STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366327	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Place Care Center	779 Glendale Milford Road Cincinnati, OH 45215

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and facility policy review, the facility failed to ensure staff performed hand hygiene during the meal service. Additionally, the facility failed to ensure staff followed sanitary practices regarding resident refrigerators. These different practices had the potential to affect all residents who received meals from the dietary department. Findings included: 1. An undated facility policy titled, General Food Preparation and Handling, indicated, Employees should wash their hands prior to putting gloves on and after removing gloves. The policy also indicated, Tongs or other serving utensils will be used to serve bread or other items to avoid bare hand contact with food.During an observation on 08/06/2025 at 4:26 PM, Dietary Aide (DA) #11 touched his facemask with his left hand, which was gloved. Without changing his glove or washing his hands, he then touched a roll of bread with the same gloved hand.During an observation on 08/06/2025 at 4:45 PM, the Assistant Dietary Director grabbed a lid that fell on the floor, then changed gloves without washing hands. The gloves she used were pulled from her pockets. At 4:50 PM, she touched a bread roll with the same gloved hands.During an interview on 08/07/2025 at 4:03 PM, DA #11 stated he had worked at the facility for the past two months. He stated he had been trained in food handling. He stated that normally, during meal service, the staff used bread tongs or a scooper to serve bread items, and he did not know why they did not have that at the beginning of the meal service on 08/06/2026. He also stated that if he touched his mask with his gloves, he should switch out the gloves and wash his hands. He stated that the staff were expected to wash their hands with every glove change.During an interview on 08/07/2025 at 4:09 PM, the Assistant Dietary Director stated she had worked at the facility since 04/2025. She stated she was trained on food handling and preparation. She stated staff were expected not to store their gloves in their pockets.During an interview on 08/07/2025 at 4:19 PM, the Certified Dietary Manager (CDM) stated that he expected staff to wash their hands with every glove change. He stated DA #11 should have washed his hands and changed his gloves after touching his mask and before touching a bread roll. He also added that staff should not be storing their gloves in their pockets.During an interview on 08/08/2025 at 8:35 AM, the Director of Nursing (DON) stated that staff should wash their hands and change gloves after touching their masks. The DON stated staff should also not store their gloves in their pockets. 2. An undated facility policy titled, Resident Refrigerators, indicated, Leftovers shall be dated upon receipt and discarded within three days.During an observation on 08/07/2025 at 1:46 PM, there was a resealable plastic bag with a container that was labeled seafood alfredo in the nourishment room refrigerator for the 100s hallway. It was dated 07/28/2025 and labeled for Resident #56.During an interview on 08/07/2025 at 1:51 PM, State Tested Nursing Assistant (STNA) #1 stated she did not know the facility policy on when food should be discarded, but she estimated four days. During an observation on 08/07/2025 at 2:11 PM, there was a resealable plastic bag of green grapes that was dated 08/01/2025 and labeled for the resident in room [ROOM NUMBER]-1.During an interview on 08/07/2025 at 2:11 PM, Licensed Practical Nurse (LPN) #4 stated that food items should be discarded after three days, and she discarded the green grapes.During an interview on 08/07/2025 at 4:03 PM, Dietary Aide (DA) #11 stated that the dietary (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	department was responsible for the resident refrigerators. He stated that he was not sure who disposed of outdated food items.During an interview on 08/07/2025 at 4:09 PM, the Assistant Dietary Director stated that the dietary department was responsible for the unit refrigerators, and they should be clearing the food items that were past date.During an interview on 08/07/2025 at 4:19 PM, the Certified Dietary Manager (CDM) stated that the dietary department was responsible for the unit refrigerators, including discarding food items older than three days. He stated all undated food items should also be thrown out. He confirmed that the seafood pasta and grapes should have been discarded.During an interview on 08/07/2025 at 5:31 PM, the CDM stated it was the evening cook who came in at 11:00 AM who rounded on the refrigerators and was responsible for those refrigerators. During an interview on 08/07/2025 at 5:32 PM, [NAME] #11 stated she had worked at the facility since 03/2025. She stated that she usually checked on the unit refrigerators when she arrived at the facility, but she did not get to it that morning. She stated that she believed the nursing staff threw away the resident items brought in from outside, and she did not touch those items because she did not know when they were put in. During an interview on 08/08/2025 at 8:35 AM, the Director of Nursing (DON) stated the dietary department was responsible for the unit refrigerators, but she did not know who specifically in dietary handled the task. She stated that food should be thrown out after three days.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. Based on record review, interview, and facility document and policy review, the facility failed to allow residents to withdraw greater than $25.00 at a time from their personal funds accounts for 2 (Resident #12 and Resident #87) of 2 residents reviewed for personal funds. This deficient practice had the potential to affect all 55 residents with personal funds accounts managed by the facility. Findings included: An undated Resident Handbook revealed the section titled, Resident Funds Policy Statement, specified, Residents/Authorized representative have access to these funds Monday-Friday from 9:00 a.m. - 5:00 p.m. Advanced arrangements may be made by the Accounting Department for funds over the weekend through the Gift Shop or Nursing Supervisor with a maximum of $25.00 dollars available for withdrawal per day. 1. An admission Record revealed the facility admitted Resident #12 on 02/01/2024. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/05/2025, revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition.During an interview on 08/04/2025 at 10:44 PM, Resident #12 stated they could only withdraw $25.00 a day from their personal funds account. A financial Trust Statement, dated 06/30/2025, revealed that Resident #12 made one Cash Withdrawal in the amount of $25.00 during the timeframe from 04/01/2025 to 06/30/2025. During an interview on 08/06/2025 at 5:58 PM, Accounts Receivable Staff stated residents could typically only withdraw $25.00 a day from their personal funds accounts. She stated that if greater than $25.00 was requested, she could possibly issue a paper check that the resident would be responsible for getting cashed. She provided an example that if a resident wanted to withdraw $75.00, the resident would have to withdraw $25.00 a day for three days. During an interview on 08/07/2025 at 2:10 PM, the Director of Nursing (DON) stated she was not very familiar with resident funds but reported that resident funds should be available for withdrawal anytime up to the amount available in a resident's personal funds account. 2. An admission Record revealed the facility admitted Resident #87 on 09/29/2023. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/02/2025, revealed Resident #87 had a Brief Interview for Mental Status (BIMS) of 14, which indicated the resident had intact cognition. During an interview on 08/04/2025 at 11:10 AM, Resident #87 stated they were only allowed to withdraw $25.00 per day from their personal funds account.A financial Trust Statement, dated 06/30/2025, revealed that Resident #87 had 30 cash withdrawals of no more than $25.00 at a time during the timeframe from 04/01/2025 to 06/30/2025. During an interview on 08/06/2025 at 10:20 AM, State Tested Nursing Assistant (STNA) #1 stated Resident #87 was the only resident who had complained to her about not being able to retrieve money from their personal funds account. During an interview on 08/06/2025 at 5:58 PM, Accounts Receivable Staff stated residents could typically only withdraw $25.00 a day from their personal funds accounts. She stated that if greater than $25.00 was requested, she could possibly issue a paper check that the resident would be responsible for getting cashed. She provided an example that if a resident wanted to withdraw $75.00, the resident would have to withdraw $25.00 a day for three days. During an interview on 08/07/2025 at 2:10 PM, the Director of Nursing (DON) stated she was not very familiar with resident funds but reported that resident funds should be available for withdrawal anytime up to the amount available in a resident's personal funds account.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interview, record review, and facility document review, the facility failed to honor a resident's right to choose a medication administration schedule consistent with resident preferences for 1 (Resident #97) of 2 residents sampled for choices. Findings included:During an interview on 08/07/2025 at 11:21 AM, the facility's Chief Nursing Officer (CNO) stated the facility did not have a policy related to resident choices and/or resident preferences. An admission Record revealed the facility admitted Resident #97 on 08/19/2024. According to the admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease, type 2 diabetes mellitus with unspecified complications, and gastro-esophageal reflux disease without esophagitis. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/19/2025, revealed Resident #97 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #97's Order Summary Report, with active orders as of 07/01/2025, contained the following orders: - aspirin (an antiplatelet) 81 milligrams (mg) by mouth one time daily for pain dated 08/13/2024.- dexlansoprazole (a proton pump inhibitor) delayed release capsule 60 mg by mouth one time a day for ulcers dated 08/13/2024.- escitalopram oxalate (an antidepressant) 10 mg by mouth one time a day for depression dated 09/21/2024.- Lantus insulin glargine (a man-made form of human insulin) inject 20 units subcutaneously one time a day related to type 2 diabetes mellitus with hyperglycemia dated 03/13/2025.- loratadine (an antihistamine) 10 mg give one tablet by mouth one time a day for allergies dated 08/13/2024- metoprolol succinate (a beta blocker) extended release (ER) 24 hour 50 mg by mouth one time a day for hypertension dated 08/13/2024.- montelukast sodium (a leukotriene receptor antagonist) 10 mg by mouth one time a day for asthma dated 08/13/2024.- Ozempic semaglutide solution (a glucagon-like peptide-1 agonist) inject 2 mg subcutaneously one time a day every Wednesday related to type 2 diabetes mellitus without complications dated 08/26/2024.- spironolactone (a potassium-sparing diuretic) 25 mg by mouth one time a day for edema dated 08/13/2024.- gabapentin (an anticonvulsant) 300 mg by mouth two times a day related to polyneuropathy dated 10/27/2024. - Percocet oxycodone with acetaminophen (an opioid pain medication) 5 mg (oxycodone) 325 mg (acetaminophen) by mouth three times a day for pain dated 09/04/2024. Resident #97's July 2025 Medication Administration Record [MAR] revealed that on 07/26/2025, the following medications had changes to the administration times: aspirin 81 mg, dexlansoprazole 60 mg, escitalopram 10 mg, insulin glargine 20 units, loratadine 10 mg, metoprolol succinate ER 50 mg, montelukast 10 mg, and spironolactone 25 mg were changed from 6:00 AM administration to 9:00 PM administration. The MAR revealed gabapentin 300 mg two times a day was changed from 6:00 AM to 9:00 AM and from 6:00 PM to 9:00 PM, and Oxycodone with acetaminophen 5 mg/325 mg three times a day was changed from 6:00 AM to 9:00 AM, 2:00 PM to 1:00 PM, and 10:00 PM to 9:00 PM on 07/26/2025. The MAR also revealed Resident #97's administration times for Ozempic semaglutide 2 mg were changed from 6:00 AM to 9:00 AM on 07/30/2025. During an interview on 08/04/2025 at 1:23 PM, Resident #97 stated their medication administration times were changed from 6 to 9 the previous week, and they were not provided an explanation why the medication administration times were switched. Resident #97 stated they would prefer to have their medications administered at the previous times before the facility changed them. During an interview on 08/05/2025 at 2:33 PM, State Tested Nursing Assistant (STNA) #1 stated if a resident communicated a concern to her related to medication times, she would inform the nurse. STNA #1 stated she was familiar with Resident #97, and the resident was, in an uproar and was worked up about their medication administration times being changed and told STNA #1 about their concerns over one week prior. STNA #1 stated she informed the nurse, Licensed Practical Nurse (LPN) #3, after speaking with Resident #97 and told them about Resident #97's concerns. During an interview on 08/05/2025 at 3:31 PM, the facility's Assistant Director of Nursing (ADON) stated if a (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident expressed a concern related to medication administration times, they would try to accommodate the resident's concern in accordance with resident rights and the resident's needs. The ADON also stated if the resident's medication administration times needed to be changed, the resident would be notified of the changes if the resident was alert and oriented. The ADON stated if a resident disagreed with the change of their medication administration times, the medication administration times would be changed back to the time the resident preferred, with approval from the resident's physician. The ADON stated sometime around the middle of August 2025, the facility would be switching pharmacies, and the resident's medication administration times were changed to keep times consistent and so the nursing staff could provide more direct care to the residents in the facility. The ADON also stated she spoke with Resident #97 a couple of days prior, and the resident wanted their medications switched back to the time they were administered before the times were changed because the medications did not sit well with the resident during meals. The ADON stated she told Resident #97 the medication administration times would be changed back to the times they were administered before the times were changed, but the change had not been implemented as of the time of the interview. The ADON stated the change was pending approval from the resident's physician.During an interview on 08/05/2025 at 4:51 PM, the facility's Director of Nursing (DON) stated if a resident had a concern related to the timeframe of their medication administration, she would expect staff to speak to the resident about the concern and contact the resident's physician to change the medication administration orders to the resident's preferred time. The DON also stated she spoke with Resident #97 the week before, regarding the resident's diuretic medication being administered at 9:00 PM and the resident's concerns related to urinating throughout the night. The DON stated she reviewed the resident's medications and did not see a diuretic medication administered at 9:00 PM. The DON also stated Resident #97 did not express concerns to her about their other medications and the administration times. The DON stated she would expect nursing staff to call the resident's physician as soon as possible if concerns were communicated related to medication administration times to change the medication administration times to the resident's preferred time if the change did not conflict with the resident's next dose of the medication. The DON stated the facility changed medication administration times, so medications were all passed around the same timeframes to allow more time for nursing staff to provide bedside care. The DON also stated the facility was just kind of moving the medication administration times unless the resident preferred a different administration time, and residents were not informed of the changes in administration times. The DON stated medication administration times should be resident-centered and would depend on the resident's preference. The DON also stated, Something that simple should not take a week.On 08/06/2025 at 5:51 PM, a telephone interview was attempted with LPN #3. The call was not answered, and a message was left for a return phone call. During an interview on 08/07/2025 at 1:00 PM, the DON stated she reached out to LPN #3 and stated, I told her to return your call. LPN #3 did not provide a return phone call.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record review, interview, and facility policy review, the facility failed to consistently provide routine baths to 1 (Resident #112) of 5 sampled residents reviewed for activities of daily living (ADLs). Findings included: A facility policy titled, Activities of Daily Living (ADL) Care, reviewed 01/2024, indicated, Policy Interpretation and Implementation: Nursing staff will assist residents with receiving care and services for residents with ADL needs which may include (but not limited to): basic-self-care tasks such as bathing, dressing, eating, toileting and mobility, oral care based on individual needs.An admission Record revealed the facility admitted Resident #112 on 05/09/2025. According to the admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting the left non-dominant side, acquired absence of right foot, adult failure to thrive, and chronic obstructive pulmonary disease. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/20/2025, revealed Resident #112 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident was dependent on staff for bathing. Resident #112's Care Plan Report included a focus area, initiated 05/22/2025, that indicated the resident had an ADL self-care performance deficit related to cerebral vascular disease, hemiparesis, chronic obstructive pulmonary disease, respiratory failure, fibromyalgia, and diabetes mellitus. Interventions initiated on 05/22/2025 directed staff to adjust the level of ADL support for fluctuations and/or declines in self-care and or mobility, assist with ADLs, and provide one-person physical assistance with bathing. The Care Plan Report did not reflect how frequently the resident was to be bathed.Resident #112's 05/2025 and 06/2025 Documentation Survey Reports revealed documentation that indicated the resident received baths on 05/12/2025, 05/13/2025, 05/22/2025, 06/05/2025, 06/07/2025, 06/08/2025, and 06/16/2025. Per the reports, a code of NA meant not applicable, a code of RX meant the resident was not available, and a code of RR meant the resident refused. The reports revealed staff documentation that indicated the resident was not available for a bath on 05/26/2025, 06/17/2025, and 06/18/2025 (per progress notes, the resident was in the hospital on these dates). The reports revealed staff documented NA for bathing on 05/17/2025, 05/20/2025, 06/03/2025, 06/13/2025 and 06/15/2025. The reports did not include documentation regarding the provision of bathing assistance on any other days and did not reflect any resident refusals. Resident #112's Progress Notes for the timeframe from 05/05/2025 through 06/17/2025 revealed no documented evidence that Resident #112 refused baths or showers. During an interview on 08/07/2025 at 10:16 AM, State Trained Nursing Assistant (STNA) #15 stated that when she documented NA on the bath/shower records, she meant that she did not offer or provide the resident a bath. During an interview on 08/08/2025 at 8:28 AM, STNA #16 stated that if a bath was not given, she documented an NA on the bath/shower records; however, she indicated she documented the same way if the resident refused their bath. During an interview on 08/08/2025 at 9:48 AM, the Director of Nursing (DON) said she expected staff to at least offer baths and document in the resident's electronic medical record (EMR). The DON stated staff should be coding the bath/shower records correctly. This deficiency represents non-compliance investigated under Complaint Number 1336365 (OH00166784).

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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. Based on record review, interview, and facility policy review, the facility failed to ensure provider orders were followed for 2 (Resident #12 and Resident # 16) of 5 residents reviewed for medication management. Findings included: A facility policy titled, Medication Administration, reviewed 03/2021, revealed, F. Follow the 5 [five] rights of medication administration when administering medications: (1) Right Drug; (2) Right Patient; (3) Right Dose; (4) Right Route; and (5) Right Time. 1. An admission Record revealed the facility admitted Resident #12 on 02/01/2024. According to the admission Record, Resident #12 had a medical history that included a diagnosis of muscle spasms. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/05/2025, revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #12's 08/2025 Order Recap [Recapitulation] Report contained an order, dated 07/29/2025, for methocarbamol (a muscle relaxer) 500 milligrams (mg) by mouth three times daily for muscle spasms. Resident #12's 08/2025 Medication Administration Record (MAR) revealed that on 08/02/2025, Licensed Practical Nurse (LPN) #8 documented a 9 for Other/See Progress Notes for the resident's 9:00 AM and 1:00 PM doses of methocarbamol. Resident #12's Progress Notes revealed Medication Administration Notes, dated 08/02/2025 at 1:47 PM and 1:49 PM, that indicated the resident's methocarbamol was on order from the pharmacy. During an interview on 08/06/2025 at 5:36 PM, LPN #8 stated she did not administer Resident #12's methocarbamol on 08/02/2025 and that she documented that it was not available. She did not recall if she reordered the medication or contacted the physician to deviate from the physician medication order. LPN #8 recalled that the medication arrived at the facility at the end of her shift on 08/02/2025. During an interview on 08/07/2025 at 10:12 AM, LPN #4 revealed she was the day shift nursing supervisor on 08/02/2025, and she was not advised that Resident #12 was out of the methocarbamol. During an interview on 08/07/2025 at 11:27 AM, the Pharmacy Consultant stated that Resident #12's methocarbamol was on automatic reorder, and per the pharmacy records, it was received at the facility on 08/02/2025. He did not want to speculate as to why two doses of the methocarbamol were missed. During an interview on 08/07/2025 at 2:22 PM, the Director of Nursing reported that the nurse was responsible for ensuring that medication orders were carried through by communicating with the pharmacy, provider, and family. She stated she did not know that two doses of the methocarbamol had not been administered to Resident #12. 2. An admission Record revealed the facility admitted Resident #16 on 09/13/2023. According to the admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominant side, multiple sclerosis, and type two diabetes mellitus. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #16's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/14/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. Resident #16's Care Plan Report included a focus area, initiated 10/10/2023, that indicated the resident had type two diabetes mellitus and chose to decline insulin at times. An intervention dated 10/10/2023 directed staff to administer diabetes medication as ordered by the doctor, to monitor/document/report to the medical doctor any signs or symptoms of hypoglycemia, and to complete fasting serum blood sugars as ordered by the doctor. Resident #16's Order Recap [Recapitulation] Report included an order, dated 04/27/2025, for insulin apart subcutaneous solution pen injector 100 units per milliliter (units/mL) per sliding scale (an order in which the dose of insulin depends upon the blood sugar value at the time of administration). The Order Recap Report also included an order, dated 02/13/2025, that indicated, If BS [blood sugar] is less than 70 [milligrams/deciliter (mg/dL)], administer glucose solution po [by mouth]; recheck BS every 30 minutes X 4. Resident #16's 06/2025 Medication Administration Record (MAR) for the month of 06/2025 revealed that on 06/09/2025 at 9:00 PM, Licensed Practical Nurse (LPN) #7 documented that no coverage of sliding scale insulin was required due to a blood sugar of 63 mg/dL. The MAR also revealed that on 06/10/2025 at 8:00 AM, LPN #9 documented that no coverage of sliding scale insulin was required due to a blood sugar of 66 mg/dL. The MAR revealed no documented evidence that glucose solution was administered or repeat blood sugar checks were performed as ordered after the resident's blood sugar was found to be less than 70 mg/dL on 06/09/2025 or 06/10/2025. Two attempts were made to interview LPN #7 on 08/06/2025 at 3:14 PM and on 08/07/2025 at 8:12 AM. Neither attempt was successful. During an interview on 08/06/2025 at 2:59 PM, LPN #9 stated if a resident's blood sugar was below 70 mg/dL, she should hold insulin and give juice, then recheck their blood sugar every 30 minutes until it came back up. She stated she had never had to give Resident #16 glucose solution and usually gave the resident something sugary, rather than the glucose solution that was ordered. LPN #9 stated that she had not talked to the physician about the order but should have. LPN #9 further stated she only did the blood sugar checks every 30 minutes if Resident #16's blood sugar fell below 60 mg/dL; however, she had not talked to the doctor about that either, but she stated she should have. During an interview on 08/07/2025 at 8:54 AM, Medical Doctor #10 stated he expected nursing staff to follow ordered parameters. He stated if a resident's blood sugar fell below 70 mg/dL, there needed to be follow-up blood sugar checks. Medical Doctor #10 stated that he preferred for staff to follow orders as written, but he would not chastise the nurse about administering a sugary beverage like orange juice rather than the glucose solution. He did state that if a nurse disagreed with the order, they needed to speak to the unit manager who could contact him, and they could fine tune the orders to improve patient care. During an interview on 08/08/2025 at 8:35 AM, the Director of Nursing stated the nursing staff should always follow the physician's orders. If the nursing staff disagreed with an order, they should discuss it with the physician.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, record review, facility document review, and facility policy review, the facility failed to ensure drugs and biologicals were stored securely in a resident room for 1 (Resident #97) of 1 resident sampled for self-administration of medications. Findings included: A facility policy titled, Self-Administration of Meds [Medications], last reviewed by the facility 03/2021, revealed, Residents may be permitted to self-administer medications when, in the judgement of the care team, it is appropriate and safe to do so. The decision to allow self-administration must be based on an interdisciplinary assessment and documented agreement that the resident has the capacity to manage their medications responsibly. The policy also revealed, Residents may be considered for self-administration of medications following an interdisciplinary review of relevant factors, which may include, but are not limited to, the resident's physical and cognitive abilities, understanding of their medications, and ability to store medications safely.A facility policy titled Medication Storage, last revised by the facility 03/2021, revealed, Except for those requiring refrigeration, medications intended for internal use are stored in a medication cart or other designated area. An admission Record revealed the facility admitted Resident #97 on 08/19/2024. According to the admission Record, the resident had a medical history that included a diagnosis of chronic obstructive pulmonary disease. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/19/2025 revealed Resident #97 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #97's Order Summary Report, with active orders as of 07/01/2025, contained the following orders: - albuterol sulfate (a bronchodilator) hydrofluoroalkane (HFA) inhalation aerosol solution 108 (90 base) micrograms per actuation (mcg/act), with instructions to inhale two puffs orally every six hours as needed for wheezing, unsupervised self-administration, dated 08/13/2024. - Fluticasone propionate suspension (a glucocorticoid steroid) two sprays in both nostrils one time a day for allergies for six months, unsupervised self-administration, dated 03/13/2025. - Incruse Ellipta (an anticholinergic) inhalation aerosol powder 62.5 mcg/act, with instructions to inhale one puff orally one time a day for shortness of breath, unsupervised self-administration, dated 08/13/2024. - Symbicort (a glucocorticoid and long-acting beta-adrenoceptor agonist) inhalation aerosol 160-4.5 mcg/act, with instructions to inhale two puffs orally at bedtime, unsupervised self-administration, dated 08/13/2024. A Self-medication Assessment, dated 10/13/2024, revealed Resident #97 was able to self-administer medications. The Self-medication Assessment also revealed Resident #97 had the dexterity to open locks and had the ability to track time, correctly state the name of medication and the use, read print on prescription labels, correctly state the proper dose of each medication, and administer inhalant medication properly. During an observation on 08/04/2025 at 1:23 PM in Resident #97's room, two inhalers were observed on the resident's bedside stand, and two medication vials were observed on the resident's nightstand near a nebulizer. During an interview concurrent with the observation, Resident #97 stated one of the inhalers was albuterol, which they took as needed, and the other inhaler was Symbicort, which they took every 12 hours. Resident #97 also stated they took the medication by the nebulizer whenever they needed it, and they had a bottle of Flonase (fluticasone) in the drawer across from their bed. Resident #97 stated they had the medication at the bedside since coming to the facility a year prior. During an interview on 08/05/2025 at 2:33 PM, State Tested Nursing Assistant (STNA) #1 stated she was not aware of any residents who self-administered their own medications or had medications in their rooms. STNA #1 also stated if she observed medications in a resident's room, she would remove the medications and inform the nurse. STNA #1 stated she had never noticed any medications in Resident #97's room. During an interview on 08/05/2025 at 3:11 PM, Licensed Practical Nurse (LPN) #2 stated she was not aware of any residents in her assignment, including (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #97, who self-administered their own medications. LPN #2 also stated if medications were found in a resident's room, even an over-the-counter medication, she would inform the resident they were not allowed to have them in their room and notify the facility's Assistant Director of Nursing (ADON) or Director of Nursing (DON). LPN #2 stated she did not notice any medications in Resident #97's room, but that day was the first time she was assigned to the resident. During an interview on 08/05/2025 at 3:31 PM, the ADON stated the facility had residents who were able to self-administer inhalant medications, but none who were able to self-administer pills. The ADON also stated if a resident wished to self-administer medications, the nurse would complete an assessment to see if the resident could administer their own medications. After the assessment showed the resident was safe to self-administer medications and after being approved by the resident's physician, the order would be entered into the electronic chart with special instructions indicating the resident could self-administer the medication. The ADON stated the medication could be kept at the resident's bedside but was not sure if the medication needed to be locked up inside of the resident's room. The ADON also stated she was not sure if Resident #97 had medications stored in their room, but they might have an as-needed inhaler in their room. During an interview on 08/05/2025 at 4:51 PM, the DON stated the facility did not have any residents who self-administered pill form medications, but some residents self-administered medications such as eye drops, nasal spray, or inhalant medications. The DON also stated if a resident wanted to self-administer medications, an assessment would be completed to ensure the resident was able to administer the medications properly and store the medications safely with return demonstration by the resident. The DON stated if a resident were assessed as able to self-administer medications and the resident's physician approved, the medication would be kept with the resident. The DON also stated she was not sure if the medications needed to be locked up inside the resident's room. During an interview on 08/07/2025 at 9:11 AM, the ADON reviewed the facility's policy titled Self-Administration of Meds and stated storing medications safely would mean the medication would be out of reach of anyone else, and if the medication was stored in the resident's room, they would be locked in a drawer or in a lock box. The ADON also stated medications should be kept secured whether the resident was inside or outside the room. During an interview on 08/07/2025 at 9:38 AM, Resident #97 stated the facility provided the resident with a plastic lock box to store their medications. Resident #97 opened a drawer in their television stand, which contained a plastic box with a locking mechanism. The plastic lock box contained two inhalers and a container of nasal spray. An observation concurrent with the interview revealed two vials of medication sitting on the resident's bedside stand near a nebulizer, unsecured. The resident stated, I didn't even think about that. During an interview on 08/07/2025 at 1:00 PM, the DON reviewed the facility's policy titled Self-Administration of Meds and stated the ability to store medication safely meant providing the resident with a lock box or having medication in a locked drawer in the resident's room. The DON also stated medications should always be kept secure unless they were being administered.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview, record review, and facility policy review, the facility failed to ensure the medical record reflected the experiences of the resident for 1 (Resident #16) of 26 sampled residents. Specifically, Resident #16's Medication Administration Records (MARs) had several missing entries in May and June 2025. Findings included:A facility policy titled, Medication Administration, dated 02/05/2020, indicated, K. After administration, return to cart and document administration in the (MAR or TAR [Treatment Administration Record]). L. If the resident refuses medication, document refusal on the (MAR or TAR).An admission Record revealed the facility admitted Resident #16 on 09/13/2023. According to the admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominant side, multiple sclerosis, and type 2 diabetes mellitus.Resident #16's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/14/2025, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment.Resident #16's Care Plan Report, included a problem statement initiated 10/10/2023, that stated Resident #16 had type 2 diabetes mellitus and would choose to decline insulin at times. Interventions directed staff to administer diabetes medication as ordered by the doctor. The Care Plan Report included a problem statement initiated 10/10/2023 that indicated the resident had altered cardiovascular status. Interventions directed staff to administer cardiac medications as ordered. The Care Plan Report included a problem statement initiated 10/10/2023 that indicated the resident was on pain medication. Interventions directed staff to administer medications as ordered.Resident #16's Order Recap [Recapitulation] Report, for the timeframe from 02/01/2025 through 08/06/2025, included the following orders: - An order dated 05/29/2025, for Cymbalta 60 milligrams (mg) delayed release capsule, with instructions to give 60 mg at bedtime for major depressive disorder. The resident's 05/2025 MAR revealed no documentation to indicate whether the medication was administered on 05/31/2025. - An order dated 04/27/2025 and discontinued 06/11/2025, for insulin glargine 100 unit/milliliter (ml), with instructions to inject 38 units subcutaneously one time a day for type 2 diabetes mellitus. The resident's 05/2025 and 06/2025 MAR revealed no documentation to indicate whether the medication was administered on 05/07/2025, 05/14/2025, 06/01/2025, 06/06/2025, and 06/11/2025.- An order dated 06/11/2025 and discontinued 07/21/2025, for insulin glargine 100 unit/ml, with instructions to inject 35 units subcutaneously one time a day for type 2 diabetes mellitus. The resident's 06/2025 MAR revealed no documentation to indicate whether the medication was administered on 06/14/2025 through 06/16/2025.- An order dated 04/27/2025 and discontinued 07/29/2025, for insulin aspart subcutaneous solution pen-injector 100 unit/ml, with instructions to administer per sliding scale for type 2 diabetes mellitus. The resident's 05/2025 MAR revealed no documentation to indicate whether the medication was administered at 9:00 PM on 05/13/2025 and 05/31/2025.- An order dated 02/13/2025, for sertraline hydrochloride (HCl) 150 mg, with instructions to give 150 mg at bedtime for major depressive disorder. The resident's 05/2025 MAR revealed no documentation to indicate whether the medication was administered 05/31/2025.- An order dated 02/13/2025, for carvedilol 12.5 mg, with instructions to give 12.5 mg twice daily for hypertension. The resident's 05/2025 MAR revealed no documentation to indicate whether the medication was administered.- An order dated 02/13/2025, for trazodone HCl 100 mg tablet, with instructions to give one tablet at bedtime for major depressive disorder. The resident's 05/2025 MAR revealed no documentation to indicate whether the medication was administered 05/31/2025.- An order dated 02/13/2025, for calcium polycarbophil 625 mg tablet, with instructions to give one tablet twice daily for preventative constipation. The resident's 05/2025 MAR revealed no documentation to indicate whether the medication was administered 05/31/2025.- An order dated 02/13/2025 and discontinued 06/24/2025, for sennosides-docusate sodium 8.6 - 50 mg (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tablet, with instructions to give one tablet twice daily for constipation. The resident's 05/2025 MAR revealed no documentation to indicate whether the medication was administered 05/31/2025.- An order dated 02/13/2025, for continuous positive airway pressure (CPAP) per home setting on at bedtime and off in the morning. The resident's 05/2025 MAR revealed no documentation to indicate whether the CPAP was administered 05/31/2025.- An order dated 02/13/2025 and discontinued 07/14/2025, for pregabalin 50 mg capsule, with instructions to give one capsule twice daily for muscle pain. The resident's 05/2025 MAR revealed no documentation to indicate whether the medication was administered 05/31/2025.- An order dated 02/13/2025, for pain scale every shift. The resident's 05/2025 and 06/2025 MAR revealed no documentation to indicate whether the pain scale was completed for the evening shift on 05/13/2025, 05/31/2025 and 06/05/2025, and for the day shift on 05/18/2025. - An order dated 02/13/2025, for titrating oxygen to maintain oxygen saturation of 92% or above every shift. The resident's 05/2025 MAR revealed no documentation to indicate whether supplemental oxygen was administered 05/13/2025 and 05/31/2025.- An order dated 02/13/2025 and discontinued 06/26/2025, for raising the head of bed as tolerated every shift. The resident's 05/2025 MAR revealed no documentation to indicate whether the residents head of bed was raised as tolerated for the evening shift on 05/06/2025, 05/13/2025, and 05/31/2025.- An order dated 02/13/2025, for pantoprazole sodium 40 mg delayed release tablet, with instructions to give one tablet one time a day for heartburn. The resident's 05/2025 and 06/2025 MAR revealed no documentation to indicate whether the medication was administered 05/07/2025, 05/14/2025, 06/11/2025, 06/14/2025, and 06/16/2025.- An order dated 02/13/2025 and discontinued 06/17/2025, for oxygen saturation levels to be checked every shift and as needed for shortness of breath. The resident's 05/2025 and 06/2025 MAR revealed no documentation to indicate whether the resident's oxygen saturation levels were checked for the evening shift on 05/06/2025, 05/13/2025, 05/31/2025, 06/10/2025, 06/14/2025, and 06/15/2025, and the morning shift on 05/18/2025 and 06/17/2025.- An order dated 02/13/2025, for weight-bearing as tolerated (WBAT) every shift for weight bearing status. The resident's 05/2025 and 06/2025 MAR revealed no documentation to indicate whether the staff checked the resident's WBAT during the evening shift on 05/31/2025 and 06/10/2025.During an interview on 08/06/2025 at 1:59 PM, Licensed Practical Nurse (LPN) #5 stated there should not have been blanks in the MAR. LPN #5 stated if a resident was unavailable, staff could have documented that the resident was not available in the MAR.During an interview on 08/06/2025 at 2:59 PM, LPN #9 stated there should not have been blanks in the MAR. During an interview on 08/06/2025 at 3:15 PM, LPN #13 stated there should not have been blanks in the MAR. LPN #13 stated that if a resident refused the medications or it could not be given for whatever reason, it should still have been documented in the MAR. During an interview on 08/08/2025 at 8:35 AM, the Director of Nursing (DON) stated there should never have been blanks in the MAR. The DON stated that if the resident refused, the staff could still have documented those refusals. She stated that it would be difficult to ascertain, just from a blank in the MAR, whether medications had been given and not documented or not administered at all.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and facility policy, the facility failed to ensure multi-use equipment was sanitized between residents for 1 (Resident #42) of 8 residents observed during medication administration. Additionally, the facility failed to ensure personal protective equipment (PPE) was donned prior to entering a transmission-based precautions (TBP) room for 1 (Resident #52) of 3 residents reviewed for TBP.Findings included: 1. A facility policy titled, Cleaning and Disinfecting Environment & Resident Care Equipment, last reviewed by the facility on 10/12/2020, indicated, Environmental Guidelines: Staff will use standard precautions, including appropriate personal protective equipment (PPE) for all rooms unless transmission-based precautions are identified as indicated on posted precaution signs located outside resident rooms. The policy revealed, Surface cleaning and disinfection will be conducted with focus on high touch areas to include, but not limited to: toilet seats & toilet flush handles, grab bars next to toilet, bed assist rails, overbed tray tables, call light buttons, TV and bed remotes, telephones, resident chairs, IV poles, blood pressure cuffs, sinks and faucets, light switches, door knobs and/or levers, countertops, desktops and tables. The policy specified, Resident Care Equipment Guidelines: Single-use equipment will be cleaned when visually soiled. Multi-use items will be routinely cleaned and disinfected after each use, particularly before use for another resident.During medication administration on 08/06/2025 at 8:30 AM, Licensed Practical Nurse (LPN) #4 obtained a blood pressure cuff that had been previously used on another resident and had not been sanitized between residents and started to enter Resident #42's room. LPN #4 was asked about the facility process for sanitizing blood pressure cuffs between residents, and LPN #4 stated there was not a policy to sanitize between residents. LPN #4 stated that she did not normally clean blood pressure cuffs between residents. LPN #4 stated she would sanitize the blood pressure cuffs between residents if a resident was on TBP or enhanced barrier precautions. During an interview on 08/06/2025 at 9:21 AM, LPN #5 stated she sanitized the blood pressure cuff between each resident use.During an interview on 08/07/2025 at 11:56 AM, the Assistant Director of Nursing (ADON), who was also the Infection Preventionist, stated equipment used for multiple residents should be sanitized between use; however (in contrast to her prior statement and the facility policy), she stated she would not expect staff to sanitize the blood pressure cuff between use of residents if the resident was not on any precautions.During an interview on 08/08/2025 at 8:34 AM, the Director of Nursing (DON) stated (in contrast to the facility policy), I do not expect for a multiuse item to be cleaned between residents if it is not known that they have an infection.2. A facility policy titled, Contact Precautions, last reviewed by the facility on 12/19/2020, specified, Staff will use standard precautions in addition to contact precautions as they apply. Staff will wear gloves; gowns, masks, or goggles IF there is a danger of being sprayed or splattered.An admission Record revealed the facility admitted Resident #52 on 03/08/2025. According to the admission Record, the resident had a medical history that included diagnoses of extended spectrum beta lactamase (ESBL) resistance and urinary incontinence.A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/13/2025, revealed Resident #52 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident was occasionally incontinent of urine and bowel.Resident #52's Order Summary Report as of 08/07/2025 revealed an order dated 08/04/2025 for contact isolation for ESBL in urine every shift.During an observation on 08/06/2025 at 11:33 AM, Licensed Practical Nurse (LPN) #6 performed a finger stick blood sugar check on Resident #52. LPN #6 obtained the supplies, performed hand hygiene, applied gloves, then entered the resident's room without donning a gown. A contact precaution sign was on the door. LPN #6 obtained the resident's finger stick blood sugar check. LPN #6 stated the resident was not on contact precautions. LPN #6 stated the PPE to be worn for contact isolation was gloves, mask, and gown. LPN #6 stated the sign read to wear a gown and gloves, but she did not wear a gown when she performed Resident #52's finger sick blood sugar (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	check. LPN #6 stated it was important to wear PPE to protect the resident and herself from disease causing micro-organisms. LPN #6 stated she should have double checked and not assumed the resident was not on precautions when she saw the sign on the door. During an interview on 08/07/2025 at 11:56 AM, the Assistant Director of Nursing (ADON), who was also the Infection Preventionist, stated she expected staff to don PPE for contact precautions. The ADON stated the PPE was a barrier to anything that could be spread through physical contact. The ADON stated staff should have worn a gown as well as gloves when performing the resident's finger sick blood sugar check. During an interview on 08/08/2025 at 8:34 AM, the Director of Nursing (DON) stated sheexpected for PPE use to be specific to that resident and if providing care for a resident on transmission-based precautions, staff should wear gloves, a gown, and a mask. The DON stated she expected gloves, a mask, and a gown to be used to obtain a finger sick blood sugar check on a resident that was on contact precautions.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview, record review, and facility policy review, the facility failed to provide education regarding the benefits and risks of influenza, pneumonia, and COVID-19 immunizations for 1 (Resident #87) of 5 residents reviewed for infection control. Specifically, Resident #87 declined all vaccinations, but there was no documentation that education was provided regarding the risks and benefits of each immunization.Findings included: An undated facility policy titled, Pneumonia Vaccine Policy, indicated, Prior to offering the pneumococcal immunization, each resident or the resident's representative will receive education regarding the benefits and potential side effects of the immunization.An undated facility policy titled, Influenza Vaccine Policy, indicated, Prior to the administration of the influenza vaccine, the person receiving the immunization, or his/her legal representative, will be provided with a copy of CDC's [Centers for Disease Control and Prevention] current vaccine information statement relative to the influenza vaccination. An admission Record indicated the facility admitted Resident #87 on 09/29/2023. According to the admission Record, the resident had a medical history that included diagnoses of hemiplegia, type 2 diabetes mellitus, stage 3 chronic kidney disease, vascular dementia, and traumatic subdural hemorrhage without loss of consciousness.Resident #87's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/02/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. Resident #87's Care Plan Report, revealed a problem statement initiated 10/23/2023, that indicated the resident's cognitive function fluctuated related to traumatic subdural hematoma. Resident #87's Immunization Audit Report revealed that the resident refused the influenza vaccination on 10/09/2024. The Immunization Audit Report revealed staff documented No in the section titled, Education Provided/By/Date.Resident #87's Immunization Audit Report revealed that the resident refused the pneumococcal vaccination on 12/15/2023. The Immunization Audit Report revealed staff documented No in the section titled, Education Provided/By/Date.Resident #87's Immunization Audit Report revealed that the resident refused the COVID-19 vaccination on 10/09/2024. The Immunization Audit Report revealed staff documented No in the section titled, Education Provided/By/Date.A nursing Health Status Note, dated 10/09/2024, revealed the facility spoke with the resident's family regarding vaccines that were to be offered to the resident that year. The note revealed the family stated it was the resident's decision. According to the note, the resident declined the influenza and COVID-19 vaccinations, but there was no mention of the pneumococcal vaccination. The note revealed no evidence that education was provided to the resident regarding the vaccinations.During an interview on 08/07/2025 at 11:56 PM, the Assistant Director of Nursing (ADON), who was also the Infection Preventionist, stated influenza vaccinations were offered annually starting in September. She stated that pneumonia vaccinations were offered annually unless the resident received a vaccination in the past five years. She stated the COVID-19 vaccinations were offered on admission or if there was a new booster. The ADON stated if residents refused vaccinations, they would document the refusal in the medical record. The ADON stated the facility educated residents and families on vaccinations. During an interview on 08/07/2025 at 1:00 PM, the ADON stated that Resident #87 was admitted to the facility before she was the Infection Preventionist, so she was not sure why the resident's education for immunizations was not documented in their medical record.