STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366261	A. Building B. Wing	02/13/2025

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Astoria Place of Barnesville	400 Carrie Avenue Barnesville, OH 43713

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, interview, and policy review the facility failed to ensure Preadmission Screening and Resident Review (PASARR) were accurately completed. This affected three residents (#3, #40, and #43) of three reviewed for PASARR. Findings include: 1. Medical record review revealed Resident #40 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, major depressive disorder, post-traumatic stress disorder (PTSD), and dementia with other behavioral disturbance. Review of Resident current orders dated 02/2025 revealed the resident received Quetiapine (anti-psychotic) 25 milligrams (mg) at bedtime for major depressive disorder. The target behaviors included agitation and aggression. Review of Resident #40's PASARR dated 02/23/24 revealed the resident had no mental illness. Interview on 02/11/25 at 5:18 P.M., with the Director of Nursing (DON) confirmed the resident had major depressive disorder and PTSD that were not reflected on the PASARR on 02/23/24. 2. Medical record review revealed Resident #43 was admitted to the facility on [DATE] with diagnoses including dementia with psychotic disturbance, anxiety, major depressive disorder, and unspecified psychosis. Review of Resident #43's admission orders dated 06/04/24 and current orders dated 02/2025 revealed Resident #43 was on Zoloft for depression Depakote for mood stabilizer. Review of Resident #43's PASARR dated 06/03/24 revealed the resident had no mental health diagnoses and did not receive anti-depressant (Zoloft) and mood stabilizer (Depakote) in the last six months. Review of Resident #43's psych notes dated 07/02/24 and 12/03/24 revealed the resident had a diagnosis of bipolar and was on Depakote 250 mg twice daily, Zoloft 150 mg daily, Aricept 10 mg at bedtime, Abilify 7.5 mg daily. (continued on next page)

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

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/11/25 at 5:24 P.M., with the DON confirmed Resident #43's diagnoses list didn't reflect the resident bipolar diagnoses and the PASARR was inaccurate to include the resident's mental health diagnoses and anti-depressant (Zoloft) and mood stabilizer (Depakote) in the last six months. Review of the facility policy titled Screen and PASRR Requirement (undated) revealed it was the policy of the facility that all individuals applying for a new admission to this facility must be screened to identify serious mental illness or mental retardation/developmental disability. 47985 3. Record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including cerebral ischemia, dementia, anxiety disorder, bipolar disorder, hypertension, major depressive disorder, and alcohol dependence. Review of an admission MDS completed on 06/07/24 revealed Resident #3 did not have a PASARR level two, was cognitively intact, and had no behaviors. Review of a PASARR completed on 10/24/19 revealed Resident #3 had a mood disorder (bipolar disorder and depression) and other psychotic disorder (alcohol dependence), but did not have a panic or anxiety disorder, or another mental disorder that may lead to chronic disability (alcohol dependence). Interview on 02/11/25 at 11:53 A.M. with Social Service Director (SSD) #178 revealed she did not have a copy of Resident #3's PASARR on file because he transferred to the facility from a different skilled nursing facility who completed the transfer level of care. SSD #178 stated she would try to get a copy of the PASARR. Interview on 02/11/25 at 3:39 P.M. with SSD #178 revealed she did not review Resident #3's PASARR upon his admission or question the diagnoses. SSD #178 confirmed anxiety disorder was not listed, and other psychotic disorder was listed but without an appropriate diagnosis. SSD #178 confirmed alcohol dependence should be considered other mental health disorder and not a psychotic disorder. SSD #178 stated resident reviews are completed within a certain timeframe of a psychiatric admission, when a resident receives a new psychiatric medication or diagnosis. SSD #178 was unable to indicate the timeframes for the resident review to be completed. Review of an undated policy titled Screen and PASRR Requirements revealed it is the policy of the facility or all individuals applying for a new admission to be screened for serious mental illness or developmental disabilities. A screen is needed prior to admission to the facility, within 14 calendar days of receiving a new diagnosis for mental illness or developmental disability, within 14 days if a resident previously identified as having a mental illness or developmental disability has a significant change in physical and/or mental status. The social worker will receive the admission documents for all new admission and will review them to determine if a level two assessment is required and if so, to make sure it was obtained by the admissions department.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on record review and interview, the facility failed to revise a comprehensive, person-centered care plan with interventions for oxygen therapy and antipsychotic medication treatment. This affected two residents (#7, #46) of seven residents reviewed for respiratory care and unnecessary medications. The facility census was 46. Findings include: 1. Medical record review revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus, chronic obstructive pulmonary disease, malignant melanoma, heart failure, and acute respiratory distress syndrome. Review of Resident #7's physician order, dated 01/18/24, revealed the order for oxygen to be administered at four liters per minute via nasal cannula continuously for low oxygen saturation. Review of Resident #7's care plan revealed it was not individualized and did not reflect the resident's treatment order for oxygen therapy. Interview on 02/11/25 at 2:01 P.M., the Registered Nurse (RN)/Minimum Data Set (MDS) #101 confirmed Resident #7's care plan was not individualized and did not indicate the resident was receiving oxygen therapy. RN #101 stated the care plan would be revised/updated. 2. Medical record review revealed Resident #46 was admitted to the facility on [DATE] with diagnoses including gastrostomy, anemia, malignant neoplasm of colon, incisional hernia without obstruction or gangrene. Review of Resident #46's Medication Administration Record (MAR), dated February 2025, revealed the resident received Zyprexa five milligrams (mg) every day. Review of Resident #46's Care Plan revealed it was not individualized and did not reflect the resident's treatment order for Zyprexa, an antipsychotic medication. Interview on 02/12/25 at 10:26 A.M., the Director of Nursing (DON) confirmed Resident #46's care plan was not individualized and did not indicate the resident was receiving Zyprexa, an antipsychotic medication.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on record review, policy review, and interview, the facility failed to ensure Resident #33's blood glucose level reading was obtained prior to administering insulin and failed to timely identify Resident #26's edema. This affected two residents (#33, #26) of three residents reviewed for change in condition and edema. Findings include: 1. Review of the medical record for Resident #33 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, dementia, encephalopathy, angina, and diabetes mellitus. Review of the admission Minimum Data Set (MDS) assessment, dated 11/22/24, revealed a Brief Interview for Mental Status (BIMs) score of 04, which indicated severely impaired cognition. The MDS further revealed Resident #33 required staff assistance with activities of daily living (ADLs). Review of physician order, dated 12/20/24, revealed the order for Degludec Subcutaneous Pen-Injector 100 units/milliliter (ml) inject 20 units subcutaneously one time a day for diabetes mellitus. Review of a physician order, dated 12/06/24, revealed the order to obtain a blood glucose level one time per day related to diabetes mellitus and to notify the physician if blood glucose is less than 60 or greater than 400. Review of the Medication Administration Record (MAR) dated February 2025 revealed Resident #33's blood glucose level was not obtained on 02/01/25 and 02/02/25 as ordered by the physician; and Insulin Degludec injection 100 units/milliliter (ml) 20 units subcutaneously was held and not administered on 02/01/25; however, it was administered on 02/02/25 without obtaining a blood glucose level prior to administration. Review of a nursing progress note, dated 12/20/24 at 7:32 P.M., revealed the nurse was unable to provide incontinence care/bathing and morning blood glucose check/insulin administration due to resident refusal. The resident became aggressive when approached for care, screaming to get out while drawing clenched fists back to strike at staff. All methods of de-escalation and calming techniques implemented without effect. The resident was left to rest as requested. Interview on 02/11/25 at 4:32 P.M. with the Director of Nursing (DON) confirmed Resident #33's blood glucose should have been obtained prior to his insulin injection on 02/02/25. The DON further confirmed the resident's blood glucose was not obtained on 02/02/24 and 02/02/25 as ordered by the physician. Review of the facility policy titled, Administering Medications, (dated April 2019), revealed medications are administered in accordance with prescriber orders, including any required time change. 32801 2. Medical record review revealed Resident #26 was admitted to the facility on [DATE] with hemiplegia and hemiparesis following cerebral infarction affecting right dominate side and diabetes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview of Resident #26 on 02/10/25 at 8:10 P.M., revealed the resident reported his right foot pain and edema. Interview on 02/11/25 at 11:20 A.M., with Resident #26 revealed his right foot was swollen. The resident reported he would let the surveyor observe his foot after lunch. Interview and observation of Resident #26 with Certified Nursing Assistant (CNA) #128 on 02/11/25 at 3:02 P. M. revealed the resident had plus four edema to the top of right foot. There was no redness or warmth noted. The resident and CNA confirmed the resident's right foot had been swollen for three or four weeks. The CNA reported the edema was reported to the nurse. The resident reported he could not recall injuring his right foot and staff had not assessed or treated the swelling/edema. Interview on 02/11/25 at 2:51 P.M., with Licensed Practical Nurse (LPN) #110 revealed she was not aware Resident #26 had edema/swelling to his right foot. The LPN reported she would assess the resident and call the resident's medical provider. Interview on 02/11/25 at 3:06 P.M., with Director of Nursing (DON) confirmed there was no documentation regarding Resident #26's swelling/edema to the right foot. The DON reported staff would notify the provider. Review of Resident #26's orders, nursing progress notes, physician notes, assessment, and care plans dated 12/27/24 to 02/11/25 revealed no evidence the resident had swelling/edema of right foot. Review of LPN #110's assessment dated [DATE] revealed the resident had plus four edema to the lower right extremity. The resident denied pain and upon assessment there was no redness or warmth areas on leg. The nurse notified the resident physician, and new orders were received for a venous doppler ultrasound of the right lower extremity. The resident was notified and agreed. Review of the facility policy titled Resident Condition or Status (dated 05/2017) revealed our facility shall promptly notify the resident, his or her attending physician and representative of changes in the resident's medical/mental condition and/or status.

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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** 47985 Based on record review, observations, and interview, the facility failed to ensure an order for an alternating air mattress was followed for a resident at risk for developing pressure ulcers. This affected one resident (#32) of four residents reviewed for pressure ulcers. The facility census was 46. Findings include: Record review revealed Resident #32 was admitted to the facility on [DATE] with diagnoses including stage three chronic kidney disease, hyperlipidemia, anxiety disorder, dementia, and osteoarthritis. Review of a care plan last updated on 08/19/22 revealed Resident #32 had the potential for impairment to skin integrity related to dermatitis, use of Plavix, neuropathy, edema, and obesity. Interventions included keeping body free of moisture, cut fingernails, follow facility protocols for treatment of injury, monitor for bruising related to Plavix, pressure reducing mattress to bed, and provide incontinence care after each incontinence episode. Review of an order dated 05/16/24 revealed Resident #32 should have a low air-loss mattress with side bolsters to her bed, placement and function checked each shift for pressure reduction. Review of a minimum data set (MDS) completed on 12/05/24 revealed Resident #32 had severely impaired cognition, no behaviors, was at risk for developing pressure injuries, and had a pressure reducing device for her bed. Observations on 02/10/25 at 7:26 P.M., 02/11/25 at 9:16 A.M., 1:13 P.M., and 2:51 P.M. revealed there was not a low air-loss mattress with side bolsters to Resident #32's bed. Interview on 02/11/25 at 2:58 P.M. with Licensed Practical Nurse (LPN) #110 confirmed Resident #32 did not have a low air-loss mattress with side bolsters to her bed.

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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** 47985 Based on record review, observations, and interview, the facility failed to ensure an order for non-skid strips was followed. This affected one resident (#32) of one resident reviewed for falls. The facility census was 46. Findings include: Record review revealed Resident #32 was admitted to the facility on [DATE] with diagnoses including stage three chronic kidney disease, hyperlipidemia, anxiety disorder, dementia, and osteoarthritis. Review of an undated fall care plan revealed Resident #32 was at risk for falls related to confusion, gait/balance, unaware of safety needs, essential tremors, bilateral knee replacements, behaviors, medication use and a history of wandering. Interventions included but were not limited to call light in reach, ensure non-skid footwear is in use, and non-skid strips to right of bed. Review of an order dated 03/22/23 revealed Resident #32 should have non-skid strips in front of her bed. Review of a minimum data set (MDS) completed on 12/05/24 revealed Resident #32 had severely impaired cognition, no behaviors, and no falls since the last assessment. Observations on 02/10/25 at 7:26 P.M., 02/11/25 at 9:16 A.M., 1:13 P.M., and 2:51 P.M. revealed there were no non-skid strips to the front of Resident #32's bed. Interview on 02/11/25 at 2:58 P.M. with Licensed Practical Nurse (LPN) #110 confirmed Resident #32 did not have non-skid strips to the front of her bed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review and interview, the facility failed to implement interventions for weight loss after a significant weight loss in one month of 5.45%. This affected one resident (#19) of two residents reviewed for nutrition. The facility census was 46. Findings include: Record review revealed Resident #19 was admitted to the facility on [DATE] with diagnoses including dementia, urinary tract infection, and type II diabetes. Review of orders revealed Resident #19 had a consistent carbs diet with regular texture dated 12/13/24. There were no additional orders for nutrition. A nutritional assessment dated [DATE] revealed Resident #19 had good intakes of meals. Review of a care plan dated 12/16/24 revealed Resident #19 had altered nutrition and/or hydration status related to therapeutic diet, type II diabetes, dementia, gastro-esophageal reflux disease, above knee amputation, depression, psychotic disorder, and acute kidney injury. Interventions included administering medications per order, honor food preferences as able, administer nutritional supplements as ordered, oral care each shift as needed, monitor diet tolerance, monitor meal/fluid intakes, and monitor weights and notify physician of significant weight loss. Review of an admission minimum data set completed 12/18/24 revealed Resident #19 was edentulous, had no swallowing concerns, required set up assistance for meals, had no behaviors, and had severely impaired cognition. Review of weight dated 01/06/25 revealed Resident #19 weighed 146.8 pounds. Review of a weight dated 02/03/25 revealed Resident #19 weighed 138.8 pounds, indicating a 5.45% weight loss in one month. Review of a dietary note dated 02/03/25 at 11:08 A.M. by Registered Dietician (RD) #500 revealed Resident #19 had a 5.4% weight loss, intakes were 50-100%, no meal issues, was at baseline weight, and skin was intact. Needs were met with current diet and no new interventions were implemented. Review of point of care documentation for meal intakes revealed over thirty days (01/15/25-02/13/25) 70% of meal intakes ranged from 0-50% meals consumed, and 11 additional meals were refused completely. Only 15% of meals were consumed at 51-100%. Interview on 02/13/25 at 10:59 A.M. with Licensed Practical Nurse (LPN) #109 revealed Resident #19's eating fluctuated. Sometimes Resident #19 would eat well, and other times she would not. LPN #109 stated the resident intakes depended on what food she has, but the staff offer alternates, and she gets what she orders. LPN #109 stated sometimes Resident #19 just is not hungry. LPN #109 stated the facility does not use appetite stimulants, except for Remeron when the patient has a diagnosis but Resident #19 was not receiving any medications or supplements to assist in maintaining her weight. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/13/25 at 12:56 P.M. with RD #500 revealed Resident #19 had been in the facility before and her baseline weight was in the mid-130's. RD #500 stated she did see there was a 5% weight loss in one month, but since it was a loss to Resident #19's previous weight during her last stay, she was not concerned and did not implement an intervention. RD #500 stated she would work on getting an intervention implemented.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on observation, record review, and interview, the facility failed to ensure a resident's oxygen humidifier bottle was changed timely. This affected one resident (#7) of one resident reviewed for respiratory care. The facility identified six residents who received oxygen therapy. Findings include: Review of the medical record revealed Resident #7 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, asthma, dementia, diabetes mellitus, congestive heart failure, and atrial fibrillation. Medical record review revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus, chronic obstructive pulmonary disease, malignant melanoma, heart failure, and acute respiratory distress syndrome. Review of Resident #7's physician order, dated 01/18/24, revealed the order for oxygen to be administered at four liters per minute via nasal cannula continuously for low oxygen saturation. Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/10/25, revealed Resident #7's Brief Interview for Mental Status (BIMS) score was 99 and the resident had memory loss. Review of Resident #7's physician order, dated 01/18/24, revealed the order for oxygen to be administered at four liters per minute via nasal cannula continuously for low oxygen saturation. Observation on 02/11/25 at 11:50 A.M. revealed Resident #7's oxygen humidifier bottle was dated 01/08/25. Interview on 02/11/25 at 11:55 A.M., Licensed Practical Nurse (LPN) #110 confirmed Resident #7's oxygen humidifier bottle was dated 01/08/25 and should be changed weekly. Interview on 02/11/25 at 12:01 P.M. with Director of Nursing (DON) confirmed all oxygen humidifier bottles should be changed weekly per policy. Review of the facility policy titled, Infection Control-Oxygen Therapy, (undated), revealed the humidifier bottles are used only for long-term oxygen administration unless the resident specifically requests it. Therefore, oxygen tanks, concentrators, etc. shall be stored without humidifier bottles. Instead, a green adapter is used to attach the cannula/mask to the oxygen unit. Humidifier bottles are replaced weekly on Sunday night shift.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, interview, and policy review the facility failed to ensure a resident had a comprehensive assessment and plan of care for Post Traumatic Stress Disorder (PTSD). This affected one resident (#40) of one reviewed for behavioral/emotional. Findings included: Medical record review revealed Resident #40 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, major depressive disorder, post-traumatic stress disorder (PTSD), and dementia with other behavioral disturbance. Review of Resident #40's admission assessment dated [DATE] revealed there was a section titled trauma. The first question was does the resident have a history of any of the following mental health diagnosis? Staff checked depression but did not check the box for PTSD. The second question of the assessment was Does the resident have a history of one or more of the following including all types of abuse, veteran, homeless, imprisonment, loss, trauma, or other. Staff indicated none. The next question was If the resident is a trauma survivor as indicated above, please interview for known triggers and document. The question was left blank. The next section was the 48-hour care plan. Staff checked the box the resident had PTSD and checked all the generic intervention, however, did not individualize the interventions. Review of Resident #40's comprehensive plan of care revealed no evidence of an individualized plan of care for PTSD. Review of Resident #40's history and physical dated 03/04/24 revealed the resident was hospitalized a few months ago. She lost her husband on July 15, 2023. After his death she moved in with her son and his girlfriend took care of her. There were some issues where she had some suicidal or homicidal ideations. Two or three times she left the house without anyone's knowledge, she was wandering and the neighbor found her. September 4th, 2023, she was taken to the State Asylum for mental health services. Last October she got bad and tried to harm herself and other people by stabbing the people and herself. She was hospitalized for 10 days and then sent home due to her insurance ran out. The family reported the resident had a history of dementia with suicidal and homicidal ideation and hallucination and delusional thoughts. Also, according to the son's girlfriend, she was having overactive sexual behaviors. There was no evidence what caused the PTSD or triggers. Review of psych notes dated 12/03/24 revealed the resident had psychotic disorder and PTSD. There was no evidence of what caused the PTSD or triggers. Further review of the resident medical record revealed no evidence of what the resident PTSD stemmed from or triggers and interventions. Observation on 02/10/25 at 8:25 P.M. and 02/11/25 at 11:45 P.M., revealed Resident #40's was in her room with the door shut. The resident resided in the memory care unit. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/11/25 at 5:17 P.M., with the Director of Nursing (DON) revealed he did not know what caused the residents PTSD to cause and there was no comprehensive assessment or care plan for the resident PTSD. Interview on 02/13/25 at 8:36 A.M., with Licensed Practical Nurse (LPN) #115 confirmed she was going to try to reach out to Resident #40's family to determine what the resident's PTSD was caused by and her triggers. Interview on 02/13/25 at 8:49 A.M. with LPN #115 revealed she was able to reach Resident #40's son girlfriend, and she was unsure, but the resident was either physical or sexually abused as a child. Men trigger her and if she sees a woman with a man she gets agitated and aggressive towards the women. When she feels threatened, she would hide. Review of the facility's policy titled Trauma Informed Care (undated) residents who are trauma survivors will receive culturally competent trauma-informed care in accordance with professional standards of practice and accounting for the residents' experiences and preferences in order to eliminate or mitigate triggers that may cause traumatization. Upon admission and with any new behavior changes, the resident would be evaluated for a history of trauma, and for specific needs and continuing interventions. Social services would interview new residents upon admission to identify possible history of trauma. The information will be gathered on admission and when any new behaviors arise. Social Service would initiate a comprehensive care plan with individualized goals and interventions when trauma history is identified.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review and interview, the facility failed to ensure a resident did not receive an unnecessary antibiotic. This affected one resident (#44) of one resident reviewed for unnecessary antibiotic. The facility census was 46. Findings include: Record review revealed Resident #44 was admitted to the facility on [DATE] with diagnoses including atherosclerotic heart disease without angina, chronic kidney disease stage 3A, urinary incontinence, and mild cognitive impairment. Review of a Urinary Tract Infection (UTI) Worksheet and Culture and Sensitivity dated 08/05/24 revealed Resident #44 had a culture revealing klebsiella in her urine and the culture and sensitivity showed the infection was resistant to Cipro (antibiotic). Review of a UTI Worksheet and Culture and Sensitivity dated 09/11/24 revealed Resident #44 had a culture revealing klebsiella and aerococcus urinae in her urine. The culture and sensitivity revealed the infection was resistant to Klebsiella. Resident #44 received Bactrim for treatment. Review of a UTI Worksheet and Culture and Sensitivity dated 10/03/24 revealed Resident #44 had a culture revealing klebsiella in her urine. The culture and sensitivity showed the infection was resistant to Cipro. Resident #44 was treated with Gentamicin. Review of a UTI Worksheet and Culture and Sensitivity dated 12/19/24 revealed Resident #44 had proteus mirabillis in her urine which was resistant to Cipro. Review of a minimum data set completed on 01/04/25 revealed Resident #44's cognition remained intact, had no behaviors, was always incontinent of bladder, and received an antibiotic. Review of a nursing note dated 01/08/25 at 1:17 P.M. revealed Resident #44's urologist was contacted to inform him of recurrent urinary tract infections. Urology gave a new order for Cipro 250 mg by mouth daily for prophylaxis. Review of orders revealed Resident #44 had an order dated 01/09/25 for Cipro 250 milligrams (mg) by mouth daily for prophylactic. Interview on 02/12/25 at 3:33 P.M. with Licensed Practical Nurse (LPN) #115 revealed the UTI in December 2024 was treated with intravenous gentamicin. LPN #115 stated Resident #44 was started on Cipro in 01/2025 by the urologist prophylactically to help manage recurrent UTIs. Resident #44 has not had a UTI since 12/2024. LPN #115 was unsure why Cipro was chosen to be used prophylactically when all the organisms Resident #44's culture and sensitivities revealed were resistant to Cipro. In addition, Resident #44 did not have a new UTI in 01/2025 to indicate need to start another antibiotic. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/12/25 at 4:16 P.M. with LPN #115 revealed she spoke with the urology nurse who stated since Resident #44 is allergic to Macrobid, which was the urologists go to prophylaxis treatment, he decided to use Cipro. LPN #115 stated she was unable to provide information as to if an alternate option was discussed related to recurrent UTIs being resistant to Cipro and there was no documentation from the urology department to support a prophylactic treatment. Interview on 02/12/25 at 4:56 P.M. with Resident #44's representative revealed she was unaware of the specific organisms related to recurrent UTIs and did not know they had all been resistant to Cipro. Review of a policy (revised in 12/2016) titled Antibiotic Stewardship revealed orientation, training and education of staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics will affect individual residents and the overall community. Education would include but would not be limited to the evolution of drug-resistant pathogens. When a culture and sensitivity is ordered, lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified or discontinued.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, review of pharmacy recommendation, interview, and policy review the facility failed to ensure appropriate diagnoses for psychotropic medication and failed to have supporting evidence for declining gradual dose reduction recommendations and increasing dose of psychotropic medication. This affected two residents (#43 and #46) of six resident reviewed for unnecessary medication review. Findings included: 1. Medical record review revealed Resident #43 was admitted to the facility on [DATE] with diagnoses including dementia with psychotic disturbance, anxiety, major depressive disorder, and unspecified psychosis. Review of Resident #43's orders dated 06/04/24 to 02/1/25 revealed on 06/13/24 the resident was ordered Abilify 5 milligram (mg) daily for psychosis related to psychosis. The targeted behaviors were agitation and paranoia. On 10/17/24 the Abilify was increased to 7.5 mg daily for cerebrovascular disease and psychosis. The resident targeted behaviors were fearful and tearful. The Depakote was ordered on 06/04/24 to administer 250 mg twice daily for a mood stabilizer and Zoloft 150 mg in the morning for depression. The targeted behaviors were fearful and tearful. Review of Resident #43's nursing notes and behavior monitoring dated 06/04/24 to 02/12/25 revealed no documented evidence the resident had any type of behavior. Review of Resident #43's pharmacy recommendation dated 06/04/24 to 02/12/25 revealed on 10/10/24 the pharmacist recommended a gradual dose reduction for Abilify 5 mg. The physician checked he disagreed due to the resident target symptoms (psychosis) continued to persist and a reduction was contraindicated. On 11/11/24 the pharmacist recommended gradual dose reduction (GDR) for Zoloft and Depakote. The physician checked he disagreed with a GDR on Zoloft due to the resident target symptoms (depression) continued to persist and a reduction was contraindicated and disagreed for a GDR on Depakote due to the resident target symptoms (mood disorder) continued to persist and a reduction was contraindicated. On 02/07/25 the pharmacist recommended a gradual dose reduction for Abilify 7.5 mg. The physician checked he disagreed due to the resident target symptoms (delusion and combative/aggression) continued to persist and a reduction was contraindicated. Review of Resident #43's nursing notes and behavior monitoring dated 06/04/24 to 02/12/25 revealed no documented evidence the resident had any type of behavior. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident Minimum Data Set (MDS) dated [DATE], 10/30/24, and 11/30/24 revealed the resident did not have any behaviors. Interview on 02/12/25 at 3:54 P.M. with the Director of Nursing (DON) confirmed the resident had no documented behaviors and the pharmacy recommendation indicated the physician disagreed with GDR due to the resident having continued target behaviors, even though there was no evidence the resident had behaviors. The DON reported the Abilify was increased in October 2024 due to the resident going to a free clinic for dementia and the nurse practitioner (NP) at the clinic recommended to increase the Abilify to 7.5 mg due to the family reported the resident was quieter, withdrawn, having difficulty sleeping at night and had hand tremors. The DON confirmed there was no documented evidence or justification documented to increase the Abilify. The DON confirmed there had been no attempts for a GDR on Abilify, Zoloft, and Depakote in the last eight months despite pharmacy recommendation to attempt GDR's. The DON provided the surveyor with a copy of the NP note from the free clinic. Review of the NP note (from the free clinic) dated 10/17/24 revealed the NP was part of neuroscience institute of memory health clinic revealed the resident was seen to follow up with dementia. The resident was accompanied by daughter and son-in-law. The family provided information. The resident had trouble finding words which were frustrating to the resident. Her mood had been stable. The resident had refused her medication for the last couple days because she thought they were causing her hair to thin. She continues to have delusions at times and feels paranoid. The resident has trouble sleeping and wakes up and night and cannot go back to sleep. She had tremors in her hands that are bothersome when she was eating. Review of the resident system was positive for dementia, anxiety, and depression. The plan included to provided recommendation to increase Abilify to 7.5 mg and melatonin for mood and sleep. The family notes withdrawal and zones at times. Can consider reducing Depakote. Referral to therapy and recommend resident to use weighted utensils for eating with tremors. Will follow up in six months. Review of the facility's policy titled Tapering Medication and Gradual Drug Dose Reduction (dated 04/2007) revealed resident who use antipsychotic drugs shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. During the first year in which the resident was admitted on antipsychotic medication or after the resident has been started on an antipsychotic medication, the staff and practitioner shall attempt a GDR in two separate quarters (with at least one month between attempts) unless clinically contraindicated. For psychopharmacological medication or after the facility had initiated such medication, the facility would attempt to taper the medication for at least two quarters (with at least one month between attempts, unless clinically contraindicated. 33019 2. Review of the medical record for Resident #46 revealed an admitted [DATE] with diagnoses including gastrostomy, anemia, malignant neoplasm of colon, acute post-thoracotomy pain, depression and anxiety. Review of the Minimum Data Set (MDS) assessment, dated 12/24/24, revealed Resident #46's Brief Interview for Mental Status (BIMS) score was 15, which indicated intact cognition. The resident did not have hallucinations, delusions, physical or verbal behaviors, or rejection of care. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a physician order, dated 01/17/25, revealed the order for olanzapine (Zyprexa) 5 milligrams (mg) by mouth daily for anxiety. Review of Resident #46's Medication Administration Record (MAR), dated February 2025, revealed the resident received Zyprexa five milligrams (mg) every day. Review of the monthly medication regimen review, dated 02/06/25, revealed the pharmacist informed the physician that Resident #46 was currently receiving Zyprexa without a supporting diagnosis. Interview on 02/15/25 at 10:26 A.M., the Director of Nursing (DON) verified the resident is receiving Zyprexa, which is an antipsychotic, without an appropriate diagnosis.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 51519 Based on record review and interview, the facility failed to submit the required staffing information for the fourth quarter of July 1st 2024 through September 20th 2024 to the payroll based journal (PBJ) data. This had the potential to affect all residents. The census was 46. Findings included: Review of Payroll Based Journal (PBJ) staffing report for the fourth quarter (July 1st 20024 through September 30th 2024) revealed the facility failed to submit data for the quarter, one star staffing rating, excessively low weekend staffing, no registered nurse (RN) hours, and failed to have licensed nursing coverage 24 hours per day. Interview on 02/13/25 at 7:55 A.M. with the Administrator revealed that corporate submits the staffing data, she has reached out to cooperates a few times this week for their proof of submitting the staffing data for the fourth quarter (July 1st 2024 through September 30th 2024). She stated corporate had not given her proof of submission. Interview with Administrator on 02/13/25 at 11:33 A.M. confirmed corporate was unable to provide evidence the facility had submitted required staffing information for the fourth quarter 7/01/24 through 9/20/24 to the PBJ data.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47985 Based on observation and interview, the facility failed to maintain infection control practices. This had the potential to affect 26 residents (#1, #2, #3, #4, #5, #6, #7, #9, #10, #11, #12, #15, #17, #18, #19, #21, #23, #25, #26, #28, #32, #35, #36, #44, #47, and #152) of 46 residents residing in the facility. Findings include: Observation on 02/11/25 at 2:53 P.M. revealed a male resident walked up to the ice chest next to the nurses' station and helped himself to some ice, with no evidence of practicing hand hygiene. The ice scoop was left inside the ice chest. Two aides were at the nurses' station at the time of the observation. Interview on 02/11/25 at 2:56 P.M. with Certified Nursing Assistant (CNA) #128 confirmed the observation and stated residents typically do not and should not help themselves to ice, but should ask for assistance.