STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366363	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Steubenville The	500 Stanton Boulevard Steubenville, OH 43952

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on observation, record review, interview and facility policy review, the facility failed to ensure Resident #289's catheter bag was covered to ensure privacy. This affected one resident (#289) of three residents reviewed for dignity. The facility identified five residents (#2, #11, #70, #289 and #297) as using catheters in the facility. The facility census was 86. Findings include: Review of the medical record for Resident #289 revealed an admitted [DATE]. Diagnoses included sepsis, muscle weakness, congestive heart failure, atrial fibrillation, sleep apnea, arthritis, kidney failure, and pulmonary fibrosis. Review of the physicians' orders for March 2025 revealed an order for Foley catheter care every shift. Review of the care plan dated 03/13/25 revealed Resident #289 was at risk for urinary tract infection and catheter related trauma. Interventions included changing the catheter and tubing, ensuring the urinary drainage bag was secured properly with the dignity cover in place and ensuring the tubing was secured. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #289 was cognitively intact. He required setup help for eating, supervision for oral and personal care, partial to moderate assistance with toileting and substantial and maximum assistance with showering. He had an indwelling catheter. Observation on 3/17/25 at 11:53 A.M. revealed Resident #289 in bed with the catheter urinary drainage bag attached to the side of the bed. There was no privacy cover on the bag. Resident #289 confirmed he had never seen a cover on the catheter bag. Interview at the time of the observation with Registered Nurse (RN) #1009 confirmed all catheter bags should have a privacy cover, and there was not one on Resident #289's catheter bag. Review of the facility policy titled Indwelling Urinary Catheter (Foley) Care and Management, dated 02/28/25, revealed urinary drainage bags would be concealed with a dignity bag.

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on record review and interview, the facility failed to ensure that advanced directives were consistent within the medical record. This affected two of two residents (#138 and #139) sampled for advanced directives. The facility census was 86. Findings include: 1. Review of Resident #138's medical record revealed an admitted [DATE] and diagnoses including dementia, repeated falls, atrial fibrillation, and moderate protein-calorie malnutrition. Further review revealed Resident #138's admission Minimum Data Set (MDS) assessment was in the process of being completed and an evaluation was completed for the Brief Interview for Mental Status (BIMS) revealing a score of three indicating Resident #138 had severely impaired cognition. Review of Resident #138's medical record revealed an order dated [DATE] and a notation in the information banner, that appears on each screen of the resident's electronic medical record, indicating Resident #138 was a Full Code meaning that if the resident's heart or breathing stopped cardiopulmonary resuscitation (CPR) was to be performed. Further review of Resident #138's medical record revealed a Do Not Resuscitate form dated [DATE] indicating Resident #138 was to have a Do Not Resuscitate Comfort Care (DNRCC) status indicating that if Resident #138's heart or breathing stopped the resident was to be allowed to expire naturally without CPR being performed. In an interview on [DATE] at 1:17 P.M. Regional Nurse #1098 verified the order and banner were not changed when the DNRCC form was signed. In an interview on [DATE] at 8:10 A.M. Licensed Practical Nurse (LPN) #1017 revealed if she was looking to see if a resident was a Full Code or DNRCC she would find the information in the computer banner or in the orders. 2. Review of Resident #139's medical record revealed diagnoses including acute and chronic respiratory failure, morbid obesity, type two diabetes mellitus, protein-calorie malnutrition, chronic obstructive pulmonary disease, atrial fibrillation (irregular heartbeat), hypertensive heart disease with heart failure and chronic pulmonary embolism. Resident #139's face sheet and the area at the top of the computer with code status information indicated Resident #139 was a Full Code. However, Resident #139 had a signed DNRCC order signed dated [DATE]. On [DATE] at 1:01 P.M., Regional Nurse #1098, provided a form dated [DATE] which indicated Resident #139 had determined to change her status to Full Code. Regional Nurse #1098 indicated the form had been in the medical records office waiting to be scanned in. On [DATE] at 8:10 A.M., LPN #197 indicated if she was looking for a resident's code status, she would search the area toward the top of the electronic health record with the code status or look in the code book at the nursing station. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:15 A.M., Registered Nurse (RN) #1100 stated if she needed to locate a resident's code status, she would look at the banner area with the code status. On [DATE] at 12:35 P.M., the Director of Nursing (DON) stated nurses were required to determine code status by looking at the orders. Regional Nurse #1098 indicated the facility also had a code status book nurses could refer to. At 12:36 P.M., the DON verified the information in the code book at the nursing station indicated Resident #139 was a DNRCC. Regional Nurse #1098 indicated they must not have updated the code status book when they clarified Resident #139 was a Full Code. 50538

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 22653 Based on observation, record review and interview, the facility failed to ensure a clean, sanitary environment for a resident with a wound. This affected one resident (#64) of 24 residents' environments which were observed. The facility census was 86. Findings include: Review of Resident #64's medical record revealed diagnoses including depression, emphysema, anemia, and thrombocytopenia. Review of toilet use information between 03/10/25 and 03/16/25 revealed assistance required varied from independent to extensive assistance. On 03/11/25, an order was written to cleanse an abscess to the left gluteal fold with normal saline, apply Aquacel AG with border gauze daily. A skin and wound evaluation dated 03/18/25 revealed Resident #64 had an abscess of the left gluteus measuring 0.9 centimeters (cm) by 0.4 cm. The depth was listed as not applicable. The assessment indicated there was no sign of infection. On 03/17/25 at 4:40 P.M., bowel movement was observed on both sides of the toilet seat. Resident #64 was on contact isolation with the personal protective equipment (PPE) disposed of in the bathroom. The sink for handwashing was also inside Resident #64's bathroom, requiring staff to go into the bathroom to dispose of PPE and perform hand hygiene. On 03/18/25 at 9:45 A.M., Registered Nurse (RN) #1009 verified Resident #64's toilet seat was soiled with bowel movement.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on observation, medical record review, facility policy review and interview, the facility failed to timely address reports of intense itching for one (Resident #60) of three residents reviewed for non-pressure-related skin impairment and failed to make timely notification of indicators of congestive heart failure for one (Resident #60) of 24 residents observed for edema. The facility census was 86. Findings include: Review of Resident #60's medical record revealed diagnoses including congestive heart failure (CHF), type two diabetes mellitus, hypertensive heart disease, peripheral vascular disease, atrial fibrillation, stage four chronic kidney disease, cardiomegaly, non-rheumatic aortic valve disorder, chronic cor pulmonale (right ventricular (RV) enlargement secondary to a lung disorder that causes pulmonary artery hypertension), history of pulmonary embolism, presence of a cardiac pacemaker, atherosclerotic heart disease, localized edema and chronic embolism and thrombosis of deep veins of bilateral distal lower extremities. a. On 02/01/25 an order was written to apply point relief pain relieving gel 12% menthol and 4% methyl salicylate to the right shoulder three times a day. The order indicated the gel could be left at bedside according to the nurse practitioner. On 03/18/25 at 7:30 A.M., Resident #60 stated she had something on her right shoulder, and it itched. Resident #60 stated staff told her it was probably arthritis, and they had been applying pain gel. Resident #60 lifted her shirt sleeve enough to allow observation of her upper right shoulder. A patch of dry skin was observed. Resident #60 stated her right shoulder to her neck was itching. On 03/18/25 between 3:00 P.M. and 3:15 P.M., Registered Nurse (RN) #1006 verified the right shoulder and shoulder blade had dry skin with some of the skin toward the mid/lower shoulder blade flaking. There appeared to be patches of skin which appeared to have scratches. RN #1006 stated Resident #60 had a history of her skin drying out and she believed it was from menthol for the pain gel. RN #1006 stated she would consult with the nurse practitioner regarding the itching and flaking skin. On 03/19/25 at 9:10 A.M., Certified Nursing Assistant (CNA) #1060 stated Resident #60 required substantial assistance to bathe and dress. Resident #60 insisted on getting up early and would not lie back down until after she left at 6:00 P.M. Review of a care plan initiated 08/20/24 revealed Resident #60 had a functional ability deficit and required assistance with self-care/mobility related to weakness, impaired mobility, shortness of breath and right shoulder pain. An intervention initiated 12/09/24 indicated Resident #60 was independent with upper body dressing but partial/moderate assistance with bathing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Review of a care plan initiated 08/20/24 indicated Resident #60 was at risk for cardiac complications related to multiple cardiovascular diseases: hyperlipidemia, hypertension, CHF, and use of a pacemaker. Interventions included observing, documenting and reporting the physician signs or symptoms of cardiac distress as needed, including shortness of breath and dependent edema, observing and reporting to the physician signs of CHF such as dependent edema of legs and feet, shortness of breath upon exertion, weight gain unrelated to intake, and abnormal breath sounds. Another intervention included observing and reporting to the physician edema and changes in weight. Review of a dietary note dated 08/25/24 at 12:40 P.M. revealed a 5.2% weight gain had been noted since a weight on 08/20/24. Meal intakes were primarily 76-100%. No edema was noted. Upon reviewing Resident #60's weight history, weight variances were normal. No shortness of breath was noted. Resident #60 had an order for daily weights. No new recommendations were provided. The dietitian indicated weights would continue to be monitored. Review of a dietary note dated 08/31/24 at 3:54 P.M. indicated Resident #60 had an 8.9% weight gain since 08/20/24. Meal intakes were primarily 76-100% and weight continued to trend up. No edema or shortness of breath was noted. Weight continued to be monitored daily for management of CHF. No new recommendations were made. A weight of 233.2 pounds was recorded. A nursing Situation, Background, Assessment, and Recommendation (SBAR) summary dated 09/18/24 at 9:15 A.M. indicated staff reported edema (new or worsening) and Resident #60's weight of 233.4 pounds but did not indicate it was a significant weight gain. The summary indicated Resident #60 was noted to have increased edema in bilateral lower legs. Resident #60's skin was tight and shiny. No redness or warmth to touch was noted. Resident #60 denied pain or discomfort related to edema but did state her legs feel like concrete, just heavy. Orders were given to start Lasix 40 milligrams (mg) (diuretic) every day, start potassium 10 milliequivalents (supplement) every day and obtain lab work (basic metabolic panel) on 09/23/24. A dietary note dated 10/08/24 at 3:09 P.M. indicated a weight gain of 11.2% was identified since the weight obtained on 08/20/24 and 5% since the weight obtained on 09/24/24. The note indicated staff reported Resident #60 was requesting double portions frequently. Weight continued to be monitored daily. No edema or shortness of breath was noted. A dietary note dated 11/14/24 indicated Resident #60 continued to trigger for a 9.2% weight gain since 08/20/24. Meal intakes were primarily 76-100%. No new recommendations were provided. No edema or shortness of breath were noted. A Nurse Practitioner (NP) note dated 11/19/24 indicated Resident #60 did not appear to be in acute distress. The NP documented Resident #60's weight and indicated there was no shortness of breath or cough. The NP made no acknowledgement of the significant weight gain but did indicate Resident #60's heart failure appeared to be compensated, and Lasix and potassium would continue. A nursing assessment dated [DATE] indicated Resident #60's breath sounds were clear. Edema was noted to both lower extremities. On 11/30/24, an order was written to apply knee high TED (anti-embolism) hose to both lower extremities: apply in the morning and remove in the evening. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note dated 12/05/24 at 12:15 P.M. indicated the NP was notified of a 25.2-pound weight gain since August 2024. No new orders were provided. Continue to monitor. A dietary note dated 12/11/24 at 2:48 P.M. indicated Resident #60 had a 13% weight gain since 08/20/24, up an additional eight pounds since a weight obtained on 11/14/24. Weight continued to be monitored daily for CHF management. No edema or shortness of breath was noted. No new recommendations were given. A dietary note dated 01/09/25 at 1:46 P.M. indicated Resident #60 had an 8.3% weight gain since 10/13/24 and a 15.6% weight gain since 08/20/24. Meal intakes were good, and Resident #60 requested double portions with meals. A nutrition recommendation form dated 01/09/25 indicated weight was being monitored daily for CHF management and was stable. A request was made to determine if weights could be decreased to weekly, and the NP agreed on 01/20/25. A NP note dated 01/28/25 indicated Resident #60 had no edema and no increased dyspnea (shortness of breath). Continue to monitor. Lungs were clear to auscultation. A dietary note dated 02/11/25 revealed a weight gain of 7.6% since 11/12/24 and a 17% weight gain since 08/20/24. Weight was monitored weekly for CHF management. No edema was noted. No new recommendations were provided. A nursing assessment dated [DATE] indicated Resident #60 had edema of both lower extremities. Breath sounds were clear. A dietary note dated 03/14/25 at 11:25 A.M. revealed Resident #60 continued to trigger for a 10.4% weight gain since 09/13/24. Weekly weights continued to be monitored. On 03/17/25 at 11:45 A.M., Resident #60 was observed sitting in a wheelchair with her legs in a dependent position. Anti-embolism hose were observed on bilateral legs with edema noted. Resident #60 indicated she was aware it would be beneficial to elevate her legs for the edema, but she did not desire to lie in bed all day. On 03/18/25 at 1:06 P.M., Resident #60 was in the wheelchair with her feet in a dependent position with her right leg more edematous than the left leg. Resident #60 stated this was baseline for her. When asked if she had shortness of breath, Resident #60 stated she was always short of breath. Regional Nurse #1098, who was present, was interviewed after the observation and addressed the significant weight gain which continued to trigger with only one note indicating the weight gain was addressed with the NP in December 2024, the edema (dependent versus baseline) and the reported shortness of breath. Regional Nurse #1098 indicated she would have Resident #60 assessed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/19/25 at 12:49 P.M., Registered Dietitian (RD) #2000 stated the facility had risk meetings and discussed residents who had significant weight changes. In the past she was told nursing would notify physicians/nurse practitioners of significant weight changes. RD #2000 stated she also provided a monthly report with significant weight changes. Although Resident #60 started with a rapid weight gain it had been slow and steady for a while. RD #2000 stated it was not until October or November of 2024 she found the responsibility of reporting significant weight changes had changed to be her responsibility. The prior Director of Nursing (DON) had informed her it was something she preferred to do. RD #2000 stated she had no risk notes regarding Resident #60 but insisted she had addressed the significant weight gain with the remainder of the team. RD #2000 acknowledged significant weight gain in a resident with a history of heart problems could represent a precursor to significant concerns such as CHF so timely notifications of significant weight gain were important as a resident's medical condition could deteriorate significantly in a short period of time. RD #2000 stated during her assessments nurses indicated there was no edema or signs of distress. Review of the facility's Weight Management policy, revised 09/22/23, indicated the dietary manager, unit manager and/or registered dietitian were responsible for communicating weight changes to the interdisciplinary team, attending physician and the resident's responsible party. The notification was to be documented in the medical record. The dietary manager or dietitian was responsible for providing a monthly summary of weight changes to the DON.

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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** 22653 Based on observation, record review, review of manufacturer information and interview, the facility failed to implement interventions to address identified risk factors for pressure ulcers and failed to implement physician orders for treatment of pressure ulcers. This affected two (Residents #49 and #139) of three residents reviewed for pressure ulcers. The facility census was 86. Findings include: 1. Review of Resident #49's medical record revealed diagnoses including type two diabetes mellitus, quadriplegia, anemia, and peripheral vascular disease. A physician's order dated 01/21/25 gave instructions to cleanse a wound to the right lateral malleolus (the bony prominence on each side of the ankle) with normal saline, pat it dry, and apply CMC fiber dressing (carboxymethylcellulose absorptive dressing for wounds with moderate to heavy exudate) to the wound bed and apply a foam patch every day and as necessary. Review of the weekly wound assessment dated [DATE] revealed Resident #49 had a stage two pressure injury (partial-thickness skin loss with exposed dermis) to the right lateral malleolus that was first identified 12/06/24. The wound measured 1.0 cm by 0.8 cm with 100% epithelial tissue and no drainage. On 03/18/25 at 1:13 P.M., Registered Nurse (RN) #1212 was observed changing the treatment on Resident #49's outer right ankle. The ankle was cleaned with normal saline and patted dry. When RN #1212 started to place the foam dressing on, RN #1002 attempted to intervene stating she believed RN #1212 was missing a step. RN #1212 insisted the order indicated the ulcer was to be cleaned and a dry dressing applied which she proceeded to do. On 03/19/25 at 4:20 P.M., RN #1212 verified she had not applied the CNC fiber dressing to Resident #49's ankle when the dressing was done on 03/18/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #139's medical record revealed diagnoses including acute and chronic respiratory failure with hypoxia, morbid obesity, type two diabetes mellitus, protein-calorie malnutrition, chronic obstructive pulmonary disease, atrial fibrillation, hypertensive heart disease with heart failure, peripheral vascular disease, lymphedema, and congestive heart failure. A nursing assessment dated [DATE] upon readmission indicated Resident #139 had a stage four sacral ulcer (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) with 1.0 cm tunneling (passageways underneath the surface of the skin), a deep tissue injury (intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister) to the outer right ankle, and a black second toe of the left foot. The baseline care plan included with the admission assessment indicated Resident #139 had actual skin breakdown with interventions to observe the location, size and treatment of the skin injury. Report abnormalities, failure to heal, signs/symptoms of infection, and maceration to the physician. A baseline care plan revealed Resident #139 was at risk for impaired skin integrity related to history of impaired skin integrity, pemphigus (autoimmune disorder that causes blisters), impaired bed mobility, incontinence of bowel and bladder, diabetes, obesity, cellulitis of both lower extremities, chronic lymphedema (condition characterized by tissue swelling caused by an accumulation of protein-rich fluid), itching, chronic moisture associated skin damage under the breasts, coronary artery disease, peripheral vascular disease, hammer toes, declining to be assisted with turning and repositioning, and choosing to remain in bed most of the time. Interventions included cueing to reposition as needed. Review of the skin and wound assessments dated 03/13/25 indicated interventions for the treatment and healing of the pressure ulcers included turning/repositioning programs and use of heel boots. A Braden scale dated 03/14/25 indicated risk factors for skin breakdown/development of pressure ulcers included bedfast status, very limited mobility, and a potential problem with friction and shear. On 03/14/25 an order was written for a bariatric bed. On 03/17/25 at 3:45 P.M., Resident #139 was observed sitting in bed with the head of the bed elevated, sitting in a position which would add pressure to the sacrum. On 03/18/25 at 9:00 A.M., Resident #139 was observed lying in bed with the head of the bed elevated up to 30 degrees with Resident #139 lying on her back. At 1:00 P.M., was observed lying on her back. RN #1212 stated Resident #139's sacral ulcer looked better than it did upon admission, and it did not have as much of a smell. RN #1212 stated the mattress utilized by Resident #139 was a regular bariatric mattress. RN #1212 stated Resident #139 usually laid on her back. RN #1212 was unable to state particular interventions which were implemented to reduce the risk factor of bed immobility and pressure, instead stating she was going to request an order for a low air loss mattress. At 2:43 P.M., Resident #139 was observed lying in bed on her back. On 03/19/25 at 8:48 A.M., Resident #139 was observed lying on her back with the head of bed elevated to 45 degrees. On 03/19/25 at 9:10 A.M., Certified Nursing Assistant (CNA) #1060 stated Resident #139 often refused to turn onto her sides. Resident #139 would lie on her back with a sheet over her face. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/19/25 at 1:09 P.M., Resident #139 was lying in bed on her back. CNA #1060 reported Resident #139 was receiving a new mattress. Review of the manufacturer information for the Panacea original and support mattress (mattress observed on when admitted) revealed the top layer provided comfortable pressure redistribution, creating individual load bearing cells that cradled users and improved air flow. Peak and valley middle layers provided suspension-like support while improving immersion on the mattress. The information indicated that the mattress might be appropriate for stage I (non-blanchable redness of intact skin) or stage II (partial thickness loss of skin). Mattresses were one part of an overall care plan to prevent and treat decubitus ulcers. A complete clinical assessment of each individual should be performed before selecting any therapeutic support surface. On 03/19/25 at 3:18 P.M., the Director of Nursing (DON) stated Resident #139 had returned from a long hospital stay. After discussing Resident #139's impaired bed mobility and refusals to reposition, the DON was asked how the facility was addressing those continued risk factors. The DON stated Resident #139 had returned to the facility on the evening of 03/13/25 and was placed on the same bariatric mattress she had used prior to hospitalization . The DON stated it took time to order and receive air mattresses. When residents were being readmitted , it was the responsibility of the marketing director to review referral information to determine if there was any change in equipment or supply needs. On 03/20/25 at 8:05 A.M., the Administrator provided the hospital referral information which indicated Resident #139 had an unstageable pressure ulcer with necrotic (dead) tissue on the sacrum. The Administrator also provided the purchase order for the air mattress dated 03/18/25. The Administrator stated the facility's interdisciplinary team would have been meeting to discuss Resident #139 the week of 03/17/25 after her readmission.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51519 Based on observation, record review, staff interview and facility policy review, the facility failed to ensure Resident #21, who was incontinent of bladder, received appropriate treatment and services to prevent urinary tract infections (UTI) and failed to ensure Resident #21, who was incontinent of bowel, received appropriate treatment and services to restore as much normal bowel function as possible. This affected one resident (#21) of one resident reviewed for bowel and bladder incontinence and UTI. The facility census was 86. Findings include: Record review revealed Resident #21 was admitted to the facility on [DATE] with diagnoses including congestive heart failure (CHF), chronic respiratory failure, type two diabetes mellitus, malnutrition, neuropathy, asthma, chronic obstructive pulmonary disorder (COPD), muscle weakness, antibiotic resistance, depression, and pacemaker. Review of the Minimum Data Set (MDS) assessment completed on 12/01/24 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating Resident #21 was cognitively intact. Resident #21 required set up or clean up assistance for meals and oral hygiene, substantial/maximal assistance for toileting hygiene, adjusting clothing before and after voiding or bowel movement (BM), substantial/maximal assistance showering or bathing, partial/moderate assistance for upper and lower body dressing and putting on and taking off footwear. Resident #21 was frequently incontinent of urine (now has a Foley catheter as of January 2025) always incontinent of bowel and had constipation present. Resident #21 was on antidepressants and diuretics. A. Record review revealed an order for a urinalysis (UA) and urine culture & sensitivity (C&S) on 01/17/25 for Resident #21 completed on 01/17/25 with results dated 01/21/25 of UA collected on 01/17/25 for 4+ leukocytes, >50 white blood cells, and trace bacteria. Culture results revealed on 01/23/25 record review revealed urine culture contained klebsiella. Record review revealed an order placed on 01/23/25 to flush Resident #21 Foley catheter as needed for patency. There was no documentation of Resident #21's Foley catheter placement date. Record review revealed an order placed 02/11/25 for a urine C&S for Resident #21 completed on 02/11/25. Record review revealed results from 02/11/25 UA/C&S revealed >50 white blood cells (WBC), trace bacteria with urine culture resulting in klebsiella and enterococcus faecalis. Record review revealed Resident #21 had a urinalysis ordered on 03/03/25 with results of a small number of leukocytes, six to ten white blood cells, and a trace number of bacteria. The C&S came back on 03/06/25 for heavy Escherichia coli (ESCCOL) and heavy Klebsiella (KLEB-ESBL). Record Review revealed no documented evidence of Foley catheter care being completed for Resident #21 for any day in 2025. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/17/25 at 11:16 A.M. reveled Resident #21 in enhanced barrier precautions (EBP) in bed in his room with an indwelling Foley catheter present. The indwelling Foley catheter drainage bag and tubing were lying on the floor to the right side of Resident #21's bed. Interview on 03/17/25 at11:45 A.M. with Certified Nurse's Aide (CNA) #1036 revealed the Foley catheter drainage bag should be hooked onto the bed and not lying on the floor. CNA #1036 confirmed the drainage bag was on the floor at this time, applied gloves and placed the tubing and drainage bag off the floor by hooking the drainage bag to the side of the bed below the bladder. Interview on 03/17/25 at 2:06 P.M. with Regional Nurse #1098 revealed the facility was to follow the Lippincott procedures for Foley catheter care and management. Interview on 03/19/25 at 8:15 A.M. with CNA #1030 revealed he was not sure how long Resident #21 has had his Foley catheter. CNA #1030 stated he was unable to locate where to chart Resident #21's Foley catheter care on Point Click Care (PCC) (electronic medical record) and it was usually in the tasks section. CNA ##1030 directed the surveyor to Registered Nurse (RN) #1002 for clarification on documentation of Foley catheter care for Resident #21. Interview on 03/19/25 at 08:19 A.M. with CNA #1048 revealed Resident #21 has had his foley for a few months. CNA #1048 stated aides are to complete Foley care with checks and changes, if the resident does not need changed at checks, then at least once a shift Foley care needs completed. Interview on 03/19/25 at 8:20 A.M. with CNA #1039 revealed Resident #21 had the Foley catheter in for at least a month or more but was not sure an exact date or exactly how long he has had it in. Interview on 03/19/25 8:24 A.M. with CNA #1060 revealed Resident #21 has had the Foley catheter in for a little while. Resident #21 had the Foley catheter when he was on the opposite side of the building in a different room when he was in isolation but does not remember when he was on the other side. Interview on 03/19/25 at 8:27 A.M. with Registered Nurse (RN) #1002 revealed Resident #21 had the foley catheter placed in January of 2025 after his UTI when urology gave the order to place the catheter, urology has since said to keep the catheter due to retention. RN #1002 stated Foley catheter care was to be completed along with checks and changes and at least once per shift. RN #1002 stated after Foley catheter care was completed, it was to be documented under the specific task in PCC. RN #1002 stated she was unable to locate the documentation or task in Resident #21's medical record. RN #1002 stated the task of Foley catheter care had not been activated in Resident #21's record which should be activated as soon as a resident received placement of an indwelling catheter. RN #1002 verified there was no documented evidence of Resident #21 receiving Foley catheter care since having the Foley catheter placed. Review of the undated Lippincott procedure for urinary Foley catheter care and maintenance revealed catheter drainage bag should be kept off the floor to reduce the risk of contamination and subsequent Catheter Associated Urinary Tract Infection (CAUTI). Review of the policy for Catheter Associated Urinary Tract Infection (CAUTI) prevention, dated 12/01/12 effective 01/28/25, revealed the catheter should be secured properly to prevent movement, the urinary collection bag and tubing should be kept off the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Record review of Resident #21's task for toilet use and continence revealed no documented evidence of a bowel movement (BM) from 02/18/25 through 02/22/25 totaling five days with no BM. Record review of Resident #21's task for toilet use and continence revealed no documentation of a BM from 02/24/25 through 03/04/25 totaling nine days with no BM. Record review of Resident #21's task for toilet use and continence revealed no documentation of a BM from 0 3/15/25 through 03/19/25 totaling five days with no BM. Record review of Resident #21's current medications revealed an order placed on 02/24/25 for tramadol HCl Oral Tablet 50 milligram (mg) (opioid pain medication) give 50 mg by mouth every 12 hours as needed for pain. Record review of Resident #21's care plan completed 10/23/23 revealed Resident #21 was at risk for constipation related to decreased mobility and medication side effects. Goals included Resident #21 will have a BM at least every three days. Interventions include administering medications as ordered and observing for ineffectiveness and side effects, reporting abnormal findings to the physician. Educate resident to notify staff of each BM if toileting self, encourage resident to sit on toilet to evacuate bowels if possible, observe for signs and symptoms of constipation: such as change in color or consistency of bowel movement, difficulty in expulsion, confusion, agitation, bradycardia, abdominal distention/tenderness/guarding/rigidity, vomiting, decreased/absent bowel sounds, diaphoresis, report abnormal findings to the physician, provide one assist to the bathroom with toileting as needed, and record BM pattern after each occurrence describing amount and consistency. Review of Resident #21's medication administration record (MAR) and treatment administration record (TAR) revealed no documentation of interventions being implemented or ordered relating to constipation on 02/18/25 through 02/22/22/25, 02/24/25 through 03/04/25, and 03/15/25 through 03/19/25. Record review of Resident #21's progress notes revealed no documentation of notification to the physician relating to absence of BMs for Resident #21 for the dates of 02/18/25 through 02/22/25, 02/24/25 through 03/04/25, and 03/15/25 through 03/19/25. Record review of Resident #21's care plan completed 01/24/25 revealed Resident #21 was at risk for UTI and catheter related trauma due to having an indwelling urinary catheter. Goals include Resident #21 will show no signs or symptoms (s/sx) of UTI through the next review date and catheter will remain patent and without complications. Interventions include ensuring catheter tubing is secured and ensuring the drainage bag is secured properly. Interventions include providing catheter care per policy. Interview on 03/19/25 at 1:17 P.M. RN #1005 revealed that there were no standing orders to follow if a resident hasn't had a BM. RN #1005 stated the policy was after three days with no BM, you are to implement interventions or reach out to the physician and get orders on what to do next to assist the resident. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/19/25 at 1:20 P.M. with Licensed Practical Nurse (LPN) #1003 revealed PCC will alert staff if the resident hasn't had a BM after three days. The unit manager then makes up a list of those who have had no BM that was available at the nurse's station for all to review. This list was updated daily first thing in the morning. It was the expectation that the nurses or aides follow up with the residents to see if they have had a BM that the staff may not be aware of. If the residents had had no BM in the last three days, nurses were to reach out to the physician and receive orders on what the plan is. LPN #1003 stated this was the expectation and procedure across the facility. LPN #1003 if the resident refused any treatment, it should be documented in the medial record. Interview on 03/19/25 at 1:32 P.M. with RN #1001 revealed that the Director of Nursing (DON) prints a bowel list every morning of all residents who have not had a BM in three days. Each nurse received a list of those residents. Throughout the day, staff will ask residents on the list when their last BM was. If it has been more than three days since their last BM, they will check if the resident has any standing orders, and if they do not, nurses were to reach out to the physician to receive orders. If a resident refused treatment, it should be documents. Interview on 03/20/25 at 10:32 A.M. CNA #1029 revealed Resident#21 does not go to the toilet in the room, he stayed in bed and does not like to get out of it. Resident #21 was always incontinent of bowel and was completely dependent on being cleaned and changed. Resident #21 at times can tell staff when he had a BM, but majority of the time, he needed checked, and then you find he needs changed. CNA #1029 stated Resident #21 gets checked every two hours. After a resident has a BM, they were to document it in the resident record.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on observation, record review, interview and facility policy review, the facility failed to ensure oxygen was administered as ordered by the physician for Resident #289 and failed to ensure oxygen tubing was dated when changed for Residents #289 and #292. This affected two residents (#289 and #292) of three residents reviewed for oxygen administration. The facility identified 18 residents (#1, #3, #15, #16, #21, #34, #44, #62, #70, #71, #139, #235, #284, #285, #289, #292, #295 and #297) who utilized oxygen. The facility census was 86. Findings include: 1. Review of the medical record for Resident #289 revealed an admitted [DATE]. Diagnoses included sepsis, muscle weakness, congestive heart failure, atrial fibrillation, sleep apnea, arthritis, kidney failure and pulmonary fibrosis. Review of the care plan dated 03/13/25 revealed Resident #289 had difficulty breathing and was at risk for respiratory complications. Interventions included observing for difficulty breathing. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #289 was cognitively intact. He required setup help for eating, supervision for oral and personal care, partial to moderate assistance with toileting and substantial and maximum assistance with showering. He had an indwelling catheter. Review of the physicians' orders for March 2025 revealed an order oxygen at two liters per minute continuously. Observation on 3/17/25 at 10:53 A.M. revealed Resident #289 was wearing his oxygen. The oxygen tank was set at three liters per minute, and there was no date on the oxygen tubing. Resident #289 was unsure how many liters of oxygen he should be receiving and could not confirm if or when the tubing on his oxygen had been changed. Interview at the time of the observation with Registered Nurse (RN) #1009 confirmed Resident #289's oxygen was set at three liters and there was no date on his oxygen tubing. She was unsure what the correct setting for Resident #289's oxygen should be. 2. Review of the medical record for Resident #292 revealed an admitted [DATE]. Diagnoses included kidney failure, heart disease, diabetes, shortness of breath, anxiety and vitamin D deficiency. Review of the care plan dated 03/11/25 revealed Resident #292 had difficulty breathing and was at risk for respiratory complications. Interventions included avoiding extreme temperatures, offering frequent periods of rest, observing for signs of difficulty breathing and obtaining labs as ordered. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #292 was cognitively intact. He required setup help for eating, supervision for oral care, partial to moderate assistance for personal hygiene and was dependent on staff for toileting and showering. He was on oxygen. Review of the physician's orders for March 2025 revealed an order oxygen at two liters per minute continuously. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/17/25 at 10:04 A.M. revealed Resident #292 was wearing his oxygen. There was no date evident on the oxygen tubing, and Resident #292 could not verify when the tubing had last been changed. Interview at the time of the observation with Licensed Practical Nurse (LPN) #1003 confirmed all tubing should be changed on Tuesday night and all should currently be dated 03/12/25. She confirmed there was no date on the oxygen tubing for Resident #292. Review of the facility policy titled Use of Oxygen, dated 02/28/25, revealed oxygen masks and tubing should be changed weekly, when soiled or dirty and dated.

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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** 45441 Based on record review, interview and facility policy review, the facility failed to ensure pre and post dialysis assessments were consistently completed for Resident #66. This affected one resident (#66) of one resident reviewed for hemodialysis services. The facility census was 86. Findings include: Review of the medical record for Resident #66 revealed an admitted [DATE]. Diagnoses included urinary tract infection, kidney disease, muscle weakness and diabetes. Review of the care plan dated 02/04/25 revealed Resident #66 had a need for dialysis due to end stage kidney disease. Interventions included dialysis Tuesday, Thursday and Saturday, administering medications as ordered, observing for side effects and ineffectiveness of medications, checking and reinforcing the dressing at the access site as needed, and utilizing the dialysis communication form to communicate with the dialysis center. Upon return from the dialysis center the communication book would be reviewed and any updates provided to the physician as needed. Review of the comprehensive Minimum Date Set (MDS) assessment dated [DATE] revealed Resident #66 was moderately cognitively impaired. He required setup help for eating, partial to moderate assistance for oral and personal hygiene in substantial or maximum assistance for toileting and showering. He was on dialysis. Review of the physician's orders for March 2025 revealed an order for dialysis every Tuesday, Thursday and Saturday. Review of the pre and post dialysis assessment forms dated 02/06/25 through 03/15/25 revealed pre and post dialysis weights, assessments of the condition of the shunt or access site, mental status and recommended medication changes were not completed consistently. Interview on 03/20/25 at 12:26 P.M. with Licensed Practical Nurse (LPN) #1003 confirmed the nurse on duty was expected to complete the pre dialysis form prior to the resident's departure and ensure dialysis had completed their portion of the form upon the resident's return. She was aware the pre and post dialysis assessments had not been completed thoroughly and had no other documented evidence to verify pre and post dialysis assessments had been completed for Resident #66. Review of the facility policy titled Hemodialysis, dated 03/05/25, revealed residents should be evaluated daily for dialysis access sites and possible complications including but not limited to signs and symptoms of infection or bleeding. The facility would complete the appropriate section of the hemodialysis communication form prior to the resident receiving dialysis and again when the resident returned.

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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** 45441 Based on record review, interview and facility policy review, the facility failed to ensure parameters were in place for the administration of pain medication and failed to ensure nonpharmacological interventions were attempted prior to administering narcotic pain medication to Resident #3. In addition, the facility failed to ensure insulin was given according to the physician's orders for Resident #21. This affected two residents (#3 and #21) of five resident reviewed for unnecessary medications. The facility census was 86. Findings include: 1. Review of the medical record for Resident #3 revealed and admitted [DATE]. Diagnoses included depression, bronchitis, history of stroke and failure to thrive. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was severely cognitively impaired. She required setup help for eating, partial to moderate assistance for oral hygiene, substantial to maximum assistance for showering and dressing and was completely dependent on staff for toileting needs. Review of Resident #3's physician's orders for March 2025 revealed an order dated 02/27/25 for Tylenol 325 milligrams (mg) give two tablets by mouth every six hours as needed for fever and an order dated 02/27/25 for Tramadol (narcotic pain medication) 50 mg every eight hours as needed (prn) for moderate and severe pain. Review of the medication administration record (MAR) for March 2025 revealed Resident #3 received Tramadol one time on 03/01/25 a pain level of three, one time on 03/02/25 for a pain level of four, one time on 03/06/25 for a pain level of five, one time on 03/10/25 for a pain level of six and one time on 03/15/25 for a pain level of five, all marked effective. Interview with the Director of Nursing (DON) on 03/20/25 at 10:23 A.M. revealed nurses were expected to call the physician if nonpharmacological interventions for pain did not work, and the patient was still reporting pain or only had controlled pain medicine ordered. She confirmed if a resident was unable to assess their pain using a traditional zero to ten pain scale with ten being the worst, nurses were expected to judge based on nonverbal expressions; she confirmed there was no clear scale to identify when to administer medications. She confirmed there was no documented evidence that the physician had ever been contacted for alternative means of pain medication management for Resident #3 and no documented evidence that nonpharmacological pain management was attempted prior to the administration of narcotic pain medication. Review of the facility policy titled Pain Management, dated 04/11/23, revealed the facility would complete a comprehensive pain assessment, determine the intensity of pain and notify the physician as needed. 51519 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review revealed Resident #21 admitted to the facility on [DATE] with diagnoses including congestive heart failure (CHF), chronic respiratory failure, type two diabetes mellitus, malnutrition, neuropathy, asthma, chronic obstructive pulmonary disorder (COPD), muscle weakness, antibiotic resistance, depression, pacemaker. Record review revealed an order placed on 11/11/24 for insulin apart flex pen subcutaneous solution pen injector 100 units per milliliter (mL). Inject 8 units subcutaneously in the evening for diabetes mellitus. Review of Resident #21 medical record revealed MDS assessment completed on 12/01/24 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating Resident #21 was cognitively intact. Resident #21 required setup or clean up assistance for meals and oral hygiene, substantial/maximal assistance for toileting hygiene, adjusting clothing before and after voiding or bowel movement (BM), showering or bathing, and partial/moderate assistance for upper and lower body and putting on and taking off shoes. Review of Resident #21 care plan initiated 09/06/22, revised 02/26/25 revealed Resident #21 was at risk for fluctuation in blood sugar levels related to diabetes mellitus, medication side effects, and requiring daily insulin. Goals included Resident #21 would be free of signs and symptoms of hypoglycemia or hyperglycemia. Interventions included administering medications as ordered, observing and reporting abnormal findings to the physician. Record review revealed an order placed on 03/03/25 for insulin glargine solution 100 units per mL. Inject 25 units subcutaneously one time a day for diabetes. Hold if blood sugar is less than 150 and notify the medical doctor (MD) if blood sugar is greater than 500. Inject 50 units subcutaneously at bedtime for diabetes. Hold if blood sugar is less than 150, and notify the MD if BS is above 500. Review of the medical record revealed on 03/07/25 documentation on Resident #21's MAR revealed Resident #21's blood sugar was 75 at 10:17 A.M., and 25 units of insulin glargine was administered by Licensed Practical Nurse (LPN) #1022 at 9:00 A.M. Review of the medical record revealed on 03/07/25 documentation on Resident #21's MAR revealed Resident #21's blood sugar was 133 at 5:28 P.M., and 50 units of insulin glargine was administered by LPN #1022 at 5:00 P.M. Review of the medical record revealed on 03/11/25 documentation on Resident #21's MAR revealed Resident #21's blood sugar was 78 at 8:17 A.M., and 25 units of insulin glargine was administered by LPN #1025 9:00 A.M. Review of the medical record revealed on 03/14/25 documentation on Resident #21's MAR revealed Resident #21's blood sugar was 75 at 6:57 A.M., and 25 units of insulin glargine was administered by LPN #1022 at 09:00 A.M. Review of the medical record revealed on 03/15/25 documentation on Resident #21's MAR revealed Resident #21's blood sugar was 100 at 8:30 A.M., and 25 units of insulin glargine was administered by LPN #1013 at 9:00 A.M. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed on 03/15/25 documentation on Resident #21's MAR revealed Resident #21's blood sugar was 101 at 4:46 P.M., and 50 units of insulin glargine was administered by LPN #1022 at 5:00 P.M. Review of documentation of Resident #21's MAR revealed Resident #21's blood sugar was 61 on 03/16/25 at 9:05 A.M. Resident #21's blood sugar was re-checked at 4:52 P.M. and was 74. There was no documented evidence that interventions were implemented for the blood sugar of 61 per the facility policy. Interview on 03/19/25 at 2:46 P.M. with the DON confirmed Resident #21's blood sugar was below 150 on above dates and insulin was administered. Insulin was not given as ordered and was given outside of parameter. The DON stated the MD should have been notified and the insulin should have been held. Review of the facility policy titled Diabetic Management, originating 03/01/13 effective 09/22/23, revealed anti-diabetic agents (insulin or oral anti diabetic agents) are administered per the physician order. If blood glucose is below 70 interventions are implemented, and blood glucose is to be re-checked 15-30 minutes after interventions. Review of the facility policy titled Medication Administration, originating 03/01/13 effective 10/17/23, revealed resident medications are administered in an accurate, safe, and timely manner in accordance with written orders of the attending physician. If a dose is inconsistent with the residents age, condition, or diagnosis contact the physician for clarification prior to administration of the medication.

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	366363	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Steubenville The	500 Stanton Boulevard Steubenville, OH 43952

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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 - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on record review, observation, interview and facility policy review, the facility failed to ensure over the counter medication had clearly labeled expiration dates. This was identified in two of four medication carts and had the potential to affect 18 residents (Residents #1, #9, #12, #25, #32, #37, #39, #47, #52, #54, #55, #59, #71, #73, #184, #285, #293, #296) of 24 residents with orders for aspirin 81 milligrams (mg). In addition, the facility failed to ensure medications were secured for Residents #289 and #292. This affected two residents (#289 and #292) of three residents reviewed for medication storage. The facility census was 86. Findings include: 1. On 03/17/25 at 9:27 A.M., RN #1006 was observed preparing and administering medication to Resident #59. One tablet of 81 mg aspirin was prepared and administered. The aspirin bottle had no expiration date. RN #1006 verified she was unable to find an expiration date during the preparation but administered the medication anyway. On 03/19/25 at 8:10 A.M., RN #1005 was observed preparing medication for administration to Resident #293. A bottle of enteric coated aspirin 81 mg was handed to the surveyor for review after it was withdrawn from the drawer. The expiration date on the bottle of aspirin was illegible. RN #1005 retrieved a new bottle of enteric coated aspirin after she inquired what the surveyor was looking for, and verified she was unable to read the expiration date either. The facility identified the following additional residents with orders for enteric coated aspirin (or orders for aspirin which did not designate if it was enteric coated or chewable) from the two involved carts: Residents #1, #9, #12, #25, #32, #37, #39, #47, #52, #54, #55, #71, #73, #184, #285, #296. Review of the pharmacy Storage and Expiration Dating of Medications and Biologicals policy, revised 08/01/24, revealed the facility should destroy and reorder medications and biologicals with illegible, worn labels. 45441 2. Review of the medical record for Resident #289 revealed an admitted [DATE]. Diagnoses included sepsis, muscle weakness, congestive heart failure, atrial fibrillation, sleep apnea, arthritis, kidney failure and pulmonary fibrosis. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #289 was cognitively intact. He required setup help for eating, supervision for oral and personal care, partial to moderate assistance with toileting and substantial and maximum assistance with showering. He had an indwelling catheter. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 03/17/25 at 10:53 A.M. with Resident #289 revealed Bengay (a topical analgesic cream used for temporary relief of minor muscle and joint pain) lying on the bedside table. Resident #289 revealed the facility was aware he had the Bengay in his possession. Licensed Practical Nurse (LPN) #1009 confirmed Resident #289 did not have an order to self-administer medication, and the Bengay should not have been left at his bedside. Review of the facility policy titled Storage and Expiration Dating of Medications and Biologicals, dated 08/01/24, revealed the facility would ensure all medications, including treatment items, were securely locked in a cabinet, cart or medication room that was not accessible to residents or visitors. 3. Review of the medical record for Resident #292 revealed an admitted [DATE]. Diagnoses included kidney failure, heart disease, diabetes, shortness of breath, anxiety and vitamin D deficiency. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #292 was cognitively intact. He required setup help for eating, supervision for oral care, partial to moderate assistance for personal hygiene and was dependent on staff for toileting and showering. Observation and interview on 03/17/25 at 10:14 A.M. with Resident #292 revealed Resident #292 was self-administering allergy eye drops. A bottle of saline nasal spray was also observed at the bedside. Interview with Registered Nurse (RN) #1003 confirmed medication should not be left at the bedside. All medications were to be administered by facility staff and secured in a medication cart or medication storage room. An interview with Resident #292's wife confirmed she had brought the medication in for the resident last week. Review of the facility policy titled Storage and Expiration Dating of Medications and Biologicals, dated 08/01/24, revealed the facility would ensure all medications, including treatment items, were securely locked in a cabinet, cart or medication room that was not accessible to residents or visitors.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on review of the medial record and interview with staff, the facility failed to ensure a physician's order was written for laboratory tests obtained and laboratory tests were obtained immediately (STAT) as ordered by the physician for Resident #2. This affected one resident (#2) of five residents reviewed for antibiotic stewardship. The facility census was 86. Findings include: Review of the medical record revealed Resident #2 was admitted to the facility on [DATE]. Diagnoses included urinary tract infection, cerebral infarction, diabetes, moderate protein-calorie malnutrition, epilepsy, abdominal aortic aneurysm, kidney failure, hemiplegia left side, myocardial infarction, obstructive and reflux uropathy, hypertensive heart disease, chronic pain syndrome, presences of cerebrospinal fluid device, and nontraumatic subarachnoid hemorrhage. Review of the Nurse's Note dated 02/05/25 at 11:31 A.M. revealed the Nurse Practitioner (NP) was called because Resident #2 was acting lethargic, with very little verbal interaction. Resident #2's vital signs were taken, documented and told to the NP. The NP ordered a STAT urine, completed blood count (CBC), and a complete metabolic panel (CMP). The NP was also advised that the resident had refused her pill that morning and her blood sugar was 114 in the morning and 88 for lunch. Review of the Nurse's Notes dated 02/06/25 at 11:34 A.M. revealed a follow-up of Resident #2's condition yesterday. She was sitting up in the common area in a chair. The resident had no complaints. She was alert, oriented and responded to questions. Her urine was obtained and sent to the laboratory last night and they were waiting for the results of urine. The physician and daughter were notified. Review of the laboratory order form dated 02/06/25 revealed the laboratory specimens, CMP, CBC, urinalysis were collected from the facility on 02/06/25 at 4:23 A.M. Review of the laboratory results dated [DATE] revealed Resident#2 had 60,000 to 70,000 colony forming units of enterococcus faecalis bacteria indication the resident had a urinary tract infection. Review of the February 2025 physician's orders revealed Resident #2 had an order for Augmentin 875-125 milligrams (mg) (antibiotic) twice a day for seven days dated 02/09/25. Further review of the physician orders revealed no order was placed in the medical record for the NP's orders for STAT urinalysis, urine culture and sensitivity, CBC, or CMP. On 03/19/25 at 3:14 P.M. an interview with the Director of Nursing (DON) revealed the laboratory had taken up to four hours to pick up a STAT lab. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/19/25 at 4:30 P.M. an interview with the DON confirmed the laboratory took too long to pick up the STAT urine culture for Resident#2. She verified there was no order written for laboratory work to be done on 2/05/25. She does not know why it was not written. She had the form where they picked up the urine culture in the early morning of 02/06/25, but she does not know the exact time they were in the facility. The facility did not have a laboratory services policy.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on review of the medical record, interview with staff, review of information from the PneumoRecs Vax Advisor application and facility policy review, the facility failed to ensure the pneumonia vaccine was up to date for Resident #19. This affected one resident (#19) of five residents reviewed for vaccination status. The facility census was 86. Findings include: Review of the medical record revealed Resident #19 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, acute respiratory failure, epilepsy, chronic kidney disease, and shortness of breath. Review of the immunizations revealed Resident #19 had the pneumococcal polysaccharide vaccine 23 (PPSV23) pneumonia vaccine on 11/19/23. Review of the PneumoRecs Vax Advisor application revealed if a resident over [AGE] years of age had the PPSV23 and no other pneumonia vaccine they should be administered the Pneumonia conjugate vaccine 15 (PCV) or PCV20 after one year of administration of the PPSV23. On 03/20/25 at 8:42 A.M. an interview with the Director of Nursing (DON) confirmed Resident #19 was not up to date with her pneumonia vaccines. Review of the facility policy titled, Pneumococcal Vaccination (PPV) of Residents, dated 03/27/23, revealed the Advisory Committee of Immunization Practices (ACIP) recommends vaccination persona at high risk for serious complications from pneumococcal pneumonia, including those [AGE] years and older and all residents of nursing homes. Each resident's pneumococcal immunization status would be determined upon admission or soon afterward and would be documented in the resident medical record. If a resident over [AGE] years of age had the PPSV23 and no other pneumonia vaccine they should be administered the Pneumonia conjugate vaccine 15 (PCV) or PCV20 after one year of administration of the PPSV23.