STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366250	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kimes Nursing & Rehab Ctr	75 Kimes Lane Athens, OH 45701

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, staff interview, and policy review, the facility failed to ensure a resident and or their resident representative was provided a bed-hold notice as required, when the resident was transferred out to the hospital. This affected one (Resident #32) of two residents reviewed for hospitalization . The facility census was 51. Findings include: Review of Resident #32's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included dementia with behavioral disturbances, unspecified intellectual disability, generalized anxiety disorder, restlessness and agitation, and hypernatremia. Her face sheet indicated the resident's sister was listed as her emergency contact #1 and her mother was her emergency contact #2. Review of Resident #32's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was sometimes able to make herself understood and was sometimes able to understand others. She had short and long term memory impairment and her cognitive skills for daily decision making was severely impaired. Review of Resident #32's progress notes revealed a nurse's note dated 09/16/24 at 5:21 P.M. that indicated the resident was sent to the hospital for an elevated sodium level of 158 milliequivalents per liter. The resident's sister was made aware of the transfer and planned to meet the resident at the emergency room . The resident was indicated to be unable to verbalize questions regarding bed-hold. There was no answer from the resident's sister when she was called back to ask if she wanted to hold the resident's bed while she was out to the hospital. Further review of Resident #32's progress notes revealed another nurse's note dated 09/17/24 at 9:02 A.M. that revealed the resident had been admitted to the hospital for an elevated sodium level. She returned to the facility on [DATE] at 5:00 P.M. Resident #32's medical record was absent for any evidence of her resident representative being provided a bed-hold when she was admitted to the hospital on 09/16/24 as required. Findings were verified by Social Service Director #116. (continued on next page)

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

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 2:30 P.M., an interview with Social Service Director #116 revealed she could not find evidence of Resident #32's representative being provided a copy of a bed-hold notice when the resident was transferred to the hospital on 09/16/24. She was surprised she could not find one as they usually did not miss those when they were necessary. Review of the facility's policy on Holding Bed Space undated revealed the facility informed residents of their bed hold policy upon admission and prior to a transfer for hospitalization or therapeutic leave. The policy interpretation and implementation revealed upon admission and at the time a resident was transferred for hospitalization or a therapeutic leave, facility would provide the resident with information concerning their bed-hold policy. When emergency transfers were necessary, the facility would provide the resident or resident representative with information concerning their bed hold policy within 24 hours of such transfer.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404 Based on staff interview and record review the facility failed to to ensure resident Pre-Admission Screening and Resident Review (PASARR) documents were accurate regarding resident current conditions and diagnoses. This affected one (Resident #4) of one resident reviewed for PASARR documents. The census was 51. Findings include: Record review of Resident #4 revealed an admitted [DATE] with pertinent diagnoses of: anxiety disorder on 07/30/21, schizoaffective disorder on 01/25/22 dementia, covid 19, type two diabetes mellitus, localized edema, hammer toe, cognitive communication deficit, macular degeneration, sensorineural hearing loss, reduced mobility, vitamin D deficiency, iron deficiency anemia, hypertension, hyperlipidemia, major depressive disorder, hypokalemia, and symbolic dysfunctions. Review of the 08/22/24 Minimum Data Set (MDS) assessment revealed the resident was severely cognitively impaired and used a walker to aid in mobility. The resident required partial moderate assistance to roll left and right, sit to lying, lying to sitting, sit to stand, chair/bed to chair, and toilet transfer. Review of the medical record on 10/15/24 at 1:15 P.M. revealed Resident #4 had a diagnosis of anxiety disorder since 07/30/21. Record review on 10/15/24 at 1:18 P.M. of the 01/25/22 Pre-Admission Screening and Resident Review (PASARR) 01/25/22 revealed there was no anxiety diagnosis listed. Interview with Marketing Director #100 on 10/17/24 at 9:45 A.M. verified Resident #4 did not have a listed anxiety diagnosis on the 01/25/22 PASARR but she had a diagnosis of anxiety disorder.

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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** 31404 Based on staff interview, and record review the facility failed to develop comprehensive care plans for Resident #36's anticoagulant use and Resident #10's anxiety care plan was not specific and patient centered. This affected two (Resident #10, and #36) of 20 residents reviewed for care plans. The facility census was 51. Findings include: 1. Record review of Resident #36 revealed an admitted [DATE] with pertinent diagnoses of: end stage renal disease, type two diabetes mellitus with diabetic chronic kidney disease, atherosclerotic heart disease of native coronary artery, congestive heart failure, acute embolism and thrombosis of right internal jugular vein, acute and chronic respiratory failure, disorder of kidney and ureter, noninfective gastroenteritis and colitis, hypertension, morbid obesity, disorders of lung, malignant neoplasm of prostate, anemia, polyneuropathy, hypoxemia, acquired absence of left leg above knee, and other malaise. Review of the 09/12/24 Minimum Data Set (MDS) assessment revealed the resident is cognitively intact and uses a wheelchair to aid in mobility. The resident receives dialysis services. Review of the medical record on 10/16/24 at 12:05 P.M. revealed a Physician Order dated 03/07/24 for apixaban Eliquis (an anticoagulant medication) Oral Tablet 5 milligrams give one tablet by mouth every 12 hours for acute deep venous thrombosis right upper extremity. Review of the care plan on 10/16/24 at 12:10 P.M. revealed there was no care plan related to the anticoagulant Eliquis. Interview with the Director of Nursing (DON) on 10/16/24 at 12:41 P.M. verified there was not an anticoagulant care plan for Resident #36 Eliquis use. 47987 2. Review of the medical record for Resident #10, revealed an admitted [DATE]. Diagnoses included but were not limited to atherosclerotic heart disease of native coronary artery without angina pectoris, type 2 diabetes, unspecified dementia, anxiety disorder, major depressive disorder, and muscle weakness. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15. The resident was assessed to require independent toilet hygiene, bed mobility and transfers with partial/moderate assistance with shower/bathe self. Review of the active care plan for Resident #10 revealed no plan of care was in place for anxiety disorder and resident specific symptoms. (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 10/16/24 at 12:40 P.M. with the Director of Nursing verified Resident #10 had no plan of care for the diagnosis of anxiety disorder and resident specific symptoms.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on record review and interview, the facility failed to ensure hospice records were available for continuity of care for one resident. This affected one (Resident #109) of one resident reviewed for hospice. Additionally, the facility failed to ensure compression stockings were applied as physician ordered. This affected one resident (#32) of one resident reviewed for edema. The facility census was 51. Findings Include: 1. Review of the medical record for Resident #109 revealed an initial admitted [DATE] with the diagnoses including but not limited to fracture of head and neck of right femur, heart failure, dementia, atrial fibrillation, chronic obstructive pulmonary disease, gout, gastro-esophageal reflux disease and anxiety disorder. Review of the resident's comprehensive admission assessment dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident's prognosis was less than six months and the resident received hospice services. Review of the plan of care dated 10/04/24 revealed the resident had a terminal prognosis of six months or less if disease follow usual course. Interventions included hospice interdisciplinary group will provide services based on identified needs of the resident, hospice nurse will educate resident/family/on medication use dosage and administration as needed, hospice skilled nursing visits one to three times a week and as needed, hospice will be financially responsible and provide all medications related to the terminal illness and hospice will have on-call services available 24 hours a day seven days a week. Review of the resident's monthly physician orders for October 2024 identified an order 09/26/24 resident receiving hospice services. Review of Resident #109's medical record revealed no evidence the facility had obtained the hospice certification, care plan or assessment. On 10/15/24 at 4:13 P.M., interview with Licensed Practical Nurse (LPN) #152 revealed LPN #138 had contacted the resident's hospice company and requested the resident's hospice information be faxed to the facility. On 10/16/24 at 10:19 A.M., interview with LPN #152 verified the resident's medical record did not contain the required hospice documentation for continuity of care. 28923 2. Review of Resident #32's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included dementia with behavioral disturbances, unspecified intellectual disability, osteoarthritis, muscle weakness, and abnormalities of gait and mobility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #32's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was sometimes able to make herself understood and was sometimes able to understand others. She had short and long term memory impairment and her cognitive skills for daily decision making was severely impaired. She was not known to have displayed any behaviors and was not noted to have rejected any care during the seven day assessment period. She needed some help/ partial assistance from another person for bathing and dressing. She had a functional limitation in her range of motion to her bilateral upper and lower extremities. She was dependent on staff for lower body dressing and putting on/ taking off footwear. Review of Resident #32's physician's visit notes revealed the resident was seen by the physician on 10/09/24. The visit note indicated the facility staff had noted an increase in the resident's chronic left lower extremity (LLE) edema. The physician noted a trace amount of pitting edema to the resident's LLE during his exam. He ordered compression stockings to be applied to the resident's legs. Review of Resident #32's physician's orders revealed an order had been written for compression stockings to be applied in the morning and removed at bedtime. The date of the order was 10/09/24 and it was to start on 10/10/24. Review of Resident #32's active care plans revealed they were absent for any care plan to address the resident's chronic edema of her LLE. None of the existing care plans mentioned edema being a problem for the resident or that she was to use compression stockings to help manage her edema. Review of Resident #32's treatment administration record (TAR) for October 2024 revealed the nursing staff were initialing the TAR to show the compression stockings were being applied as ordered. The nurse working 10/15/24 (Tuesday) signed off that the resident's compression stockings were applied that morning. On 10/15/24 at 1:44 P.M., an observation of Resident #32 noted the resident to be sitting up in the common area on a sofa. She had her feet down on the floor in front of her. She was wearing slacks put the pant legs were hiked up exposing her legs from the mid-calf area down. She was noted to have some edema in her lower extremities and was not wearing compression stockings as ordered. On 10/15/24 at 4:07 P.M., further observation of Resident #32 noted her to be sitting in the common area again across from the nurses station seated on the sofa. Her pant legs were again raised exposing her lower extremities. Her legs were not elevated and her feet were in contact with the floor. She continued to not have any compression stockings on as ordered and as signed off as being in use on the TAR. On 10/15/24 at 5:05 P.M., an interview with Certified Nursing Assistant (CNA) #126 revealed Resident #32 was known to have swelling in her feet. The CNA had just come back to work yesterday and noticed the swelling in the resident's feet. She was not aware of the resident having an order for compression stockings. The night shift got her up in the morning and she was usually already dressed when she arrived to work. She was asked to check the resident's room to see if the resident had any compression stockings in her room. The CNA searched the resident's room checking her dresser and the closet, but could not find any compression stockings. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 5:07 P.M., an interview with LPN #136 revealed Resident #32 was known to have some swelling in her ankles. She was asked what they did to try to alleviate the swelling in the resident's legs. She stated they try to keep her legs elevated when lying down and will raise her feet when she is sitting in her recliner. She did not mention anything about the resident having the use of compression stockings. She acknowledged the resident was not wearing her compression stockings as ordered. She further acknowledged she had initialed the TAR to reflect the compression stockings were in place on the resident, when they were not.

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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** 32654 Based on observation, record review and interview, the facility failed to ensure physician ordered pressure reduction devices were implemented as ordered. This affected two residents (#45 and #109) of four residents reviewed for pressure ulcers. The facility census was 51. Findings Include: 1. Review of the medical record for Resident #109 revealed an initial admitted [DATE] with the diagnoses including but not limited to fracture of head and neck of right femur, heart failure, dementia, atrial fibrillation, chronic obstructive pulmonary disease, gout, gastro-esophageal reflux disease and anxiety disorder. Review of the resident's admission nursing assessment dated [DATE] revealed the resident was admitted to the facility with a stage I pressure ulcer to the right outer ankle measuring 2.0 centimeters (cm) by 2.0 cm. The resident also had an abrasion to the right hip measuring 3.0 cm by 0.2 cm and an abrasion to the left buttocks measuring 2.0 cm by 0.2 cm. Review of the resident's Braden scale dated 09/23/24 revealed a score of 15 indicating the resident was at risk for skin breakdown. Review of the plan of care dated 10/04/24 revealed the resident had skin integrity deficits and is at risk for pressure injury related to incontinence bowel and bladder, mobility deficit, thin fragile skin, non-weight bearing to right lower extremity, due to inoperable right hip fracture, resident typically requires on maximum assist with bed mobility, transfers and toileting task. Interventions included air mattress per order, bilateral assist rails to enable resident to turn and reposition self, Braden assessment for the first four weeks then quarterly and as needed, creams per order, diet as ordered, encourage and assist to turn and reposition every two hours and as needed, medication as ordered, nurse to monitor skin every week, keep heels off bed and recliner chair (elevate with pillows). Review of the resident's monthly physician orders for October 2024 identified an order 09/23/24 encourage to use pressure reducing cushion while in wheelchair, encourage to keep heels elevated off surface of bed, encourage to turn and reposition every two hours as needed, weekly skin assessment, non-weight bearing to right lower extremity due to hip fracture, off loading boot to right foot when in bed every shift, 10/03/24 air mattress to bed and 10/09/24 Zinc 40% topically to sacrum every shift for moisture associated skin damage (MASD). On 10/15/24 at 11:14 A.M., observation of Resident #109 revealed the physician ordered off loading boot at all times was not implemented to the resident's right foot. Further observation revealed the physician ordered air mattress was not placed on the resident's bed. On 10/15/24 at 1:45 P.M., observation of Resident #109 revealed the physician ordered off loading boot remained off. Further observation revealed the physician ordered air mattress was not on the resident's bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 4:13 P.M., interview with Licensed Practical Nurse (LPN) #152 verified the off loading boot and the air mattress to the resident's bed was not implemented as physician ordered. 47987 2. Review of the medical record for Resident #45, revealed an admitted [DATE]. Diagnoses included but were not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, pressure ulcer of left buttock, stage 2, pressure ulcer of right heel, unstageable, and cerebral infarction with a diagnosis of abnormal weight loss as of 06/29/24. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of the resident is rarely/never understood. The resident was assessed to require substantial/maximal assistance with shower/bathe self, dependent on toilet hygiene, bed mobility, and transfers. This resident was also assessed to be at risk for developing pressure ulcers and has a pressure reducing device for bed. Review of the active care plan for Resident #45 revealed a Potential for Skin Integrity Deficit with an intervention for an air mattress to order. Review of the active physician order for Resident #45 revealed alternating air mattress to bed and check function each shift. Review of the most recent weight obtained for Resident #45 on 10/02/24 revealed the resident to weight 133 pounds. Review of the most recent Braden skin assessment completed on 10/10/24 revealed a score of 11.0 indicated moderate risk for skin breakdown. Observation on 10/15/24 at 9:24 A.M. revealed Resident #45 to be on an alternating air mattress set to a weight of 450 pounds. Reobservation on 10/15/24 at 3:52 P.M. revealed Resident #45 to be on an alternating air mattress set to a weight of 450 pounds. Interview on 10/15/24 at 3:53 P.M. with Licensed Practical Nurse #152 revealed she was unsure as to what pounds Resident #45's air mattress should be set on and verified it was set to 450 pounds. Observation on 10/15/24 at 3:58 P.M. with Registered Nurse Clinical Compliance Specialist #158 set Resident #45's bed to appropriate weight. This deficiency represents non-compliance investigated under Complaint Number OH00158165.

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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** 28923 Based on record review, observation, staff interview, and policy review, the facility failed to ensure fall prevention interventions were implemented as per the plan of care for residents who were at risk for and/ or had a history of falls. This affected two (Resident #33 and #38) of four residents reviewed for falls. The census was 51. Findings include: 1. Review of Resident #33's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included a history of a left hip fracture and a left rib fracture secondary to a fall at home, difficulty walking, muscle weakness, and need for assistance with personal care. His diagnoses list was updated to reflect he had a right hip fracture on 08/19/24, after his admission to the facility. Review of Resident #33's care plans revealed he had an active care plan in place for being at risk for additional falls related to having a history of falls resulting in multiple fractures, a history of waking up through out the night confused and would get out of bed resulting in falls. The goal was for the resident to have decreased opportunities for falls. The interventions included encouraging the resident to use the call light to ask for assistance before attempting to transfer or ambulate and the use of a visual reminder to use call light. Review of Resident #33's nurses' progress notes revealed a nurse's note dated 08/15/24 at 4:40 A.M. that indicated the nurse was called to the resident's room after responding to the resident call for help. The resident was found lying on his back in the bathroom doorway with his feet pointing towards the toilet. The resident's call light was on the bed rail but was not activated. His right leg was externally rotated. The resident was subsequently transferred to the hospital and admitted for a fracture to his right hip. Further review of Resident #33's progress notes revealed an interdisciplinary team (IDT) note dated 08/16/24 at 11:30 A.M. that indicated the IDT met to review the resident's recent fall. The new fall prevention intervention added, after that fall to prevent additional falls from occurring, was to use a visual reminder to use use his call light. On 10/16/24 at 4:52 P.M., an observation of Resident #33's room revealed there was no visual reminder posted in the resident's room for the resident to use his call light, as per his plan of care. Finding was verified by the Director of Nursing (DON). On 10/16/24 at 4:57 P.M., an interview with the DON confirmed the resident had a fall on 08/15/24, when he attempted an unassisted transfer from his bed to the bathroom. She reported the IDT reviewed that fall and added the use of a visual reminder posted in his room to remind him to use his call light. She acknowledged there was not a sign posted in his room as a visual reminder to the resident to use his call light. She stated she was not sure what had happened to it and would make sure another sign was posted. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47987 2. Review of the medical record for Resident #38, revealed an admitted [DATE]. Diagnoses included but were not limited to anxiety disorder, altered mental status, depression, and unspecified dementia. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 00 indicating severe cognitive impairment. The resident was assessed to require substantial/maximal assistance with shower/bathe self, bed mobility, transfers and dependent on toilet hygiene. Review of the active care plan for Resident #38 revealed fall risk with dycem to wheelchair at all times on top of alarm pad and under alarm pad. Review of Resident #38's progress note dated 10/12/24 at 10:20 A.M. revealed the resident was laying on the floor in front of wheelchair. Further review of the progress notes for Resident #38 dated 10/12/24 at 10:47 A.M. revealed dycem not in place to wheelchair at the time of the incident and reeducated staff on need to have dycem in wheelchair. Interview on 10/16/24 at 8:59 A.M. with the Director of Nursing verified the fall on 10/12/24 involving Resident #38 the fall intervention for the dycem to be in wheelchair at all times was not in place at the time of the fall and should have been per care plan. Review of the facility's Falls Management Policy and Procedure undated revealed the intent of the policy was to ensure residents received adequate supervision and assistive devices based on individual risk factors to reduce and/ or prevent falls. The purpose was to develop and implement appropriate interventions to reduce or prevent falls based on the resident's individual risk factors. Residents who were assessed as a high risk for falls would have individualized care plan developed that would include the problem, measurable individualized goals, and appropriate interventions to promote resident safety. A licensed nurse, based on initial observation of the fall would implement a keep safe plan, which would include an alternate/ new intervention in an effort to prevent recurrent falls. The new intervention would be documented in the medical record.

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Kimes Nursing & Rehab Ctr	75 Kimes Lane Athens, OH 45701

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 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** 31404 Based on record reviews and interviews, the facility failed to ensure a resident with Post Traumatic Stress Disorder (PTSD) was appropriately assessed to identify the cause of the residents PTSD and minimize triggers and/or re-traumatization. This affected one resident (#37) identified by the facility as having PTSD/trauma. The facility census was 51. Findings include: Record review of Resident #37 revealed an admitted [DATE] with pertinent diagnoses of: post traumatic stress disorder chronic 07/12/23, heart failure, morbid obesity, Alzheimer's disease, need for assistance with personal care, repeated falls, unspecified psychosis, hyperlipidemia, paranoid personality disorder, delusional disorders, abnormal posture, cognitive communication deficit, dementia, hypothyroidism, hypertension, tinea unguium, cardiomegaly, mood affective disorder, obstructive sleep apnea,anxiety disorders, major depressive disorder, and nightmare disorder. Review of the 09/11/24 quarterly Minimum Data Set (MDS) assessment revealed the resident was cognitively intact and used a walker to aid in mobility. The resident was listed as having a diagnosis of post traumatic stress disorder. Review of Resident #37 medical record on 10/15/24 at 1:50 P.M. revealed there was no assessment or care plan for PTSD. Interview with Registered Social Worker #116 on 10/17/24 at 10:00 A.M. revealed she was unaware of what Resident #37 PTSD was from and she had no knowledge of Resident #37 having a care plan or assessment for PTSD. Interview with the Director of Nursing (DON) on 10/16/24 at 12:41 P.M. verified there was not an assessment or care plan for PTSD. The DON said Psychiatric services talks to her but we dont really know what happened or what her triggers are.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404 Based on observation, record review, policy review, and staff interview the facility failed to follow infection prevention guidelines when they failed to wear appropriate personal protective equipment for enhance barrier precautions when doing would care for Resident #36. This affected one (Resident #36) of five residents reviewed for infection control. The facility census was 51. Findings include: Record review of Resident #36 revealed an admitted [DATE] with pertinent diagnoses of: end stage renal disease, type two diabetes mellitus with diabetic chronic kidney disease, atherosclerotic heart disease of native coronary artery, congestive heart failure, acute embolism and thrombosis of right internal jugular vein, acute and chronic respiratory failure, disorder of kidney and ureter, thrombocytopenia, gout, noninfective gastroenteritis and colitis, hypertension, morbid obesity, disorders of lung, malignant neoplasm of prostate, anemia, polyneuropathy, hypoxemia, acquired absence of left leg above knee, and other malaise. Review of the 09/12/24 Minimum Data Set (MDS) assessment revealed the resident is cognitively intact and uses a wheelchair to aid in mobility. The resident receives dialysis services. Review of the medical record on 10/15/24 at 9:52 A.M. revealed Resident #36 had a right lateral heel unstageable pressure ulcer and was receiving dialysis care. Observation of a on 10/16/24 at 4:00 P.M. revealed Resident #36 had a sign on his door for enhanced barrier precautions and to clean their hands including before entering room and when leaving room and to wear gloves and a gown for the following high contact resident care activities: Transferring, providing hygiene, device care or use, wound care or any skin opening requiring a dressing. Observation of a on 10/16/24 at 4:06 P.M. revealed State tested Nurse Aide (STNA)#127 assisting with Resident #36 wound care. STNA #127 put on gloves, but did not put on a gown and then assisted with the wound care by holding Resident #127 leg in the air for a minimum time of two minutes. She was visibly touching the side of the bed with her clothing. Interview with STNA #127 on 10/16/24 at 4:11 P.M. verified did not put on gown and resident was on enhanced barrier precautions. Review of the 08/01/22 facility Enhance Barrier Precautions policy revealed enhance barrier precautions are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms to residents. Gloves and gowns are applied prior to performing high contact resident care activity. Example of high contact resident activity requiring the use of gown and gloves include: dressing, transferring, providing hygiene, changing linens, wound care.

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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** 32654 Based on record review and interview, the facility failed to ensure one resident (#21) was not treated with an antibiotic prior to the return of the culture and sensitivity (C&S) results. This affected one (Resident #21) of two residents reviewed for urinary tract infection (UTI). The facility census was 51. Findings Include: Review of the medical record for Resident #21 revealed an initial admitted [DATE] with the latest readmitted [DATE] with the diagnoses including but not limited to neurocognitive disorder with Lewy bodies, repeated falls, anxiety disorder, dementia, Alzheimer's disease, mood disorder, hypertension, osteoarthritis, metabolic encephalopathy and osteoporosis. Review of the plan of care dated 03/05/23 revealed the resident had toileting deficits related to dementia, cognitive function fluctuates, short and long term memory deficits, sometimes understood and sometimes understands others, supervision to limited assist with toileting, frequently incontinent of bowel and bladder and can be resistive to toileting and incontinent care. Interventions include assist with toileting tasks as needed, assure adequate pericare after incontinent episode, encourage proper peri-care, encourage to request assist with toileting tasks before urge is too strong, encourage to toilet every two hours and as needed, assist with toileting tasks as needed, follow facility protocol episodes of constipation, labs per orders, report results to physician, medications as ordered, monitor and record bowel movements every shift, monitor for signs/symptoms of UTI. Review of the resident's bowel and bladder program screener dated 09/03/24 revealed the resident was a candidate for scheduled toileting. Review of the resident's quarterly MDS assessment dated [DATE] revealed the resident had a severe cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors. The assessment indicated the resident was always incontinent of bladder and frequently incontinent of bowel. Review of the progress note dated 09/12/24 at 6:14 P.M. revealed the resident was noted to have increased lethargy and sleeping in recliner. The resident was hitting staff and speaking in sentences that are not formed. The resident was noted to have not voided in 12 hours. The physician was noted and new orders were obtained. Review of the progress note dated 09/12/24 at 6:42 P.M. revealed new orders were received from the resident's physician for straight cath every eight hours as needed if no void, UA and culture and sensitivity (UA/C&S), stat complete blood count (CBC), complete metabolic panel (CMP) and Rocephin 1 gram every 24 hours for three days. Review of the UA/C&S results collected on 09/13/24 and resulted on 09/14/24 revealed the resident cloudy urine with urine ketones at 20 and urine urobilinogen at 2.0. Three or more morphotypes were identified suggesting probable contamination during specimen (urine) collection. Suggested repeat if clinically indicated. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 09/16/24 revealed the facility received the resident's urinalysis (UA) results with the recommendation to repeat if clinically indicated. The resident had received Rocephin for three days with the resident's behavior being back to baseline. The resident's physician was notified and determined there was no need for a repeat UA. On 10/16/24 at 4:06 P.M., interview with the Director of Nursing (DON) verified the resident was treated with antibiotics prior to the results of the UA/C&S.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50538 Based on review of medical records, resident vaccination consent forms and staff interview the facility failed to offer each resident a pneumococcal immunization. This affected four (Residents #10, #36, #37 and #46) of five residents sampled for influenza, pneumococcal and COVID-19 immunization review. The census was 51. Findings include: 1. Review of Resident #10's medical record revealed an admitted [DATE] and diagnoses of atherosclerotic heart disease, diabetes, hypothyroidism, dementia of unspecified severity, anxiety, depression, hypertension and hyperlipidemia. Review of the immunization record revealed Resident #10 received a dose of an unknown type of pneumococcal vaccine on or around 07/10/19. Review of Resident #10's physicians orders revealed no orders for pneumococcal vaccine. Review of the facility form titled Vaccine Administration Record (VAR)/informed Consent for Vaccinations at LTCF Pharmerica revealed a line where the resident or responsible party could indicate if they wished to receive a COVID-19 vaccination, influenza vaccination or other vaccination. Resident #10's form indicated that the resident wished to receive the COVID-19 vaccination and influenza vaccination. There were no vaccinations indicated in the space designated other. 2. Review of Resident #36's medical record revealed an admitted [DATE] and diagnoses of end stage renal disease, diabetes, congestive heart failure, chronic respiratory failure, prostate cancer, anemia, hypertension and morbid obesity. Review of the immunization record revealed Resident #36 had not received a pneumococcal vaccine. Review of Resident #36's physicians orders revealed no orders for pneumococcal vaccine. Review of the facility form titled Vaccine Administration Record (VAR)/informed Consent for Vaccinations at LTCF Pharmerica revealed a line where the resident or responsible party could indicate if they wished to receive a COVID-19 vaccination, influenza vaccination or other vaccination. Resident #36's form indicated that the resident wished to receive the influenza vaccination. There were no vaccinations indicated in the space designated other. 3. Review of Resident #37's medical record revealed an admitted [DATE] and diagnoses of heart failure, morbid obesity, Alzheimer's disease, hyperlipidemia, hypertension, anxiety and depression. Review of the immunization record revealed Resident #37 had not received a pneumococcal vaccine. Review of Resident #37's physicians orders revealed no orders for pneumococcal vaccine. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility form titled Vaccine Administration Record (VAR)/informed Consent for Vaccinations at LTCF Pharmerica revealed a line where the resident or responsible party could indicate if they wished to receive a COVID-19 vaccination, influenza vaccination or other vaccination. Resident #37's form indicated that the resident wished to receive the influenza vaccination. There were no vaccinations indicated in the space designated other. 4. Review of Resident #46's medical record revealed an admitted [DATE] and diagnoses of pulmonary embolus, Myocardial infarction, respiratory failure, diabetes, anxiety, anemia, hypertension, and dementia. Review of the immunization record revealed Resident #46 had not received a pneumococcal vaccine. Review of Resident #46's physicians orders revealed no orders for pneumococcal vaccine. Review of the facility form titled Vaccine Administration Record (VAR)/informed Consent for Vaccinations at LTCF Pharmerica revealed a line where the resident or responsible party could indicate if they wished to receive a COVID-19 vaccination, influenza vaccination or other vaccination. Resident #46's form indicated that the resident wished to receive the influenza vaccination. There were no vaccinations indicated in the space designated other. An interview on 10/17/24 at 10:16 AM with the Director of Nursing (DON) revealed there was not a specific consent for pneumococcal vaccine. The DON stated if a resident or resident's family wishes for the resident to receive the pneumococcal vaccine, it is written in on the Vaccine Administration Record (VAR)/informed Consent for Vaccinations at LTCF Pharmerica form in the space designated other. The DON indicated the residents or responsible party are asked on admission and then yearly, when the facility is obtaining consents for influenza vaccinations, if they would like to receive the pneumococcal vaccine. The DON acknowledged that the facility does not have proof Residents #10, 36, 37 and 46 were asked about receiving the pneumococcal vaccine.