STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366400	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beavercreek Health and Rehab	3854 Park Overlooke Drive Beavercreek, OH 45431

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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** 25908 Based on observation, record review, and staff interviews, the facility failed to treat all residents with dignity and respect. This affected two (#28, and #29) of three residents reviewed for dignity. The facility census was 70. Findings Include: 1) Review of Resident #28's medical record revealed an admitted [DATE]. Diagnoses included dysphasia, atrial fibrillation, and hemiplegia. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #28 was severely cognitively impaired and required substantial assistance with eating. Observation of Resident #28 on 09/23/24 at 11:30 A.M., revealed he was in the dining room/lounge area with other residents and the afternoon meal was being served by the staff. All the other residents were served their lunch, and they were eating with the exception of Resident #28. Resident #28 continued to face the other residents as they were eating, including another resident seated at the same table. At 12:10 P.M., Resident #28 still wasn't served his lunch and continued to face other residents while they were eating. All the other residents finished eating and were leaving the dining room while Resident #28 remained in the dining room without being served a lunch. Interview with State tested Nursing Assistant (STNA) #362 on 09/23/24 at 12:15 P. M., revealed Resident #28 needed assistance to eat his meal. STNA #362 verified Resident #28 wasn't served lunch at the same as the other residents. Interview with Resident #28 at 12:20 P.M. revealed he was hungry, and the food smelled good. Observation at 12:25 P.M., revealed Resident #28 received his tray after STNA #362 asked for it. The resident ate 75 percent of his meal. 44070 2) Review of the medical record for Resident #29 revealed an admitted [DATE]. Diagnoses included osteomyelitis, chronic pulmonary disease, diabetes, emphysema, dysphagia and failure to thrive. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's order dated 09/20/24 revealed Resident #29 had a catheter with instructions for catheter care daily. Observation on 09/23/24 at 10:24 A.M. revealed Resident #29's foley catheter bag was full of urine, visible form the hallway and without a proper dignity cover in place. Interview on 09/23/24 at 10:46 A.M. with STNA #324 verified the facility had privacy covers for the foley catheter bags and Resident #29 did not have one in place. Interview on 09/23/24 at 4:38 P.M. with Administrator and Director of Nursing (DON) verified Resident #29's foley catheter bag was uncovered and visible from the hallway. Review of the facility policy titled Dignity dated 02/21 revealed residents were to provided with a dignified and respect. This deficiency represents non-compliance investigated under Complaint Number OH00157658.

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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 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** 42731 Based on medical record review, staff interview, and policy review, the facility failed to ensure accuracy of code status in the medical record. This affected three (#29, #32, and #58) of nineteen residents reviewed for advanced directives. This had the potential to affect all 70 residents in the facility. Findings include: 1) Review of the medical record of Resident #58 revealed an admitted [DATE]. Diagnoses included metabolic encephalopathy, alcoholic cirrhosis of liver, respiratory failure, chronic obstructive pulmonary disease (COPD), anxiety, depression, obsessive-compulsive disorder (OCD), and hypertension. Review of the Do Not Resuscitate (DNR) order form located in the paper (hard) chart dated 09/28/23 for Resident #58, revealed the resident was to be a DNR-Comfort Care-Arrest (CCA). Review of the physician orders in the electronic medical record (EMR) for Resident #58 revealed an order dated 10/05/23 for the resident to be a Full Code. Interview on 09/23/24 at 3:45 P.M., Licensed Practical Nurse (LPN) #319, verified Resident #58's code status differed between the EMR and the signed DNR order form in the paper (hard) chart. LPN #319 further stated, when checking a code status, she would most likely refer to the EMR to check a resident's code status. 2) Review of the medical record of Resident #32 revealed an admitted [DATE]. Diagnoses included chronic atrial fibrillation, major depressive disorder, paranoid schizophrenia, mild cognitive impairment, nondisplaced fracture of middle phalanx of right middle finger, essential hypertension, epilepsy, hyperlipidemia, anxiety, human immunodeficiency virus (HIV), gastro-esophageal reflux disease, and irritable bowel syndrome. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #32 had impaired cognition. Review of the DNR order form located in the paper (hard) chart dated 01/12/24 revealed Resident #32 was to be a DNR-Comfort Care (CC) Review of the physician orders in the EMR for Resident #32, revealed an order dated 01/15/24 for the resident to be a full code. Interview on 09/24/24 at 10:27 A.M. LPN #319, verified the EMR status did not match the code status in the paper (hard) chart. 44070 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) Review of the medical record for Resident #29 revealed an admitted [DATE]. Diagnoses included osteomyelitis, chronic pulmonary disease, diabetes, emphysema, dysphagia and failure to thrive. Review of the physician orders in the EMR dated 09/20/24 for Resident #29 revealed a code status of DNR-CC. Review of an undated DNR signed physician form in the paper (hard) chart revealed Resident #29 had DNR-CC-A on file. Interview on 09/25/24 at 9:34 A.M. with Director of Nursing (DON) verified Resident #29's code status was mismatched in medical record with the documents and orders saying both DNRCC and DNR-CC-A. Review of the facility policy titled, Advance Directives, dated 09/2022, revealed the residents' advance directive wishes would be communicated to the resident's direct care staff and physician by placing the advance directive documents in a prominent, accessible location in the medical record.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on observations, staff interview and record review, the facility failed to ensure residents had to a safe, clean, comfortable and homelike environment. This affected one (#18) resident of one reviewed for physical environment. The facility census was 70. Findings include Review of the medical record for Resident #18 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), diabetes, dysphagia, heart failure, unspecified psychosis, respiratory failure and morbid obesity. Observation on 09/23/24 at 1:18 P.M., revealed Resident #18 had a large hole in the drywall behind her bed. Resident had a bariatric bed and a board affixed to the wall behind her bed to protect the drywall from damage from the bed. On the right side of the board was damage to the drywall with estimated size of about six inches by 18 inches. Interview on 09/26/24 at 12:50 P.M. with Maintenance Director (MD) #364, verified damage to the drywall. MD #364 revealed he had not been informed of the damage. MD #364 stated the damage was significant enough where a patch would not work and to do a repair, he would need to order drywall and cut out a large section and replace it. Review of facility policy, Homelike Environment, dated 02/2021 revealed resident shall be provided a safe clean comfortable and homelike environment. Facility shall maintain a clean and orderly environment.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on resident interviews, staff interviews, and record review, facility failed to document and follow up on resident concerns from the resident council meetings. This affected seven (#09, #19, #26, #30, #56, #62, and #221) residents who participated in resident council. The facility census was 70. Findings include 1) Review of the medical record for Resident #09 revealed an admitted [DATE]. Resident #09 was cognitively intact. 2) Review of the medical record for Resident #19 revealed an admitted [DATE]. Resident #19 was cognitively intact. 3) Review of the medical record for Resident #26 revealed an admitted [DATE]. Resident #26 was cognitively intact. 4) Review of the medical record for Resident #30 revealed an admitted [DATE]. Resident #30 was cognitively intact. 5) Review of the medical record for Resident #56 revealed an admitted [DATE]. Resident #56 was cognitively intact. 6) Review of the medical record for Resident #62 revealed an admitted [DATE]. Resident #62 had mild cognitive impairment. 7) Review of the medical record for Resident #221 revealed an admitted [DATE]. Resident #221 was cognitively intact. Review of Resident Council meeting minutes dated 08/30/23 revealed resident concerns related to dietary snacks, meat varieties, nursing call lights, showers, night shift concerns and housekeeping concerns. The facility provided no documented evidence of what was discussed including concerns brought up by the residents and plans to address concerns. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the correlating concern forms dated 08/30/23 revealed the State tested Nursing Assistants (STNAs) were not giving snacks out at night. The action taken section of the form was left blank. Another concern form dated 08/30/23 revealed call lights were taking a long time on night shift. The response indicated the Administrator, the Director of Nursing (DON) and Assistant DON (ADON) reviewed times and completed random audits. The action taken section of the form was left blank. Another concern form dated 08/30/23 revealed showers were not being done and the STNAs were saying the residents refused when they did not. A response indicated DON and ADON reviewed the shower sheets and noted the STNAs should be completing shower sheets and nurse signs the sheet, then the DON and ADON verify the sheets were complete. The action taken section of the form was left blank. Another concern from dated 08/30/23 revealed the residents wanted more snack varieties for evening snacks and more deli meat varieties with the additional snacks ordered. The action taken section of the form was left blank. Review of Resident Council meeting minutes dated 09/27/23 revealed resident concerns related to dietary (no specifics documented), nursing, snack and drink pass concerns. The facility provided no documented evidence of what was discussed including concerns brought up by residents and plans to address concerns. Review of Resident Council meeting minutes dated 10/17/23 revealed resident concerns related to nursing, tray pass and pick up concerns. It was documented on the form; education would be provided to staff. There was no documented evidence, of any resolution being completed. Review of Resident Council meeting minutes dated 11/22/23 revealed resident concerns related to nursing, snack and drink pass concerns on night shift. Staff education and audits would be completed. There was no documented evidence of any resolutions being completed. Review of Resident Council meeting minutes dated 12/20/23 revealed resident concerns related to showers not being done, call lights and snack and drink pass concerns as well as dietary concerns of snack and drink pass issues. The minutes revealed staff education would be completed for the concerns. There was no documented evidence of any resolutions being completed. Review of Resident Council meeting minutes dated 01/31/24 revealed resident concerns related to passing out snacks and drinks at night and more check-ins throughout the night. The facility provided no documented evidence of what was discussed including concerns brought up by the residents and plans to address concerns. Review of a correlating concern form dated 01/31/24 revealed issues with snack and drink pass on nights and residents reported not getting offered snacks or drinks with response that nurse was assigned to snacks at night and audits would be put in place. The action taken section of the form revealed the Interdisciplinary Team (IDT) was informed of the customer service and snacks were to be offered. There was no documented evidence provided by the facility that indicated the actions were followed up on. Another concern form dated 01/31/24 revealed the residents felt they needed to be checked on more throughout the night. A response indicated that audits would be put in place. The action taken section of the form revealed nursing and aides were given education on customer service and check and changes. There was no documented evidence provided by the facility of the audits and the education being completed. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident Council meeting minutes dated 02/28/24 revealed resident concerns related to passing out snacks and drinks at night. The facility provided no documented evidence of what was discussed including concerns brought up by the residents and plans to address concerns. Correct Review of Resident Council meeting minutes dated 03/27/24 revealed resident concerns related to nursing with no specific, menu, activity, and maintenance. The facility provided no documented evidence of what was discussed including concerns brought up by the residents and plans to address concerns. Review of Resident Council meeting minutes dated 04/24/24 revealed resident concerns related to nursing, menu, activities, and maintenance. The facility provided no documented evidence of what was discussed including concerns brought up by the residents and plans to address concerns. Review of Resident Council meeting minutes dated 05/29/24 revealed resident concerns related to nursing, menu, activities, and maintenance. The facility provided no documented evidence of what was discussed including concerns brought up by the residents and plans to address concerns. Review of a correlating concern form dated 05/29/24 revealed concerns about aides being on their phones when providing resident care. A response indicated education would be provided to the aides about cellphone usage and policy. There was no documented evidence provided by the facility of the education being completed. Review of Resident Council meeting minutes dated 06/26/24 revealed resident concerns related to nursing, menu, activities, and maintenance. The facility provided no documented evidence of what was discussed including concerns brought up by the residents and plans to address concerns. Review of Resident Council meeting minutes dated 07/30/24 revealed resident concerns related to nursing, menu, activities, and maintenance. The facility provided no documented evidence of what was discussed including concerns brought up by the residents and plans to address concerns. Review of Resident Council meeting minutes dated 08/28/24 revealed resident concerns related to nursing, menus, activities, and maintenance. The facility provided no documented evidence of what was discussed including concerns brought up by the residents and plans to address concerns. Interviews on 09/26/24 from 9:25 A.M. to 9:40 A.M. with Residents #09, #19, #26, #30, #56, #62, and #221 revealed the facility does not follow up timely on concerns brought up by the residents. The residents revealed some of the same things were brought up every meeting including snacks and drinks being passed out at night, showers not being done, call lights timeliness and food palatability concerns. The residents indicated the staff take very detailed notes at each meeting; however, they don't get to see the meeting notes. The residents stated that when they review the previous month's council minutes, they are very general and do not go into much detail about the concerns brought up in the previous meeting and doesn't mention what the facility did to address those concerns. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/26/24 at 10:30 A.M. with the Administrator Activity Director (AD) #311 revealed AD #311 takes detailed notes on the concerns brought up during the Resident Council meetings. AD #311 stated the notes were not put in the meeting minutes as she was told not to by management. AD #311 verified the Residents are still making complaints of snack and drink pass, tray pass, call lights, showers and staffing and revealed those are consistent brought up at most meetings. AD #311 verified these concerns were not documented in the Resident Council minutes from 03/2024 to 08/2024. AD #311 verified there was no follow-up documented in the Resident Council meeting notes; however, any issues brought up had concern forms completed and sent to the managers for follow-up. AD #311 and the Administrator acknowledged facility should have evidence and documentation of the concerns being addressed that are brought up by the residents. Interview on 09/26/24 around 12:30 P.M. with Regional Director of Operations (RDO) #400 and the Administrator revealed they looked through files and could only find forms for 08/2023, 01/2024 and 05/2024. RDO #400 confirmed the facility was unable to locate any additional concern forms for 09/2024, 10/2023, 11/2023, 12/2023, 02/2024, 03/2024, 04/2024, 06/2024, 07/2024, and 08/2024 and their resolutions. RDO #400 also verified the facility was unable provide documented evidence of the follow ups, the education and the audits noted on the for. Review of facility policy titled Resident and Family Grievances, dated 09/29/22 revealed the facility shall provide prompt efforts to resolve and include facility acknowledgement for a complaint or grievance and actively work toward a resolution of the complaint or grievance. Facility shall take immediate actions needed to prevent further potential violations of residents rights and record information about the concern and actions taken.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on record review, staff interview, and policy review, the facility failed to ensure residents were provided with notification indicating the reason for transfer upon a transfer to the hospital. This affected three (#21, #43, and #56) residents of the four residents reviewed for hospitalization . The facility census was 70. Finding included: 1) Review of the medical record for Resident #43 revealed an admitted [DATE]. Diagnoses included osteomyelitis of vertebra, heart failure, cellulitis, kidney failure, and edema. Review of Resident #43's admission census record revealed the resident was hospitalized from 01/25/24 to 03/13/24, again from 04/13/24 to 05/06/24 and 08/13/24 to 08/14/24. Further record review found no documented evidence of Resident #43 nor Resident #43's representative being provided with a notification for reason of transfer for any of these three hospitalization s. 2) Review of the medical record for Resident #56 revealed an admitted [DATE]. Diagnoses included cerebral palsy, diabetes, encephalitis, heart failure, and paraplegia. Review of Resident #56's census record revealed the resident was hospitalized from 07/26/24 to 07/29/24. Further record review found no documented evidence of Resident #56 being provided with a notification for reason of transfer for hospitalization from [DATE] to 07/29/24. Interview on 09/25/24 at 4:40 P.M. with Regional Director of Operations (RDO) #400 revealed the facility was unable to find any documented evidence of Residents' (#43 and #56) nor their representatives being provided with a notification for reason of transfer to the hospital. 42731 3). Review of the medical record of Resident #21 revealed an admitted [DATE]. Diagnoses included acute respiratory failure with hypercapnia, severe sepsis, acute and chronic respiratory failure, multiple sclerosis, moderate protein-calorie malnutrition, traumatic subcutaneous emphysema, gastro-esophageal reflux disease, depression, hypertension, myasthenia gravis, pulmonary embolism, congestive heart failure, epilepsy, dysphagia. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 had moderately impaired cognition. Review of the medical record revealed Resident #21 was transferred to the hospital on 08/13/24 and readmitted to the facility on [DATE]. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical record revealed no documented evidence of Resident #21 nor the resident's representative being notified of the reason for transfer to the hospital in writing prior to the hospitalization . Interview on 09/26/24 at 4:20 P.M., Business Office Manager (BOM) #334 verified Resident #21 nor the resident's representative were not notified in writing of the reason for discharge to the hospital prior to the hospitalization . Review of the facility policy titled, Transfer or Discharge, Facility Initiated, dated 10/2022, revealed a notice of transfer would be issued as soon as practicable before the transfer.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on record review and staff interview, facility failed to ensure residents were provided with bed hold notification upon a transfer to the hospital. This affected three (#21, #43, and #56) residents of four residents reviewed for hospitalization . The facility census was 70. Finding included: 1) Review of the medical record for Resident #43 revealed an admitted [DATE]. Diagnoses included osteomyelitis of vertebra, heart failure, cellulitis, kidney failure, and edema. Review of Resident #43's census record revealed the resident was hospitalized from 01/25/24 to 03/13/24 and again from 04/13/24 to 05/06/24. Review of a Bed Hold Notice dated 03/13/2/4 revealed Resident #43 was hospitalized from 01/25/24 to 03/13/24. The form was provided to the resident on the date of discharge from the hospital and therefore was not provided timely and upon admission to the hospital. Review of a Bed Hold Notice dated 05/06/24 revealed Resident #43 was hospitalized from 04/13/24 to 05/06/24. The form was provided to the resident on the date of discharge from the hospital and therefore was not provided timely and upon admission to the hospital. 2) Review of the medical record for Resident #56 revealed an admitted [DATE]. Diagnoses included cerebral palsy, diabetes, encephalitis, heart failure, and paraplegia. Review of Resident #56 census record revealed the resident was hospitalized from 07/26/24 to 07/29/24. Review of the Bed Hold Notice dated 07/29/24 revealed Resident #56 was hospitalized from 07/26/24 to 07/29/24. The form was provided to the resident on the date of discharge from the hospital and therefore was not provided timely and upon admission to the hospital. It was noted to have been delivered to the resident on 07/29/24. Interview on 09/26/24 at 11:28 A.M. with Director of Nursing (DON), verified the dates on the bed hold notices for Residents (#43 and #56) which included the entire hospital stay. The DON also verified the bed hold notice forms were given to Residents (#43 and #56) after the hospital stay ended. 42731 3) Review of the medical record of Resident #21 revealed an admitted [DATE]. Diagnoses included acute respiratory failure with hypercapnia, severe sepsis, acute and chronic respiratory failure, multiple sclerosis, moderate protein-calorie malnutrition, traumatic subcutaneous emphysema, gastro-esophageal reflux disease, depression, hypertension, myasthenia gravis, pulmonary embolism, congestive heart failure, epilepsy, dysphagia. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beavercreek Health and Rehab	3854 Park Overlooke Drive Beavercreek, OH 45431

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 had moderately impaired cognition. Review of the medical record revealed Resident #21 was transferred to the hospital on 08/13/24 and readmitted to the facility on [DATE]. Review of the Bed Hold Notice revealed Resident #21 had eight bed hold days remaining, which included the hospitalization dated 08/13/24 through 08/28/24. The form was signed and dated 08/29/24. Interview on 09/26/24 at 4:20 P.M., Business Office Manager (BOM) #334 verified bed hold notices were issued following the hospital stay instead of at the time the residents were sent to the hospital. Review of the facility policy titled, Transfer or Discharge, Facility Initiated, dated 10/2022, revealed notice of facility bed hold and return policies are provided to the resident and representative within 24 hours of emergency transfer.

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on record review, staff interview, and review of hospital records, the facility failed to allow a resident to return to the facility timely following a hospital stay. This affected one (#43) of four residents reviewed for hospitalization . The facility census was 70. Finding included: Review of the medical record for Resident #43 revealed an admitted [DATE]. Diagnoses included osteomyelitis of vertebra, heart failure, cellulitis, kidney failure, and edema. Review of Resident #43 census revealed the resident was hospitalized from 08/13/24 to 08/14/24. Review of a nurse's progress note for Resident #43 dated 08/13/24 at 4:49 P.M., revealed the resident was sent to hospital for critical laboratory findings (labs) per the Nurse Practitioner (NP). Review of a nurse's progress note for Resident #43 dated 08/14/24 at 10:57 A.M. revealed the resident returned home from the hospital with a new order for Levaquin 500 milligrams (mg) once daily for seven days for urinary tract infection (UTI) and Pneumonia. Review of medical record found no evidence of discussions with hospital staff on resident stabilization or concern of return back to the facility and no evidence to support any concerns. Review of an emergency room (ER) discharge note dated 08/13/24 at 5:16 P.M., revealed Resident #43 was diagnosed with a catheter associated UTI and multifocal pneumonia with a plan to discharge back to the facility on an antibiotic and follow up with primary care physician. The physician's note revealed the resident was admitted to the ER with a chief complaint of abnormal labs per the facility. The ER completed various tests including labs and found the resident's white blood cell (WBC) count to be 20.6 (elevated) and blood urea nitrogen (BUN) of 102 (elevated). The physical exam indicated the resident appeared to be at baseline. Resident #43 was given fluids for likely dehydration. Resident #43 had no fever and borderline tachycardia. The suspicion of dehydration should be addressed with fluids and there was a low suspicion of acute kidney injury (AKI) as the resident currently had creatinine of 2.0 (elevated); however, they were improved levels. Resident #43 appeared to have a UTI from the urinalysis and multifocal pneumonia and was started on Levaquin intravenous (IV) antibiotics. The results were discussed with the resident and was comfortable discharging the resident. The resident should follow up with their primary physician to ensure infection and dehydration were improving. Review of an ER note dated 08/13/24 at 8:00 P.M. authored by an ER nurse, revealed she contacted the facility and spoke with the Director of Nursing (DON) who informed the ER that they could not accept the resident back because she was too critical for our care. The ER staff spoke with the ER Physician who reported they had no reason to admit the resident and she was stable for discharge back to the facility and the ER staff should continue with the plan for discharge. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an ER note dated 08/13/24 at 8:33 P.M. authored by an ER nurse revealed she spoke with the DON at the facility who informed her the resident could not return because of her labs. The ER nurse spoke with the ER physician who explained that the resident received IV fluid and IV antibiotics and would need to continue antibiotics at facility then have follow up labs completed. The ER physician reported the resident was appropriate for nursing facility level of care. Review of ER note dated 08/13/24 at 8:45 P.M. authored by an ER nurse revealed she attempted to call a report, and the nurse reported it was unnecessary as the facility would refuse for resident to return and send her back to the hospital immediately. Review of ER note dated 08/13/24 at 8:52 P.M. authored by an ER nurse, revealed the resident's discharge instructions were explained, and the resident was discharged in stable condition back to her nursing facility by a stretcher transport. Review of ER note dated 08/13/24 at 9:26 P.M. authored by an ER nurse, revealed Resident #43 arrived back to at the ER after being discharged to the facility an hour ago and. The staff at the facility declined to accept the resident stating the resident was unstable and needed to remain at the hospital. Review of ER note dated 08/13/24 at 9:30 P.M. authored by an ER nurse , revealed he spoke with the facility staff and the resident was sent back to the ER due to the facility refusing to accept the resident back. ER nurse spoke with the facility nurse who stated the DON instructed her to refuse the resident due to being unstable. The ER nurse requested to speak with the DON to clarify the resident's condition and stability concerns and was informed the DON would not speak with ER nurse. The ER nurse was told the facility's Physician informed the staff to refuse the resident and to stop taking calls from hospital regarding this resident. The resident was visibly upset upon return. Review of ER note dated 08/13/24 at 9:36 P.M. authored by the ER physician, revealed Resident #43 was diagnosed with a catheter associated UTI and multifocal pneumonia with a plan to discharge back to the facility on an antibiotic. The ER Physician note revealed the resident was refused at her nursing facility and was sent back without any explanation. Multiple conversations with nursing facility revealed the resident had no new or different symptoms or complaints. The resident denied any new symptoms. Review of ER note dated 08/13/24 at 10:00 P.M. authored by ER nurse revealed the resident was visibly upset and crying stating I want to go back, I belong there. Review of ER note dated 08/13/24 at 10:30 P.M. authored by ER nurse, revealed two messages were sent to facility physician to have a physician-to-physician conversation about the resident's discharge. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of ER note dated 08/14/24 at 7:10 A.M. authored by ER nurse, revealed Facility Physician #450 contacted the ER to discuss why the resident was refused to return to facility the previous night. The ER nurse indicated the facility nurse deemed the resident was unstable although the ER physician reported the resident was stable and could be discharged . Physician #450 was asked if he had evaluated the resident as per previous conversation with facility's DON, since the physician had been the one to refuse the resident's return. Physician #450 stated he spoke with the DON and was informed of the resident's condition. ER Nurse noted the facility stopped taking calls from the ER staff to discuss the resident's stability, Facility Physician #450 stated he would speak with the DON and would get an update. Interview with LPN #315 on 09/25/24 at 3:57 P.M., revealed she was the nurse working the night shift on 08/13/24 when the resident returned from the hospital and was sent back to the ER from the front entrance of the facility. LPN #315 stated she did not know the resident's condition when she left for the hospital, and revealed the DON had talked with the hospital throughout the evening and ultimately declined the resident to return to the facility. LPN #315 stated the Physician had been reviewing the labs from the hospital and had been in contact with DON. LPN #315 stated she spoke with ambulance transport staff, but the DON was on the phone with them at that time as well and informed them the facility was refusing the resident and instructed them to return her to the hospital. LPN #315 indicated Resident #43 was not brought back into the facility. LPN #315 stated the resident was not assessed and also stated the DON and Physician #450 were not present when the resident returned to the facility on evening of 08/13/24. Interview with Regional Director of Operations (RDO) #400 on 09/25/24 at 4:40 P.M. revealed he spoke with the staff about the incident involving Resident #43 and was under the impression the hospital staff would not respond to the calls from the facility. RDO #490 verified facility had no documentation to support communication or reasoning for refusing to allow Resident #43 to return to the facility following the ER visit on 08/13/24. RDO #400 stated he would have allowed the resident to be brought in, assessed her, and if any concerns arose, then resend her back to the hospital instead of refusing her at the facility entrance. RDO #400 verified the facility physician, and the DON were not at the facility when Resident #43 returned the first time and Resident #43 was not reassessed before being returned to the hospital. Interview with Facility Physician #450 on 09/26/24 at 8:48 A.M. revealed he received one call from the DON about not wanting to accept Resident #43 back following the ER visit on 08/13/24. Physician #450 stated the DON informed him of the resident's labs and stated she had talked with hospital staff and felt the resident was unstable. Physician #450 stated the resident's BUN level was slightly elevated from her baseline and thought she would get fluids and be kept overnight. Physician #450 stated he had a message from the hospital nurse manager from late in the evening about Resident #43 being refused at the entrance of the facility and was sent back to the hospital due to the facility refusing to accept the resident. Physician #450 stated the on-duty nurse, nor the DON had contacted him at any point after the initial conversation. Physician #450 stated the resident had stabilized and was able to return in the morning after speaking with the DON. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Transfer of discharge date d 10/2022, revealed if the facility determined a resident cannot return to the facility, the medical record shall indicate the facility made efforts to determine if resident still required services of the facility and was eligible for skilled services and ascertain an accurate status if the resident's condition which can be accomplished via communication between the hospital and facility staff and or through visits by staff to the hospital and work with the hospital to ensure the resident's condition and needs are within the facility's scope of care. This deficiency represents non-compliance investigated under Complaint Number OH00156858.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 42731 Based on observation, staff interview, and policy review, the facility failed to ensure dairy products were served at the appropriate temperature. This had the potential to affect 68 residents in the facility. The facility identified two residents (#08 and #21) who did not receive food from the kitchen. The facility census was 70. Findings include: Observation on 09/25/34 at 8:06 A.M. of the dining area on the facility's Red unit revealed fifteen trays lined up on the counter. Each tray contained a meal ticket, silverware, insulating covers, and a carton of milk. Observation on 09/25/24 at 8:25 A.M. revealed dietary staff started trayline, plating food and placing it in the insulated covers. Continued observation revealed nine trays were placed on a cart and delivered to the residents by the staff. Further observation revealed dietary staff placed an additional four trays on a cart for delivery. Observation on 09/25/24 at 8:41 A.M. revealed the milk on the tray of Resident #23 was 46.6 degrees Fahrenheit. Interview at the same time, Dietary Aid (DA) #349 verified the milk on Resident #23's tray was 46. 6 degrees Fahrenheit. DA #349 stated she did not know what temperature at which the milk should be served. Continued observation on 09/25/24 at 8:42 A.M. revealed DA #349 replaced the milk cartons on the tray of Resident #23 and trays after that; however, the four trays already on the cart received the same milk that was already on the trays during the initial observation at 8:06 A.M. Observation on 09/25/24 beginning at 8:45 A.M. revealed the four trays which had the original milk were delivered to the resident's rooms. Interview on 09/25/24 at 8:54 A.M., Dietary Manager (DM) #345 stated the milk should be maintained at 41 degrees Fahrenheit or less. DM #345 stated the milk was placed in the freezer 30 minutes prior to being brought to the unit. Interview on 09/25/24 at 9:07 A.M. DA #349 verified she did not switch the milk on the four trays that were already on the cart following identifying the milk temped at 46.6 degrees Fahrenheit. Interview on 09/25/24 at 9:22 A.M., Resident #58 stated the milk she received at breakfast could have been a little colder. Review of the facility policy titled, Assistance with Meals, dated 03/2022, revealed cold foods should be held at 41 degrees or below until served.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731 Based on medical record review, observation, resident interview, staff interview, and policy review, the facility failed to ensure residents were provided adaptive equipment as ordered. This affected one (#55) of one resident reviewed for adaptive equipment. The facility identified ten residents who utilized adaptive equipment. The facility census was 70. Findings include: Review of the medical record of Resident #55 revealed an admitted [DATE]. Diagnoses included dementia and oropharyngeal dysphagia. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #55 had severely impaired cognition. Review of the Speech-Language Pathology (SLP) discharge summary, dated 03/05/24, revealed Resident #55 utilized a provale cup for safe intake of thin liquids and was assessed as independent with the use of the provale cup. Review of a physician order for Resident #55 revealed an order dated 03/12/24 for a regular, dysphagia mechanical soft diet with regular liquid consistency and a provale cup. Review of the plan of care dated 06/19/24 revealed Resident #55 had a physical functioning deficit related to impaired mobility and impaired cognition. Interventions included to provide a provale cup. Observation on 09/25/24 at 9:04 A.M., Resident #55 had a brown-handled provale cup on her tray; however, there was no lid for the cup observed. The cup was observed with remnants of orange juice, which had already been consumed. Further observation revealed Resident #55's meal ticket indicated the resident should have a 10 cubic centimeters (CC) provale cup (brown). Interview at the time of the observation, Resident #55 stated she was not provided with the lid for her provale cup. Interview on 09/25/24 at 9:05 A.M., Dietary Manager (DM) #345 verified Resident #55's provale cup did not have a lid. DM #345 stated the resident did not like to use the lid, so they typically do not provide it. DM #345 was observed attempting to locate the lid for the provale cup in the dietary service area and was unable to locate it. DM #345 verified adaptive equipment should be provided if it is listed on the meal ticket. Review of the facility policy titled, Assistance with Meals, dated 03/2022, revealed adaptive devices, including specialized cups, would be provided for residents who need them.

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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. 42731 Based on observation, staff interview, and policy review, the facility failed to ensure food was stored and prepared in a manner to prevent against the potential spread of foodborne illness. This had the potential to affect 68 residents in the facility. The facility identified two residents (#08 and #21) who did not receive food from the kitchen. The facility census was 70. Findings include: 1) Observation on 09/23/24 at approximately 8:20 A.M. of the facility's walk-in cooler revealed gray and white speckled areas throughout the eight wire shelves and several plastic milk crates. Further observation revealed a puddle of brown liquid, measuring approximately two feet by two feet, on the floor below a box of potatoes, which was positioned on the lowest shelf of a wire rack. A large box of cucumbers was observed on the top shelf of the rack and was leaking onto the shelves below and into the box of potatoes. Interview at the same time, Dietary Staff (DS) #306 stated the gray and white speckled areas throughout the cooler were mold and stated it had just started. DS #306 verified the cooler continued to be utilized to store food. DS #306 further verified liquid from the cucumbers was leaking into the potatoes and caused a subsequent puddle on the floor of the cooler. Interview on 09/23/24 at approximately 8:25 A.M., Dietary Manager (DM) #345 stated the walk-in cooler had just been cleaned and she was told the gray and white speckled areas were coming from a dirty fan. Review of the undated document titled, Timeline for Walk-in, revealed the Maintenance Director (MD) #364 cleaned the fan on 08/27/24. Interview on 09/25/24 at 2:53 P.M., MD #364 stated he was asked to clean the fan of the walk-in cooler and stated he vacuumed off the blades and cleaned the cover to the fan blades at that time. 2) Observation on 09/23/24 at 8:15 A.M. of the walk-in freezer, revealed two boxes of vegetable protein loafs which were open and not sealed, exposing the food to air. Interview at the same time, DS #306 verified the two boxes of vegetable protein loafs were not sealed and open to air. 3) Observation on 09/23/24 at approximately 8:30 A.M. revealed the hood vents were coated in a dark gray fuzzy substance. Further observation revealed a dark gray fuzzy substance coating and dangling from the sprinklers underneath the hood, above the stove. A sticker on the hood indicated the hood was last cleaned 05/2024. Interview at the same time, DS #306 verified the hood vents and sprinklers were coated in a dark gray fuzzy substance. Review of the facility policy titled, Basic Food Storage, undated, revealed food storage areas would be kept clean and free of spills and leaks. Review of the facility policy titled, Food Service, undated, revealed the facility would store, prepare, distribute and serve food under sanitary conditions.