STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366201	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Whitehall	4805 Langley Avenue Whitehall, OH 43213

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. 50008 Based on record review and staff interview, the facility failed to provide notice to residents and or resident representative when the resident funds account reached $200 less than the Supplemental Security Income (SSI) resource limit for one person. This affected three (Residents #14, #55, and #87) of five residents reviewed for resident funds. The facility census was 126 residents. Findings include: Review of the medical records for Residents #14, #55, and #87 revealed they have Medicaid as a payor source. Review of the Resident Fund account for Resident #14 revealed on 04/29/24, the balance was $2,140.02. The balance remained at or above $2,110.02 through 06/13/24. Resident #14 did not receive a spend down notification until 06/03/24. Review of the Resident Fund account for Resident #55 revealed on 04/03/24, the balance was $2,242.31. The balance remained at or above $2,159.31 through 05/20/24. Resident #55 did not receive a spend down notification until 06/03/24. Review of the Resident Fund account for Resident #87 revealed that on 12/01/23, the balance was $3,234. 71. The balance remained at or above $2,250.05 through 06/13/24. Resident #87 did not receive a spend down notification until 06/03/24. Interview with Business Office Manager #610 on 06/13/24 at 3:20 P.M. verified Business Office Manager #610 did not realize that she had to give spend down notices prior to 06/03/24, when she initiated spend down notification letters for Residents #14, #55, and #87. Review of the facility policy titled Resident Personal Funds 2023 revealed residents whose care is funded by Medicaid: the facility will deposit the resident's personal funds in excess of $50 in an interest bearing account. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person and; if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 47987 Based on resident and staff interviews, observations, and review of the facility policy, the facility did not maintain a safe and sanitary living environment for the residents who utilized the common area refrigerators. This had the potential to affect all residents in the facility except for the 22 residents residing on the memory care unit. The facility census was 126. Findings include: Interview on 06/10/24 at 10:46 A.M. with Resident #113 stated he attempted to use the resident refrigerator for a personal food item. He stated there was no room in it and there were flies and gnats in it, and it was not clean. He stated it was the refrigerator in the activities area located on the 200 Hall. Observation on 06/10/24 at 11:02 A.M. of the refrigerator on the 200 hall activity area revealed there was no temperature log and a sign was posted on the front of it stating it was a resident refrigerator and to date all items. Inside the refrigerator, there was a spilled drink on the ground, it was full of undated food from various restaurants and grocery bags with mold-like substance on the food items, and had gnats and flies coming out it. The freezer also contained several food items not dated and it was not clean. Interview on 06/10/24 at 11:04 A.M. with Activities Assistant #301 stated she was not sure who takes care of the refrigerator. Interview on 06/10/24 at 11:06 A.M. with Licensed Practical Nurse (LPN) #481 stated she was not sure who cares for the refrigerator. Observation of the 200 hall activity refrigerator and interview on 06/10/24 at 11:12 A.M. with the Administrator revealed he thought activities cares for the refrigerator and verified there was no temperature log, there were flies, gnats, a spilled drink, and undated old food/moldy food items. The Administrator verified the freezer had food items undated and both the refrigerator and freezer were in unsanitary conditions. The Administrator verified residents use the 200 hall refrigerator as well as another one located on the 100 hall. Observation on 06/10/24 at 11:23 A.M. of the 100 hall refrigerator revealed there was no temperature log and one opened item of hotdogs that was not dated. The freezer contained several items not dated. Observation and interview on 06/10/24 at 11:26 A.M. with LPN #533 of the 100 hall refrigerator verified there was no temperature log and the undated/opened hotdogs with the several undated freezer items. LPN #533 stated they try to keep a temperature log, but the residents remove it and verified no temperature logs can be produced for the past year. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Refrigerators and Freezers revised December 2014 revealed refrigerators and freezers will be kept clean, free of debris, and mopped with sanitizing solution on scheduled bases and more often as necessary. Monthly tracking sheets for all refrigerators and freezers will be posted to record temperatures and will include time, temperature, initials and actions taken.

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F 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 41271 Based on personnel file review, staff interview, and facility policy review, the facility failed to ensure new hired staff had reference checks completed prior to employment. This had the potential to affect all 126 residents residing at the facility. Finding include: Review of the personnel files for Registered Nurse (RN) #575, #641, #628, State tested Nursing Assistant (STNA) #589, #644, Business Office Manager (BOM) #610, and Social Services Director (SSD) #656 revealed these staff members did not have any reference checks completed prior to being hired. Interview on 06/13/2024 at 3:10 P.M. with Human Resources (HR) #720 confirmed reference check was part of the new hire process and was required to be available in each employees personal file. HR #720 confirmed RN #575, RN #641, RN #628, STNA #589, STNA #644, BOM #610 and SSD #656 did not have reference checks completed prior to being hired. Review of the facility's undated policy titled Abuse Prevention Program revealed the facility conducts employee background checks per state and federal regulations.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on staff interview and record review, the facility failed to assess, document, and complete a transfer of a resident to the hospital for evaluation and treatment. This affected one (Resident #123) of one resident reviewed for hospitalization s. The facility census was 126. Findings include: Review of Resident #123's medical record revealed an admitted [DATE] with diagnoses including Parkinson's disease, atrial fibrillation, type two diabetes mellitus, and chronic pain syndrome. Resident #123 had intact cognition and was able to make needs known. Resident #123 was discharged to the hospital on 05/06/24 for unknown reason. Review of Resident #123's baseline care plan dated 05/04/24 revealed Resident #123 required assistance for discharge planning. Review of the vital sign listing dated 05/06/23 at 10:40 A.M. revealed Resident #123's pain level was three out of ten. Review of the physician's order dated 05/06/24 at 1:45 P.M. by Physician #710 revealed an order to send Resident #123 to the emergency room (ER) for evaluation and treatment for pain. Review of Resident #123's medical record dated 05/06/24 revealed there were no entries for Resident #123's health status, assessment of condition, or family request for Resident #123's reason for transfer to the ER for evaluation and treatment for 05/06/24. Interview on 06/13/24 at 8:47 A.M. with the Director of Nursing (DON) confirmed there were no progress notes or Interact assessments completed for Resident #123 prior to being transferred to the ER for evaluation and treatment. The DON stated the expectation of the floor nurses are to assess the resident, complete an Interact assessment form in the computerized medical record, notify the physician and family, and document in the progress notes the health status of the resident, any change in condition, and the reason for the transfer of the resident.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41271 Based on medical record review, observations, resident and staff interview, and facility policy review, the facility failed to ensure residents who smoked had a personalized smoking care plan. This affected two (Residents #94 and #113) of the two residents reviewed for smoking. The facility census was 126. Findings include: 1. Review of the medical record for Resident #94 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, acute and chronic respiratory failure, cognitive impairment, and long term, current use of opiate analgesic. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #94 had intact cognition for daily decision making abilities. Review of the Safe Smoking Review dated 06/10/24 revealed Resident #94 was not a cigarette/Tobacco smoker, Resident #94 smokes recreational marijuana intermittently. Educated on safe smoking practices and smoking policy provided, and resident agreeable. Review of the progress note dated 06/10/24 at 10:30 A.M. created by Director of Nursing (DON) revealed Resident #94 was noted in the smoking area with oxygen tubing on arm rest of wheelchair. Resident #94 was observed with marijuana paraphernalia and lighter in hands, and resident stated that he was not smoking, and his oxygen was turned off. A head to toe assessment completed, no new injury/areas noted. Resident #94 states I wasn't doing anything wrong, I was smoking and weed is legal, the cops told me, this is my home I can do it here The resident denies pain at this time, alert and orient times four, and smoking policy and education discussed with resident, smoking evaluation completed, discussed safety with oxygen use, and also discussed with resident marijuana use is not permitted on property at this time. Resident #94 was agreeable to follow policy and procedure of facility at this time- signed facility smoking policy and given copy. Review of Resident #94's current plan of care revealed no evidence of a smoking care plan. Observation on 06/10/24 at 11:58 A.M. revealed Resident #94 was sitting in the facility's courtyard with lighter, and pipe in his hand which appeared to have marijuana paraphernalia in it. Resident #94 was noted to have oxygen tank on back of wheelchair with the oxygen tubing placed around the wheelchair's arm. Interview on 06/10/24 at 12:00 P.M. with Resident #94 revealed when he first admitted to the facility, the nursing staff asked him if he smoked and he told them no. Resident #94 claimed if they wanted to know if he smoked anything other than tobacco, they need to clarify their questions because everyone knows if you are asked if you smoke, its tobacco, not marijuana. Resident #94 claims he has smoked marijuana since he was 15 and has done it the entire time he has been at this facility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/10/24 at 12:10 P.M. with Licensed Practical Nurse (LPN) #487 revealed he has worked here for years and was never aware that Resident #94 smoked tobacco or marijuana. LPN #487 confirmed observation on 06/10/24 at 11:58 A.M. of Resident #94 revealed he had a lighter, a pipe and what appeared to be marijuana paraphernalia. 47987 2. Review of the medical record for Resident #113 revealed an admitted [DATE]. Diagnoses included end stage renal disease, dependence on renal dialysis and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #113's cognition was intact. The resident was assessed to be a smoker. Review of the current list of smokers for the facility as of 06/10/24 revealed Resident #113 was listed as active. Review of the active care plans for Resident #113 revealed there was no smoking care plan. Interview on 06/12/24 at 8:54 A.M. with the Administrator and the Director of Nursing verified Resident #113 did not have a care plan for smoking. Review of the facility policy titled Smoking Policy-Residents revised July 2017 revealed any smoking-related privileges, restrictions, and concerns (for example, close monitoring), shall be noted on the care plan and all personnel caring for the resident shall be alerted to these issues.

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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** 49794 Based on medical record review, staff interview, and review of the facility policy, the facility failed to provide a resident who required assistance from staff with activities of daily living (ADL) adequate assistance with eating. This affected one (Resident #56) of four residents reviewed for ADLs. The facility census was 126. Findings include: Review of the medical record for Resident #56 revealed an admitted [DATE]. Diagnoses included polyneuropathy, diabetes mellitus type two, chronic kidney disease, psychotic disorder hallucinations, adult failure to thrive, protein calorie malnutrition, and heart failure. Review of Resident #56's care plan last revised on February 2024 revealed Resident #56 was nutritional risk related to mechanically altered diet, abnormal labs, diuretic therapy, refusals to eat, and vitamin deficiency, behaviors such as refusal of care and hallucinations, failure to thrive and malnutrition with hospice care, oral health and dental problems due to missing teeth, chronic pain related to spinal stenosis, radiculopathy, fibromyalgia, and osteoarthritis, cognitive impairment related to Alzheimer's disease and episodes of psychosis, and need for assistance with ADLs. Interventions included staff assistance with eating and drinking during meals, assessing residents needs such as food, thirst, toileting, comfort as indicated, offer substitutes for foods not eaten, document, and provide supplements as ordered, and record amount consumed. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #56 was dependent on staff for activities of daily living (ADLs) including eating and oral care. Observations on 06/12/24 from 8:10 A.M. to 8:20 A.M. revealed Resident #56's tray was placed on table in front of the resident. The food on the tray did not look as if any of it had been eaten. Resident #56 was awake but not interviewable. Staff were not present to assist with feeding. At 8:14 A.M., State tested Nursing Aide (STNA) #588 walked into Resident #56's room and could be heard from the hall saying Oh, Miss [Resident #56's first name], you don't want to eat? Oh, you're not eating, you should eat. STNA #588 then exited the room. STNA #588 returned to the room with a supplement drink at 8:17 A.M. and left the room again at 8:19 A.M. with tray of uneaten food for Resident #56. Interview on 06/12/24 at 8:16 A.M with STNA #588 revealed Resident #56 has days she doesn't want to eat. Staff #588 stated hospice sits with the resident for about hour a day but someone doesn't sit with her for every meal. Observation on 06/13/24 at 8:13 A.M. revealed the food tray was already in Resident #56's room at time of room entry. Resident #56 was eating oatmeal, and no staff were present in room to assist with feeding. At 8:33 A.M., STNA #568 removed the resident's tray from Resident #56's room. Resident #56 ate part of oatmeal but not the rest of food on the tray. Interview on 06/13/24 at 08:25 A.M with Licensed Practical Nurse (LPN) #487 stated if they see that Resident #56 needs help, then they help her but she can eat on her own. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/13/24 at 8:34 A.M. with STNA #568 confirmed Resident #56 did not receive assistance with feeding. STNA #568 stated LPN #487 assisted Resident #56 with feeding when they went into room earlier that day. Interview on 6/13/24 at 8:35 A.M. with LPN #487 revealed she encouraged her to eat when they gave her medications and tried to get her to take a bite. LPN #487 confirmed they did not sit down to try to feed her. Interview on 06/13/24 at 09:23 A.M. with MDS Coordinator #628 confirmed Resident #56 was dependent on staff for eating. MDS Coordinator #628 confirmed someone should be helping her eat by sitting with her for every meal. MDS Coordinator #628 confirmed some resident can feed themselves, but if they were not eating all of their meals then they need to be assisted with meals by staff. Interview on 06/13/24 at 10:13 A.M. with the Director of Nursing (DON) revealed staff help Resident #56 with meals on an as needed basis. The DON stated Resident #56 was able to feed self but the resident refuses to eat and doesn't like a lot of food and doesn't like the alternative. The DON confirmed the expectation of staff when assisting a resident that needs help would be for staff to sit next to her and try to encourage her to eat and not just ask her. Review of the facilities ADL policy dated 2023 revealed residents who are unable to carry out ADLs will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41271 Based on medical record review, staff interview, and facility policy review, the facility failed to complete accurate pressure ulcer assessments. This affected one (Resident #24) of the three residents reviewed for pressure ulcer care. The facility census was 126. Findings include: Review of the medical record for Resident #24 revealed a re-entry date of 11/20/18. Diagnoses included multiple sclerosis, reduced mobility, contracture in left and right knee, and colostomy status. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #24 had intact cognition for daily decision making abilities. Resident #24 was noted to experience an impairment to bilateral lower extremities. Resident #24 was noted to have two stage three pressure ulcers (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed.) which were noted to be facility acquired and two stage four pressure ulcers (Full thickness tissue loss with bone, tendon or muscle. Slough of eschar may be present on some parts of the wound bed) which were also facility acquired. Review of the plan of care last revised on 05/17/24 revealed Resident #24 had impaired skin integrity including a stage four to the sacral region, stage three to the left ischium, and a stage four to the right ischium. Interventions included the use of an air mattress to bed, assess and document skin condition, assess for pain and treat, assist with bed mobility, assist with toileting, check for incontinence and provide care, notify the medical director of worsening or not improvement in wound, pressure reducing cushion to chair, supplements as ordered, and wound treatment as ordered. Review of the weekly pressure ulcer assessment for Resident #24's left ischium revealed the following: -This area was first observed on 02/22/24 measuring 3.0 centimeter (cm) in length by 2.8 cm in width by 1.0 cm in depth. During this initial assessment, this pressure wound was staged as stage three with granulation tissue exposed and a moderate amount of serosanguineous drainage. -On 05/02/24, the assessment revealed this pressure wound was originally unstageable and currently unstageable measuring 3.0 cm in length by 4.5 cm in width by 1.0 cm in depth and noted as unchanged. -On 06/06/24, the assessment revealed this ulcer was originally a stage three pressure ulcer and currently a stage three pressure ulcer with measurements of 0.9 cm in length by 0.5 cm in width by 0.3 cm in depth and noted to be improving. Review of the weekly pressure ulcer assessment for Resident #24's right ischium revealed the following: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-This area was first observed on 02/29/24 and noted to have been in facility acquired on 02/22/24. This pressure ulcer was noted to be a stage three measuring 3.0 cm in length by 2.8 cm in width by 1.0 cm in depth with granulation tissue and one to 24% slough tissue. -On 05/02/24, the assessment revealed this pressure wound was originally a stage four and was currently a stage four measuring 0.6 cm in length, by 0.6 cm in width by 0.1 cm in depth. -On 06/06/24, the assessment revealed this pressure wound was originally a stage four and currently a stage four measuring 0.8 cm in length by 0.9 cm in width by 0.2 cm in depth and noted to be improving. Review of the weekly pressure ulcer assessment for Resident #24's sacrum revealed the following: -This area was first observed on 02/29/24 and was noted as a stage four measuring 3.0 cm in length by 3.0 cm in width by 0.2 cm in depth with granulation tissue. -On 05/02/24, the assessment revealed this pressure wound was originally a stage three and currently a stage three measuring 4.0 cm in length by 4.0 cm in width by 0.3 cm in depth. -On 06/06/24, the assessment revealed this pressure wound was originally a stage four and currently a stage four measuring 0.5 cm in length by 0.5 cm in width by 0.1 cm in depth. Interview on 06/13/224 at 12:30 P.M. with the Director of Nursing confirmed Resident #24's wound assessments were not accurate or consistent. When a wound is staged, it can not go up in a stage and then go back down and the resident's current wound measurements did not accurately reflect the documented current pressure ulcer stage. The DON also confirmed Resident #24's right ischium was noted with a pressure wound that was first observed on 02/22/24 but not documented on until 02/29/24. Review of the facility policy titled Wound Care dated 10/2010 revealed under Documentation: the following information should be recorded in the resident's medical record, the type of wound care given, the date and time the wound was given, any changes in resident's condition, and all assessment data including wound bed color, size, drainage, etc.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008 Based on observations, staff interview, review of the facility policy, and record review, the facility failed to ensure a resident received treatment and care for good foot health. This affected one (Resident #99) of one resident reviewed for podiatry. The facility census was 126 residents. Findings include: Medical record review revealed Resident #99 was admitted on [DATE]. Diagnoses included dementia, type II diabetes mellitus, and Alzheimer's disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #99 was severely impaired cognition. Resident #99 was dependent on staff for personal hygiene. Review of Resident #99's comprehensive care plan revealed the resident was at risk for complications due to diabetes mellitus. Interventions listed on her care plan included seeing a podiatrist for routine and as needed foot care, and a skin inspection weekly, paying particular attention to the feet. Review of Resident #99's weekly skin assessments dated 06/03/24 and 06/10/24 revealed no mention of the condition of resident's feet or toenails. Review of the Hospice Registered Nurse (RN) visit notes from 05/28/24 revealed the resident had a nail abnormality integumentary assessment finding. The indication and location of the nail abnormality was noted that Resident #99's toenails were thick and overgrown. Observations on 06/10/24 at 2:16 P.M. and 06/11/24 at 11:32 A.M. revealed Resident #99's toenails on bilateral feet were long, thick, and jagged. Her right great toenail was observed to be approximately one half inch in length hanging over her toe and curved. Her left great toenail was observed to be approximately one quarter inch over her skin and a thickness of approximately one quarter of an inch. An interview with Licensed Practical Nurse (LPN) #456 on 06/12/24 at 3:15 P.M. verified Resident #99's toenails on bilateral feet were long, thick, and jagged. LPN #456 stated he did not realize that her toenails were long and jagged. LPN #456 stated they would tell Social Services to add her to the podiatry list. An interview with Registered Nurse (RN) #710 on 06/12/24 at 3:15 P.M. revealed that during the hospice nurse visit on 05/28/24, Resident #99's toenails were long and overgrown. RN #710 stated they would have normally referred this to a doctor, and that RN #710 was not permitted to cut toenails on diabetic residents. Review of the podiatrist list revealed Resident #99 was not on the podiatry list for the past six months. (continued on next page)

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Majestic Care of Whitehall	4805 Langley Avenue Whitehall, OH 43213

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's 2023 policy titled Nail Care revealed staff should report unusual or abnormal conditions of the nails to the physician and the responsible party (e.g. curling, color changes, separation from the nail bed, redness, bleeding, pain, odor, infection, etc.). Identify conditions that increase risk for foot or nail problems, such as diabetes mellitus, peripheral vascular disease, heart failure, renal disease, or stroke. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. Routine nail care, to include trimming and filing will be provided on a regular schedule (such as weekly on Wednesday). Nail care will be provided between scheduled occasions as the need arises. Nails should be kept smooth to avoid skin injury. Only licensed nurses shall trim or file fingernails of residents with diabetes. Toenails of residents with diabetes or circulation problems should be filed only. If a resident has diabetes mellitus, toenail trimming should be performed by a physician or practitioner.

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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, observations, resident and staff interviews, and facility policy review, the facility failed to ensure residents were evaluated for safe smoking and provide adequate supervision and monitoring of residents who smoke. This affected two (Resident #94 and #113) of two residents reviewed for safe smoking. The facility census was 126. Findings include: 1. Review of the medical record for Resident #94 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, acute and chronic respiratory failure, cognitive impairment, and long term, current use of opiate analgesic. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #94 had intact cognition for daily decision making abilities. Review of the Safe Smoking Review dated 06/10/24 revealed Resident #94 was not a cigarette/Tobacco smoker, Resident #94 smokes recreational marijuana intermittently. Educated on safe smoking practices and smoking policy provided, and resident agreeable. Review of the progress note dated 06/10/24 at 10:30 A.M. created by Director of Nursing (DON) revealed Resident #94 was noted in the smoking area with oxygen tubing on arm rest of wheelchair. Resident #94 was observed with marijuana paraphernalia and lighter in hands, and resident stated that he was not smoking, and his oxygen was turned off. A head to toe assessment completed, no new injury/areas noted. Resident #94 states I wasn't doing anything wrong, I was smoking and weed is legal, the cops told me, this is my home I can do it here The resident denies pain at this time, alert and orient times four, and smoking policy and education discussed with resident, smoking evaluation completed, discussed safety with oxygen use, and also discussed with resident marijuana use is not permitted on property at this time. Resident #94 was agreeable to follow policy and procedure of facility at this time- signed facility smoking policy and given copy. Review of Resident #94's current plan of care revealed no evidence of a smoking care plan. Observation on 06/10/24 at 11:58 A.M. revealed Resident #94 was sitting in the facility's courtyard with lighter, and pipe in his hand which appeared to have marijuana paraphernalia in it. Resident #94 was noted to have oxygen tank on back of wheelchair with the oxygen tubing placed around the wheelchair's arm. Interview on 06/10/24 at 12:00 P.M. with Resident #94 revealed when he first admitted to the facility, the nursing staff asked him if he smoked and he told them no. Resident #94 claimed if they wanted to know if he smoked anything other than tobacco, they need to clarify their questions because everyone knows if you are asked if you smoke, its tobacco, not marijuana. Resident #94 claims he has smoked marijuana since he was 15 and has done it the entire time he has been at this facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/10/24 at 12:10 P.M. with Licensed Practical Nurse (LPN) #487 revealed he has worked here for years and was never aware that Resident #94 smoked tobacco or marijuana. LPN #487 confirmed observation on 06/10/24 at 11:58 A.M. of Resident #94 revealed he had a lighter, a pipe and what appeared to be marijuana paraphernalia. LPN #487 also confirmed Resident #94 had a supplemental oxygen tank on the back of his wheelchair while in the facility's designated smoking area. Review of the facility policy titled Smoking Policy-Residents, dated 07/2017 revealed oxygen use is prohibited in smoking area and all smoking material will be kept in a secured area by staff. Resident are not permitted to have any smoking related material. 47987 2. Review of the medical record for Resident #113 revealed an admitted [DATE]. Diagnoses included end stage renal disease, dependence on renal dialysis and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #113 had intact cognition. The resident was a smoker. Review of Resident #113's admission assessment completed on 03/08/24 revealed no safe smoking evaluation was completed, only the smoking evaluation stating the resident does smoke. Resident #113 did not have a smoking care plan in place. Review of the facilities current list of smokers for the facility revealed Resident #113 was listed as active and unsupervised. Interview on 06/10/24 at 10:51 A.M. with Resident #113 revealed the resident was a smoker and stated I go out whenever I want, I don't smoke all the time, but I do enjoy going out later at night when no one else is out there. Resident #113 verified the resident was never supervised for smoking. Subsequent interview on 06/12/24 at 8:43 A.M. with Resident #41 revealed the resident smokes outside of the posted smoking times per the facility as he was deemed a safe unsupervised smoker. Interview on 06/12/24 at 8:59 A.M. with the Administrator verified the facility does have smoking times posted, but not all residents were supervised as they were assessed on admission to be supervised or not. The unsupervised residents have been going out whenever they want as they were assessed to be safe. The Administrator verified the facility policy stated all smokers need supervised. Interview on 06/12/24 at 9:03 A.M. with the Director of Nursing (DON) revealed smoking assessments were done on admission and a care plan was placed for the residents safety on restrictions and needs to be a safe smoker. The DON verified Resident #113 did not have a competed safe smoking evaluation and was classified as unsupervised by the facility. Review of the facility policy titled Smoking Policy-Residents revised July 2017 revealed all residents will be supervised during smoking. Any smoking-related privileges, restrictions, and concerns (for example, need close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted of these issues. Smoking times are at the discretion of the Executive Director. Residents will be informed of the scheduled smoking times. This deficiency represents non-compliance investigated under Master Complaint Number OH00154655.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41271 Based on medical record review, observation, resident and staff interview, and review of the facility policy, the facility failed to ensure a resident had physician orders for oxygen administration. This affected one (Resident #94) of three residents reviewed for respiratory care. The facility census was 126. Findings include: Review of the medical record for Resident #94 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD) and acute and chronic respiratory failure. Review of Resident #94's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #94 had intact cognition. Review of the physician orders for Resident #94 revealed Resident #94 did not have any routine or as needed orders for oxygen administration. Resident #94 had orders dated 01/08/24 to apply two liters of oxygen at night for sleep apnea. Observation on 06/10/24 at 11:58 A.M. revealed Resident #94 sitting in the facility's courtyard with a oxygen tank on the back of his wheelchair with the oxygen tubing placed around the wheelchair's arm. Interview on 06/10/24 at 12:00 P.M. with Resident #94 revealed he has used oxygen for a while now but knows how to turn it on and off and does it himself all the time. Interview on 06/10/24 at 1:30 P.M. with the Director of Nursing (DON) confirmed Resident #94 required supplemental oxygen to maintain an appropriate oxygen saturation level. The DON also verified Resident #94 currently did not have an physician order for the use of supplement oxygen. Review of the facility's undated policy titled Oxygen Administration revealed oxygen is administered under orders of a physician, except in the case of an emergency.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on record review, staff interviews, review of hospital records, and policy review, the facility failed to properly assess and treat Resident #11's pain after a fall with major injury. This affected one (#11) of two residents reviewed for pain management. The facility census was 126. Findings include: Review of the medical record for Resident #11 revealed an admitted [DATE]. Diagnoses included restlessness, agitation, and dementia. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #11 had memory problems and required assistance from staff with transferring. Review of Resident #11's active care plan revealed the resident was at risk for acute and/or chronic pain with an intervention to observe for symptoms of non-verbal pain which included: changes in breathing, vocalizations, mood/behavior, eyes, face and body signs and symptoms. Review of the progress note dated 05/25/24 at 8:05 A.M. revealed Resident #11 was on the floor. Resident #11 stated she was trying to get in her chair and fell and hit her shin on the bedside table. Resident #11 complained of pain to the touch. Injury noted, bilateral shin swollen, and the physician ordered a stat x-ray of the right tibia and fibula. Review of the Incident and Accident Investigation Form for Resident #11 revealed the fall occurred on 05/25/24 at 5:45 A.M. with a statement made by State tested Nurse Aide (STNA) #421 indicating the resident attempted to get into the locked wheelchair unassisted from the bed. Resident #11 had pain to touch/movement and was given Tylenol, with no pain scale documented. Review of Resident #11's active physicians orders revealed Tylenol oral tablet 325 milligrams (mg) give two tablets by mouth every six hours as needed for pain. The physician orders dated 05/25/24 at 7:34 A.M. was for a stat x-ray on right tibia and fibula two view due to fall and to monitor for pain, swelling and bruises on bilateral lower legs until resolved. Review of Resident #11's Medication Administration Record (MAR) revealed Tylenol oral tablet 325 mg two tablets were administered at 6:00 A.M. with no pain scale noted but follow up pain relief was effective with pain scale (zero was no pain and ten was the most severe pain) being a zero at 7:00 A.M. Review of Resident #11's pain scale dated 05/25/24 at 7:31 A.M. revealed a numerical number of five. There was no documentation on interventions attempted to address the resident's pain. Review of a Focused Charting entry for Resident #11 by Licensed Practical Nurse (LPN) #481 dated 05/25/24 at 8:13 A.M. revealed no assessment of pain noted. Review of a change of condition assessment for Resident #11 dated 05/25/24 at 10:16 A.M. revealed a fall with fracture with no assessment of pain noted. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #11's transfer to the hospital on 05/25/24 at 10:45 A.M. revealed a numerical pain scale of zero at 10:41 A.M. There was no nonverbal assessment of Resident #11's pain was completed. Review of the Hospital Notes for Resident #11 revealed on admission on 05/25/24 the resident was noted to have neck, chest and hip pain with an x-ray of the pelvis confirmed the right tibia and fibula fracture, but also revealed a non-displaced proximal tibia fracture. Interview on 06/13/24 at 10:35 A.M. with LPN #481 revealed Resident #11 had a history of manic episodes that affects her cognition and stated When she is in that state of mind, she has trouble answering questions appropriately, but I did ask her about her pain several times before sending her out and she didn't have any. When they would move her in bed, however, she would scream out and she did not like it. Her shins were also very swollen. LPN #481 verified no nonverbal pain scales were completed at any time before sending out the resident to the hospital on 05/25/24 and when Resident #11 would scream out due to being moved, no pain medication was administered and no non-pharmalogical interventions were attempted. LPN #472 verified she documented a pain scale of five on 05/25/24 at 7:31 A.M. with no follow up on pain with notification to the physician, non-pharmacological and/or pharmacological pain medication administered. Interview on 06/13/24 at 11:15 A.M. with the Regional Nurse Consult (RNC) #669 verified the facility staff should have been completing non-verbal pain scales for Resident #11 after the fall and verified there was no follow up for the resident's pain being a five on 05/25/24 at 7:31 A.M. RNC #669 verified screaming out in pain when being moved is a nursing assessment of pain and should be addressed. Review of the facility policy titled Pain Management dated October 2018 revealed for a non-interviewable resident, pain medications will be prescribed and given based upon nursing assessment of the following: non-verbal sounds, vocal complaints of pain, facial expressions and protective body movements or postures.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41271 Based on medical record review, and staff interview, this facility failed to ensure residents with a diagnosis of post-traumatic stress disorder (PTSD) had the appropriate assessment and documented triggers regarding this diagnosis. This affected three (Residents #33, #92, and #104) of five residents reviewed for emotional needs and behaviors. The facility census was 126. Findings include: 1. Review of the medical record for Resident #33 revealed an initial admitted [DATE] with a re-entry date of 04/04/22. Diagnosis included PTSD. Review of Resident #33's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #33 had intact cognition for daily decision making abilities with no behaviors noted. Resident #33 was noted to receive antipsychotic and antidepressants daily. Review of the plan of care last revised on 03/29/22 revealed Resident #33 had a diagnosis of anxiety, PTSD, and major depressive disorder. Resident #33 reports that she continuously struggles with symptoms of depression related to her second husband dying of suicide. Interventions included to provide behavioral health consults as needed, notify behavioral health specialist of changes or no improvement in mood, encourage resident to express feeling, administer medication as ordered, complete labs and diagnostic testing as ordered, and document abnormal findings. Resident #33's medical record revealed no evidence of this resident having a PTSD assessment completed. Interview on 06/12/24 at 9:21 A.M. with Social Services Worker (SSW) #656 verified Resident #33 did not have assessments completed for their PTSD diagnosis as well as triggers identified in their active care plans. SSW #656 stated she was fairly new to the facility so she would look into this further. Subsequent interview on 06/12/24 at 3:00 P.M. with SSW #656 confirmed she was not able to locate any additional information for Resident #33's PTSD care needs. 2. Review of the medical record for Resident #92 revealed an admitted [DATE]. Diagnosis included PTSD. Review of Resident #92's annual MDS 3.0 assessment dated [DATE] revealed Resident #92 had intact cognition for daily decison making abilities. Resident #92 was noted to receive antipsychotic, antidepressants, and opioids daily. Review of the plan of care dated 09/16/21 revealed Resident #92 had a diagnosis of PTSD. Resident #92's daughter passed away at age 11 from a brain tumor where he states he began using drugs and alcohol. Interventions included to consult behavioral health as needed, encourage resident to express feelings, administer medication as ordered, assist to identify strengths, positive coping skills and reinforce these. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #92's medical record revealed no evidence of this resident having a PTSD assessment completed. Interview on 06/12/24 at 9:21 A.M. with the SSW #656 verified Resident #92 did not have assessments completed for their PTSD diagnosis as well as triggers identified in their active care plans. Subsequent interview on 06/12/24 at 3:00 P.M. with SSW #656 confirmed she was not able to locate any additional information for Resident #92's PTSD care needs. 47987 3. Review of the medical record for Resident #104 revealed an admitted [DATE]. Diagnosis included PTSD. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #014 had intact cognition. The resident had PTSD. Review of the active care plans dated 08/02/23 revealed a plan of care was in place addressing the cause of PTSD, but did not include triggers which may cause re-traumatization or interventions to reduce the risk of re-traumatization and provide care for PTSD. Resident #104's medical record did not have an assessment identified for the cause of PTSD and to identify potential triggers which may cause re-traumatization. Interview on 06/12/24 at 9:19 A.M. with Social Services Worker (SSW) #656 verified an assessment of the cause of PTSD and possible triggers for Resident #104 had not been completed.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 47569 Based on record review and staff interview, the facility failed to provide evidence of the completion of nurse aide performance reviews. This affected two State tested Nursing Assistants (STNAs) out of four STNA personnel files reviewed and had the potential to affect all 126 residents residing in the facility. Findings include: Review of STNA #441's personnel file revealed STNA #441 was initially hired on 10/26/11 with a previous healthcare provider of the facility. STNA #441's hire date for the current healthcare provider of the facility was 04/26/19. STNA #441's annual performance evaluation was not available for review. Review of STNA #578's personnel file revealed STNA #578's hire date of 05/05/23. STNA #578 had a 90-day evaluation completed on 11/01/23. STNA #578's annual evaluation was not available to be reviewed and there was no evidence to prove the annual evaluation had been completed. Interview on 06/13/24 at 2:30 P.M. with Human Resources (HR) staff #720 confirmed STNA #441's annual evaluation was not available for review and there was no evidence to prove they had been completed. HR #720 also confirmed STNA #578's annual evaluation was not available to review and there was no evidence to prove the annual evaluation had been completed.

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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** 37100 Based on medical record review, staff interview, and facility policy review, the facility failed to ensure residents were free from unnecessary medication use. This affected four (Residents #10, #67, #83, and #91) of five residents reviewed for medication administration. The census was 126. Findings include: 1. Review of Resident #10's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included fracture of upper end of left tibia and right tibia, end stage renal disease, peripheral vascular disease, and osteoarthritis. Review of the Minimum Data Set (MDS) assessment, dated 04/22/24, revealed Resident #10 was cognitively intact. Review of Resident #10's physician orders, dated 05/20/24 to 06/13/24, revealed she had orders for the following as needed pain medications: Oxycodone five milligrams (mg) every four hours as needed for pain and acetaminophen 500 mg every six hours as needed for pain. The physician orders did not have parameters in place for the as needed pain medications. Review of Resident #10's medication administration records (MAR), dated 05/01/24 to 06/13/24, revealed acetaminophen was administered one time on 05/01/24 for a pain level of three, and Oxycodone was administered 24 total times, with 13 of the 24 doses (05/01/24, 05/02/24, 05/23/24, 05/25/24, 05/26/24, 05/27/24 (three doses), 05/30/24, 06/04/24 (two doses), 06/05/24, and 06/10/24) being administered at a pain level of five or below. Interview with Director of Nursing (DON) on 06/13/24 at 7:45 A.M. confirmed there should be parameters in place for as needed pain medications. The nurses should have had directions on what pain levels each medication should have, to be administered. She confirmed Resident #10 as needed pain medications did not currently have parameters in place. Interview with Licensed Practical Nurse (LPN) #487 and LPN #409 on 06/13/24 at 8:14 A.M. and 10:00 A.M. confirmed as needed pain medications should have parameters. They stated if there were no parameters for a pain medication, they will take a resident's pain level, and then ask them what pain medication they would want (if the resident is cognitively intact). If the resident is not cognitively intact, they will use non-verbal gestures and cues to determine the resident's pain level, and then provide the as needed pain acetaminophen for pain level five or below, and Oxycodone for pain level six and above. 2. Review of Resident #67's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included chronic obstructive pulmonary disease (COPD), atrial fibrillation, and hypertension. Review of the Minimum Data Set (MDS) assessment, dated 03/14/24, revealed Resident #67 has severe cognitive impairment. Review of Resident #67 current physician orders, dated 04/14/24, revealed he had an order for Metoprolol Succinate ER tablet 50 milligrams (mg) by mouth twice daily. The medication was to be held if his systolic blood pressure was less than 100 or her pulse was less that 60. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #67 MAR, dated April 2024 to June 2024, revealed nine different administrations (04/04/24, 04/24/24, 05/05/24, 05/10/24, 05/18/24, 05/22/24, 05/28/24, 06/05/24, and 06/09/24) of Metoprolol Succinate when his pulse was less than 60. Interview with Director of Nursing (DON) on 06/13/24 at 7:45 A.M. confirmed Resident #67's medications should not have been administered when his pulse was less than 60. Interview with Licensed Practical Nurse (LPN) #487 on 06/13/24 at 8:14 A.M. confirmed medications were to be given as physician ordered, which included following the physician ordered parameters. 47990 3. Review of the medical record for Resident #83 revealed an admitted [DATE]. Medical diagnosis included hypertensive heart disease with heart failure. Review of quarterly Minimum Data Set (MDS) assessment, dated 05/01/24, revealed Resident #83 had severely impaired cognition. Review of Resident #83's physicians orders revealed an order dated 03/25/24 for hydralazine (a medication to lower blood pressure) 30 milligrams (mg) by mouth three times daily. The order included parameters to hold for a systolic blood pressure less than 100 or a heart rate greater than 100 beats per minute. Review of Resident #83's April 2024, May 2024, and June 2024 Medication Administration Record (MAR) revealed no correlating blood pressure or heart rate documented prior to medication administration. Review of Resident #83's electronic medical record contained no evidence that his blood pressure or heart rate was monitored prior to being administered his three times daily hydralazine. An interview on 06/13/24 at 8:51 A.M. with Licensed Practical Nurse (LPN) #502 revealed she usually checked Resident #83's blood pressure prior to administering the ordered hydralazine but was unaware of any of physician-ordered parameters for any of the medications. An interview on 06/13/24 at 9:09 A.M. with the Director of Nursing (DON) verified Resident #83's record contained no evidence of blood pressure and heart rate monitoring prior to hydralazine administration. The DON verified the resident's blood pressure and heart rate should be checked prior to administration as the order provided physician-ordered parameters of when to hold the medication. 4. Review of the medical record for Resident #91 revealed an admitted [DATE]. Medical diagnosis included heart disease with heart failure and atrial fibrillation. Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/17/24, revealed Resident #91 had severely impaired cognition. (continued on next page)

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	366201	A. Building B. Wing	06/18/2024

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #91's physician's orders revealed an order dated 07/25/23 for metoprolol (a medication to lower blood pressure and/or heart rate) 12.5 milligrams (mg) by mouth once daily in the morning. The order included parameters for hold if the resident's systolic blood pressure is less than 110 or heart rate is less than 65. Review of Resident #91's April 2024, May 2024, and June 2024 Medication Administration Record (MAR) revealed no correlating blood pressure or heart rate documented prior to medication administration. Review of Resident #91's electronic medical record contained no evidence that her blood pressure or heart rate was monitored prior to being administered the daily dose of metoprolol. An interview on 06/13/24 at 8:47 A.M. with Licensed Practical Nurse (LPN) #502 revealed Resident #91 never refuses her medications. LPN #502 reported she sometimes checked Resident #91's blood pressure and heart rate prior to medication administration but stated she does not record this anywhere in the medical record at the time of medication administration. An interview on 06/13/24 at 9:09 A.M. with the Director of Nursing (DON) verified Resident #91's record contained no evidence of blood pressure and heart rate monitoring prior to metoprolol administration. The DON verified Resident #91's blood pressure and heart rate should be checked prior to administration as the order provided physician-ordered parameters of when to hold the medication. Review of the policy Administering Medications, revised April 2019, revealed medications are administered in a safe and timely manner, and as prescribed. The policy additionally identified medications are administered in accordance with prescriber orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on observation, staff interview, review of manufacture guidelines, and review of facility policy, the facility failed to remove two expired vials of Tubersol (tuberculin (TB) solution) from circulation. This had the potential to affect 66 residents who the facility identified were new admits to the facility in the last six months. The facility census was 126. Findings include: Observation on [DATE] at 8:35 A.M. revealed an opened partially used multiple dose of TB solution with the lot number 68154 and expiration date of [DATE]. The vial was in a plastic container without the original packaging box inside the refrigerator of the 300-hallway medication storage room. There was no open as of date written on the vial and no instruction on how to administer the solution. Interview on [DATE] at 8:45 A.M. with Licensed Practical Nurse (LPN) #510 confirmed the opened vial of TB solution, found in the 300-hallway medication storage room refrigerator, was without an open as of date written on the vial. LPN #510 stated the vial needs to be removed form circulation and disposed of due to not knowing when it was opened and if it had been longer then 30 days when the vial was opened. Observation on [DATE] at 8:55 A.M. revealed an opened partially used multiple dose vial of TB solution with the lot number 57798 and the expiration date of ,d+[DATE]. The vial was in the original packaging box inside a plastic container in the refrigerator of the memory unit medication storage room. There was no open as of date written on the packaging box or on the vial. Interview on [DATE] at 8:55 A.M. with LPN #469 confirmed the opened expired vial of TB solution, found in the memory unit medication storage room refrigerator, was expired and had no open as of date. LPN #469 stated the vial will be removed and disposed of due to being past the expiration date. Review of the TB solution manufacturer guidelines dated ,d+[DATE] revealed a vial of Tubersol which has been entered and in use for 30 days should be discarded. Do not use after the expiration date. Review of the facility's policy titled Storage of Medications dated ,d+[DATE] revealed discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 47569 Based on personnel record review, staff interview, and facility policy review, the facility failed to administer and read tuberculin (TB) tests for newly hired staff as required. This had the potential to affect all 126 residents residing in the facility. Findings include: 1. Review of State tested Nursing Aides (STNA) #644's personnel file revealed a hire date of 03/01/24. STNA #644 received the first step of TB skin test on 02/23/24 to the left forearm by with the negative results being read on 02/26/24. STNA #644 received the second step of TB skin test on 03/13/24 to the left forearm with no dated results available or recorded on STNA #644's Employee Immunization Record. Interview on 06/13/24 at 2:30 P.M. with Human Resource (HR) #720 confirmed STNA #644's second step TB skin test results were not recorded on the Employee Immunization Records for STNA #644. 2. Review of STNA #589's personnel file revealed a hire date of 06/14/23. STNA #589 received the first step of TB skin test on 06/06/23 to the right forearm with the negative results being read on 06/08/23. STNA #589 received the second step of the TB skin test on 06/20/23 to the right forearm with no dated results available or recorded on STNA #589's Employee Immunization Record. Interview on 06/13/24 at 2:30 P.M. with Human Resource (HR) #720 confirmed STNA #589's second step TB skin test results were not recorded on the Employee Immunization Records for STNA #589. 41271 3. Review of the personnel file for Registered Nurse (RN) #575 revealed a hire date of 04/06/23. RN #575 was noted to have an initial Tuberculin Skin Test (TST) dated 04/03/23 noted to the right upper arm. Nurse who administered this initial test did not sign this document. This initial test was noted to have been read on 04/06/23 with no results noted. Continued review of RN #575's TST form revealed the second step was given on 04/17/24 to the right forearm. This second step did not have a date of the results or a result reading. Interview on 06/13/2024 at 2:30 P.M. with Human Resource (HR) #720 confirmed RN #575 did not have an completed TST completed or available in his personnel file. Review of the facility's policy titled Infection Prevention and Control Program, dated 01/2024, revealed a system of surveillance is utilized for prevention, identifying, reporting, investigation, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services to the facility. Direct care staff shall be tested for TB upon hire.

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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** 37100 Based on medical record review, staff interview, review of the facility's infection control log, and facility policy review, the facility failed to provide adequate justification and monitoring regarding the use of an antibiotic. This affected one (Resident #38) of five residents reviewed for medications. The facility census was 126. Findings include: Medical record review revealed Resident #38 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease and acute and chronic respiratory failure. Review of the Minimum Data Set (MDS) assessment, dated 03/06/24, revealed Resident #38 was cognitively intact. Review of Resident #38's physician orders, dated 12/07/23, revealed the resident was prescribed and administered Azithromycin (antibiotic) 500 milligrams (mg) every Monday, Wednesday, and Friday for prophylactic. There was no evidence of monitoring the effectiveness of the antibiotic and no evidence of justification for the use of the antibiotic. Review of the facility's Infection Control logs, dated December 2023 to May 2024, revealed Resident #38 usage of Azithromycin was never included on any of the logs. Interview with Director of Nursing (DON) and Regional Nurse Consultant (RNC) #669 on 06/13/24 at 11:33 A. M. and 1:15 P.M. confirmed they were not doing any monitoring and/or testing to determine the effectiveness or need for Resident #38 Azithromycin. RNC #669 stated she spoke with the physician and he does not do any monitoring for long term/extended use of antibiotics for chronic diagnoses. RNC #669 stated if they were to do monitoring, they would monitor residents for Clostridioides difficile (CDiff), which would have symptoms such as abdominal pain. The DON and RNC #669 confirmed that all antibiotics that are prescribed, are documented on the monthly infection control logs as part of the antibiotic stewardship program and monitoring. Review of the facility's Antibiotic Stewardship policy, dated December 2016, revealed antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. If an antibiotic is indicated, providers will provide complete antibiotic orders including the following items: drug name, dose, frequency of administration, duration of treatment (start and stop date or number of days of therapy), route of administration, and indications for use. Review of the facility's undated Infection Prevention and Control Program revealed antibiotic use protocols and a system to monitor antibiotic use will be implemented as part of the antibiotic stewardship program.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 47987 Based on resident and staff interviews, observations, review of the facility's pest invoices, and review of the facility policy, the facility failed maintain effective pest control within the facility. This affected three residents (#7, #96, and #113) and had the potential to affect all residents in the facility except for the 22 residents residing on the memory care unit. The facility census was 126. Findings include: 1. Interview on 06/11/24 at 10:46 A.M. with Resident #113 revealed he attempted to use the resident refrigerator in the activities area located on the 200 Hall for a personal food item but there were flies and gnats inside of the refrigerator. Observation on 06/10/24 at 11:02 A.M. of the fridge on the 200 hall activity area revealed when opened, there were gnats and flies coming out it. Observation and interview on 06/10/24 at 11:12 A.M. with the Administrator verified there were flies and gnats inside the refrigerator on the 200 hall activity area. 41271 2. Observation on 06/10/24 at 9:49 A.M. of Resident #7's room revealed the residents room had multiple flies and gnats flying around room. There was also food noted in the resident's bed along with a large box beside the residents bed piled up with empty food containers and empty drinking containers and on the floor beside the bed. Observation and interview on 06/12/24 at 10:00 A.M. of Resident #96's room revealed resident was sitting on the side of her bed with her breakfast meal tray sitting on the bedside table in front of her. Multiple flies were noted in her room along with landing on her meal tray and food. Resident #96 stated there were always flies in her room. Interview on 06/13/24 at 10:18 A.M. with Maintenance Assistant (MA) #411 revealed the facility has a pest control company who comes out monthly to complete preventative treatments and will come out as needed. Part of their preventative treatment is for flies and small fruit flies or gnats. Review of the facility's pest control invoices dated 06/10/24 revealed treatment was completed of all drains and under and behind equipment targeting breeding and harboring areas to aid in the control of small flies. Light fruit fly activity found in the kitchen and dishwasher areas. Review of facility policy titled Pest Control Policy dated 02/2021 revealed the facility will strive to maintain a pest free environment.