STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366285	A. Building B. Wing	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare of Shadyside	60583 State Route 7 Shadyside, OH 43947

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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 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** 51074 Based on medical record review and interview the facility failed to notify the resident representative of an unwitnessed fall that resulted in the resident's injury. This affected one resident (#181) of four residents reviewed for accidents. The facility census was 75. Findings include: Review of the medical record for Resident #181 revealed the resident was admitted on [DATE] on hospice services with a facility discharge date of [DATE]. The resident's diagnoses included senile degeneration of the brain, chronic obstructive pulmonary disease, dementia, Alzheimer's disease, malignant neoplasm of the bronchus or lung and repeated falls. Review of the baseline care plan dated 02/08/25 revealed Resident #181 was at risk for elopement/wandering related to dementia, at risk for falls and potential injury related to history, psychoactive medication required due to alteration in mood and behavior related to anxiety and wandering without purpose. Interventions included to have commonly used articles within easy reach, maintain clear pathways, monitor for side effects of psychotropic medications, room close to nurses' station. Review of facility investigation dated 02/10/25 revealed Resident #181 was found on the floor on 02/07/25 at 7:30 P.M. Review of Resident #181's medical record revealed no documented evidence the resident had fallen on 02/07/25, nor was there documented evidence the resident's representative or physician was notified of the fall. Interview on 04/17/25 at 11:33 A.M. with Regional Clinical RN #198 confirmed Resident #181 had fallen on 02/07/25, however the fall was not documented in the medical record nor was the responsible party or physician notified until 02/10/25 after the resident was hospitalized on [DATE]. Review of the facility Fall policy (dated 02/2018) revealed the facility was to assure proper review of resident fall risk and implementation of interventions to attempt to prevent or reduce falls/accidents and injuries related to falls. Section Two identified Assessments and Notification revealed appropriate medical care will be provided as needed, including calling for emergency transport to the emergency room if needed. The physician will be notified of the fall and outcome. The resident representative will be notified of a fall. The DON/Designee will be notified of each fall. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00162774.

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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 - 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** 51074 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on closed record review, facility policy review and interview, the facility failed to provide a timely assessment and necessary and timely treatment for Resident 3181 following an unwitnessed fall with injury. This affected one resident (#181) of two residents reviewed for accident hazards. Actual harm occurred on 02/07/25 at 7:30 P.M. when Certified Nursing Assistant (CNA) observed Resident #181 on the floor in front of her wheelchair. The CNA notified Registered Nurse (RN) #109 of the resident having an unwitnessed fall; however, the RN failed to assess and provide needed treatment to the resident thereby delaying necessary treatment including transfer to the hospital. Following the incident, the resident complained of pain to her hip and had a decrease in mobility. However, the resident was not transferred to the emergency room until 02/09/25 at which time she was admitted for treatment of an acute right hip fracture. Findings include: Review of the closed medical record for Resident #181 revealed the resident was admitted to the facility on [DATE] for a five-day hospice respite stay. Resident #181 was readmitted to the facility on [DATE] receiving hospice services. The resident was discharged from the facility on 02/09/25 to the hospital and then discharged (from the hospital) to home. Resident #181 had diagnoses including senile degeneration of the brain, chronic obstructive pulmonary disease, dementia, Alzheimer's disease, malignant neoplasm of the bronchus or lung and repeated falls. Review of the resident's Admission Packet dated 02/07/25 revealed the resident was oriented to self only, was confused, with short term memory loss with mild cognitive impairment. The resident was ambulatory and had scratches noted to right iliac crest with multiple falls within the last six months. The resident had no limitations in range of motion. Review of the facility's incident and accident investigation report dated 02/07/25 at 7:30 P.M. revealed Resident #181 had a fall in the hallway from her wheelchair. Review of the baseline care plan dated 02/08/25 revealed Resident #181 was at risk for elopement/wandering related to dementia, at risk for falls and potential injury related to history, and received psychoactive medication which was required due to alteration in mood and behavior related to anxiety and wandering without purpose. Interventions included commonly used articles within easy reach, maintain clear pathways, monitor for side effects of psychotropic medications, and a room close to nurses' station. Review of the medical record revealed a progress note on 02/07/25 at 3:30 P.M. that identified Hospice was contacted to confirm the resident's orders for respite admission. The orders were confirmed. There was nothing noted on this date in the medical record regarding an unwitnessed fall or an assessment of the resident for falls or injury. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the medical record revealed a progress note on 02/08/25 at 12:50 A.M. that identified the resident was administered Lorazepam 0.5 milligrams (orally) for anxiety, restlessness. Review of hospice visit note by Hospice Registered Nurse (RN) #102 on 02/09/25 at 5:57 P.M. revealed Resident #181 had facial grimacing and was unable to be consoled with touch and verbal communication. Facial pain scale denoted 8 out of 10 on a 1 to 10 pain scale. RN #109 administered Morphine (for moderate to severe pain), with little effect. RN #109 reported that Resident #181 normally walked with a shuffled gait and held onto the walls, rails or furniture, throughout the day. On 02/09/25, Resident #181 had not ambulated. RN #109 denied Resident #181 had any falls. Resident #181's daughter reported Resident #181 had several falls at home prior to being admitted (to the facility on [DATE]) but had no signs of injury. An assessment completed by Hospice RN #102 revealed Resident #181's left leg was notably longer than the right leg, RN #109 verified the findings during the 02/09/25 visit. New orders were received for Resident #181's bilateral hips, pelvis, and lumbar spine to be x-rayed. Review of the medical record revealed the next progress note dated 02/09/25 at 7:55 P.M. indicated the resident was administered Morphine sulfate 20 mg/5ml, liquid by mouth one ml for pain rated 9-10 or shortness of breath. There was no comprehensive assessment of the resident that identified what complaints of pain the resident was experiencing or the condition of the resident. Review of Resident #181's medication administration record (MAR) reflected the resident received Morphine Sulfate oral solution 20mg/5ml, one ml on 02/09/25 at 7:55 P.M. for a pain rating of nine (9). It was documented as effective. Review of the medical record revealed the next progress note dated 02/09/25 at 8:19 P.M. identified Morphine sulfate 20 mg/5 ml, every 1 hour as needed for pain 9-10 or shortness of breath. The PRN administration was identified as effective and the follow up pain scale was four (4). There was no comprehensive assessment of the resident that identified what complaints of pain the resident was experiencing or the condition of the resident. Review of Resident #181's medication administration record (MAR) reflected the resident received Morphine Sulfate oral solution 20mg/5ml, 0.75 ml by mouth on 02/09/25 at 9:19 P.M. for a pain rating of seven (7). It was documented as U unknown for effectiveness. Review of a progress note dated 02/09/25 at 11:22 P.M. revealed Resident #181's daughter came in to visit and asked if her mother had been in bed all day. The nurse explained that since Resident #181 had arrived, she would be active, get tired, and then go to her bed and rest. The daughter pointed out to the nurse that the resident was indicating that she was having pain when her right leg was moved. The progress note indicated that the Hospice Nurse also came in and assessment was collaborative. Morphine Sulfate liquid was given hourly as needed for pain. A call was placed to the resident's physician for orders for mobile x-rays stat. The x-rays were completed and identified a right hip fracture. The physician was notified of the x-ray results and ordered the resident to be transferred to the hospital for evaluation related to fracture of the right hip. The resident was transferred to the hospital (on 02/09/25) at 10:45 P.M. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the Emergency Department (ED) provider note dated 02/09/25 at 11:17 P.M. revealed Resident #181 presented to ED today by ambulance from the facility to be evaluated for right hip pain. The x-ray showed a minimally displaced and minimally angulated fracture of the distal femoral neck area. An orthopedic consultation was ordered, and Resident #181 was admitted to the hospital. Active hospital diagnoses include hip fracture, right distal femoral neck, acute hypoxia- patient required oxygen for desaturation likely related with sedation, Stage IV metastatic adenocarcinoma of the right lung to mediastinum, chronic obstructive pulmonary disease, presenile dementia, anxiety and depression. Review of the resident's facility medical record revealed a progress note titled General Note dated 02/10/25 at 11:54 A.M. indicating Resident #181 presented with new onset of pain on 02/09/25 to right lower extremity. As needed Morphine was given. The floor RN assessed the resident and provider was notified of clinical findings with orders given for hip x-ray. X-ray performed same day with findings of acute right hip fracture at the intertrochanteric region. The medical provider was notified of the findings with order to send to the ED that evening for evaluation and continued treatment. The resident's daughter was aware of the findings. The resident was admitted to the hospital for orthopedic management. Upon facility investigation, the resident had a fall on 02/07/25, found sitting in the hallway in from of room [ROOM NUMBER]. The note included the resident continued to ambulate that night per baseline with no reports of pain present until 02/09/25. The facility was to assess root cause of the fall and implement fall intervention pending the resident's return to the facility. Review of a hand written statement from CNA #152 dated 02/09/25 (from the incident dated 02/07/25) revealed Resident #181 was sitting in her wheelchair outside of room [ROOM NUMBER] when CNA #152 came on shift at 7:00 P.M. Around the time of the incident, the CNA was assisting another resident and RN #109 was standing at the nurse's cart. When CNA #152 came around the corner she saw Resident #181 was sitting on the floor next to her wheelchair. The CNA informed the nurse (RN #109) that the resident was on the floor and it was unwitnessed. CNA #152 walked back to the resident and the nurse never came to assess the resident. So, CNA #152 then helped the resident up off of the floor and back into her wheelchair and pushed her into the day room. Review of a handwritten statement from RN #109 dated 02/09/25 for an incident dated 02/09/25 (note- this date is in error and should reflect the incident date 02/07/25) revealed she didn't remember seeing a resident on the floor Friday (02/07/25). RN #109's statement identified that she was not aware of Resident #181 being on the floor Friday (02/07/25). Review of a typed statement dated 02/11/25 at 2:50 P.M. by the Administrator revealed he had called and spoken with Resident #181's daughter regarding the resident being transferred to the emergency roiagnom on [DATE]. The daughter stated the resident had been admitted to the hospital on 02/09/25 with a diagnosis of right hip fracture. Review of a document titled personal witness statement, revealed a hand written statement signed by the Director of Nursing (DON) dated 02/18/25 that identified the DON had spoken with CNA #152 and made her aware if a situation where a resident was on the floor and the nurse was not assessing them, the CNA should make another nurse on the floor aware or call the DON personally. The CNA was not to pick the resident up without being properly assessed. The CNA said she understood. The CNA stated she had helped her (Resident #181) off the floor only because the resident was already attempting to get up herself. The CNA did not want the resident to cause potential further injury. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview on 04/16/25 at 2:50 P.M. with Regional Clinical RN #198 revealed the facility completed an investigation and determined Resident #181 had a fall on the evening of 02/07/25' however, there was no documentation of the fall in the resident's medical record or of a resident assessment being completed. Per Regional Clinical RN #198, CNA #152 had notified RN #109 that Resident #181 was sitting on the floor next to her wheelchair and the fall had been unwitnessed. Regional Clinical RN #198 verified that Resident #181 was not assessed by the nurse and the resident was assisted back into wheelchair by CNA #152. Interview on 04/17/25 at 6:29 A.M. with CNA #152 revealed around 7:30 P.M. (on 02/07/25) Resident #181 was sitting back by room [ROOM NUMBER] and attempted to ambulate multiple times. CNA #152 assisted Resident #181 back into her wheelchair and CNA #152 went to assist another resident. When CNA #152 came back out, Resident #181 was observed sitting on the floor in front of the wheelchair. CNA #152 told RN #109 that Resident #181 was on the floor. CNA #152 stated she waited with Resident #181 for at least five minutes and the nurse did not come to assess Resident #181. Prior to the fall on 02/07/25, the resident was ambulating on the unit, with no signs of pain observed. Review of the Fall Policy dated 02/2018 revealed the facility was to assure proper review of resident fall risk and implementation of interventions to attempt to prevent or reduce falls/accidents and injuries related to falls. Section Two: Assessments and Notification, appropriate medical care would be provided as needed, including calling for emergency transport to the emergency room if needed. The physician would be notified of the fall and outcome. The resident representative would be notified of a fall. The DON/Designee would be notified of each fall. The deficiency was corrected on 02/10/25 after the facility implemented the following corrective actions: On 02/09/25 Resident #181 was assessed by nursing staff, x-rays completed on this date, and the resident was transferred to the hospital for care and treatment including surgical correction of a fractured hip. On 02/10/25 the Director of Nursing (DON)/designee completed audits of all current residents in the facility for pain and new skin alterations to ensure no incidents had occurred to cause any of the same. There were no negative findings upon assessment of all residents. On 02/10/25 the DON completed all staff education regarding the facility Fall policy to ensure staff know what to do when a resident was seen on the floor. The DON ensured that 100% of all staff were educated. On 02/10/25 the DON completed all nurses education on the facility Fall policy and proper assessment, fall investigation, provider and family notification, and documentation of falls. The DON ensured that 100% of all staff were educated. On 02/10/25 an Ad Hoc QAPI meeting was conducted with the Medical Director, Executive Director, DON, Assistant DON, and RN Unit Manager. The meeting was convened to thoroughly review the Self-Imposed Action Plan developed in response to the incident involving Resident #181 on 02/07/25. Key areas discussed included analysis of the circumstances surrounding the fall, review of current safety protocols and identification of potential gaps, proposed modifications to existing procedures to enhance resident safety, and assignment of responsibilities for implementing the Action Plan. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Beginning on 02/10/25 the DON/designee completed audits 3-4 times per week of of 5-10 random residents for four (4) weeks for new onsets of pain and new skin alterations and if any falls occurred to ensure a note was entered into the resident electronic health record (EHR), immediate interventions were put into place, care plan updated, and fall follow-up was accurate. During the survey timeframe of 04/14/25 through 04/22/25 surveyor review of facility education records, completed audits, and resident record reviews revealed the facility corrective action steps were completed. This deficiency represents non-compliance investigated under Complaint Number OH00162774.

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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** 32801 Based on observation, medical record review, review of operational manual, observation, and interview the facility failed to ensure a pressure relieving air mattress was accurately set per the resident's weight and maintained per the manufacturer's guidelines. This affected one resident (#34) of four residents reviewed for pressure ulcers. Findings included: Medical record review revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including suspected deep tissue injury (SDTI) (purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue), peripheral vascular disease, anemia, chronic kidney disease, vascular dementia, hemiplegia, protein-calorie malnutrition, and diabetes. Review of Resident #34's Minimum Data Set (MDS) dated [DATE] revealed the resident was at risk for pressure injury and had one unstageable pressure ulcer. Review of Resident #34's impaired skin integrity plan of care dated 03/18/25 and revised 04/14/25 revealed the resident had a pressure injury to the coccyx/bilateral buttocks region. Interventions included an air mattress with a pump for comfort and wound. Review of Resident #34's wound assessment revealed the resident had developed a SDTI on his coccyx 03/18/25 that measured 10 centimeter (cm) by seven cm by unable to determine (UTD). A pressure reduction mattress per facility protocol was in place. Review of Resident #34's weight dated 04/04/25 revealed the resident weighed 174.5 pounds. Review of Resident #34's treatment administration record (TAR) and orders dated March 2025 and April 2025 revealed staff were signing off the air mattress was checked every shift for function and no issues noted. Observation on 04/14/25 at 10:24 A.M., of Resident #34 revealed the pressure relieving air mattress weight setting was set on eight (441-500 pounds) and the service light was on. The label on the bed indicated a resident weight between 163-244 pounds should be set on three and eight was for a resident weighing 441-500 pounds. Observation on 04/15/25 at 8:20 A.M., revealed the pressure relieving air mattress was set on eight (441-500 pounds) and the light was on to service the mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/15/25 at 9:56 A.M., with the Assistant Director of Nursing (ADON)/wound nurse (WN) #195 confirmed the pressure relieving air mattress was set on eight and according to the weight plate the setting should have been set on three for a resident weighing between 163-244 pounds. ADON/WN reported she was not sure why the service light was on, and she would have to investigate that due to the mattress being rented from a company. The facility usually sets the mattress for residents' comfort, and she would have to look at the manufacturer's guidelines for the weight as well. Observation and interview on 04/15/25 at 2:32 P.M of Resident #34 with Certified Nursing Assistant (CNA) #110 revealed the CNA confirmed the resident's last weight was 174.5 pounds and the mattress was set on 441-500 pounds (eight), and it should have been set on three since the resident weighed between 163-244 pounds per the label on the bed. The CNA #110 confirmed the service light was on. Review of Prius 3-1 alternating anti-decubitus system manufacturer's manual (undated) revealed the mattress provided alternating therapy to prevent and treat pressure ulcers. When the mattress was fully inflated, set the dial in accordance with the patient's size and weight. P3 was for a weight of 163-244 and P8 was for weight of 441-500 pounds. The service light indicated service was required after 8760 hours of use. Interview on 04/15/25 at 10:37 A.M. and 3:21 P.M., with ADON/WN #195 revealed the company was going to come and replace the mattress. The ADON confirmed the facility was not aware the comfort setting was referencing the resident weight. The ADON confirmed the setting should have been on three not an eight according to the manual. The ADON reported the company reported the service light didn't indicate the mattress was not functioning properly it was just a warning the mattress needed service after so many hours of use. The company confirmed they were not tracking the service light, and it was the facility's responsibility to notify them when the service light was activated. The ADON confirmed the service light was activated and staff did not report the service light was activated nor was the facility aware the staff need to notify the company when the light was activated.

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F 0689 Level of Harm - 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 medical record review and interview, the facility failed to ensure Resident #8's bedroom furniture was maintained in a safe manner to prevent the resident from sustaining an injury when her foot hit the board as she was attempting to sit up. This affected one resident (#8) of two residents reviewed for edema. Actual harm occurred on 05/21/24 when Resident #8 required seven sutures to the top of her right foot as a result of her foot being cut on the footboard of her bed. Following the incident, the facility identified the footboard was in need of repair as it was torn and rough in texture. Findings Include: Record review revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including respiratory failure, chronic obstructive pulmonary disease, and type II diabetes. Review of a nursing note dated 05/21/24 at 3:48 A.M. revealed Resident #8 had cut her right foot on her footboard. Resident #8 reported she was trying to sit up and used her foot to push. The footboard was torn on the left side of the bed. A Certified Nursing Assistant (CNA) applied pressure to the wound which was four centimeters (cm) by 0.5 cm with an unknown depth. A Registered Nurse (RN) came to see the wound and was unsuccessful at approximating the wound. The wound stopped bleeding, a dry dressing was applied and Resident #8 was transferred to the hospital. Review of a nursing note dated 05/21/24 at 7:30 A.M. revealed Resident #8 returned from the hospital with seven sutures on top of her right foot. Resident #8's family and the physician were notified. Review of an interdisciplinary team note dated 05/21/24 at 11:44 A.M. and authored by Licensed Practical Nurse (LPN) #195 revealed Resident #8 received a skin laceration to her right foot while trying to swing her legs around to the side of the bed so she could sit up. Resident #8 bumped her foot on the footboard causing the laceration and was sent to the emergency department where she received six sutures. The maintenance department smoothed out the rough edges on the footboard and it was then padded with a pool noodle. Interview on 04/16/25 at 5:04 P.M. with Maintenance Technician (MT) #132 revealed he sanded Resident #8's footboard after she cut her foot on it. MT #132 verified there was a rough patch on the foot board. There was no evidence provided to ensure the facility had a system in place to provide for the ongoing maintenance and timely repairs of resident equipment to prevent resident injury. Interview on 04/16/25 at 5:06 P.M. with LPN #195 verified Resident #8 cut her foot (on 05/21/24) at approximately 3:00 A.M. The LPN revealed Resident #8 had a lot of swelling in her legs, so her skin was fragile. The LPN recalled Resident #8's wound looked like a clean cut and was not jagged. LPN #195 stated Resident #8 had a new bed with a different footboard now. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 04/17/25 at 9:44 A.M. with Resident #8 revealed she recalled the incident where she had to get sutures on her right foot. The resident reported the injury had been caused from the foot board of her bed. The resident indicated she had been able to feel when her foot was sliced, but was not able to visualize the appearance of the footboard to determine why the injury occurred.

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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** 32801 Based on observation, medical record review, interview, and policy review the facility failed to ensure dialysis dietary recommendation to administer protein snack at night was implemented and failed to ensure meal intakes were adequately monitored and documented. This affected two residents (#44 and #51) of three residents reviewed for nutrition. Findings included: 1. Medical record review revealed Resident #51 was admitted to the facility on [DATE] with end stage renal disease, protein-calorie malnutrition, heart failure, diabetes, and liver disease. Review of Resident #51's dialysis plan of care dated 02/21/25 and revised 03/20/25 revealed the resident dialysis days were Monday, Wednesday, and Friday at 10:30 A.M. There was no evidence to provide a protein snack at night. Review of Resident #51's plan of care for compromised nutritional status dated 02/21/25 revealed to offer increased protein in the diet. There was no evidence to offer a protein snack at night. Review of dialysis nutrition note dated 03/24/25 (re-faxed 04/16/25) revealed the Dialysis Dietician (DD) #303 had faxed the dietary note to the facility originally on 03/24/25. The DD #303 had recommended high-protein snacks at night. The resident's albumin was 3.2 and goal range was greater than 4.0. The DD #303 indicated the resident's albumin may be low if she was not eating enough protein. Review of the facility's dietary notes dated 03/26/25 and 04/16/25 revealed no evidence of a protein snack at night. Review of Resident #51's orders dated 03/2025 and 04/2025 revealed no evidence of an order for high-protein snack at night. Review of the resident supplement orders list dated 04/17/25 revealed no evidence Resident#51 was receiving a supplement at night. Interview on 04/16/25 at 1:06 P.M., via phone with the DD #303 revealed she had recently started faxing over her assessments to the facility's dietician in the last month. Prior, they had spoken on the phone monthly. DD #303 reported the facility's dietician had reached out to her today per the surveyor's request for dietary notes and she had to remind the facility's dietician that she had faxed her recommendation over last month. The facility's dietician reported to DD#303 she had misplaced them. The Dialysis Dietician reported she did not have access to the resident medical record at the time of the phone interview, however she had made some adjustments in the resident diet due to her labs. (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 04/17/25 at 7:30 A.M. with Dietary Manger (DM) #170 confirmed the kitchen prepares nighttime snacks and there was no resident currently with a special order, such as a high protein snack. The DM reported she usually put peanut butter and jelly sandwiches, ham or chicken salad sandwiches, chips, cookies, pudding, or leftover snacks (cakes/pies) on the snack cart. The dietary staff or floor staff would help distribute the snacks around 6:30 P.M. to 6:45 P.M. nightly. Interview on 04/17/25 at 7:40 A.M., with Resident #51 revealed she doesn't receive a snack at night unless she asks for one. She has never received a protein snack at night from the facility, however occasionally she will not eat the one the dialysis center gives her, a protein bar, and she will bring it back to the facility for a snack. Interview on 04/17/25 at 7:55 A.M., with the Director of Nursing (DON) confirmed Resident #51 was not ordered a protein snack at night per the dialysis dietician recommendation. The DON reported the facility's dietician was contracted and was not in the facility full time, however the number on the fax cover sheet was the facility's fax number the dialysis dietician had faxed to on 03/24/25. 51519 2. Record review revealed Resident #44 was admitted to the facility 07/19/23 with diagnoses including dementia, anemia, HLD, HTN, depression, protein - calorie malnutrition, anxiety, overactive bladder, cognitive communication deficit, difficulty walking, weakness, dorsalgia, gastroesophageal reflux disease (GERD), major depressive disorder. Review of a quarterly minimum data set (MDS) completed 02/22/25, section C revealed a brief interview for mental status (BIMS) score of 00 indicating cognitive impairment. Section D revealed the resident was feeling down, depressed, or hopeless, and had a poor appetite or overeating for a total severity score of 06 and often feels socially isolated. Section GG functional abilities revealed for eating the resident's had the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. Resident #44 required set up or clean up assistance. Review of care plan completed 09/02/21, revised 02/04/25 revealed resident #44 was at nutrition/hydration risk due to diagnoses of left hip fracture with surgical repair, urinary tract infection, diabetic therapeutic diet, body mass index (BMI) low, history of edema, diuretic use, psychoactive medication use, non-significant weight loss. Resident desired to eat meals in room, malnutrition, poor intakes/appetite, refused alternate foods/fluids, dementia, and tube feedings declined. Goals included Resident #44 will consume more than 75% of most meals, resident will maintain weight without unplanned significant weight changes. Interventions included to assess and report signs of edema to Medical Director, assess for signs and symptoms of aspiration, assist with meals as needed, encourage compliance with diet guide lines, ,encourage resident to dine in dining room as is appropriate, encourage resident to make healthful diet choices, honor food preferences as able, administer medications as ordered, monitor blood glucose levels per order and PRN, monitor consistency of diet served, monitor for signs and symptoms of dehydration, monitor labs as ordered, obtain food preferences, offer meal alternate if resident refuses meal, oral care as needed, occupational therapy referral as needed, provide assistance with meals and snacks as necessary, provide diet as ordered, provide supplements as ordered, registered dietician referral as needed, speech therapy referral as needed, weights as ordered. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident weights revealed the following: 04/14/25 Resident #44 weighed 80.0 pounds (Lbs) 04/07/25 78.0 Lbs, 03/31/25 81.0 Lbs, 03/24/25 81.0 Lbs, 03/24/25 81.0 Lbs, 03/11/25 76.0 Lbs, 03/03/25 80.0 Lbs, 02/24/25 80.0 Lbs, 02/17/25 80.0 Lbs, 02/10/25 77.0 Lbs, 02/03/25 80.0 Lbs, 01/27/25 77.0 Lbs, 01/20/25 79.0 Lbs, 01/13/25 78.0 Lbs, and 01/06/25 75.0 Lbs. Record review for the task of what percentage of the meal was eaten, revealed no documentation for any meal on 03/20/25, 03/22/25, 03/27/25 (Resident #44 was out of the facility for lunch and breakfast meals and returned to the facility on [DATE] at 3:44 P.M.) , 03/30/25, 04/04/25, 04/05/25, 04/12/25, 04/15/25. Record review for the task of what percentage of the meal was eaten for Resident #44 revealed 57 documented meals in the past 30 days (03/18/25 through 04/16/25) Resident #44 consumed 25% of one meal, 25-50% of five meals, 51-75% of 31 meals, and 76-100% of 20 meals. (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 04/16/25 at 8:20 A.M. with Certified Nursing Assistant (CNA) #184 revealed Resident #44's appetite can fluctuate day by day. CNA #184 stated Resident #44 really likes sweets, she snacks with activities when she goes. CNA #184 stated she is not sure if Resident #44 receives a snack at bedtime because she does not work night shift but the cart typically goes around 6:45 P.M. to 7:00 P.M CNA #184 stated for each meal they are to document how much the residents eat and drink. They used the computer to document intakes for every meal and if there was any meals they receive outside of the scheduled meals. CNA #184 stated if a resident refused a meal they were to document it as refused, if the resident was out of the facility they were to document resident not available, and if they set up the residents tray and they ate nothing but do not refuse it is a 0% intake. Observation on 04/16/25 at 8:38 A.M. revealed Resident #44 eating cream of wheat with two 3/4 cup of orange juice, 1/2 cup of vanilla ice cream, 8 fluid ounces of water, 2 scrambled eggs, and 2 slices of bacon. Resident #44 was sitting up, tray was set up by staff, and the resident was feeding herself. At this time, 25% of meal consumed.

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F 0695 Level of Harm - 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** 51519 Based on record review, hospital record review and interview, the facility failed to provide adequate and timely respiratory care and treatment for Resident #2, related to a decline in the resident's respiratory status and need for oxygen use. This affected one resident (#2) of one resident reviewed for edema. Actual harm occurred beginning on 03/10/25 when the facility failed to adequately and timely treat respiratory complications exhibited by Resident #2 which included shortness of breath, abnormal lung sounds and decreased oxygen saturation. On 03/11/25 staff had increased the resident's oxygen to seven liters (the resident had an order for oxygen at one to five liters at that time) with no additional intervention noted. On 03/14/25 at 11:45 P.M. Resident #2 was transferred to the hospital and admitted for a six day hospitalization for treatment of acute respiratory failure with hypoxia, acute exacerbation of chronic obstructive pulmonary disease (COPD), and pneumonia requiring intravenous antibiotics. Findings Include: Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following a cerebral infarction, non-displaced fracture of lateral malleolus of left fibula, subsequent encounter for closed fracture with routine healing, aphasia, pneumonia, morbid obesity, anemia, hemorrhoids, reduced mobility, allergic rhinitis, weakness, COVID-19, chronic obstructive pulmonary disorder (COPD), asthma, anemia, hypertension (HTN) , hyperlipidemia, gastrointestinal reflux disease (GERD), seizures, diaphragmatic hernia. Review of Resident #2's care plan dated 08/09/24 revealed the resident had COPD. Goals included the resident would display optimal breathing patterns daily through review date. Interventions include giving aerosol or bronchodilators as ordered. Monitor/document any side effects and effectiveness. Head of bed elevated to prevent shortness of breath. Identify and eliminate sources of respiratory irritation such as cigarette smoke, pollen, perfumes, etc. Monitor for difficulty breathing (dyspnea) on exertion. Remind resident not to push beyond endurance. Monitor for signs and symptoms (s/sx) of acute respiratory insufficiency: anxiety, confusion, restlessness, shortness of breath (SOB) at rest, cyanosis, somnolence. Monitor/document for anxiety. Offer support, encourage resident to vent frustrations and fears. Reassure. Give as needed (PRN) medications for anxiety as ordered. Monitor/document/report PRN any s/sx of respiratory infection: fever, chills, increase in sputum (document the amount, color and consistency), chest pain, increased difficulty breathing (dyspnea), increased coughing and wheezing. Record review of the Minimum Data Set (MDS) assessment completed 02/14/25 revealed a Brief Interview For Mental Status (BIMS) score of 00 indicating the resident had cognitive impairment. The MDS did not reflect the resident utilized oxygen. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Review of a progress note dated 03/08/25 at 8:56 P.M. and authored by Licensed Practical Nurse (LPN) #180 revealed the resident presented with a productive cough and redness noted to face. Vital signs included blood pressure (BP) 122/74, temperature 99.8 Fahrenheit (F), heart rate (HR) 95, respiratory rate 18 and oxygen saturation (Sp02) 90% on room air (RA). The resident was noted to have swelling to left side of face. An order was received from Nurse Practitioner (NP) #999 to transfer resident to the emergency room (ER) for evaluation. Review of a progress note dated 03/08/25 at 11:58 P.M. and authored by Licensed Practical Nurse (LPN) #195 revealed on 03/08/25 at 11:17 P.M. the resident's temperature was 99.5 Fahrenheit (F), lung sounds were congested and the resident had nasal congestion. Oxygen saturation was 93% on room air. The resident had complaints of feeling chilled. The LPN notified Nurse Practitioner (NP) #888 who ordered a chest x-ray (CXR) and Tamiflu. Record review revealed a chest x-ray completed 03/08/25 with findings of bibasilar atelectasis on Resident #2. Record review revealed an order obtained on 03/09/25 from NP #999 for oxygen at 1-5 liters per minute (LPM) via nasal cannula (N/C). May titrate. May remove for care, treatment and activities as needed every shift. This order was discontinued on 03/18/25. Review of a progress note dated 03/09/25 at 12:33 P.M. and authored by LPN #180 revealed this nurse called the hospital for an update on the resident. The resident tested positive for Influenza A. The resident would be discharging back to the facility when transportation was available. A progress note dated 03/10/25 at 10:21 A.M. by LPN #160 revealed the resident had labored breathing with a pulse ox of 79% with the resident wearing three liters of oxygen. The oxygen was increased to five liters with no change in pulse ox reading. High flow concentrator obtained, resident placed on seven liters of oxygen with a saturation of 95%. The note indicated NP #999 was aware of all, care on going at this time. A progress note dated 03/11/25 at 00:00 A.M. by NP #999 revealed the resident was seen to assess comfort and dyspnea (shortness of breath). The note revealed the resident had been sent out on Saturday (03/08/25) for dyspnea and diagnosed with Influenza A. O2 saturation was 91% with O2 flow rate of seven liters. Respiratory status noted the resident had scattered rhonchi. The resident had influenza due to identified novel influenza A virus with other respiratory manifestations. The plan was to continue Tamiflu through 03/14/25. No other treatments or orders were provided at that time. Record review revealed no documented evidence of assessment or monitoring from 03/12/25 through 03/13/25 of Resident #2's respiratory or neurological status. Record review revealed no documentation of Resident #2's plan of care reflecting use of oxygen. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Record review revealed a progress note dated 03/14/25 at 11:58 P.M. and authored by LPN #180 that indicated Resident #2 presented with (new) onset shortness of breath (SOB) and chest pain. Vital signs include blood pressure (BP) 146/74, heart rate (HR) 75, respiratory rate (RR) 22, oxygen saturation 92% on seven liters (L). The resident was noted to have two plus pitting edema to right lower extremity (RLE). Respirations were abnormal and included inspiratory and expiratory wheezing and rhonchi noted bilaterally. The nurse called 911 at 11:35 P.M. The resident was transferred out of facility at 11:45 P.M. to the hospital via stretcher and two attendants. Report was called to the hospital at 11:50 P.M. Record review revealed a progress note dated 03/15/25 at 4:25 A.M. authored by LPN #180 that indicated the hospital was called to get a report on the resident's status. The facility was informed the resident was being admitted to the hospital with a diagnosis of hypoxia. Record review revealed a progress note dated 03/19/25 at 1:47 P.M. authored by LPN #206 which indicated the resident was admitted to the hospital with a diagnosis of pneumonia. Review of the March 2025 medication administration record (MAR) treatment administration record (TAR) for Resident #2 revealed documentation of oxygen in use and on resident from 03/10/25 through 03/14/25 on day and night shift over the ordered 1-5 LPM. Documentation revealed five days oxygen was administered to Resident #2 at seven liters per minute via nasal cannula. Record review revealed no new orders or documentation of new orders being implemented for assessments, interventions, or medications by NP #999 on 03/10/25 or 03/11/25 for Resident #2 following the identification of labored breathing, scattered rhonchi, increased swelling, and increased oxygen demand. Review of hospital documentation for Resident #2 revealed the resident was admitted for acute respiratory failure with hypoxia, acute exacerbation of COPD, and pneumonia. Resident #2 was prescribed Vancomycin and Zosyn while hospitalized from 03/14/25 through 03/19/25. Interview on 04/16/25 at 6:51 A.M. with LPN #180 revealed she did not work for a few days prior to Resident #2 being transferred to the hospital (on 03/14/25). She said when she got to the facility on this date and went in to see Resident #2 she realized something was not right and began to assess the resident and then subsequently had her transferred out of the facility (to the hospital) for more treatment. Interview on 04/16/25 at 8:58 A.M. with LPN #160 revealed staff were concerned about Resident #2's status on 03/11/25 as the resident was having ongoing issues. The LPN stated she saw Resident #2 that day and knew something wasn't right with the resident; the resident was having labored breathing. LPN #160 revealed she called NP #999 who instructed her to keep Resident #2 at the facility as long as her oxygen level stayed up. LPN #160 revealed she was unsure if NP #999 came in that day but believed she did; however, no new orders were provided. LPN #160 stated she continually went into the room to check on Resident #2 and looped the CNA staff in as well.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **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 dialysis orders to hold medications were clarified and implemented. This affected one resident (#51) of one resident reviewed for dialysis. Findings included: Medical record review revealed Resident #51 was admitted to the facility on [DATE] with end stage renal disease, protein-calorie malnutrition, heart failure, diabetes, and liver disease. The resident was hospitalized from 02/10/25 to 02/20/25. Review of Resident #51's dialysis plan of care dated 02/21/25 and revised 03/20/25 revealed the resident dialysis days were Monday, Wednesday, and Friday at 10:30 A.M. There was no evidence to hold medication on dialysis days. Review of Resident #51's orders dated 02/08/25 to 04/16/25 revealed no evidence to hold medication on dialysis days. Review of Resident #51's medication administration record (MAR) dated 02/08/25 to 04/16/25 revealed in February (2025) staff held A.M. medication on dialysis three of four days, in March (2025) 11 out of 13 dialysis days, and six out of seven dialysis days in April (2025) without a physician order. Further review of April (2025) MAR revealed the resident's A.M. medication included: Allegra 180 milligrams (mg) in the morning for allergies, Aspirin 81 mg in the morning for clot prevention, Budesonide 9 mg in the morning for colitis, Cardizem (blood pressure) 180 mg in the morning, Miralax in the morning for constipation, Singular 10 mg in the morning for allergies, Omeprazole (proton-pump inhibitor) 40 mg in the morning, Vitamin B-12 (supplement) injection once every Monday, Colace (stool softener) 100 mg twice daily, Lactulose 30 milliliters (ml) twice a day for constipation, Prostat (supplement) 30 ml twice daily, Senna Plus twice daily for constipation, Calcium Acetate 667 three times daily before meals, and Levoalbuterol nebulizer three times daily. Interview on 04/16/25 at 8:42 A.M. and 12:42 P.M. with the Director of Nursing (DON) revealed the resident was discharged home on 01/28/25 and was readmitted on [DATE]. The resident had an order from a previous admission to hold medications on dialysis days. The DON confirmed in February, March, and April (2025) staff continued to hold all A.M. medication without a physician order on dialysis days. The DON reported she had updated the resident physician and dialysis of the medication errors. Interview on 04/16/25 at 1:21 P.M. interview with the DON revealed dialysis sent over a new order and dialysis only wanted the resident blood pressure medication to be held on dialysis days not all A.M. medications. Review of the facility policy titled Dialysis dated 01/01/25 revealed to coordinate with dialysis center and provider regarding medication administration times.

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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** 51074 Based on medical record review and interview the facility failed to ensure medications were reconciled correctly on admission. This affected one resident (#181) of one resident reviewed for psych/opioid medication review. The census was 75. Findings include: Review of the closed medical record review for Resident #181 revealed the resident was admitted on [DATE] under hospice services and discharged to the hospital on 02/09/25. The resident's diagnoses include senile degeneration of the brain, chronic obstructive pulmonary disease, dementia, Alzheimer's disease, malignant neoplasm of the bronchus or lung and repeated falls. Review of the baseline care plan dated 02/08/25 revealed Resident #181 was at risk of injury related to smoking, at risk for elopement/wandering related to dementia, at risk for falls and potential injury related to history, psychoactive medication required due to alteration in mood and behavior related to anxiety and wandering without purpose. Intervention included to have commonly used articles within easy reach, maintain clear pathways, monitor for side effects of psychotropic medications, room close to nurses' station. Review of Resident #181's hospice medication list dated 01/24/25 revealed Resident #181 was receiving Lorazepam Oral Tablet 0.5 milligram (MG) give 1 tablet by mouth every four hours for anxiety and/or restlessness. Morphine Sulfate Oral Solution 20 milligrams (MG)/5 milliliters (ML) give 0.25 ml by mouth every 1 hours as needed for pain 1-3 or shortness of breath, Morphine Sulfate Oral Solution 20 MG/5ML give 0.5 ml by mouth every 1 hours as needed for pain 4-6 or shortness of breath for 14 Days, Morphine Sulfate Oral Solution 20 MG/5ML give 0.75 ml by mouth every 1 hours as needed for pain 7-8 or shortness of breath, Morphine Sulfate Oral Solution 20 MG/5ML give 1 ml by mouth every 1 hours as needed for pain 9-10 or shortness of breath. Review of a progress note dated 02/07/25 at 11:55 PM revealed RN #109 contacted hospice to confirm Resident #181's medication orders on admission. Review of physician orders dated 02/07/25 revealed Lorazepam Oral Tablet 0.5 milligram (MG) give 1 tablet by mouth four times a day for anxiety/restlessness (not every four hours per hospice order). Review of the Medication Administration Record (MAR) for February 2025 revealed Lorazepam Oral Tablet 0. 5 milligram (MG) give 1 tablet was administered four times a day. Further review of the February 2025 MAR revealed 0.75 milliliter (ml) of Morphine Sulfate Oral Solution 20 milligram (MG)/5 milliliter (ML) was administrated on 02/09/25 at 7:55 P.M. and 1.0 milliter (ml) administrated at 9:19 P.M. Review of the Narcotic count sheet (undated) revealed the Morphine Sulfate Oral Solution 20 MG/5ML 0.5 milliter (ml) was administered at 5:30 P.M. and 6:40 P.M. which did not match the MAR. (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 04/17/25 at 2:10 P.M. with Regional Clinical RN #198 confirmed the Ativan order was not correctly entered on admission due to the hospice order was for Ativan 0.5 mg every four hours and staff entered it as four times a day. RN #198 also confirmed the Morphine Sulfate Oral Solution 20 MG/5ML administered on 02/09/25 was not accurately documented on the narcotic count sheet.

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Continuing Healthcare of Shadyside	60583 State Route 7 Shadyside, OH 43947

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **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 antibiotics usage met criteria. This affected four residents (#7, #28, #51, and #54) of four residents reviewed for antibiotic use. Findings include: 1. Medical record review revealed Resident #51 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure with hypoxia, heart failure, and liver disease. On 04/05/25 the resident reported having pain in upper left side ribcage area. The physician was notified and ordered a chest x-ray. The x-ray result indicated an increase in left basilar infiltrates (from previous x-ray completed 01/14/25) and pleural effusion was noted. On 04/07/25 the physician was notified of x-ray results and ordered Omnicef (antibiotic) 300 milligrams (mg) twice daily for seven days as well as DuoNeb four times daily for seven days. The physician was aware the resident didn't meet McGeer's criteria and no new orders given. There was no documented evidence of why the resident needed Omnicef when she didn't meet the criteria. Review of Resident #51's medication administration record (MAR) dated 04/2025 revealed the resident was ordered and received Omnicef 300 mg from 04/07/25 to 04/14/25 for pneumonia. Review of McGeer's Criteria for Infection Surveillance Checklist dated 04/07/25 revealed Resident #51 did not meet any criteria to receive an antibiotic for pneumonia. Interview on 04/16/25 at 11:55 A.M. with Infection Preventionist (IP) #161 confirmed there was no documented evidence Resident #51 met criteria for antibiotic treatment due to the x-ray did not show pneumonia and the resident had respiratory symptoms. The IP confirmed the physician did not provide an explanation why the antibiotic was warranted. 2. Medical record review revealed Resident #28 was admitted to the facility on [DATE] with diagnoses including heart failure, diabetes, and benign prostatic hyperplasia with lower urinary tract symptoms. Review of Resident #28's progress note dated 04/12/25 revealed the resident returned back to facility after the hospital re-inserted a foley catheter. Per the nurse the resident had some minor bleeding and a few clots, however after irrigating the foley the urine was pale yellow. The resident will return with new orders for Bactrim twice daily for seven days for a urinary tract infection. Review of the infection control log dated 04/2025 revealed no evidence the resident was listed on the infection control log nor was there McGeer papers completed for the resident. Review of Resident #28's medication administration record dated 04/2025 revealed the resident had started the Bactrim on 04/12/25 and continued to receive the medication twice daily as of 04/16/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/16/25 at 12:44 P.M., with IP #165 confirmed Resident #28 did not have McGeer criteria completed nor was the resident list on the infection control log. Interview on 04/16/25 at 1:21 P.M., with the Director of Nursing (DON) and Registered Nurse (RN) #301 confirmed Resident #28 did not meet criteria for antibiotic treatment due to the urine growing less than 10, 000 mixed flora. The DON confirmed that the IP nurse didn't notify the physician until today the resident did not meet criteria. 3. Medical record review revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including dementia, diabetes, and anxiety. Review of Resident #7's progress note dated 04/03/25 revealed the physician reviewed urine results and a culture was not completed. New order to obtain another urine with reflex and then to start Keflex 500 mg three times a day for five days. Orders placed in chart and urine collected without complications. Review of Resident #7's progress note dated 04/04/25 revealed the Nurse Practitioner visited and reviewed urine results and wanted Keflex continued until sensitivity was available. Review of Resident #7's MAR dated 04/2025 revealed the resident received Keflex for five days (04/03/25 to 04/08/25). Review of McGeer's Criteria for Infection Surveillance Checklist dated 04/03/25 revealed the form was not completed. Interview on 04/16/25 at 2:14 P.M., with IP #165 confirmed Resident #7 did not meet criteria for antibiotic treatment due to there was no culture performed with either urine collected. The IP nurse confirmed there was no evidence the physician was notified there was no culture with the second urine that was collected on 04/03/25. Review of the facility policy titled Antibiotic Stewardship dated 09/25/24 revealed the facility has the potential to limit antibiotic resistance in the post-acute care setting, while improving treatment efficacy and resident safety, and reducing treatment-related costs. The Centers for Disease Control (CDC) has reported that antibiotic resistance was one of the major threats of human health, especially because some bacteria have developed resistance to all known classes of antibodies. According to the CDC, improving the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance as national priority. Diseases caused by these bacteria and increasing in long-term care facilities and contributing to higher rates of morbidity and mortality. The IP would be responsible for infection surveillance and MSRO tracking, The IP would collect and review data as such. The IP would collect and review data such as whether appropriate tests such as cultures would obtain before ordering antibiotics. 47985 4. Record review revealed Resident #54 was admitted to the facility on [DATE] with diagnoses including dementia, ileus, and dysphagia. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a nursing note dated 01/25/25 at 4:06 P.M. revealed Resident #54 was having behaviors including opening doors and being combative towards an aide. A call was placed to a medical provider and awaiting further instructions. Review of a nursing note dated 01/25/25 at 8:26 P.M. revealed Resident #54 was in the emergency room and had no significant behaviors. Resident #54 would be treated for a urinary tract infection (UTI) and sent back to the facility. Review of a nursing note dated 01/25/25 at 7:58 P.M. revealed Resident #54 readmitted to the facility with a new order for Keflex (antibiotic) 250 mg by mouth four times a day for seven days. Family and provider were updated. Review of a urinalysis completed on 01/25/25 at the hospital revealed Resident #54's urine had no significant growth over 48 hours. Review of McGeer's Criteria for Infection Surveillance Checklist dated 01/26/25 revealed Resident #54 did not meet any criteria to receive an antibiotic for a UTI. Review of a nursing note dated 01/28/25 at 8:18 A.M. by Director of Nursing (DON) revealed Resident #54 was started on antibiotics in the emergency room for a UTI but he did not meet McGeer's criteria for an antibiotic. The DON made the medical provider aware who gave an order to continue the medication related to change in condition, agitation and increased confusion. Review of a policy titled Antibiotic Stewardship dated 12/01/23 revealed it is the facility's policy to implement an antibiotic stewardship program which will promote the appropriate use of antibiotics while optimizing the treatment of infections at the same time reducing the possible adverse events associated with antibiotic use.