Director, Dietary Manager, and another staff member were present. The sheet revealed Resident #9 was still on a pureed diet and the facility was having trouble getting her to eat, discussed her degenerative tongue issue, reviewed her weight, and the resident's guardian wanted to know if or when hospice should step in and discussed potential of comfort foods. No further information was documented in the chart as a follow-up to this care conference. Review of a social services note dated 03/14/24 at 2:05 P.M. by Social Services Assistant (SSA) #123 revealed Resident #9's guardian gave permission to get a hospice consult due to weight loss with no preference for hospice provider. A referral was sent and an additional note at 2:09 P.M. revealed SSA #123 was awaiting a response regarding hospice consult from the hospice provider. Review of a progress note dated 03/15/24 at 11:38 A.M. by previous Director of Nursing (DON) #160 revealed a referral was sent to a different hospice provider and the social worker was to come to facility at noon for intake paperwork. An additional note at 2:39 P.M. revealed hospice representative was present and received paperwork. Review of a progress note dated 03/18/24 at 3:47 P.M. by previous DON #160 revealed the facility was awaiting paperwork from the hospice provider. Review of a progress note dated 03/22/24 at 7:16 P.M. by Registered Nurse (RN) #389 revealed Resident #9 was admitted to Hospice for severe protein calorie malnutrition, routine level of care, continue DNRCC (do not resuscitate-comfort care), and continue all current medications. Review of written orders dated 03/22/24 revealed Resident #9 admitted to Hospice for severe protein calorie malnutrition, routine level of care, and to continue all current orders. Hospice services were discontinued on 03/24/24 with no evidence of notification to the physician, resident or guardian at that time. In addition, there was no evidence of follow-up to resolve why services were discontinued at this time. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nutrition note dated 03/26/24 at 2:05 P.M. by Registered Dietitian (RD) #352 revealed Resident #9 recently admitted to hospice care, overall goal was for comfort and quality of life with hospice, expect a decline in weight, skin and intakes as the disease state progresses. Review of a Nutritional Assessment Review completed by RD #352 on 03/26/24 revealed Resident #9's BMI was 13.6 and her goal weight was 110 lbs., she did not have swallowing issues, and her overall goal was for comfort and quality of life with hospice, expect decline in weight, skin integrity, and intakes as disease state progress. Recommendations included discontinuing weekly weights order due to hospice, consider discontinuing monthly weights due to hospice and monitor as needed. Review of a significant change MDS completed on 04/03/24 revealed Resident #9 had moderately impaired cognition, had no behaviors, required set-up help for eating, had no signs of a swallowing condition, had a weight loss of five percent or more in the last month or loss of ten percent or more in the last six months and was not on a prescribed weight-loss regimen, received a mechanically altered diet, and received hospice care. Interview on 06/25/24 at 8:50 A.M. with Resident #9 revealed she thought she did receive hospice services. Interview on 06/25/24 at 2:31 P.M. with Registered Nurse (RN) #223 revealed in January 2024, Resident #9's guardian had requested hospice but services were terminated due to a clerical issue with the paperwork involving her last name. RN #223 stated Resident #9 had not been receiving hospice services for weeks and she was told her legal guardian had not contacted hospice to start services. Interview on 06/26/24 at 4:11 P.M. with Resident #9's legal guardian revealed she was unaware resident was no longer receiving hospice services. Interview on 06/26/24 at 4:44 P.M. with Hospice Receptionist #111 revealed Resident #9 was admitted to hospice services on 03/22/24 and services were discontinued two days later (03/24/24). Hospice Receptionist #111 stated Resident #9 was re-evaluated on 04/01/24, but had no additional information and stated the services were discontinued due to a clerical issue with Resident #9's last name. Interview on 06/26/24 at 4:54 P.M. with Hospice Administrator (HA) #112 revealed Resident #9's medical card had a different last name than what her guardian signed her name with so services were discontinued. Interview on 06/27/24 at 1:40 P.M. with Resident #9's guardian revealed she had been in contact with hospice to sign new paperwork and re-admit. Guardian stated the facility had still not been in contact with her. Interview on 06/27/24 at 5:56 P.M. with RN #223 and #389 revealed they asked facility management each week to call and get hospice re-established with no results. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/02/24 at 7:37 A.M. with Administrator revealed the Social Services Director (SSD) is in charge of coordinating hospice services. Administrator revealed Social Services Assistant (SSA) #123 was the previous SSD but things weren't getting done so she took the assistant position. Administrator stated hospice services are being monitored more closely now. Administrator stated the hospice company did not notify the facility Resident #9 had enrolled in services, but did notify them when she was discontinued from services. Interview on 07/02/24 at 7:47 A.M. with SSD #200 revealed she took over the position in late April or early May and does have previous experience as a social worker in a nursing facility. SSD #200 stated she did not know Resident #9 had actually signed up for hospice because everything on the facility's end stated pending. SSD #200 stated since she took over the position, she has been trying to get the department moving in the right direction which has been a struggle. SSD #200 stated one call for a follow up to hospice services being discontinued was not sufficient but she is working on building a better relationship with all the hospice providers the facility works with. SSD #200 stated she does not have many communications with the hospice company providing services to Resident #9 but she is trying to rectify the situation. SSD #200 stated she planned on reaching out to arrange a conference and establish a better relationship with the hospice company. Interview on 07/02/24 at 8:06 A.M. with SSA #123 revealed she had been attempting to get referrals out to hospice services prior to March, and has since attempted to contact Resident #9's guardian without success. SSA #123 confirmed there was no documented evidence of her attempting to contact hospice or Resident #9's guardian, aside from the care conference note on 04/09/24. SSA #123 stated she is working on getting better at documentation. SSA #123 stated she usually communicates with hospice companies via telephone. SSA #123 confirmed one or two residents currently receive hospice from the provider for Resident #9. SSA #123 stated hospice is invited to care conferences and additionally hospice will talk to unit managers. SSA #123 confirmed it was her responsibility to coordinate hospice services. Review of the hospice agreement (dated 02/27/24) revealed the facility must designate a representative to work in conjunction with the hospice to coordinate care to the patient, the party must have a clinical background, function within their state scope of their practice, and have the ability to access the patient or have access to someone who has the skills and capabilities to access a patient. This person is responsible for coordinating facility staff participation in the hospice care planning process, should communicate with the hospice medical director, the patients attending physician, and all other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. The facility must provide orientation to the hospice staff in policies and procedures of the facility, including patients' rights, appropriate forms, and record keeping requirements. Review of a policy titled Hospice Program (dated January 2014) revealed when a resident has been classified as terminally ill, the Director of Nursing (DON) should contact a hospice agency and request a consult with the resident/family. All hospice services are provided under a contractual agreement, complete details outlining the responsibilities of the facility and hospice agency are contained in this agreement, and a copy of the agreement is kept on file.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review, observation, and interviews, the facility failed to ensure enhanced barrier precautions were in place for residents with indwelling medical devices. This affected one resident (#59) of three residents reviewed for infection control. Additionally, the facility failed to ensure vaccination consents were fully completed, affecting two residents (#9 and #59) of five residents reviewed for vaccinations; and the facility failed to track infectious organisms. This had the potential to affect all 77 residents residing in the facility. The census was 77. Findings include: 1. Record review revealed Resident #59 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, pneumonia, respiratory failure with hypoxia, and anorexia. Review of an admission minimum data set completed on 05/30/24 revealed Resident #59's cognition was intact. Review of an undated Patient Vaccination Informed Consent/Declination Form revealed Resident #59 declined to receive the vaccination but did not specify which vaccination was being declined. Empty check boxes included the options on pneumonia and flu shots. Interview on 07/02/24 at 3:24 P.M. with Unit Manager (UM) #330 confirmed the informed consent/declination form was not filled out completely. 2. Record review revealed Resident #9 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, unspecified psychosis, anemia, and adult failure to thrive. Additional review of record revealed Resident #9 had a legal guardian of person in place. Review of a Patient Vaccination Informed Consent/Declination form (dated 10/19/23) revealed Resident #9 elected to have the flu shot. There was no indication Resident #9's guardian was aware. Review of an Informed Consent for Covid-19 Vaccination form (dated 11/27/23) revealed Resident #9 elected to have the Covid vaccination. There was no indication Resident #9's guardian was aware. Interview on 07/02/24 at 1:26 P.M. with UM #440 confirmed Resident #9 signed the Covid-19 vaccination form and her guardian was not aware. Interview on 07/02/24 at 3:55 P.M. with UM #330 confirmed Resident #9 signed the Flu vaccination consent form and her guardian was not aware. 3. Record review revealed Resident #59 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, pneumonia, respiratory failure with hypoxia, and anorexia. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a care plan dated 05/22/24 revealed Resident #59 had enhanced barrier precautions in place related to a colostomy and PICC line. Interventions included to have a sign on the door, and wear gloves and gowns for high contact resident care. Observation on 06/24/24 at 9:40 A.M. revealed Resident #59 did not have precautions in place. Interview on 06/24/24 at 4:35 P.M. with Registered Nurse (RN) #223 verified Resident #59 did not have enhanced barrier precautions in place. Interview on 06/25/24 at 10:42 A.M. with UM #440 revealed each resident who is on enhanced barrier precautions should have a sign on their door and a cart outside their door. 4. Review of the infection control log for January 2024 revealed four residents had tested positive for a urinary tract infection (UTI) but the pathogens were not logged and tracked for patterns. Review of the infection control log for February 2024 revealed four residents had tested positive for a UTI but two residents' pathogens were not logged or tracked for patterns. Review of the infection control log for April 2024 revealed three residents had tested positive for a UTI but the pathogens were not logged or tracked for patterns. Review of the infection control log for May 2024 revealed six residents had tested positive for a UTI but four residents' pathogens were not logged or tracked for patterns. Review of the infection control log for June 2024 revealed two residents had tested positive for UTIs but the pathogens were not logged or tracked for patterns. Interview on 07/02/24 at 1:01 P.M. with Director of Nursing and UM #440 confirmed pathogens for UTIs had not been logged and tracked to monitor any patterns or spreading of infections. Review of a policy titled Vaccination of Residents (dated August 2017) revealed prior to receiving vaccinations, the resident or their legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations. Review of a policy titled Enhanced Barrier Precautions (EBP) Policy and Procedure (dated 04/01/24) revealed EBPs are indicated for residents with wounds or indwelling medical devices regardless of multi-drug resistant organism (MDRO) status and for infections or colonization with an MDRO when contact precautions do not otherwise apply.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review and interview, the facility failed to ensure residents required antibiotics prior to administration of antibiotics. This affected two residents (#237 and #50) of six residents reviewed for antibiotic stewardship. The facility census was 77. Findings include: 1. Record review revealed Resident #50 was admitted to the facility on [DATE] with diagnoses including obsessive compulsive disorder, anemia, chronic pain, and gastro-esophageal reflux disease. Review of the infection control log for February 2024 revealed Resident #50 had a urinary tract infection which was treated with Amoxicillin. Review of a McGeer Criteria for Infection Surveillance (dated 02/14/24) revealed to meet criteria for treatment of a UTI criteria one (at least one of the following: acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate; fever or leukocytosis and one or more of the following- acute costovertebral angle pain or tenderness, suprapubic pain, gross hematuria, new or marked increase in incontinence or urgency or frequency; and if no fever or leukocytosis then two or more of the following- suprapubic pain, gross hematuria, new or marked increase in incontinence or urgency or frequency) and two (at least one of the following microbiologic criteria: equal to or great than 100,000 cfu/mL of no more than 2 species of organisms in a voided urine sample or 100,000 cfu/mL of any organism in a specimen collected by an in-and-out catheter) must be met. McGeer criteria was marked as met for acute dysuria or pain and new or marked increase in incontinence, urgency and frequency as well as at least 100,000 cfu/mL of no more than two species of organisms in a voided sample. Review of a culture and sensitivity completed on 02/14/24 revealed 30-40,000 cfu/mL of streptococcus agalactiae were noted in the urine sample, not the required 100,000 cfu/mL. 2. Record review revealed Resident #237 was admitted to the facility on [DATE] with diagnoses including cancer, type II diabetes, atrial fibrillation and hypertension. Review of the infection control log for January 2024 revealed Resident #237 tested positive for a UTI. Review of a McGeer Criteria for Infection Surveillance Checklist (completed on 01/23/24) revealed Resident #237 met the criteria for acute dysuria or pain, suprapubic pain, gross hematuria, new or marked increase in frequency, and he did not meet criteria two. Resident #237 was treated with Macrobid 100 milligrams by mouth twice daily for 10 days from 01/23/24 to 02/02/24. Review of a urinalysis completed on 01/23/24 revealed Resident #237 did not have an infection and a culture and sensitivity was not indicated. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/02/24 at 1:01 P.M. with Director of Nursing (DON) and Unit Manager #440 confirmed Residents #237 and #50 did not meet the McGeer criteria for antibiotic usage. Review of a policy titled Antibiotic Stewardship- Orders for Antibiotics (dated 12/2016) revealed appropriate indications for use of an antibiotic included criteria met for clinical definition of active infection or suspected sepsis and pathogen susceptibility, based on culture and sensitivity, to antimicrobial. When a culture and sensitivity is ordered, it will be completed and lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued.