STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366241	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steubenville Country Club Manor	575 Lovers Lane Steubenville, OH 43953

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on observation, medical record review and interview, the facility failed to implement the use of a stop sign across a resident's room to deter wandering residents from entering her room. This affected one (Resident #29) of three residents reviewed for falls. The facility census was 46. Findings include: Review of Resident #29's medical record revealed diagnoses including dementia, need for assistance with personal care, and cognitive communication deficit. Review of a care plan initiated 01/14/14 indicated Resident #29 had a self care performance deficit with potential for fluctuations and/or decline related to dementia, forgetfulness and impaired decision making. The care plan was updated to initiate a stop sign to the doorway to deter wandering residents from entering starting 01/26/24. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #29 was able to make herself understood and was able to understand others. Resident #29 was assessed as being severely cognitively impaired. On 05/16/24 at 1:35 P.M., Resident #29 was observed lying in bed. A sign posted on the wall indicated a stop sign (a mesh sign that is velcroed to each side of a resident's door and indicates stop on the sign to deter residents from entering room uninvited). was to be used at all times. There was a stop sign present at the entrance of the room but it was not across the door. On 05/16/24 at 2:24 P.M. Resident #29 was lying in bed. The stop sign was not across the door. Both ends of the stop sign were attached to the left doorframe. Interview of State tested Nursing Assistant (STNA) #110, who was passing by, revealed the stop sign was initiated to keep Resident #47 (no longer residing at the facility) out of the room so the stop sign was not utilized. On 05/16/24 at 2:37 P.M., Licensed Practical Nurse (LPN) #140 stated Resident #29's stop sign was initiated to deter wandering residents from entering her room. Although Resident #47 was no longer in the facility, the facility had another wandering resident, (Resident #31) but she seldom wandered into other resident rooms. LPN #140 verified the stop sign should have been in place and the LPN #140 hung the stop sign. On 05/20/24 at 10:58 A.M., Resident #29 was observed lying in bed. The stop sign was not across the door. Three unidentified staff members passed by the doorway without addressing it/placing the stop sign in the appropriate position. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/20/24 at 1:22 P.M., Resident #29 was observed lying in bed. The stop sign was not over the doorway. LPN #140 passed the room without addressing the stop sign.

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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** 22653 Based on medical record review, policy review, and interview, the facility failed to ensure Resident #18's family/responsible party and physician were notified when Resident #18 was located outside the facility unaccompanied by staff. This affected one (Resident #18) of three residents reviewed for elopement. The facility census was 46. Findings include: Review of Resident #18's open medical record revealed diagnoses including dementia with agitation, type two diabetes mellitus, peripheral vascular disease, major depressive disorder, muscle wasting, anxiety disorder, long term use of insulin, vitamin B12 deficiency, and acute angle-closure glaucoma in bilateral eyes. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #18 was moderately cognitively impaired with a score of nine out of a possible score of 15. The MDS indicated Resident #18 was able to make herself understood and was able to understand others. The assessment did not indicate any wandering during the specified time frame. Review of a wandering risk scale dated 12/15/23 revealed Resident #18 was assessed as a high risk to wander: The assessment revealed Resident #18 was ambulatory and able to communicate. Resident #18 had a history of wandering, had a medical diagnosis of dementia/cognitive impairment, had a diagnosis impacting gait/mobility or strength, and had wandered in the past month. The assessment indicated Resident #18 had often wandered around the facility stating she was going home. No interventions were noted on 12/15/23 when Resident #18 was assessed at high risk for wandering with knowledge that she was stating she wanted to go home. Review of a Brief Interview for Mental Status exam (BIMS) dated 01/23/24 revealed a score of three (out of a possible score of 15) indicating Resident #18 was severely cognitively impaired. Review of an incident report dated 03/03/24 at 11:23 P.M. indicated Resident #18 was found outside the back of the building by housekeeping staff stating she was going home. No injuries were noted. The mental status portion of the incident report indicated Resident #18 was oriented to person only but was confused to place and time. The incident report indicated Resident #18 was ambulatory without assistance. No notification of the physician or family/responsible party were noted according to the report. No nursing note was located regarding Resident #18 being found outside unaccompanied by staff on 03/03/24. On 05/21/24 at 5:02 P.M., Registered Nurse (RN) #100 was informed a note was not located for the 03/03/24 incident and there was no evidence of notification of the physician or responsible party. No further information was provided. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/24 at 1:49 P.M., RN #125 verified she worked on 03/03/24 when Resident #18 was located by staff outside the facility on night shift and she returned without incident. RN #125 indicated she did not recall if she called the physician or family to notify them but she did text the Administrator. Review of the facility's Elopement policy, dated 03/18/15, revealed management was to notify the family and physician of an elopement incident.

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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. 22653 Based on medical record review, the facility post-fall monitoring report and interview, the facility failed to ensure neurological checks (series of assessments which reflect a resident's brain and neurological function) where completed, after unwitnessed falls, for one (Resident #13) of three residents reviewed for falls. The census was 46. Findings include: Review of Resident #13's medical record revealed diagnoses that included right sided paralysis, muscle wasting, contracture of the right hand, heart failure, stiffness of the right shoulder, speech disturbance, history of falling and hypertension. A physician's order dated 01/07/24 revealed the bed was to be in the lowest position at all times. Review of the fall information with Registered Nurse (RN) #100 revealed the following information. a. A nursing note dated 01/19/24 at 6:48 P.M. indicated a State tested Nursing Assistant (STNA) notified the nurse Resident #13 was on the floor, in the bathroom, laying on his left side. No injuries were noted. Resident #13 was educated on the importance of using the call light for assistance. Neurological checks were started. On 05/21/24 at 9:48 A.M., RN #100 provided the facility's post fall 72-hour monitoring report which indicated an unwitnessed fall, or a fall in which a resident struck his/her head, required neurological checks. An initial check was to be completed followed by checks every 15 minutes four times, then every 30 minutes twice, then every hour twice and once per shift for 72 hours. RN #100 verified staff documented neurological checks on 01/19/24 between 6:00 P.M. and 7:00 P.M. only. b. Review of a nursing note dated 02/19/24 at 6:50 P.M. indicated Resident #13 was attempting to go to the bathroom without assistance when he stood and fell over. No injuries were noted. Neurological checks were initiated. On 05/21/24 at 8:51 A.M., RN #100 verified the neurological checks were initiated at 4:00 P.M. and were completed until 8:00 A.M. on 07/20/24, not fulfilling the expectation for 72 hour monitoring. c. Review of a nursing note dated 05/02/24 at 2:46 P.M. indicated the nurse was notified by an STNA that Resident #13 was found on his bathroom floor at 12:45 P.M. Resident #13 was ambulating without assistance. No injuries were noted. The note indicated neurological checks were initiated. On 05/02/24 at 9:05 A.M., RN #100 verified there was no record of neurological checks being initiated.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 22653 Based on medical record review and interview, the facility failed to provide restorative nursing services, according to program instruction, to maintain residents' range of motion for four (Residents #2, #9, #10 and #42) of four residents reviewed for range of motion. The facility identified 11 residents on restorative programs for range of motion. The facility census was 46. 1. Review of Resident #10's medical records revealed diagnoses including chronic obstructive pulmonary disease (COPD), type two diabetes mellitus with diabetic neuropathy, malignant neoplasm of the glottis (center of the larynx (voice box)), chronic peripheral venous insufficiency, heart disease, and macular degeneration. Review of a care plan initiated 02/05/24 revealed Resident #10 was on a restorative nursing program (RNP). Interventions included documenting participation in RNP, report to nursing complaints of pain during restorative active range of motion (AROM) programs and the registered nurse (RN) was to review compliance of and effectiveness of RNP. Review of restorative task revealed a program for bilateral lower extremity (BLE) AROM six to seven days a week, repetitions of ten while using three pound weights, cue to perform ten repetitions of abduction, adduction, external rotation and internal rotation of bilateral hips, cue to perform ten repetitions of dorsal flexion, plantar flexion, eversion and inversion to bilateral ankles, and cue to provide ten repetitions of flexion and extension to bilateral hips/knees. Review of restorative delivery records revealed the week of 04/28/24 to 05/04/24 revealed the RNP was offered once with a record of four minutes minutes provided. No refusals were documented. Records reflected the week of 05/05/24 to 05/11/24 the RNP was provided once for four minutes. The week of 05/12/24 through 05/18/24 documentation indicated the RNP was offered three times with two refusals. During review of restorative delivery records with RN #100 on 05/23/24 at 12:20 P.M., she verified the records did not indicate the RNP program was offered/delivered in accordance with program. On 05/23/24 at 1:12 P.M., Resident #10 stated staff rarely offered his ROM exercise program. 2. Review of Resident #9's medical record revealed diagnoses including heart disease, depression, pain in the right shoulder, muscle wasting, and dementia. A care plan initiated 04/03/23 revealed Resident #9 had AROM restorative program to his right shoulder related to complaints of pain. Resident #9 was able to perform range of motion (ROM) but required cues from staff and encouragement as needed. Interventions included documenting participation in the restorative program and report to nursing any pain/discomfort during the restorative program. A care plan initiated 04/03/23 revealed the resident had AROM restorative program to the right shoulder related to complaints of pain. The resident was able to perform ROM but required cues from staff and encouragement as needed. Interventions included documenting participation in the restorative program, report to nursing any signs or symptoms (s/s) of pain/discomfort during the restorative program. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the restorative delivery records revealed there were two programs. The first program was for assisted active range of motion (AAROM) to the right shoulder six to seven days a week, twice a day. The resident was to be cued to perform seven to ten repetitions to the left should while in a lying position, in bed or sitting in the chair of forward flexion and extension, abduction and adduction, and external/internal rotation. A hot pack was to be applied to the left shoulder to alleviate/decrease pain. Review of delivery records from 04/24/24 to 05/23/24 revealed the only day the services were documented twice in a day was on 04/29/24. Documentation revealed the week of 04/28/24 through 05/04/24 revealed the services were provided four days. Between 05/05/24 and 05/11/24 the RNP was documented twice with one of the sessions being four minutes. Between 05/12/24 and 05/18/24 documentation revealed the RNP was provided four days. No refusals were documented. On 05/23/24 at 12:20 P.M., RN #100 verified the records did not revealed the RNP was implemented as written. On 05/23/24 at 12:58 P.M., Resident #9 stated STNAs did not do his exercise program with him. He believed the only ones who did exercises consistently was when he received therapy. 3. Review of Resident #2's medical record revealed diagnoses including COPD, seizures, altered mental status, osteoarthritis and muscle wasting. Review of a care plan initiated 08/23/23 revealed Resident #2 was on restorative nursing programs for AAROM to both lower extremities and a transfer program. Interventions included documenting participation in RNP. Review of the restorative delivery records revealed between 04/28/24 and 05/04/24 the restorative program for transfers was provided three times. The AAROM program was provided four times. Restorative delivery records between 05/05/24 and 05/11/24 indicated both RNP programs were offered twice. Review of Restorative delivery records between 05/12/24 and 05/18/24 indicated both RNP programs were offered twice. On 05/23/24 at 12:20 P.M., RN #100 verified the records did not revealed the RNP was implemented as written. 4. Review of Resident #42's medical record revealed diagnoses including dementia with behavioral disturbance, Alzheimer's disease, and major depressive disorder. A care plan initiated 08/23/23 that indicated RNPs for Passive Range of Motion (PROM) to be provided six to seven days a week and transfers to be provided twice a day. Review of the restorative delivery records between 04/28/24 and 05/04/24 indicated the ROM RNP was provided one time. There was no documentation of the transfer program being provided. Review of the restorative delivery records from 05/05/24 and 05/11/24 indicated both programs were administered one day. Review of restorative delivery records between 05/12//24 and 05/18/24 indicated both programs were provided one day. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/23/24 at 2:28 P.M., Restorative Aide #175 reported she worked four days a week but she was pulled to work the floor three to four of those days. Restorative Aide #175 stated she tried to do programs as time permitted (in addition to her floor assignment). She stated Management was aware. The only decline she had noted was with Resident #28 after she had returned from the hospital. Restorative aide #175 stated she had spoken to other aides about completing the restorative programs on their assignments when she was unavailable to do them. However, some of the other aides acted like it was not their responsibility and did not provide the programs.

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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** 22653 Based on medical record review, review of incident reports, policy review, review of manufacturer information for wanderguards, and interview, the facility failed to ensure elopement interventions were implemented, wanderguards and exit doors were monitored to ensure appropriate functionality, and failed to ensure a comprehensive fall prevention program was implemented. This affected two (Residents #13 and #18) of six residents reviewed for falls and elopement. The census was 46. Findings include: 1. Review of Resident #18's open medical record revealed diagnoses including dementia with agitation, type two diabetes mellitus, peripheral vascular disease, major depressive disorder, muscle wasting, anxiety disorder, long term use of insulin, vitamin B12 deficiency, and acute angle-closure glaucoma in bilateral eyes. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #18 was moderately cognitively impaired with a score of nine out of a possible score of 15. The MDS indicated Resident #18 was able to make herself understood and was able to understand others. The assessment did not indicate any wandering during the specified time frame. Review of a wandering risk scale assessment dated [DATE] revealed Resident #18 was assessed as a high risk to wander: The assessment revealed Resident #18 was ambulatory and able to communicate. Resident #18 had a history of wandering, had a medical diagnosis of dementia/cognitive impairment, had a diagnosis impacting gait/mobility or strength, and had wandered in the past month. The assessment indicated Resident #18 had often wandered around the facility stating she was going home. No interventions or care plan were noted on 12/15/23 when Resident #18 was assessed at high risk for wandering with knowledge that she was stating she wanted to go home. Review of a Brief Interview for Mental Status exam (BIMS) dated 01/23/24 revealed a score of three indicating Resident #18 was severely cognitively impaired. Review of a nursing note dated 03/04/24 at 6:13 P.M. revealed the nurse noted Resident #18 wandering outside on the patio after dinner. A wander guard was in place and functioning properly earlier in the shift and when Resident #18 was assisted back inside. The note indicated the physician was notified of Resident #18's exit seeking/elopement and the family request of anti- anxiety on an as needed basis. The daughter was notified. A care plan initiated 03/07/24 indicated Resident #18 was at risk of wandering/elopement with a goal for Resident #18's safety to be maintained. Interventions included identifying if there were triggers for wandering/eloping, identifying if there was a pattern and purpose of wandering, and identifying wandering/elopement de-escalation behaviors. A wandering risk assessment dated [DATE] indicated Resident #18 remained at high risk to wander. Risk factors were similar to the assessment done 12/15/23 with information added that Resident #18 had a wanderguard. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan initiated 03/18/24 indicated Resident#18 was combative with exit seeking behaviors. Interventions included anticipating and meeting Resident #18's needs, caregiver to provide the opportunity for positive interactions and attention, explaining all procedures to the resident before starting and allowing Resident #18 to adjust to changes. If reasonable, discuss Resident #18's behavior and intervene as necessary to protect the rights and safety of others. Monitor behavior episodes and attempt to determine underlying cause and praise progress and improvement in behavior. Another section of the care plan initiated 03/27/24 indicated Resident #18 was at risk for elopement related to wandering. A goal was added for Resident #18 to demonstrate happiness with daily routine through the review date. Interventions included assessing fall risk and distracting Resident #18 from wandering by offering pleasant diversions, structured activities, food, conversation, television and books Resident #18 preferred and identifying pattern of wandering : is wandering purposeful, aimless or escapist? Was Resident #18 looking for something? Did it indicate the need for more exercise? Intervene as appropriate. On 05/20/24 the care plan was updated with an intervention from 03/03/24 for a wanderguard to the walker. Review of an incident report dated 03/03/24 at 11:23 P.M. indicated Resident #18 was found outside the back of the building by housekeeping staff stating she was going home. No injuries were noted. The mental status portion of the incident report indicated Resident #18 was oriented to person only but was confused to place and time. The incident report indicated Resident #18 was ambulatory without assistance. No notifications were found according to the report. An incident report dated 03/04/24 at 5:55 P.M. indicated the nurse was at the nurse's station and noted Resident #18 walking outside on the patio and stating she was going home. The note revealed the wander guard was functioning earlier in the shift when checked and when Resident #18 returned inside the wander guard alarmed. Resident #18 was oriented to person only. No injuries were observed. Resident #18 was ambulatory without assistance. No predisposing factors were noted. The physician was notified on 03/04/24 at 6:12 P.M. On 05/20/24 between 2:30 P.M. and 2:35 P.M., RN #100 verified there was no order or care plan regarding the use of a wanderguard. Observations with RN #100 revealed a wanderguard was present on Resident #18's walker. RN #100 stated wanderguards were monitored and staff signed off on the Treatment Administration Record (TAR) on resident orders. RN #100 verified with no physician order staff would be signing off monitoring of the wanderguard. RN #100 verified with RN #105 the TAR was the single place where staff would document monitoring of the placement and function of the wanderguard. On 05/20/24 at 2:43 P.M., Resident #18 was observed ambulating in the hall to the shower room with her walker. After Resident #18 entered the shower, RN #100 obtained her walker and took it to the front door to monitor its function and when the walker was taken closer to the front door, the door locked. It remained locked until the walker was taken to the nursing station and moved approximately half way down the side of the nursing station at which time the door lock released. RN #105, who was present at the nursing station, stated the wanderguard only worked at the front door. The other exit doors had a 15 second delayed release with alarms sounding when the doors were opened unless a code was put in. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/21/24 at 8:39 A.M., RN #100 stated the facility had been unable to locate any type of investigation/witness statements for the incidents on 03/03/24 or 03/04/24. RN #100 stated the Administrator stated he thought the previous Director of Nursing (DON)/RN #200 had a file that staff had been unable to locate. On 05/21/24 at 5:02 P.M., RN #100 was informed/reminded although Resident #18 was assessed at high risk for wandering in December 2023 no documented interventions, orders or care plans were located indicating action had been taken to address the risk related to wandering. No additional information was provided. On 05/21/24 at 5:21 P.M., State tested Nursing Assistant (STNA) #110 stated around December 2023 to January 2024 Resident #18 would state she wanted to go home. Prior to March 2024, Resident #18 had been observed hanging around the doors exit seeking. On 05/23/24 at 1:15 P.M., State tested Nursing Assistant (STNA) #120 stated Resident #18 would sometimes walk around her room without the walker but usually utilized the walker to ambulate longer distances. A couple weeks prior to the interview, she had observed Resident #18 pushing on the exit door at the end of the 100 hall, trying to open the door but was unsuccessful. STNA #120 stated she did not recall working on 03/03/24 and 03/04/24 when Resident #18 left the facility unaccompanied by staff or if she had she was not aware of it because it got so hectic. On 05/23/24 at 1:23 P.M., Licensed Practical Nurse (LPN) #115 stated Resident #18 would sometimes walk a little bit without her walker. LPN #115 stated she was unaware Resident #18 had a wanderguard on her walker. LPN #115 stated Resident #18 would be able to ambulate from the nursing station to the front door without a walker. On 05/23/24 at 1:49 P.M., RN #125 verified she worked on 03/03/24 when Resident #18 was located by staff outside the facility on night shift and she returned without incident. RN #125 stated nobody had asked her for any additional details other than what she had reported. RN #125 stated she believed Resident #18 exited the facility out the door by the kitchen. RN #125 stated she was not sure if the door alarmed or if it was shut off. When Resident #18 was returned into the facility a wanderguard was placed on her ankle. RN #125 indicated she was unaware Resident #18 had her wanderguard placed on the walker currently. RN #125 stated she did not routinely check wanderguards after they were initially applied. RN #125 stated Resident #18 might be able to walk from the nursing station to the front door without her walker. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/24 at 2:38 P.M., the circumstances regarding Resident #18 being assessed with high risk for elopement in December 2023 with no interventions noted at that time, the lack of witness statements or an investigation regarding elopements, lack of documentation regarding the 03/03/24 elopement in progress notes and lack of evidence of monitoring the wanderguard after its implementation were discussed with the Administrator. The Administrator stated after the nurses reported the incidences to RN #200 she stated she would handle it from there and he believed she had followed up on it. When told of staff interviews indicating Resident #18 could ambulate short distances without the use of the walker and was asked if the wanderguard placed on the walker was the most desirable place for its effectiveness, the Administrator stated he had just discussed that with staff but Resident #18 was still out for her appointment. The Administrator stated if Resident #18 left the door which was indicated during the interview with RN #125 it would have had to been out the door to the back patio. The Administrator indicated he was not sure if the door was alarmed. It used to have a battery operated alarm but he would double check. On 05/23/24 at 3:15 P.M., observation of the door in the dining room near the kitchen revealed a white alarm box. There was no sound when RN #100 opened the door three times. The door led to a courtyard with a gate which could be opened without alarming. RN #125 accompanied RN #100 and the surveyor outside and revealed Resident #18 was located outside the fenced in area and she ambulated with her around the building before going back inside on 03/03/24. On 05/23/24 at 3:17 P.M., the Administrator was informed no sound was heard when the door was opened. The Administrator responded the alarm did not sound at the door but there was a unit that alarmed at the nursing station. No alarming was heard at the nursing station and the Administrator confirmed he was unable to locate the box that he referred to. On 05/23/24 at 3:47 P.M., Resident #18 was sitting outside with staff for an activity, listening to music. A wanderguard was observed on her right wrist. On 05/23/24 at 4:22 P.M., activity staff #130 stated Resident #18 cycled in her attempts to leave the facility. Activity staff #130 stated Resident #18 would be consistent in trying to get out of the facility for a while then it would decrease in frequency. Some days Resident #18 was easily redirected but some days she was not. Activity staff #130 stated Resident #18 thought she had young children to get home to and that the behavior had been exhibited for a while. On 05/23/24 at 5:25 P.M., RN #135 who was identified as the nurse who worked during the elopement on 03/04/24, was interviewed via phone. RN #135 stated she could not recall if she heard an alarm when Resident #18 left the faciity on [DATE] before she observed her on the patio. RN #135 stated someone (she thought RN #200) had told her she saw a visitor let Resident #18 outside but was unable to answer why RN #200 would watch Resident #18 be let out of the facility and not go out and redirect her at that time or stay with her outside instead of waiting for RN #135 to observe her later. RN #135 stated it was around that time a technician had gone to the facility to check the door system and it was discovered several of the wanderguards at the nursing station were not functioning properly. The technician had to show her how to check the wanderguards. RN #135 stated she could not recall many details about that day. On 05/28/24 at 4:26 P.M., the Administrator stated the elopement on 03/03/24 occurred between 6:30 P.M. and 7:00 P.M. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/28/24 at 4:59 P.M. the Administrator stated he was unable to verify or find any written records for the last time the alarm on the dining room door was checked or monitored. Review of the facility's Elopement policy, dated March 2024 revealed elopement was the unsupervised wandering of a resident that resulted in the resident leaving the facility without notice or detection. The policy revealed at risk residents would be identified/assessed. Residents would be re-assessed at least quarterly. Educate staff to at risk status and interventions developed to reduce/prevent elopement. To safe guard at risk residents individualized interventions were to be developed and implemented. A care plan was to be completed for at risk residents with individualized interventions. Actual elopement occurrences were to be investigated, including determining the means of elopement and risk for repeated elopement. A quality assurance review was to be completed to determine similar opportunities/risks for elopement for other residents. Effectiveness of recommendations was to be monitored. Review of the accutech wanderguard manufacturer guidelines/instructions revealed recommendations to check the battery life once a week. 2. Review of Resident #13's medical record revealed diagnoses included right sided paralysis, muscle wasting, contracture of the right hand, heart failure, stiffness of the right shoulder, speech disturbance, history of falling and hypertension. A physician's order dated 01/07/24 revealed the bed was to be in the lowest position at all times. A fall risk assessment dated [DATE] revealed Resident #13 remained at high risk for falls. a. On 05/20/24 at 5:22 A.M., Resident #13 was lying in bed which was raised about 2.5-3 feet from the floor. Resident #13 was grunting to get attention to get his urinal emptied. At 7:04 A.M. Resident #13 continued to lie in the bed which did not appear to be in the lowest position. At 7:08 P.M., Human Resource employee (HR) #150 verified the bed was not in the lowest position and lowered it. b. Review of fall information with Registered Nurse (RN) #100 revealed the following information. b1. A nursing note dated 11/05/23 at 6:38 P.M. revealed Resident #13 slid himself down to the floor in his bathroom. No injuries were noted. The note indicated neurological checks would be completed. On 05/21/24 at 8:45 A.M., RN #100 verified she could not locate a post fall evaluation or new interventions implemented. b 2. A nursing note dated 01/19/24 at 6:48 P.M. indicated a State tested Nursing Assistant (STNA) notified the nurse Resident #13 was on the floor in the bathroom laying on his left side. No injuries were noted. Resident #13 was educated on the importance of using the call light for assistance. Neurological checks were started. On 05/21/24 at 9:48 A.M., RN #100 indicated on 12/19/24 Resident #13 was assessed as moderately cognitively impaired and education was not an effective intervention. b 3. Review of a nursing note dated 02/21/24 at 1:24 A.M. revealed it was a late entry for 7:20 P.M. Resident #13 was found on the floor in the bathroom with three red areas on his head and he was complaining of right leg pain. Resident #13 was sent to the hospital. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/21/24 at 8:54 A.M., RN #100 stated she recalled discussing the fall in a risk management meeting with the Administrator and RN #200 but could not recall if any action was taken to prevent further falls upon Resident #13's return from the hospital because she was unable to locate the risk management book. b 4. Review of a nursing note dated 05/02/24 at 2:46 P.M. indicated the nurse was notified by a STNA that Resident #13 was found on his bathroom floor at 12:45 P.M. Resident #13 was ambulating without assistance. No injuries were noted. The note indicated neuro checks were initiated. On 05/21/24 at 9:05 A.M., RN #100 revealed the fall had not yet been reviewed because the risk management meeting had been postponed. No new interventions had been implemented. c. On 05/23/24 at 1:03 P.M., Resident #13 was over-heard grunting. Resident #13 was observed sitting on the commode with no staff in the room. Resident #13 stood independently. While trying to finish his care, he fell backwards onto the commode. Due to no staff being observed in the immediate area, STNA #165 was alerted that Resident #13 needed assistance. STNA #165 was heard telling Resident #13 not to go to the bathroom by himself. Signs had already been posted on the bathroom door prior to this incident and Resident #13 had a history of falls in the bathroom with education provided. This deficiency represents non-compliance investigated under Master Complaint Number OH00152953.

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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 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on review of personnel files and interview, the facility failed to ensure nursing assistants received required training prior to providing direct care to residents. This had the potential to affect all 46 residents. Findings include: 1. On [DATE] at 11::15 A.M., Employee #145 (who introduced herself as a nurse aide in training) stated she had not yet started nurse aide training classes. Employee #145 stated she had worked in a group home in the past. Employee #145 stated she had four 12 hours days of orientation with another aide. Employee #145 indicated her duties included helping with meals, providing showers, and providing incontinence care. Employee #145 stated she was performing all the same duties as state tested nursing assistants. Employee #145 stated she had never received dementia training or how to deal with aggressive behaviors. During orientation she received information about specific residents and their behaviors and preferences. On [DATE] at 1:26 P.M., Human Resource (HR) employee #150 verified Employee #145 was not in classes but was functioning as a state tested nursing assistant. HR #150 stated she was told by the Administrator that employees could work for four months until they got into a class. HR #150 stated Employee #145 had experience in a group home before hired but acknowledged the training was different. Review of Employee #145's personnel file indicated she was hired [DATE] as a nurse aide trainee. Review of the application for employment revealed Employee #145 had attended one year of nursing school but had not graduated. The year of nursing school attendance was not listed. Work experience over the last [AGE] years included a teacher's aide ([DATE] to [DATE], a laborer/intake personnel from [DATE] to [DATE], and a home manager from [DATE] to the time of the application. An orientation/annual skills checklist indicated Employee #145 had been signed off on nursing care on [DATE]. During review of the personnel records on [DATE], Registered Nurse (RN) #105 stated it was the aide who was orienting new nursing assistants who signed off on the skills checklist. 2. Review of State tested Nursing Assistant (STNA) #155's personnel file revealed a date of hire of [DATE]. Review of the application revealed STNA #155 had graduated high school. Her work experience included jobs in collections and retail. A nurse aide registry check dated [DATE] revealed she was not on the nurse aide registry. Review of a nurse aide orientation/annual skills checklist form revealed skills were checked off on [DATE]. Review of a certificate of successful completion of a nurse aide training and competency evaluation program (NATCEP) revealed a completion date of [DATE]. (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of nurse aide registry information revealed an original approval date of [DATE]. On [DATE] at 11:37 A.M., the Administrator was asked to explain the discrepancy between the completion of the skills checklist on [DATE] when the form indicated a hire date of [DATE]. On [DATE] at 1:46 P.M., the Administrator stated the [DATE] hire date was incorrect. The actual hire date was [DATE]. 3. Review of STNA #120's personnel file revealed a date of hire of [DATE]. Review of the application for employment revealed STNA #120 had attended some nursing classes but had not graduated. The years of attendance were not documented. Review of a nurse aide registry check revealed STNA #120 was not on the registry with a hand-written note that her registration had expired on [DATE]. Review of an orientation checklist revealed all skills were checked off on the date of hire. Review of a certificate of successful completion of a NATCEP program revealed a completion date of [DATE]. Review of nurse aide registry information revealed an original approval date of [DATE]. 4. Review of STNA #110's personnel file revealed a hire date of [DATE]. Review of the application for employment revealed STNA #110 started training as a medical assistant but did not graduate. The year of attendance was not documented. Work experience included retail, a housekeeping aide, and an aide for private home health. Review of a nurse aide registry check dated [DATE] revealed STNA #110 was not on the nurse aide registry. Review of an orientation /skills check list revealed all skills were signed off the date of hire. Review of a certificate of successful completion of a NATCEP program revealed a completion date of [DATE]. Review of nurse aide registry information revealed an original approval date of [DATE]. On [DATE] at 9:48 A.M., HR #150 verified all four of the above employees were hired as nursing assistants without being on the nurse aide registry at the time of hire and not being enrolled in nurse aide registry classes or enrolled in nursing school at the time of hire. The facility believed they had four months to get the aides into the nurse aide classes. HR #150 verified some of the employees had worked longer than four months but stated the Administrator decided who entered the NATCEP program and when.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 22653 Based on medical record review, review of pharmacy recommendations, and interviews the facility failed to ensure pharmacy recommendations were acted upon timely. This affected four (Residents #10, #13, #34, and #40) of five residents reviewed for medication use. The facility census was 46. Findings include: 1. Review of Resident #13's medical record revealed diagnoses including hemiplegia (paralysis of one side of the body) affecting the right dominant side, rhabdomyolysis (condition in which damaged skeletal muscle breaks down rapidly, contracture of the right hand, heart failure, benign prostatic hyperplasia (a condition in which the flow of urine is blocked due to the enlargement of prostate gland)., gastroesophageal reflux disease, stiffness of the right shoulder, speech disturbance, acquired absence of the spleen, history of falling, hypertension, and muscle wasting. Review or a medication regimen review dated 03/13/24 revealed a diagnosis was needed to support the use of risperidal (an antipsychotic medication). The physician response was blank. A physician order for risperidal 0.25 milligrams every day was written on 03/04/24. On 05/21/24 at 8:28 A.M., Registered Nurse (RN) #100 stated she had been unable to locate all the pharmacy reviews for the residents over the past six months so she had to contact pharmacy to get the reviews/recommendations resent to her and she was attempting to make sure the reviews had been addressed. RN #100 verified she had been unable to locate a diagnosis to justify the use of the risperidal. On 05/21/24 at 12:19 P.M., RN #100 stated the risperidal was originally started on 03/04/24 for behaviors. Resident #13 was followed by psychiatric services who indicated the risperidal was for behaviors. RN #100 verified she was unable to locate any information indicating an approved diagnosis for the use of antipsychotic medication or why the benefit of using risperidal would outweigh the risks. 2. Review of Resident #40's medical record revealed diagnoses including hypothyroidism and bipolar disorder. On 05/05/23 an order was written for synthroid 150 micrograms every day for hypothyroidism. Review of a pharmacy recommendation dated 11/26/23 addressed the use of synthroid with no Thyroid Stimulating Hormone (TSH) level scheduled in the chart. The area for the physician response revealed no response. There was no TSH level observed in the medical record since 11/26/23. On 05/21/24 at 8:28 A.M., RN #100 stated the facility had no previous TSH order written since the pharmacy review on 11/26/23. The last TSH obtained was 12/20/22. Review of the TSH level obtained 05/21/24 (after identification the lab test had not been obtained since 12/20/22) revealed the TSH level was 1.58 uIU/ML (equivalent to mili-international units/liter) with a reference range of 0.35 - 3.74 uIU/ML. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #34's medical record revealed diagnoses including type two diabetes mellitus and severe dementia with psychotic disturbance. On 08/01/23 an order was written for an insulin sliding scale with novolog (subcutaneously) (SQ) for blood sugar levels starting at 150 milligrams (mg) per deciliter (dL) of blood On 01/22/24, an order was written for levemir (long acting insulin) five units SQ every day. Review of the pharmacy review/recommendations since November 2023 revealed on 03/13/24 the pharmacy identified there was no order for an A1c level (test that measured average blood sugar levels over a two to three month period) although Resident #34 was receiving insulin. There were no A1c levels located since the review/recommendation. There was no physician response as the facility had to contact the pharmacy to provide pharmacy reviews since the reviews had not been available. On 05/21/24 at 8:28, RN #100 revealed the last A1c level she located was obtained 06/20/23 and the pharmacy recommendation had no been addressed. 4. Review of Resident #10's medical record revealed diagnoses including type two diabetes mellitus with diabetic neuropathy and chronic peripheral insufficiency. Insulin orders included: On 12/27/23 novolog 100 u/ml SQ per sliding scale with insulin starting for a blood glucose level of 165 mg/dL (normal range from 60-100) and on 12/27/23 tresiba 100 u/ml: administer 60 units in the morning SQ. Review of a pharmacy recommendation dated 11/26/23 revealed Resident #10 was receiving insulin but did not have an A1c level scheduled in the chart. No response was documented by the physician. No A1c results were located in the medical record since the pharmacy review was completed on 11/26/23. On 05/21/24 at 8:28 A.M., RN #100 stated Resident #10's last A1c was drawn 04/13/23 and when she contacted the doctor about the pharmacy review the physician stated he had provided standing orders that indicated if a resident was receiving insulin they should be followed by obtaining A1c labs. On 05/21/24 at at 12:16 P.M., RN #100 indicated she had gotten copies of pharmacy recommendation for the past six months and was trying to ensure they were addressed. The RN verified she was unable to locate the reviews for the last six months. This deficiency represents non-compliance investigated under Master Complaint Number OH00152953.

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 22653 Based on medical record review, review of drug-related information on www.medscape.com, and interview, the facility failed to ensure a resident had adequate indications for use of a psychotropic medication. This affected one (Resident #13) of five residents whose medications were reviewed. The facility census was 46. Findings include: Review of Resident #13's medical record revealed diagnoses including hemiplegia (paralysis of one side of the body) affecting the right dominant side, rhabdomyolysis (condition in which damaged skeletal muscle breaks down rapidly)., contracture of the right hand, heart failure, BPH (a condition in which the flow of urine is blocked due to the enlargement of prostate gland)., gastroesophageal reflux disease, stiffness of the right shoulder, speech disturbance, acquired absence of the spleen, history of falling, hypertension, and muscle wasting. A physician order for risperidal (anti-psychotic) 0.25 milligrams every day was written on 03/04/24. On 05/21/24 at 8:28 A.M., Registered Nurse (RN) #100 stated she located a diagnosis of dementia to support the use of risperidal. RN #100 verified dementia was not an acceptable indication for use of risperidal. On 05/21/24 at 12:19 P.M., RN #100 stated the risperidal was originally started on 03/04/24 for behaviors, Resident #13 was followed by psychiatric services and an unsuccessful attempt at a gradual dose reduction had been attempted. RN #100 verified she was unable to locate any information indicating why the benefits of use of the risperidal would outweigh the risks. Review of risperidal information on the Medscape web-site revealed a black box warning for the use of risperidal. The warning indicated risperidal was not approved for elderly residents with dementia-related psychosis. Elderly residents with dementia-related psychosis who were treated with antipsychotic drugs were at increased risk of death. Deaths in trials appeared to be either cardiovascular or infectious in nature. Review of additional information about risperidal revealed a risk of orthostatic hypotension being higher in the elderly with its use.

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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** 22653 Based on observations, interviews and review of Medscape online information regarding humalog insulin storage the facility failed to ensure the proper labeling and storage of medications. This affected five residents (Resident #1, #21, #33, #45 and #48) of 46 residents with medications secured in the two facility identified medication carts. Findings include. 1. While observing the 100/200 hall medication cart with Registered Nurse (RN) #135 on 05/16/24 at 1:38 P. M., Resident #21 had two bottles of opened humalog insulin. The insulin was not dated as to when it was opened. RN #135 stated the insulin vials were transferred with Resident #21 from another facility upon admission so she did not know how long they had been opened. Review of the Electronic Health Record (EHR) revealed Resident #21 was admitted to the facility on [DATE]. Review of Medscape information on humalog insulin revealed open vials could be stored/used for up to 28 days after opening the vial. 2. While observing the 100/200 hall medication cart with Registered Nurse #135 on 05/16/24 at 1:38 P.M., Resident #1 was observed to have earwax removal solution opened on 03/21/24 with a label indicated the order was for a limited time. RN #135 stated once the order had been fulfilled, the earwax removal solution should have been discarded. 3. While observing the 100/200 hall medication cart with Registered Nurse #135 on 05/16/24 at 1:38 P.M., an inhaler with only the last name of Resident #48 was observed in the medication cart with no label. RN #135 stated the label would have been on the box. The empty box must have been sent with Resident #48 upon discharge. Review of the EHR revealed Resident #48 discharged from the facility 05/14/24. 4. During observations of the 300/400 medication cart with Licensed Practical Nurse (LPN) #140 on 05/16/24 at 1:50 P.M., she verified Resident #35's athlete's foot cream and triamcinolone cream, Resident #33's lotrisone cream, Resident #45's nystatin topical powder, and two additional topical creams she had removed from the cart were stored with residents' oral medications. None of the pills were observed to be contaminated by the creams. During an interview on 05/21/24 at 3:34 P.M., RN #100 stated the policy for storing medications was not specific but creams should be in the treatment cart, not with medications. Insulin was to be stored in accordance with manufacturer recommendations. This deficiency represents non-compliance investigated under Master Complaint Number OH00152953.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 22653 Based on record review and investigation, the facility failed to ensure administrative staff maintained records in a secure and accessible area and failed to ensure incidents of elopement were investigated and evaluated to ensure safety of wandering residents. This affected all 46 residents. Findings include: 1. During an entrance conference with the Administrator on 05/16/24 at 12:51 P.M., a request was made for infection control surveillance logs for the past three months. On 05/16/24 at 4:50 P.M., the Administrator stated he could not locate evidence of infection control logs since February 2024. The prior Director of Nursing (DON)/Registered Nurse (RN) #200 kept the information on her personal ipad and her employment had ended on 05/15/24 and no records were available. On 05/21/24 at 9:15 A.M., RN #100 stated she was able to locate some infection control paper work through February 2024 but could find nothing since then. RN #100 stated she had been unable to find any information that showed an evaluation of the infection data and never recalled RN #200 discussing evaluations of any patterns or action needed in relation to infections. On 05/23/24 at 2:38 P.M., the Administrator reported the facility had requested the infection surveillance records from RN #200 and was told she left everything at the facility except what had been on her Macbook and she had deleted all of it. 2. During review of elopements by Resident #18 on 03/03/24 and 03/04/24, a request was made for any type of investigation. On 05/21/24 at 8:39 A.M., RN #100 stated the facility had been unable to locate any type of investigation/witness statements for the incidents on 03/03/24 or 03/04/24. RN #100 stated the Administrator informed he thought the previous Director of Nursing (DON)/RN #200 had a file that staff had been unable to locate. On 05/23/24 at 1:49 P.M., RN #125 verified she worked on 03/03/24 when Resident #18 was located by staff outside the facility on night shift and she returned without incident. RN #125 stated nobody had asked her for any additional details other than what she had reported. RN #125 stated she believed Resident #18 exited the facility out of the door by the kitchen. RN #125 stated she was not sure if the door alarmed or if it was shut off. (continued on next page)

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/23/24 at 2:38 P.M., the circumstances regarding Resident #18's elopement and lack of investigation was discussed with the Administrator. The Administrator stated after the nurses reported the elopement incidences to RN #200 she stated she would handle it from there and he believed she had followed up on it. The Administrator stated if Resident #18 left the door which was indicated during the interview with RN #125 it would have had to been out the door to the back patio. The Administrator indicated he was not sure if the door was alarmed. It used to have a battery operated alarm but he would double check. On 05/23/24 at 3:15 P.M., observation of the door in the dining room near the kitchen revealed a white alarm box. There was no sound when RN #100 opened the door three times. The door led to a courtyard with a gate which could be opened without alarming. RN #125 accompanied RN #100 and the surveyor outside and revealed Resident #18 was located outside the fenced in area and she ambulated with her around the building before going back inside on 03/03/24. On 05/23/24 at 3:17 P.M., the Administrator was informed no sound was heard when the door was opened. The Administrator responded the alarm did not sound at the door but there was a unit that alarmed at the nursing station. No alarming was heard at the nursing station and the Administrator confirmed he was unable to locate the box that he referred to. On 05/28/24 at 4:26 P.M., the Administrator stated the elopement on 03/03/24 occurred between 6:30 P.M. and 7:00 P.M. On 05/28/24 at 4:59 P.M. the Administrator stated he was unable to verify or find any written records for the last time the alarm on the dining room door leading to the patio was checked or monitored.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 22653 Based on record review and interview, the facility failed to ensure the accuracy and completeness of medical records. This affected three known residents (Resident #13, 18, and #47) but had the potential to affect all residents in the facility. The census was 46. Findings include: 1. a Review of Resident #18's open medical record revealed diagnoses including dementia with agitation, type two diabetes mellitus, peripheral vascular disease, major depressive disorder, muscle wasting, anxiety disorder, long term use of insulin, vitamin B12 deficiency, and acute angle-closure glaucoma in bilateral eyes. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #18 was moderately cognitively impaired with a score of 9 out of a possible score of 15. The MDS indicated Resident #18 was able to make herself understood and was able to understand others. The assessment did not indicate any wandering during the specified time frame. Review of a nursing note dated 03/04/24 at 6:13 P.M. revealed the nurse noted Resident #18 wandering outside on the patio after dinner. A wander guard was in place and functioning properly earlier in the shift and when Resident #18 was assisted back inside. The note indicated the physician was notified of Resident #18's exit seeking/elopement and the family request of anti- anxiety on an as needed basis. The daughter was notified. On 05/20/24 at 2:15 P.M., Registered Nurse (RN) #105 was asked for any information she had on Resident #18 being located outside without supervision. Resident #105 provided documentation which revealed Resident #18 was also found at the rear of the facility on 03/03/24 unaccompanied by staff. On 05/20/24 between 2:30 P.M. and 2:35 P.M., the lack of documentation of the 03/03/24 incident was discussed with RN #100 who was unable to provide an explanation. Review of a Medical Records policy (dated 03/18/15) addressed photocopying of medical records on request. The content of the charts were not addressed. Review of a Medical Records policy (dated 03/18/15) addressed reviewing a resident's chart by a resident, guardian, a durable power of attorney or a family member. The contents of the chart was not addressed. Review of a Resident Incidents policy (dated March 2022) revealed an incident report was to be completed at the time any incident involving a resident occurred. All falls and incidents were to be charted on by nursing staff. The incident reports were not part of the resident's medical record and were only used for internal communications and statistical information for quarterly meetings. Review of the facility's Elopement policy (dated March 2024) revealed staff were to update plans of care with interventions to protect from further elopement. An incident report was to be completed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 b During an interview with RN #100 on 05/23/24 at 10:04 A.M., she revealed it was the facility's policy to bathe/offer to bathe every resident every other day. Review of bathing records for Resident #18 from 04/20/24 to 05/20/24 revealed eight baths were recorded RN #100 reported she believed the bathing occurred but staff were not documenting. Review of Resident #18's bladder documentation revealed most entries revealed Resident #18 was incontinent. No entries were made for 04/23/24, 04/25/24, 04/27/24, 04/28/24, 05/01/24, 05/02/24, 05/04/24, 05/06/24 through 05/08/24, 05/11/24 - 05/14/24, 05/16/24, or 05/19/24. Only on 04/22/24 did staff document on two shifts. Interview of RN #100 on 05/23/24 at 10:04 A.M. revealed she believed it was a documentation issue. 2. On 05/23/24 at 1:23 P.M., Licensed Practical Nurse (LPN) #115 stated she had heard of nurses on day shift giving night shift medications then night shift nurses signed off the were administered but she had never witnessed it and she administered/signed off administration of all her own medications. LPN #115 could or would not specify the dates/times/residents involved. On 05/23/24 at 1:49 P.M., Registered Nurse (RN) #125 stated she had worked night shift and two day shift nurses would sometimes administer 8:00 P.M. medications with medications ordered for 6:00 P.M. administration. RN #125 stated the day shift nurses thought they were helping and verified she had signed off administration of medications she had not personally administered. Review of the facility's Medication Administration policy (dated 07/24/23) revealed after a medication was administered the nurse should sign the Medication Administration Record (MAR). 3. Review of Resident #13's medical record revealed diagnosis included right side paralysis, muscle wasting, and stiffness of the right shoulder. Review of Resident #13's bathing records from 04/20/24 and 05/20/24 did not reveal baths were offered/provided every other day. Review of Resident #13's toilet use records from 04/20/24 and 05/20/24 revealed multiple days and/or shifts when there was no documentation of toileting assistance or incontinence care being provided. During an interview of RN #100 on 05/23/24 at 10:05 A.M., she reported she believed it was a documentation issue that baths were not provided every other day per policy or toileting/incontinence care was provided every shift. RN #100 stated she did not know if there was a written policy for baths but it was scheduled that residents in even rooms got showers on even days and residents in odd rooms got baths on odd days. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 05/21/24 at 3:34 P.M., RN #100 provided a list of medications that had not been signed off as administered over the period of 05/14/24 through 05/20/24 per request. Among those not signed as administered were Resident #18's humalog via sliding scale on 05/14/24 at 4:00 P.M., Resident #15's exelon patches scheduled at 5:59 A.M. on 05/19/24 and 05/20/24, Resident #46's exelon patches scheduled at 5:59 A.M. on 05/19/24 and 05/20/24, Resident #19's exelon patches scheduled at 5:59 A.M. on 05/19/24 and 05/20/24, Resident #45's IV zosyn (antibiotic) scheduled for administration at 4:00 P.M. on 05/14/24, Resident #42's exelon patch scheduled for administration at 5:59 A.M. on 05/19/24 and 05/20/24. and Resident #10's novolog insulin scheduled by sliding scale on 05/14/24 at 4:00 P.M. The report also indicated a blood sugar was not recorded for Resident #38 on 05/14/24 at 5:00 P.M. On 05/21/24 at 3:34 P.M., RN #100 indicated she could not verify if the medications were administered and the blood sugar obtained or if nurses failed to document the administration. 48567 5. Review of the medical record for Resident #47 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included severe protein-calorie malnutrition, chronic obstructive pulmonary disease (COPD), acute respiratory failure with hypoxia, alcohol dependence with alcohol-induced persisting dementia, acute kidney failure, pneumonitis due to inhalation of food and vomit, dependence on supplemental oxygen, Barrett's esophagus without dysplasia, and unspecified toxic encephalopathy. Review of the Minimum Data Set (MDS) 3.0 assessment completed on 05/01/24 revealed Resident #47 had severely intact cognition. Further review of the MDS revealed Resident #47 was dependent for toileting, bathing, dressing, and personal care and required substantial assistance for toilet and tub transfers. The MDS assessment also revealed Resident #47 was always incontinent of bowel and bladder. Review of the care plan dated 01/15/24 revealed Resident #47 had an activities of daily living (ADL) self-care deficit related to impaired cognition, risk for falls, incontinence, impaired communication, and status post hospitalization due to multiple respiratory infections. Interventions included adjusting the level of support during the provision of Resident 47's ADL according to his changing abilities, cleaning and trimming nails on scheduled bath days, and providing Resident #47 a sponge bath in the event he is unable to tolerate a full bath or shower. Review of the care plan further revealed Resident #47 had bladder incontinence. Interventions included cleaning his perineal area with each episode of incontinence and monitoring and documenting any signs of urinary tract infection or changes in urinary frequency. Review of the physician orders revealed an order dated 03/29/24 for Resident #47 to have incontinence checks every one hour every day and every night. Review of bathing records for Resident #47 revealed no documentation of bathing during the last 30 days of his facility stay from 04/02/24 through 04/10/24, from 04/17/24 through 04/24/24, or from 04/27/24 through discharge date of [DATE]. Review of the medical record revealed Resident #47 had gone to the emergency roiagnom on [DATE] and returned 04/07/24. Review of the record for toilet use for the last 30 days of Resident #47's facility stay revealed no documentation of toilet use from 04/04/24 through 04/11/24, 04/13/24, 04/14/24, from 04/17/24 through 04/24/24, or from 04/28/24 through 05/01/24. Further review revealed documentation of Resident #47's refusal of toileting on 04/26/27. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/21/24 at 4:55 P.M. with Registered Nurse (RN) #100 verified the periods when no bathing was documented and stated she believed Resident #47 was receiving his baths and it was a documentation issue. Further interview with RN #100 verified the records only indicated the support provided for the bathing activity and did not specify what type of bath was provided. During this interview, RN #100 also verified toileting records were incomplete. This deficiency represents non-compliance investigated under Master Complaint Number OH00152953 and Complaint Number OH00152844.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on observation, interview, and policy review, the facility failed to provide evidence of infection control surveillance and failed to implement proper hand hygiene and use of personal protective equipment (PPE) during care of a feeding tube. This affected Residents #3 and #22 and had the potential to affect all residents. The facility census was 46. Findings include: 1. During an entrance conference with the Administrator on 05/16/24 at 12:51 P.M., a request was made for infection control surveillance logs for the past three months. On 05/16/24 at 4:50 P.M., the Administrator stated he could not locate evidence of infection control logs since February 2024. Registered Nurse (RN) #200 kept the information on her personal ipad and her employment had ended on 05/15/24 and no records were available. On 05/20/24 at 8:04 A.M., RN #100 stated since the facility had been unable to locate infection control logs/surveillance she had calls out to the pharmacy to get antibiotic reports and was looking at orders in medical records. On 05/21/24 at 9:15 A.M., RN #100 carried some papers with her and stated she had some infection control sheets through February 2024 but could find nothing since then. When infections were discussed in risk meetings she did not recall RN #200 (the previous infection control preventionist) discussing evaluation of any trends or any action needed taken so RN #100 could not speak to evaluation of gathered information. RN #100 stated when she completed Minimum Data Set assessments she reviewed anybody on antibiotics to ensure they met McGeer's criteria for coding purposes but that was not documented either. On 05/23/24 at 2:38 P.M., the Administrator reported the facility had requested the infection surveillance records from RN #200 and was told she left everything at the facility except what had been on her Macbook and she had deleted all of it. 2. During medication administration observations on 05/20/24 at 5:10 A.M., Licensed Practical Nurse #170 dropped four pills on the cart while attempting to pour them from a plastic sleeve into a medication cup. LPN #170 used her bare hands to pick up two of the pills to put them back into the cup and stated she should not have done that. LPN #170 donned gloves to pick up the other two pills and placed them in the medication cup. After adding additional medications to the cup, all the medications were administered to Resident #22. 48567 3. Review of the Medical record for Resident #3 revealed she was admitted to the facility on [DATE] with diagnoses including displaced intertrochanteric fracture of the left femur, interstitial pulmonary disease, chronic obstructive pulmonary disease (COPD), emphysema, protein-calorie malnutrition, anorexia, cachexia, dehydration, adult failure to thrive, and gastrostomy status. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 had severely impaired cognition. Further review of the MDS revealed Resident #3 had a feeding tube and received 51% or more of her calories from tube feedings. Review of the care plan dated 05/17/24 revealed Resident #3 the potential for nutritional problems related to tube feedings, adult failure to thrive, COPD, unspecified protein-calorie malnutrition, anorexia/cachexia, hypothyroidism, potential for altered fluid status, edentulous, hypokalemia, depression, variable oral intake, and the need for nutrition support and therapeutic diet. Interventions included providing enteral feedings and supplements as ordered. Review of the physician orders revealed an order dated 05/16/24 for Resident #3's percutaneous endoscopic gastrostomy (PEG) tube (a surgically placed tube into the stomach of the resident for nutrition) to be flushed with 135 milliliters (ml) of water four times a day. Further review of the orders revealed an order dated 04/22/24 for enhanced barrier precautions instructing staff to wear a gown and gloves when providing device care or using devices, including a feeding tube. Review of the care plan dated 05/17/24 revealed Resident #3 the potential for nutritional problems related to tube feedings, adult failure to thrive, COPD, unspecified protein-calorie malnutrition, anorexia/cachexia, hypothyroidism, potential for altered fluid status, edentulous, hypokalemia, depression, variable oral intake, and the need for nutrition support and therapeutic diet. Interventions included providing enteral feedings and supplements as ordered. Observation on 05/21/24 at 12:12 P.M. of licensed practical nurse (LPN) #115 administering Resident #3's water flush revealed LPN #115 did not don a gown and did not wash her hands prior to donning gloves and starting the procedure. Further observation revealed LPN #115 paused the procedure after blousing 100 ml of water to obtain more water from Resident #3's bathroom sink to flush through the PEG tube. During this observation, no glove change or hand hygiene was performed as LPN #115 manipulated the sink faucet, refilled the graduate (plastic container used for measuring liquids) with water, and proceeded to administer another bolus of water through Resident #3's PEG tube. Interview on 05/21/24 at 12:18 P.M. with LPN #115 confirmed she did not perform hand hygiene prior to the water bolus via Resident #3's PEG tube. An additional interview conducted on 05/21/24 with LPN #115 at 3:40 P.M. confirmed her typical practice does not include donning a gown when providing tube feedings or rendering feeding tube care and that she had no gown on when she flushed Resident #3's PEG tube with water. Review of the policy dated 03/18/15, titled Hand Hygiene/Washing, revealed hands were to be washed thoroughly before and after providing direct resident care to reduce the transmission of organisms from nursing staff to resident and vice-versa. Review of the policy titled Enhanced Barrier Precautions, dated 03/27/24, revealed use of standard precautions, as well as donning a gown, was required for high contact resident care activities which included use or care of a feeding tube. This deficiency represents non-compliance investigated under Master Complaint Number OH00152953.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 22653 Based on review of infection surveillance records and interview, the facility failed to ensure a minimum of one individual was qualified to perform the job of an infection preventionist. This had the potential to affect all 46 residents. Findings include: During the entrance conference with the Administrator on 05/16/24 at 12:51 P.M., he reported the Director of Nursing (DON) who had also been assigned as the facility's Infection Preventionist (IP) had a last day of employment at the facility on 05/15/24. On 05/21/24 at 9:15 A.M., Registered Nurse (RN) #100 verified the facility had no other staff member who had completed specialized training in infection prevention and control to serve as the IP.