STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366403	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bath Creek Estates	186 West Bath Road Cuyahoga Falls, OH 44223

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observations, interviews, record review, and review of facility policy, the facility failed to ensure emergency call devices/call lights were within reach of Resident #12, #16, #20, #23 and #64. This affected five residents (#12, #16, #20, #23, #64,) out of seven residents reviewed for emergency call devices within reach. The facility census was 94. Findings include: 1. Review of the medical record for Resident #20 revealed an admitted [DATE] with diagnoses including unspecified fall, wedge compression fracture of fifth lumbar vertebra, history of falling, severe protein calorie malnutrition, chronic obstructive pulmonary disease (COPD), osteolysis , and secondary malignant neoplasm (cancer) of bone. Review of the admission Minimum Data Set (MDS) 3.0 assessment, dated 03/06/25, revealed Resident #20 was moderately impaired cognitively, was dependent on staff for activities of daily living and for all mobility, and was frequently incontinent of bowel and bladder. The resident had a fall in the last month prior to admission, had a fracture related to a fall in the six months prior to admission, but had no falls since admission. Review of the facility document titled John Hopkins Fall Risk, dated 02/28/25, revealed Resident #20 was a moderate fall risk. Further review of Resident #20's medical record revealed an admission progress note, dated 02/28/25 which indicated the resident was at an advanced age, was very fragile, had very thin skin, and was admitted with bruises at both knees from a fall prior to admission. Review of the nurse practitioner note, dated 03/03/25, revealed Resident #20 was alert and frail. Review of the care plan, created on 02/28/25, revealed Resident #20 was at risk for falls related to COPD, weakness, glaucoma, and use of oxygen tubing. Interventions included bed in lowest position, and keep familiar objects/commonly used items within reach. Observation on 03/11/25 at 9:00 A.M. revealed Resident #20 was in bed and her emergency call device (call light) was observed out of reach as the call device was observed sitting on the bedside table. At the time of observation, Resident #20 stated she was unable to reach the call light. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/11/25 at 9:02 A.M. with Assistant Director of Nursing (ADON) #360 confirmed the call light was out of reach and proceeded to place the call light within reach of Resident #20. 2. Review of the medical record for Resident #16 revealed an admitted [DATE] with diagnoses including altered mental status, Alzheimer's disease, age related osteoporosis without current pathological fracture, unspecified mood disorder, and other abnormalities of gait and mobility. Review of the 03/12/25 admission MDS 3.0 assessment for Resident #16 revealed it was in progress. Review of the Brief Interview for Mental Status (BIMS) 2023, dated 03/06/25, revealed Resident #16 was severely impaired cognitively. Review of section GG supportive documentation tool, dated 03/10/25, revealed Resident #16 required partial/moderate assistance from staff for eating, oral and personal hygiene, and to sit to stand; substantial/max assistance for toileting hygiene, shower/bathe self, dressing and putting on footwear, and transfers. Walking ten feet was not attempted during the assessment reference period, and the resident was dependent on staff for wheelchair maneuverability. Review of the care plan dated 03/05/25 revealed Resident #16 was at risk for falls related to Alzheimer's, mood disorder, and communication deficit. Interventions included ensure resident was wearing nonskid footwear, bed in lowest position, and keep familiar objects/commonly used items within reach. Observation on 03/11/25 at 9:06 A.M. revealed Resident #16 was observed sleeping in bed with her head elevated and the emergency call device was on the floor under Resident #16's head of the bed. Interview on 03/11/25 at 9:07 A.M. with Environmental Services Manager (ESM) #406 confirmed the call light was not in reach for Resident #16. 3. Review of the medical record for Resident #12 revealed an admitted [DATE] with diagnoses including cerebral infarction, localization related symptomatic epilepsy and epileptic syndromes with complex partial seizures, anemia, vitamin D deficiency, hemiplegia and hemiparesis following cerebral infarction, COPD), and complete traumatic amputation of lower leg. Review of the annual MDS 3.0 assessment, dated 02/06/25, revealed Resident #12 was cognitively intact, was dependent on staff for most activities of daily living and for mobility, had an indwelling catheter and was always incontinent of bowel, and had no falls since previous assessment. Review of the facility document titled John Hopkins Fall Risk assessments dated 05/11/24, 08/04/24, and 11/06/24 revealed the resident was moderate fall risk. Review of the care plan, created on 07/07/23, revealed Resident #12 was at risk for falling related to weakness, impaired mobility, and antidepressant medication. Interventions included positioning pillow to help him determine edge of bed, low bed when occupied, keep personal items and frequently used items within reach, and keep call light in reach at all times. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/11/25 at 9:26 A.M. revealed Resident #12 was sitting up in his bed. His emergency call devise was on the floor near the base of his overbed table. Interview with Resident #12 at the time of observation revealed he was unable to reach his emergency call device. Interview on 03/11/25 at 9:30 A.M. with Registered Nurse (RN) #354 confirmed Resident #12's emergency call device was out of reach. 4. Review of the medical record for Resident #64 revealed an admitted [DATE] with diagnoses including unspecified intellectual disabilities, other seizures, mild protein calorie malnutrition, and insomnia. Review of the admission MDS 3.0 assessment, dated 02/19/25, revealed the resident was moderately impaired cognitively, required supervision from staff for oral hygiene and dressing, substantial/maximum assistance from staff for shower/bathe self and sit to lying, and was dependent on staff for toileting hygiene and sit to stand. Transfers and walking had not been attempted during the assessment reference period, and the resident was always incontinent of bowel and bladder. The resident hadn't had a fall since admission, however, the resident had a fall in the last two to six months and had a fracture related to a fall in the last six months. Review of the facility document titled John Hopkins Fall Risk assessment, dated 02/13/25, revealed Resident #64 was a moderate fall risk. Review of the care plan dated 12/11/24 revealed Resident #64 was at risk for falls related to right ankle fracture, seizures, incontinence, debility, and cognitive deficits. Interventions included encourage resident to wear non-skid footwear when out of bed, encourage bed to be in low position, provide toileting assistance as needed/per routine, and keep familiar objects/commonly used items within reach. Observation on 03/11/25 at 9:28 A.M. revealed Resident #64 was sitting in her wheelchair next to her bed with her back wheels in front of her bedside table and the resident was facing away from bedside table. The emergency call device was observed wrapped around the position bar on the left side of her head of bed, which was beside the back wheel of Resident #64's wheelchair and was out of reach of the resident. Interview with Resident #64 at the time of observation revealed the resident voiced she was unable to reach the call light. Interview on 03/11/25 at 9:31 A.M. with RN #354 confirmed Resident #64's emergency call device was out of reach of the resident. 5. Review of the medical record for Resident #23 revealed an admitted [DATE] with diagnoses including severe protein calorie malnutrition, end stage renal disease, chronic obstructive pulmonary disease, dementia, muscle weakness, anemia, cerebral infarction, anorexia, unsteadiness on feet, and bipolar disorder. Review of the annual MDS 3.0 assessment, dated 03/01/25, revealed Resident #23 was severely impaired cognitive, rejected care one to three days of the assessment reference period, and was dependent on staff for most activities of daily living and required substantial/maximum assistance from staff for mobility. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility document titled John Hopkins Fall Risk assessments for Resident #23 revealed on 09/30/24 resident was at moderate fall risk and on 03/13/25 the resident had increased to a high fall risk. Review of the facility incident log revealed Resident #23 had a fall on 10/25/24. Review of the facility's fall investigation material revealed Resident #23 had been found on the floor next to his low bed on 10/25/24 at 3:50 A.M. The resident was assessed to have no injuries and was unable to say what happened. The resident was wearing nonskid footwear and current fall interventions had been in place. The resident had no injuries. Review of the care plan, created on 07/07/23, revealed Resident #23 was at risk for falling related to weakness, refusal of care, episodes of incontinence, medication use, history of shortness of breath secondary to COPD. Interventions included position pillows when in bed; mat to floor at bedside; dycem (polymer nonslip material) to recliner; dycem to wheelchair cushion above and below; keep personal items and frequently used items within reach; keep bed in lowest position with brakes locked; and keep call light in reach at all times. Observation on 03/12/25 at 8:18 A.M. revealed Resident #23 was awake in his bed, which was in low position and a mat was observed on the ground next to the bed. The resident's call light was not in reach with the soft touch emergency call device observed sitting on top of the mini refrigerator sitting next to his low bed. Interview at the time of observation with Certified Nursing Assistant (CNA) #320 confirmed the emergency call device was on top of the mini refrigerator and was not in reach of the resident. Review of the facility policy titled Resident Communication System and Call Light Policy, revised on 06/30/17, revealed when the resident is in bed or in a chair, be sure the call light is within easy reach. This deficiency represents non-compliance investigated under Complaint Number OH00162087 and OH00161805.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of facility policy, the facility failed to ensure Resident #94 was provided incontinence care according to physician order and to maintain good hygiene for skin integrity. This affected one resident (Resident #94) out of three residents reviewed for incontinence. The facility census was 94. Findings include: Review of Resident #94's medical record revealed an admitted [DATE] and diagnoses included heart failure, Parkinson's Disease, and dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. Review of Resident #94's physician orders dated 10/26/23 revealed Resident #94 was to be checked and changed every two hours as tolerated every shift. Review of Resident #94's care plan dated 05/21/24 included Resident #94 was incontinent of bowel and bladder related to debility and dementia, and Resident #94 would not exhibit skin breakdown. Interventions included to report signs of skin breakdown or perianal excoriation, use barrier cream with each brief change, use brief to enhance dignity and check and change every two to three hours and as needed. Review of Resident #94's annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #94 was rarely or never understood. Resident #94 did not reject care during the seven-day assessment look-back period. Resident #94 was dependent for toileting hygiene, personal hygiene and upper and lower body dressing. Resident #94 was always incontinent of urine and bowel. Resident #94 did not have open lesions, skin tears, or Moisture Associated Skin Damage (MASD). Review of Resident #94's progress notes dated 02/10/25 through 03/12/25 did not reveal evidence Resident #94 had any reddened or open areas to the buttocks nor surrounding areas. Review of Resident #94's skin observations from 03/11/25 through 03/12/25 did not reveal evidence Resident #94 had an open area to the left buttock or her buttocks were very reddened. Review of a Wound Evaluation for Resident #94, dated 03/12/25 and written by Wound Nurse Practitioner (WNP) #501, included Resident #94 had a new partial thickness abrasion of her left buttock. Measurements were length 0.5 centimeters (cm), width 0.5 cm and depth 0.1 cm. Treatment was cleanse with mild soap and water, pat dry, apply generous application of barrier cream every shift and as needed after any incontinent episode. During routine hygiene care a new partial thickness abrasion to the left buttock was found. Resident #94 was seen via telehealth. The surrounding tissue was blanching (a temporary whitening or paleness of skin when pressure is applied, indicating good blood flow that returns to normal when pressure is applied). Resident #94 had discoloration throughout the buttocks consistent with scar tissue from a previous injury but no other acute trauma breakdown. Suspect the area was caused by the incontinence brief rubbing against fragile tissue. Instructions were to apply a generous application of barrier cream, ensure appropriate fitting briefs, and frequent hygiene care to minimize incontinence exposure and monitor for closure. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #94's Nurse Practitioner notes written by Certified Nurse Practitioner (CNP) #502 dated 03/14/25 included staff reported Resident #94 had an abrasion on the left buttock found during care. Resident #94 was incontinent of urine and feces. Resident #94 was evaluated by WNP #501 via telehealth with orders for barrier cream. Resident #94 received hospice services and skin issues were expected due to terminal condition. Resident #94 had an abrasion to the left buttock with clear drainage, and measurements were length 0.5 cm, width 0.5 cm and depth was 0.1 cm. Observation on 03/11/25 at 3:30 P.M. of Resident #94 revealed she was sitting in a padded wheelchair in the common area. Observation on 03/11/25 at 4:17 P.M. revealed Resident #94 was sitting in a padded wheelchair in the common area and Certified Nursing Assistant (CNA) #301 pushed her back to her room. Interview on 03/11/25 at 4:17 P.M. with CNA #301 revealed Resident #94 was assisted out of bed into her padded wheelchair around 11:30 A.M. CNA #301 stated she was going to put Resident #94 back to bed to change her incontinence brief and then get her back up for the dinner meal, but she needed the help of a second aide because Resident #94 used a mechanical lift. CNA #301 indicated Resident #94 needed to be up for all meals because she needed assistance with feeding. CNA #301 revealed Resident #94 had been in the padded wheelchair since 11:30 A.M. so Resident #94 was last checked and changed for incontinence care over four and a half hours ago. Observation on 03/11/25 at 4:37 P.M. revealed CNA #385 arrived at Resident #94's room to assist with her transfer. CNA #301 and CNA #385 assisted Resident #94 back to her bed and proceeded to provide incontinence care. Observation revealed Resident #94's incontinence brief was heavily saturated with urine, her bilateral buttocks were very reddened in color, and an open area was noted on her left upper, inner buttock. The open area wound bed was pink in color. CNA #301 applied barrier cream to the open area which was about the size of a quarter. When asked if this was a new area and if the nurse knew about it CNA #301 stated she thought the nurse knew about it because they check residents' skin, but she did not tell the nurse Resident #94 had an open area to the left buttock. CNA #385 stated he took care of Resident #94 a couple days ago and she did not have the open area to the left buttock. Observation on 03/12/25 at 11:30 A.M. of Resident #94 revealed she was sitting in a padded wheelchair in the common area. Observation on 03/12/25 at 1:14 P.M. of Resident #94 revealed she was sitting in the dining area and an unidentified aide finished feeding her and pushed her into the common area without checking or changing her incontinence brief. Observation on 03/12/25 at 2:20 P.M. of Resident #94 revealed she was still sitting in a padded wheelchair in the common area. There was no observation Resident #94's incontinence brief was checked or changed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/12/25 at 4:24 P.M. of CNA #342 and #370, with Licensed Practical Nurse (LPN) #349 present during the observation, revealed both CNA assisted Resident #94 back to her bed using a mechanical lift and proceeded to provide incontinence care. Resident #94's incontinence brief was heavily soaked with urine, her buttocks were very red, and her upper, inner left buttock had a quarter sized open area. The left buttock open area was dark red in color. Further observation revealed two long dark red marks on Resident #94's right inner, upper thighs and one long dark red mark on the left upper, inner thigh. CNA #342 and #370 stated the red marks looked like they were caused by Resident #94's incontinence brief. LPN #349 confirmed the presence of the left buttock open area and the three red marks on Resident #94's thighs. LPN #349 stated the areas were not reported to her by any aide. Measurements obtained by LPN #349 revealed the inner left buttock had a length of 0.5 cm, width of 0.5 cm, the depth was not measured, and the wound bed was dark red. Resident #94's right thigh marks measured length of 7.0 cm, width 0.5 cm, and depth was not measured and the second right thigh mark measured length 5.0 cm, width 0.5 cm, and the depth was not measured. Resident #94's left thigh mark measured length 3.5 cm, width 0.25 cm, and depth was not measured. LPN #349 stated the marks on Resident #94's upper, inner thighs blanched but seemed a little sluggish. CNA #370 stated she arrived for work at 3:00 P.M. and Resident #94 was sitting in the common area and had not been changed since she arrived at work at 3:00 P.M. Interview on 03/12/25 at 5:30 P.M. with CNP #502 revealed she evaluated Resident #94's open area to the left buttock and the three long red marks on her right and left upper, inner thighs. CNP #502 indicated the marks on Resident #94's thighs and the open area on her left buttock looked like MASD (moisture associated skin damage caused by prolonged exposure to a source of moisture such as urine or stool). CNP #502 stated the Wound Nurse Practitioner (WNP) #501 would see Resident #94 via virtual visit. Review of the facility policy titled Wound Documentation Policy reviewed 01/18/2017 revealed included in the definition of a wound was moisture-associated skin damage which should be immediately reported to nursing by the CNAs who identify it, and a wound assessment should be documented immediately once the wound is identified. Review of the facility policy titled Incontinent Resident Care revised 01/2014 included incontinent residents would be cared for by nursing personnel to ensure adequate skin care, odor control and provide personal hygiene. This deficiency represents non-compliance investigated under Complaint Number OH00162087 and OH00161805.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observations, interviews, record review, and facility policy, the facility failed to ensure fall interventions were in place as ordered to prevent accidents for three residents (#23, #25, and #72) out of three residents reviewed for accidents. The facility census was 94. Findings include: 1. Review of the medical record for Resident #23 revealed an admitted [DATE] with diagnoses including severe protein calorie malnutrition, end stage renal disease, chronic obstructive pulmonary disease (COPD), dementia, muscle weakness, anemia, cerebral infarction, anorexia, unsteadiness on feet, and bipolar disorder. Review of the annual Minimum Data Set (MDS) 3.0 assessment, dated 03/01/25, revealed Resident #23 was severely impaired cognitively, rejected care one to three days of the assessment reference period, and was dependent on staff for most activities of daily living and required substantial/maximum assistance from staff for mobility. Review of the facility document titled John Hopkins Fall Risk assessments for Resident #23 revealed on 09/30/24 resident was at moderate fall risk and on 03/13/25 the resident had increased to a high fall risk. Review of the facility incident log revealed Resident #23 had a fall on 10/25/24. Review of the facility's fall investigation documents revealed Resident #23 had been found on the floor next to his low bed on 10/25/24 at 3:50 A.M. The resident was assessed to have no injuries and was unable to say what happened. The resident was wearing nonskid footwear and current fall interventions had been in place. The resident had no injuries. Review of Resident #23's physician orders revealed orders dated 09/30/24 for dycem (nonslip polymer material) to wheelchair above and below wheelchair cushion, dycem to recliner, perimeter mattress to bed, positioning pillow when in bed, and bed in low position when occupied, and an order dated 10/25/24 for floor mats at bedside. Review of the care plan, created on 07/07/23, revealed Resident #23 was at risk for falling related to weakness, refusal of care, episodes of incontinence, medication use, history of shortness of breath secondary to COPD. Interventions included position pillows when in bed; mat to floor at bedside; dycem to recliner; dycem to wheelchair cushion above and below; keep personal items and frequently used items within reach; keep bed in lowest position with brakes locked; and keep call light in reach at all times. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/12/25 at 8:18 A.M. revealed Resident #23 was awake in his bed, which was in low position and a mat was observed on the ground next to the bed. The resident's call light was not in reach with the soft touch emergency call device observed sitting on top of the mini refrigerator sitting next to his bed. Interview at the time of observation with Certified Nursing Assistant (CNA) #320 confirmed the emergency call device was on top of the mini refrigerator and was not in reach of the resident. Observation on 03/13/25 at 7:56 A.M. of Resident #23's room revealed the resident was in his bed, and the bed was in low position. A grey floor mat was observed folded up and had been leaning between the wall and his mini refrigerator. The recliner in his room did not have dycem on it , and the wheelchair in the bathroom did not have dycem applied to the top and bottom of the cushion in the wheelchair. His soft touch emergency call device was in reach. His room was uncluttered and pillows were positioned as requested by the family. Interview on 03/13/25 at 8:02 A.M. with CNA #336 confirmed Resident #23's mat was folded up against the wall and there was no dycem applied to the resident's recliner in his room or above and below the resident's wheelchair cushion. She stated she was newer to the area where Resident #23 resided, and she had just started her shift and hadn't had time to investigate what fall interventions Resident #23 should have in place. Interview on 03/13/25 at 4:59 P.M. with the Director of Nursing (DON) revealed nurses knew fall interventions for residents by the orders written in the medical record and fall interventions should be in place. The DON stated nurses should go over in report every fall intervention a resident has in place especially if the aide was not familiar with the resident. She confirmed verbal report was the only way for an aide to know what fall interventions should be in place for a resident. Review of facility policy Fall Prevention and Management Policy, revised on 08/06/24, revealed residents would be assessed for fall risk on admission, quarterly, and as needed. If risks were identified, preventative measures would be put in place and care planned. 2. Review of the medical record for Resident #72 revealed an admitted [DATE] and diagnoses included dementia, major depressive disorder, age-related osteoporosis without current pathological fracture, severe-protein calorie malnutrition, encounter for palliative care, cognitive communication deficit, and history of falling. Review of Resident #72's quarterly MDS 3.0 assessment, dated 03/04/25, revealed the resident was severely impaired cognitively, was dependent on staff for activities of daily living and mobility, and had no falls since the previous assessment. Review of Resident #72's care plan, dated 07/27/23, revealed the resident was at risk for falling related to weakness and antidepressant medication use. Approaches included sensor alarm to wheelchair; sensor alarm to bed; provide proper well-maintained footwear; visual cues in bathroom; visual cues to remind resident to use call light for assistance; encourage to lay down after meals; encourage common areas when restless; encourage resident to be up for meals; encourage bed in lowest position with mat to floor; dycem to wheelchair; observed frequently and place in supervised area when out of bed; give resident verbal reminders not to ambulate/transfer without assistance; and place resident in a fall prevention program. Review of Resident #72's John Hopkins Fall Risk assessments dated 03/03/24, 04/10/24, 06/05/24, 07/31/24, and 12/02/24 revealed the resident was a high fall risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #72's physician orders revealed orders dated 05/23/23 for dycem (nonslip polymer material) to wheelchair, encourage resident to be up for meals, encourage resident to lay down after meals, visual cues in room and bathroom to utilize call light for assistance, an order dated 12/23/23 to encourage bed in lowest position, an order dated 08/01/24 for mat to floor at bedside; an order dated 11/18/24 for hospice services with a diagnoses of protein calorie malnutrition, and an order dated 12/02/24 for a sensor alarm to bed. Review of progress notes in Resident #72's medical record revealed on 11/30/24 the resident was found on the floor on the side of her bed at the foot of the bed. The resident had no major injury with a new intervention to have Hospice come in and see the resident. A progress note dated 12/03/24 revealed when Resident #72 had her fall all current interventions had been in place and a new intervention for an alarm to bed had been added. Observation on 03/13/25 at 8:09 A.M. of Resident #72's room revealed a blue mat was folded into thirds and leaning up against the right wall as the resident was sleeping in her bed. Interview with the DON at 8:10 A.M. confirmed the mat had been folded against the wall and after looking at Resident #72 physician orders her medical record, the DON confirmed the mat should have been down on the floor. Interview on 03/13/25 at 4:59 P.M. with the Director of Nursing (DON) revealed nurses knew fall interventions for residents by the orders written in the medical record and fall interventions should be in place. The DON stated nurses should go over in report every fall intervention a resident has in place especially if the aide was not familiar with the resident. She confirmed verbal report was the only way for an aide to know what fall interventions should be in place for a resident. Review of facility policy Fall Prevention and Management Policy, revised on 08/06/24, revealed residents would be assessed for fall risk on admission, quarterly, and as needed. If risks were identified, preventative measures would be put in place and care planned. 3. Review of the medical record for Resident #25 revealed an admitted [DATE] with diagnoses including anemia, unspecified fall, acute on chronic diastolic (congestive) heart failure, restless leg syndrome, paroxysmal atrial fibrillation, and cognitive communication deficit. Review of admission Minimum Data Set (MDS) assessment, dated 02/20/25, revealed Resident #25 was severely impaired cognitively, required substantial/maximum assistance for oral and toilet hygiene, required partial/moderate assistance from staff for sit to stand, chair to bed transfer, and toilet transfer, and supervision from staff to walk up to 150 feet. The resident was independent with wheelchair maneuverability, was occasionally incontinent of bowel and bladder, and had a fall in the past month. Review of the care plan created on 02/14/25 revealed Resident #25 was at risk for falls related to psychotic medications, anemia, restless leg, neuropathy, and weakness. Interventions included a reacher, perimeter mattress to bed, out of bed for meals, display signage as visual cues to remind resident of fall prevention call don't fall, encourage resident is wearing nonskid footwear, bed in lowest position, and keep familiar objects commonly used objects within reach. Review of the facility document titled John Hopkins Fall Risk assessment , dated 02/14/25, revealed Resident #25 was high fall risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician orders revealed an order dated 02/17/25 for visual cues to remind resident to use call light and wait for assistance. Review of progress notes in Resident #25's medical record revealed a progress note dated 02/20/25 which indicated the resident had an unwitnessed fall in his room. The resident was observed on the floor with both arms on the recliner. The resident stated he was sitting on the edge of bed and fell trying to transfer himself on to the recliner. The resident was noted to have no apparent injuries. The resident was educated on use of call light for assistance. Another progress note dated 02/21/25 revealed the nurse had been notified by the aide that the resident was on the floor. The nurse found resident sitting on floor with no major injury. The resident stated he tried to get up and slide from the bed. Observation on 03/13/25 at 8:05 A.M. of Resident #25's room revealed the resident was in a low bed with a perimeter mattress with familiar items being kept within reach. There was a reacher in his room, however, there was no observation of a posted sign to call for assistance. Interview at the time of observation with Registered Nurse (RN) #354 confirmed there was no sign posted to call for assistance and could not give an explanation on why the sign wasn't posted. Interview on 03/13/25 at 4:59 P.M. with the DON revealed nurses knew fall interventions for residents by the orders written in the medical record and fall interventions should be in place. The DON stated nurses should go over in report every fall intervention a resident has in place especially if the aide was not familiar with the resident. She confirmed verbal report was the only way for an aide to know what fall interventions should be in place for a resident. Review of facility policy Fall Prevention and Management Policy, revised on 08/06/24, revealed residents would be assessed for fall risk on admission, quarterly, and as needed. If risks were identified, preventative measures would be put in place and care planned. This deficiency represents non-compliance investigated under Complaint Numbers OH00163348 and OH00161805.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on observation, interview, record review and review of facility policy, the facility did not ensure Resident #25, #26 and #74 received sugar-free pancake syrup in accordance with their low concentrated sweets (LCS) therapeutic diet order to meet their needs. This affected three residents (#25, #26 and #74) out of three residents reviewed for food/nutrition. The facility identified 14 residents (#7, #12, #25, #26, #32, #34, #37, #45, #54, #58, #63, #69, #74 and #88) as receiving a LCS diet. The facility census was 94. Findings include: 1.Review of the medical record for Resident #74 revealed a current admitted [DATE] and original admitted [DATE]. Pertinent diagnoses included type two diabetes mellitus, acquired absence of left foot, and morbid obesity diet to excess calories. Review of Resident #74's physician orders revealed an order dated 02/08/25 for a LCS (low concentrated Sweets) diet with large portions. Review of the admission Minimum Data Set (MDS) 3.0 assessment, dated 02/14/25, revealed Resident #74 was cognitively intact, required set up for eating, and was on a therapeutic diet. Review of Resident #74's Medical Nutrition Therapy Observation, dated 10/30/24, revealed the resident was on a therapeutic diet (LCS diet) , and the diet was appropriate for his diagnosis of type two diabetes mellitus. The nutritional intervention was to provide the therapeutic diet as ordered with the addition of large portions. Review of the care plan, dated 10/30/24, revealed Resident #74 had increased nutrition/hydration risk related to being on a therapeutic diet and having type two diabetes mellitus. Interventions included review preferences per routine and as needed; respect/honor resident dietary choices; provide diet per order; monitor weight per protocol, monitor dietary and nutritional intake; and encourage compliance with diet guidelines. Observation on 03/12/25 at 8:29 A.M. of Resident #74's breakfast tray as Certified Nursing Assistant (CNA) #336 was collecting the tray revealed on the tray was an empty individual regular syrup. The tray ticket on Resident #74's breakfast tray indicated the resident was on a LCS (low concentrated sweets) diet and was to receive two diet syrups. At the time of observation, CNA #336 confirmed regular instead of diet syrup had been served to the resident. 2. Review of the medical record for Resident #25 revealed an admitted [DATE]. Pertinent diagnoses included type two diabetes with diabetic neuropathy, chronic kidney disease stage three, and cognitive communication deficit. Review of Resident #25's physician orders revealed an order dated 02/27/25 for a LCS (Low Concentrated Sweets) diet with double entree. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #25's admission MDS 3.0 assessment, dated 02/20/25, revealed the resident was severely impaired cognitively, independent for eating, and was on a therapeutic diet. Review of the care plan, dated 02/20/23, revealed Resident #25 was at increased nutritional/hydration risk related to type two diabetes with therapeutic diet prescribed with use of insulin. Approaches included review preferences per routine and as needed; respect/honor resident dietary choices; provide diet as ordered; monitor weight per protocol; and monitor dietary intake. Observation on 03/12/25 at 8:31 A.M. of Resident #25's breakfast tray as the resident was finishing his breakfast in the unit dining room revealed on the tray was an empty individual regular syrup. The tray ticket on Resident #25's breakfast tray indicated the resident was on LCS (low concentrated sweets) diet and was to receive two diet syrups. At the time of observation, Dietary [NAME] #357 confirmed the resident had regular syrup on this meal tray and should have been given diet syrup. 3. Review of the medical record for Resident #26 revealed an admitted [DATE]. Pertinent diagnoses included type two diabetes with diabetic chronic kidney disease. Review of Resident #26's physician orders revealed an order dated 05/23/23 for a LCS (low concentrated sweets) diet. Review of the quarterly Medical Nutritional Therapy Observation, dated 01/08/25, revealed Resident #26 was on a LCS restricted diet and had no significant weight changes with intakes meeting nutritional and fluid needs. Review of the care plan dated, 10/16/23, revealed Resident #26 was at risk for complications related to diabetes. Approaches included dietary consultation to discuss and determine meal planning, meal choices, dietary restriction and dietary adequacy and explain dietary regime and restrictions and how to prevent complications. Observation on 03/12/25 at 8:33 A.M. of Resident #26's breakfast tray in the resident's room revealed on the tray was an individual container of regular syrup. The tray ticket on Resident #26's breakfast tray indicated the resident was on a LCS (low concentrated sweets) diet and was to receive two diet syrups. At the time of observation, Laundry/Housekeeping #376 confirmed there was regular syrup on Resident #26's breakfast tray. Interview on 03/12/25 at 11:37 A.M. with Regional Director of Dietary Services (RDDS) #500 revealed a LCS diet was pretty liberal and the only difference between a LCS diet and a regular diet was the LCS diet received sugar free condiments and smaller portions of sweet desserts. RDDS #500 indicated the diet guide sheet guided staff on what food items and serving sizes should be served for each diet and the tray ticket would state what beverage and condiments a resident should receive. RDDS #500 confirmed residents who were on a LCS diet should have received sugar-free syrup on their breakfast trays instead of regular. Interview on 03/12/25 at 2:39 P.M. with CNA #320 revealed the kitchen had been sending regular jelly and syrup on the LCS breakfast trays a lot lately. Interview on 03/12/25 at 2:18 P.M. with CNA #329 revealed she had seen regular condiments being sent on the residents' breakfast trays who are on a LCS diet. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Bath Creek Estates North Fall Winter 24/25 Diet Guide Sheet revealed on Wednesday of week four of the menu (03/12/25) residents on a LCS diet were to receive two pancakes and one sausage patty for breakfast. Review of the facility's dietary staff education documentation with staff signatures revealed on 03/06/25 dietary staff had been educated on various topics which included providing meal items per tray ticket. Review of the facility policy Diet Orders Policy, revised on 03/18/24, revealed the Food and Nutrition Services Manager will utilize a tray card identification system to ensure each resident receives his or her diet as ordered, and that the diet in the medical record reflects the diet in the tray card system. This deficiency represents non-compliance investigated under Complaint Number OH00163395.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of facility policy, the facility failed to ensure hand hygiene was implemented during medication administration for Resident's #18, #42, #43, #46 and #84 and during care for Resident #101. The facility also failed to ensure appropriate personal protective equipment (PPE) was worn during PEG (percutaneous endoscopic gastrostomy) tube care for Resident #46. This affected six residents (Resident's #18, #42, #43, #46, #84 and #101) and had the potential to affect an additional 37 residents (Resident's #3, #4, #6, #12, #17, #19, #21, #28, #33, #34, #36, #38, #40, #41, #46, #47, #49, #50, #54, #56, #58, #60, #63, #64, #66, #67, #70, #75, #79, #82, #83, #86, #88, #89, #91, #92, #94) residing on the 300 and 400 nursing units. The facility census was 94. Findings include: 1. Observation on 03/12/25 at 7:35 A.M. of Licensed Practical Nurse (LPN) #349 revealed LPN #349 was standing at the medication cart preparing medications to be administered to Resident #43. After LPN #349 prepared Resident #43's medications and placed the medications in a small plastic cup without first sanitizing or washing her hands she walked into Resident #43's room and administered them to Resident #43. Resident #43 asked for pain medication and LPN #349 returned to the medication cart, prepared the pain medication for administration and walked back into Resident #43's room to give her the pain medication. LPN #349 exited Resident #43's room, walked to the medication cart and began preparing Resident #42's medication for administration. LPN #349 did not wash her hands or use hand sanitizer after exiting Resident #43's room or before beginning to prepare Resident #42's medications. Observation on 03/12/25 at 7:58 A.M. of LPN #349 revealed she was standing at the medication cart preparing Resident #42's medications for administration. After she was finished preparing the medications she placed the pills in a small plastic cup and walked into Resident #42's room to administer the medications. After administering Resident #42's medications LPN #349 walked back to the medication cart without washing her hands or using hand sanitizer and began preparing Resident #84's medications for administration. Observation on 03/12/25 at 8:05 A.M. of LPN #349 revealed she was standing at the medication cart preparing Resident #84's medications for administration. After she was finished preparing Resident #84's medications for administration she placed the pills in a small plastic cup and walked into Resident #84's room to administer the medications. After administering Resident #84's medication LPN #349 walked back to the medication cart without washing her hands or using hand sanitizer. Interview on 03/12/25 at 8:24 A.M. with LPN #349 confirmed she did not use hand sanitizer or wash her hands during Resident's #43, #42 and #84's medication administration. Observation on 03/12/25 at 8:26 A.M. of LPN #306 revealed she was standing at the medication cart preparing Resident #18's medications for administration. LPN #306 did not sanitize or wash her hands before the medication preparation for Resident #18. After she was finished preparing Resident #18's medications for administration she placed the pills in a small plastic cup and walked into Resident #18's room to administer the medications. After administering Resident #18's medication LPN #306 walked back to the medication cart without washing her hands or using hand sanitizer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/12/25 at 8:38 A.M. revealed LPN #306 was standing at the medication cart and an unidentified aide walked up to her and told her Resident #101 needed the assistance of nurse. Without washing her hands or using hand sanitizer LPN #306 walked into Resident #101's room to assist him. Resident #101 stated he threw up and it went on his gown. LPN #306 pulled Resident #101's bed linens up without putting gloves on, noticed some emesis had fallen on a towel lying on Resident #101's bed, put gloves on and removed the soiled towel from the bed. Interview on 03/12/25 at 8:38 A.M. with LPN #306 confirmed she did not use hand sanitizer or wash her hands during Resident #18's medication administration or before she entered Resident #101's room to assist him. 2. Review of Resident #46's medical record revealed an admitted [DATE] and diagnoses included cerebral palsy, dysphagia and attention deficit hyperactivity disorder. Review of Resident #46's care plan dated 03/05/25 included Resident #46 was at increased nutritional risk elated to gastric tube use. Gastric tube related to nothing by mouth, dysphagia. Resident #46 had enteral feeding, supplements to support normal lab levels. Interventions included to check tube placement prior to medication, tube feeding administration; enhanced barrier isolation. Review of Resident #46's physician orders dated 03/12/25 revealed Isolation, Transmission Based Precaution: Enhanced Barrier Precautions. Observation on 03/12/25 at 9:13 A.M. of Resident #46's room did not reveal an Enhanced Barrier Precaution (EBP) sign was on the door to his room and there was no plastic cart with PPE near the door to his room or PPE hanging on the door to the room. Observation on 03/12/25 at 9:13 A.M. of LPN #306 revealed Certified Nursing Assistant (CNA) #375 told her Resident #46's tube feeding pump was not working. LPN #306 walked into Resident #46's room without washing her hands or using hand sanitizer, did not don an isolation gown, and went over to Resident #46's tube feeding pump to see why it was not working. LPN #306 tried to turn the pump on, stated the PEG tube was clogged and she needed to flush Resident #46's PEG tube. LPN #306 returned to the medication cart without washing her hands or using hand sanitizer and prepared Resident #46's medications for administration and found a clean syringe to flush the PEG tube. LPN #306 walked into Resident #46's room with the medications and clean syringe and did not don an isolation gown. LPN #306 proceeded to flush Resident #46's PEG tube with water, then administered the medications via the PEG tube. After LPN #306 flushed his PEG tube and administered Resident #46's medications she connected the tube feeding and turned the pump on to continuously administer Isosource 1.5 at 45 cc per hour per physician orders. LPN #306 washed her hands before leaving the room. LPN #306 confirmed she did not don an isolation gown before providing care for Resident #46's feeding tube and administering medications via the feeding tube. Interview on 03/12/25 at 9:20 A.M. with the Director of Nursing (DON) confirmed Resident #46 did not have a sign for Enhanced Barrier Precautions on his door or PPE near the entrance to his room. The DON indicated she was going to make sure PPE was available near the entrance to Resident #46's room and a sign was placed on his door going forward. The DON stated LPN #306 confirmed she did not don an isolation gown prior to providing care for him. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Transmission-Based Precautions and Isolation Policy revised 04/15/24 included EBP (Enhanced Barrier Precautions) were intended to prevent transmission of multi-drug resistant organisms (MDROs) via contaminated hands and clothing of healthcare workers to high risk residents. EBP are indicated for high contact care activities for residents with chronic wounds and indwelling devices (such as central lines, urinary catheters, and trachs) and for all those colonized or infected with a MDRO currently targeted by the CDC1. Other MDROs may be included at the discretion of the facility Infection Control Committee unless required by state guidance. Review of the facility policy titled Hand Hygiene/Handwashing Policy revised 02/28/2025 included hand hygiene was the most important component for preventing the spread of infection. Use of gloves did not replace the need for hand cleaning by either hand rubbing or hand washing. Unless hands were visibly soiled, an alcohol-based hand rub was preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: immediately before touching a patient, before performing an aseptic task (for example, placing an indwelling device) or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids, or contaminated surfaces, immediately after glove removal.