STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366418	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Dublin	4075 West Dublin-Granville Road Dublin, OH 43017

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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** 44070 Based on observation, interviews, and policy review, the facility failed to treat residents with dignity and respect. This had the potential to affect one residents (Resident #22) out of two residents reviewed for dignity and respect. The facility census was 99. Findings included: 1. Review of the medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included multiple sclerosis, failure to thrive, weakness, chronic pain, and diabetes. Review of progress note dated 02/14/22 revealed resident saw dentist with exam recommending extractions of #4, #5, #6, #7, #8, #9, 11, #12, and #13 and have dentures made. Progress note dated 08/08/22 revealed appointment for [NAME] dental clinic for 09/01/22 at 1:00 P.M. Progress note dated 09/01/22 revealed resident was seen in the hallway when he should have been at his appointment. Resident informed social services that transportation could not locate the building and blamed social services. Resident also stated they would not see him due to not having any information. Social Services informed resident he had all paperwork he needed in the packet provided by facility. Social Service informed Resident #22 what he had done at the appointment and not caring about the appointment which took effort just to blow off was inappropriate and rude and rude to everyone who it affected. Resident did not take responsibility for himself and guardian was discussed for him if he was not going to take responsibility. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was cognitively intact with a BIMS of 15. Interview on 10/21/24 at 2:35 P.M. with Resident #22 revealed staff were disrespectful and do not speak to him in a dignified manner. He reported staff have yelled and had been rude at times. Interview on 10/23/24 at 4:10 P.M. with Social Services Director #520 confirmed a social service aide had assisted in arranging dental service follow up for Resident #22 and was upset when resident missed his appointment. Social Service Director #520 revealed Social Service Aide (SSA) #805 was yelling at resident, she over heard and broke it up herself. She revealed SSA #805 had not worked at facility in while and revealed she was unsure why SSA #805 told resident she would get him a guardian if his behavior continued as resident was alert and oriented and did not qualify for a guardian. (continued on next page)

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 facility policy titled, Resident Rights and Facility Responsibilities, dated 11/30/23 revealed facility shall abide by all resident rights. Residents shall be treated with dignity, courtesy and respect. This deficiency represents non-compliance under Complaint Number OH00158801 and OH00158752.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47059 Based on record review, observations, staff interview, and review of the facility policy, the facility failed to ensure call lights were within the resident's reach. This affected one (Resident #15) of three residents reviewed for call lights. The facility census was 99. Findings include: Record review for Resident #15 revealed Resident #15 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, quadriplegia, schizophrenia, anxiety disorder, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 08/13/24, revealed Resident #15 had mildly impaired cognition. Resident #15 was totally dependent on staff for bed mobility, transfers, toileting, and eating. Review of the care plan dated 01/12/24 revealed Resident #15 was to have a disc call button on the left side of her head within reach so she can activate it as she turns her head to push it. Observation on 10/21/24 at 11:46 A.M. revealed Resident #15 was lying in bed and the call light cord was clipped to the resident's pillow, but the pad was hanging off the side of the bed, The resident was unable to reach the call light pad to call for help if needed. Observation on 10/23/24 at 9:08 A.M. revealed Resident #15 was lying in bed and the call light pad was clipped to the resident's pillow, but she could not reach it with her chin to call for help. Interview on 10/23/24 at 9:11 A.M. with Staff Member #500 confirmed Resident #15 could not reach her call light. Review of the facility policy titled Call Light dated 06/08/22 revealed the staff needs be sure call lights are placed within reach of resident at all times. This deficiency represents non-compliance investigated under Complaint Number OH00158922.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on staff interview, closed record review, and facility policy review, the facility failed to ensure resident funds were returned upon discharge or account closure. This affected one resident (#363) of one reviewed for closed resident fund accounts. The facility census was 99. Findings include: Review of the medical record for Resident #363 revealed an admitted [DATE]. Diagnoses included unspecified dementia, diabetes, malnutrition, bipolar disorder, and delirium. Review of Resident #363's quarterly statements dated 01/23/24 revealed resident had $1,331.19 in the resident fund account. The statement reported the account was closed for this amount. Interview on 10/24/24 at 10:00 A.M. with Business Office Manager (BOM) #500 revealed she started at facility 07/2024 and revealed Resident #363 had discharged and closed the account. She revealed she had not found evidence of a check being provided to Resident #363 upon discharge. Interview on 10/24/24 at 11:45 A.M. with BOM #500 revealed facility had sent the account closure to facility administrator to approve the check to be dispersed and the Administrator had never approved the dispersal of funds. BOM confirmed Resident #363 was never sent their money from closing the account in 01/2024 and revealed they were still waiting on Administrator approval as of 10/2024. Review of facility policy titled, Resident Rights and Facility Responsibilities, dated 11/30/23 revealed facility shall abide by all resident rights. Upon transfer or discharge, the resident fund account shall be closed and a final accounting be made with all remaining funds returned to the resident or resident representative. Funds must convey funds to resident within 30 days of discharge.

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on staff interview and record review, the facility failed to ensure residents were provided spenddown notifications as required. This affected two Residents (#6, and #74) of six reviewed for resident funds. The facility census was 99. Findings include 1. Review of the medical record for Resident #6 revealed an admitted [DATE]. Diagnoses included dementia, schizophrenia, nutritional anemia and diabetes. Review of resident personal fund statement dated 01/2024 revealed Resident #6 had a balance $1,987.16 and $1,953.36. Review of resident personal fund statement dated 02/2024 revealed Resident #6 had a balance $2003.82. Review of resident personal fund statement dated 03/2024 revealed Resident #6 had a balance $2053.82. Review of resident personal fund statement dated 04/2024 revealed Resident #6 had a balance $2054.82 and 2104.69. 2. Review of the medical record for Resident #74 revealed an admitted [DATE]. Diagnoses included hypertensive heart disease, heart failure, atrial fibrillation, pulmonary hypertension, bipolar disorder, and mood disorder. Review of resident personal fund statement dated 04/26/24 revealed Resident #74 had a deposit of $5,057. 62 and a balance of $6,139.57. Review of resident personal fund statement dated 05/2024 revealed Resident #74 had a balance $6,089.85. Review of resident personal fund statement dated 06/2024 revealed Resident #74 had a balance $6.139.85. Review of resident personal fund statement dated 07/2024 revealed Resident #74 had a balance $6,162.30. Interview on 10/24/24 at 10:00 A.M. with Business Office Manager (BOM) #500 revealed she started at facility 07/2024 and revealed facility gave out quarterly spenddown notifications, but also revealed facility had no evidence of any notifications that were provided. BOM confirmed spenddown notifications would be given for residents with over $1500.00 and would be given a personalized letter about how much they have in the account and instructions to spend down resources to remain under the Medicaid limits. (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy, Resident Personal Funds Policy, dated 11/30/23 revealed the facility had the responsibility to safeguard funds and financial affairs. The policy revealed for Medicaid recipients the facility will inform the resident or legal representative in writing when the balance of the resident account comes within $2000.00 of the Medicaid resource limit. Review of facility policy titled, Resident Rights and Facility Responsibilities, dated 11/30/23 revealed facility shall abide by all resident rights. Each resident shall be promptly notified when the amount in the resident funds reached two hundred dollars less than the maximum amounts permitted for a recipient of Medicaid. The notice shall include an explanation of the potential effect on eligibility for Medicaid exceeds the maximum assets a Medicaid recipient may retain.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. 44070 Based on resident and staff interviews and record review, the facility failed to ensure mail was delivered timely and on the weekends. This had potential to affect all facility residents. The facility census was 99. Findings include Interviews on 10/23/24 at 10:30 A.M. with Resident #1, #11, and #34 revealed resident's do not get mail passed on Saturday's. They revealed activity staff do not work on the weekends and they were the staff that pass the mail out. Interview on 10/28/24 at 1:30 P.M. with Receptionist #489 revealed facility gets mail on Monday through Saturday's. She revealed she distributes resident mail to the Activity Director who passes out the mail to the residents. She confirmed resident mail delivered on Saturday is kept either at the front desk or in the copy room until Monday. Interview on 10/28/24 at 2:48 P.M. with Activities Director #464 revealed facility did not have staff from activity department on weekends and Saturday mail is passed on Monday morning. Review of facility notice titled, Mail, dated 11/30/23 revealed residents shall be allowed to communicate privately with individuals and shall receive personal mail unopened. Mail shall be delivered including Saturday deliveries.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36648 Based on observation, staff interview and policy review the facility failed to notify the physician of a change of condition for one resident . This had the potential to effect one resident (#68) out of six residents reviewed for nutrition. The census was 99. Findings include: Review of the medical record for Resident #68 revealed an admitted [DATE] with no cognitive deficits. Diagnoses included diabetic II hypertension, hyperlipidemia and status post exploratory laparoscopy on 8/23/2024 with extensive lysis of additions, segmental small bowel resection with anastomosis and serosal repair of cecum. Complicated with persistent partial small bowel. Review of Resident #68 physician orders on 09/24/24 to 10/22/24 revealed she was receiving Total Parenteral Nutrition (TPN) Electrolytes Intravenous Concentrate (Parenteral Electrolytes) Use 1700 ml intravenously (IV) one time a day for TPN order. Infuse 1700 ml IV for 12 hours. Administer via central line. In addition, she was ordered a clear liquids diet regular texture, regular consistency , clear liquids only, Jello, fruit juice, broth for each meal tray. On 10/04/24 she was ordered a frozen nutritional treat at lunch and dinner. Review of the vital signs for Resident # 68 revealed on admission 09/24/24 she weighed 215 pounds. On 10/14/24 she weighed 205.6 pounds . In 19 days, she lost 9.4 pounds a total 4.37 % of body weight. Review of Resident #68 nurses progress notes 09/27/24 to 10/22/24 revealed the physician, or dietician was not notified of Resident #68 weight loss. Interview on 10/22/24 at 10:30 A.M. with Resident #68 revealed she has been loosing weight and does not know why. She has been in the facility for over three weeks, and she wants to go home. Interview by telephone on 10/22/24 at 10:45 A.M. with Resident #68 sister revealed she is very concerned about her sister, she seems to be depressed, losing weight and no one has updated her or Resident #68 on her condition and when she can go home. Interview on 10/28/24 with Registered Nurse # 384 and Dietician #610 confirmed the physician and the dietician were not notified of Resident # 68 weight loss and confirmed no additional weights were available for Resident #68. Review of facility policy titled Change in Resident's Condition dated 11/30/23 . Revealed the facility shall notify the resident's, his or her attending physician, and representative (sponsor) of changes in the resident's medical /mental condition.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on observations, resident and staff interview, and record review, the facility failed to ensure lighting issues were addressed timely for one Resident (#34) of one reviewed for lighting concerns. Facility census was 99. Findings include: Review of the medical record for Resident #34 revealed an admitted [DATE]. Diagnoses included alcoholic cirrhosis of liver, diabetes, acute osteomyelitis, cellulitis, diabetes, bipolar disorder, and atrial fibrillation. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 was cognitively intact. Review of maintenance log dated 07/01/24 to 10/20/24 revealed no entries or mention of the over the bed light being out. Interview on 10/23/24 at 11:10 A.M. with Resident #34 revealed his over the bed light had been out for several weeks. Resident revealed he told the Maintenance Director #514 and was informed it was $2500 for the order and was waiting on approval from corporate. Observation and interview on 10/23/24 at 11:20 A.M. with Maintenance Director (MD) #514 and Resident #34 revealed the light above the bed was out and Maintenance Director was aware. Resident asked if the order from a few weeks ago had come in and MD informed Resident #34 they had sent the wrong type of lights and they had to reorder. MD informed resident he was waiting on the new bulbs to come in. Interview on 10/23/24 from 12:00 P.M. and 4:00 P.M. with Maintenance Director #514 revealed he found some bulbs and was going to change out Resident's over the bed light. Maintenance revealed he was unsure how long ago resident had reported the light being out and revealed he was unsure when a request was sent to corporate for approval. MD confirmed facility was unable to provide any records, including requests for approval for order, the approval or the actual order or reorder for the equipment to provide a timeline of how long resident waited for his light to be replaced or the timeliness of their efforts. This deficiency represents non-compliance investigated under Complaint Number OH00158407.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on staff interview and record review, facility failed to ensure resident fund accounts were free from misappropriation. This affected one Resident (#22) of six reviewed for resident funds. The facility census was 99. Findings include: Review of the medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included multiple sclerosis, failure to thrive, muscle weakness and diabetes. Review of the Resident funds statement dated 01/2024 to 10/2024 for Resident #22, revealed resident received two separate pensions and social security income as deposits and three withdrawals which totaled all but $50 accounting for each month. Statement entry dated 09/19/24 revealed an additional $1,136.00 was removed from Resident #22's account which was the total balance leaving resident with $0.00 in the account. Review of email communication between Regional Business Office Manager (RBOM) #777 and Business Office Manager #500 acknowledged an extra withdrawal was made from Resident #22's personal fund account. RBOM #777 stated we are not allowed to withdrawal funds from QIT accounts from personal funds. Interview on 10/24/24 at 10:00 A.M. with Business Office Manager (BOM) #500 confirmed facility took $1136. 00 from Resident #22's account. BOM #500 revealed she thought the money was withdrawn to pay for an outstanding balance for Resident's care. She revealed a RBOM #778 told her to withdrawal the money from his personal fund account. BOM #500 confirmed resident was not informed of this and facility had no written authorization to remove all money from Resident #22's account. Interview on 10/24/24 at 11:45 A.M. with BOM #500 revealed facility had mistakenly taken the money from his account and were told to replace the money. Facility was unable to provide any evidence of where the money had gone from 09/19/24 until surveyor intervention found the misappropriation of funds. Review of facility policy, Resident Personal Funds Policy, dated 11/30/23 revealed the facility had the responsibility to safe guard funds and financial affairs. The policy revealed once authorization had been received, only resident or their representative may have access to resident funds and all withdrawal transactions require a signature. Resident accounts shall be audited quarterly. All suspicions of misappropriations shall be reported and fully investigated and reported per facility Abuse Prevention Policy. Review of facility policy, Abuse, Neglect, Exploitation and Misappropriation Policy, dated 11/30/23 revealed Residents had the right to be free from abuse, neglect and misappropriation. The policy revealed Misappropriation included the deliberate misplacement, or wrongful temporary or permanent use of resident's belongings or money without resident consent.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41266 Based on medical record review, review of bed hold notices, staff interviews, and facility policy review, the facility failed to include a daily room rate on bed hold notices for four residents (Residents #9, #37, #43, and #68) who were transferred to the hospital. This affected four residents (Residents #9, #37, #43, and #68) of four reviewed for hospitalization s. The facility census was 99. Findings Include: 1. Review of the medical record Resident #37 revealed an admitted on 04/22/22. Medical diagnoses included chronic respiratory failure, history of falling, repeated falls, anxiety disorder, major depressive disorder, mood (affective) disorder, and need for assistance with personal care. Review of clinical census revealed Resident #37 was hospitalized on [DATE]. Resident #37's payer source was a managed care insurance provider which supplied both Medicare and Medicaid coverage. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment revealed Resident #37 had mildly impaired cognition and scored an 11 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #37's primary language was Spanish. Resident #37 required varied amounts of assistance ranging from set up assistance to substantial assistance from staff to complete Activities of Daily Living (ADLs). Review of the progress notes revealed on 08/20/24 at 6:39 P.M., Resident #37 was transferred to a local hospital for further evaluation following a fall at the facility. At 6:47 P.M., Resident #37 was provided with a Notice of Transfer and Bed Hold upon being transferred to the hospital. Review of the Notice of Transfer and Bed Hold, dated 08/20/24, revealed the notice did not include a daily room rate. Interview on 10/24/24 at 12:04 P.M. with the Director of Nursing (DON) confirmed the bed hold notice did not include a daily room rate. 2. Review of the medical record for Resident #43 revealed an admitted on 07/18/18. Medical diagnoses included spinal stenosis thoracolumbar region, unspecified dementia, wedge compression fracture of third lumbar vertebra (07/03/23), age-related osteoporosis without current pathological fracture, post-traumatic headache (10/08/24), low back pain (10/08/24), and repeated falls (10/08/24). Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #43 had impaired cognition and scored eight out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #43's primary language was Chinese. Resident #43 used a walker for ambulation. Resident #43 required varied amount of assistance from staff to complete Activities of Daily Living (ADLs) which ranged from set up assistance to substantial assistance from staff. Review of the clinical census revealed Resident #43 was hospitalized on [DATE]. Resident #43 had a managed care insurance payer which provided both Medicare and Medicaid insurance coverage. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the progress notes revealed on 10/07/24 at 2:48 P.M., Resident #43 was transferred to the hospital due to uncontrolled pain. At 3:13 P.M., Resident #43 was provided a Notice of Transfer and Bed Hold. Review of the Notice of Transfer and Bed Hold, dated 10/07/24, revealed the bed hold notice did not include a daily room rate. Interview on 10/24/24 at 12:04 P.M. with the Director of Nursing (DON) confirmed the bed hold notice did not include a daily room rate. 36648 2. Review of the medical record for Resident #68 revealed an admitted [DATE] with no cognitive deficits. Diagnoses diabetic II hypertension, hyperlipidemia and status post partial small bowel resection with grossly patent enteroenteric anastomosis with in the central lower abdomen. Review of Resident #68 nurses progress notes 09/27/24 to 10/22/24 revealed she transferred to the hospital on 10/16/24 due to problems with her peg tube site . Review of Resident #68 Electronic Notice of Transfer and Bed Hold Notification form dated 10/16/24 notified the resident sponsor of the reason for transfer , explained a bed could be held for Resident #68 , but did not give the rate in which the resident would be charged for the bed hold each day. Interview on 10/22/24 at 4:30 P.M. with the Licensed Social Worker #520 and the Business Office Manager #500 confirmed they do not issue the bed hold notification when residents are sent to the hospital. It is the nursing staff who complete the notification form. They verified Resident #68 form dated 10/16/24 does not include the rate to hold the bed each day. 44070 4. Review of the medical record for Resident #9 revealed an admitted [DATE] Diagnoses included metabolic encephalopathy, chronic pulmonary disease, Crohn's disease, diabetes, seizure disorder and dysphasia. Review progress notes dated 09/20/24 revealed resident was given notice of transfer and bed hold notice upon being transferred to the hospital. Review of bed hold notice dated 09/20/24 revealed residents were given the bed hold policy upon admission and made a decision at that time if they wanted to hold their bed. Residents were not provided opportunity to make a change to their selection upon transfer. The bed hold rate was not provided to residents to make an informed decision in the bed hold notice. Review of the facility policy, Resident Transfer & Discharge Policy, reviewed 11/30/23, revealed the facility policy stated, For a Facility-Initiated Transfer, at the time a resident is transferred to the hospital or goes on a therapeutic leave (or in cases of an emergency transfer, within 24 hours) the resident or representative will be provided the following written information pertaining to bed-holds: Non-Medicaid residents will be provided written notice of the facility's policy on bed-holds, including the amount of the bed-hold.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on observation, resident and staff interviews and record review, facility failed to ensure resident had a care plan for dental care. This affected one Resident (#22) of 27 residents in the sample. Facility census was 99. Findings include: Review of the medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included multiple sclerosis, failure to thrive, weakness, chronic pain, and diabetes. Review of progress note dated 02/14/22 revealed resident saw dentist with exam recommending extractions of #4, #5, #6, #7, #8, #9, 11, #12, and #13 and have dentures made. Progress note dated 04/22/22 revealed a care conference was held and resident stated he wanted teeth extractions which he had declined a few weeks prior. Review of progress notes revealed no evidence of resident getting the extractions as needed. Review of physician orders for 04/22/24 revealed an order for dentist referral for two teeth extractions. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was cognitively intact. Review of the plan of care dated 10/21/24 revealed no dental care plan or any mention of dental needs. Interview and observation on 10/21/24 at 2:35 P.M. with Resident #22 revealed he had teeth that needed to be pulled. Resident used his hand and easily wiggled his two front teeth. Interview on 10/23/24 at 4:10 P.M. with Social Services Director #520 confirmed she had no knowledge of a physician order being placed 04/2024 and confirmed resident had no follow up or social service intervention since then for dental services. Interview on 10/23/24 at 5:40 P.M. with Regional Administrator #803 acknowledged no dental care plan but revealed facility would look. Interview on 10/28/24 around 2:00 P.M. with Clinical Regional RN #605 acknowledged facility was unable to find an active care plan for Resident #22's dental needs.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on resident and staff interviews and record review, facility failed to assist a resident in a timely manner with referrals for transfer. This affected one Resident (#22) of two reviewed for discharge. Facility census was 99. Findings include: Review of the medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included multiple sclerosis, failure to thrive, weakness, chronic pain, and diabetes. Review of progress note dated 02/27/23 revealed resident wanted to move closer to [NAME], Ohio. Five referrals were sent with two not taking insurance, one with no beds and two with referrals pending. Progress note dated 03/01/23 revealed resident was updated on the referral status. It was discussed to send referrals to Columbus area and he said he would think about it. Progress note dated 01/22/24 revealed social services met with resident and daughter to discuss where they wanted Columbus, OH referrals sent, and three facility were requested. Progress note dated 01/26/24 revealed medical records were sent to the requested facilities. One of the facilities only had independent and assisted living. Facility showed no evidence of transfer referrals or discharge planning being done from 01/26/24 to 10/20/2024. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was cognitively intact with a BIMS of 15. Interview on 10/21/24 at 2:35 P.M. with Resident #22 revealed he had requested to transfer and revealed facility was not helping him. He revealed they made referrals months ago, but reported staff had not assisted in several months. Interview on 10/23/24 at 4:10 P.M. with Social Services Director #520 confirmed referrals were made several months ago and revealed she would check back with Resident when he requested her. Social Services acknowledged resident had requested a transfer several years prior and confirmed he had not received assistance in transferring out to a new facility. Social Services confirmed she had never provided resident with a list from insurance for in network nursing facilities. Review of facility notice titled, Discharge Planning, dated 11/30/23 revealed residents shall assist residents and representatives in selecting a post acute care provider in goals of care and treatment preferences.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 41266 Based on medical record review, observations, resident and staff interviews, and facility policy review, the facility failed to consistently engage in effective communication with one resident (Resident #37) whose primary language was Spanish. This affected one (Resident #37) of three reviewed for language and communication. The facility census was 99. Findings Include: Review of the medical record Resident #37 revealed an admitted on 04/22/22. Medical diagnoses included chronic respiratory failure, history of falling, repeated falls, anxiety disorder, major depressive disorder, mood (affective) disorder, and need for assistance with personal care. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment revealed Resident #37 had mildly impaired cognition and scored an 11 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #37's primary language was Spanish. Resident #37 required supervision or touching assistance with showering/bathing and ambulation. The resident required partial assistance from staff for toileting. Review of the care plan for Resident #37 revised 10/05/23 revealed the resident had a communication problem related to language barrier and unspecified hearing loss. Interventions included provide translator as necessary to communicate with the resident. Review of progress notes revealed on 08/19/24 at 2:30 A.M., Resident #37 was found sitting on the floor in the bathroom. Resident was unable to communicate to the nurse what happened. Resident #37 was unable to make any statement. However, was noted to be in the bathroom trying to take shower when the fall occurred. There was no evidence that a translator was utilized. On 08/19/24 at 3:16 A.M., Resident #37 was found sitting on the floor in her bathroom. The resident was unable to tell this nurse what happened. There was no evidence that a translator was utilized. On 08/20/24 at 5:41 P.M., Resident #37 had an unwitnessed fall. The nurse assessed the resident and noted a lump on the back of her head. The nurse was unable to get an accurate description due to language barrier. Resident #37 was transferred to the hospital for further evaluation due to possible head injury. There was no evidence a translator was utilized to determine what had occurred. Review of the fall investigation dated 08/19/24 at 2:30 A.M., Resident #37 was found sitting on the floor in her bathroom. When asked what happened, patient could not tell this nurse due to communication barrier. There was no evidence a translator was utilized during the investigation. Observations on 10/22/24 at 10:21 A.M. and 10/24/24 at 6:00 P.M. revealed there was no information related to how to reach a translator found in the resident's room. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews on 10/22/24 at 10:21 A.M. and 10/24/24 at 6:00 P.M. with Resident #37 revealed the resident's primary language was Spanish. The resident was able to speak and understand some English but had difficulty understanding some simple questions. When asked if staff use a translator to help better communicate with her, Resident #37 shrugged her shoulders. When asked how a translator could be reached if needed, the resident pointed to the phone in her room. When asked if she knew the phone number or to call a translator if needed, Resident #37 stated, no. Interview and observation on 10/24/24 at 6:04 P.M. with Licensed Practical Nurse (LPN) #495 confirmed there was some difficulty with communicating with Resident #37. LPN #495 stated Resident #37 was able to speak a little bit of English but she will speak Spanish frequently. LPN #495 was not able to locate any instructions on how to reach a translator for Resident #37. LPN #495 stated he was not aware of any tools, like a translator or communication board or phone application, offered or utilized to help with communication with Resident #37. LPN #495 confirmed he had not been educated or informed of a phone number that could be used to reach a translator when needed. Interview on 10/28/24 at 9:54 A.M. with the Director of Nursing (DON) confirmed there was a phone number that could be used in order to reach a translator if needed. The DON stated the information was kept in a binder at the nurse's station. The DON confirmed staff should be aware of this information but did not have any evidence of education or in-service training being completed with staff. The DON confirmed there should not be indications of an inability to communicate with a resident due to a language barrier. Review of the facility policy, Translation/Language Services, reviewed 11/20/23, revealed the policy stated, routine and scheduled translation/language services are available to meet the resident's needs through Propio Language Services. Staff will assist with connections as needed for Telephonic Interpreting Services. This deficiency substantiates Complaint Number OH00158801.

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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** 49039 Based on record review, observation, and interview, the facility failed to adequately meet personal care needs which included shaving for Resident #33. This affected one (Resident #33) of two residents reviewed for shaving needs. The facility census was 99. Findings Include: Review of the medical record revealed Resident #33 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus with diabetic chronic kidney disease, obesity, dislocation of lumbar vertebra, bilateral osteoarthritis, and history of transient ischemic attack. Review of Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #33 was cognitively impaired, had bilateral impairments on upper and lower extremities, and required maximum assistance from staff for personal hygiene needs. Review of the shower log revealed Resident #33 was scheduled to receive two showers per week, specifically on Fridays and Sundays. Review of shower/bath sheets revealed Resident #33 received a shower on 10/15/24, 10/18/24, 10/23/24, and 10/25/24; during those dates, no note of completion or refusal of removal of facial hair was documented. Review of the care plan dated 02/14/24 revealed Resident #33 has an activities of daily living self care/mobility/functional ability performance deficit related to fatigue and pain with interventions of transfer assistance of two and required extensive assistance with toileting and personal hygiene. Observation on 10/22/24 at 7:50 A.M., 10/23/24 at 5:08 P.M., and 10/28/24 at 9:46 A.M. revealed Resident #33 did not have a clean-shaven face. A large amount of facial hair was present on her chin, cheeks, and upper lip. Interview on 10/23/24 at 5:08 P.M. with Resident #33 expressed a desire for staff to remove her facial hair when it becomes long; however, she stated that staff would only do this upon her request. Interview on 10/28/24 at 1:28 P.M. with the Director of Nursing (DON) confirmed staff should proactively ask residents if they would like their facial hair trimmed. Informed the DON that Resident #33 had maintained a significant amount of unkempt facial hair throughout the duration of the survey. Observation on 10/28/24 at 3:20 P.M. of Resident #33 with the DON revealed that long facial hair was still present on the resident. (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 Activities of Daily Living (ADL) policy dated 11/30/23 revealed the facility attempts to preserve activities of daily living function, promote independence, and increase self-esteem and dignity. Grooming interventions include planning the task and gathering supplies, combing and/or styling hair, washing the face and hands, brushing teeth, shaving or applying make-up, oral hygiene, self-manicure, and/or application of deodorant or powder.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on observation, resident and staff interviews and record review, the facility failed to ensure activities were provided daily and to meet resident interests. This affected two Residents (#55 and #100) of two reviewed for activities. Facility census was 99. Findings include: 1. Review of the medical record for Resident #55 revealed an admitted [DATE]. Diagnoses included cerebrovascular disease, diabetes, cerebrovascular disease, cognitive communication deficit, dysphasia, muscle weakness, and adjustment disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed preferences were marked as very important to listen to music, keep up on the news, and go outside to get fresh air, and somewhat important to do activities of interest. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 was cognitively impaired and required set up assistance with eating, partial moderate assistance for personal hygiene, and substantial/maximum assistance for bed mobility. Review of the Minimum Data Set (MDS) assessment dated [DATE], 08/03/24 and 08/19/24 revealed activity preferences were not assessed. Review of the plan of care dated 10/21/24 revealed resident enjoyed independent activities such as resting, watching TV and spending time with family and friends with interventions to assist in planning leisure time activities, assist in transportation from activities of choice, and provide supplies and materials for leisure activities as needed /requested. Observation on 10/21/24 at 2:40 P.M. with Resident #55 revealed Resident #55's bed was low to the ground with mattress pads on both sides for fall interventions. Resident was laying flat on his back staring up at the ceiling in the dark with no music or television playing. Observation on 10/22/24 around 1:10 P.M. and 2:45 P.M. revealed Resident #55 was laying in a low bed in the dark with no music or television. Resident was not seen interacting with residents at any group activities and was not observed to be invited to any activities. Observation on 10/24/24 around 2:30 P.M. revealed resident was laying in a low bed in the dark with no music or television. Resident was not seen interacting with residents at any group activities and was not observed to be invited to any activities. Observation on 10/28/24 around 9:10 A.M. revealed Activity Aide was observed to be leaving the unit after passing out the daily chronicle. Resident was observed to be laying in bed with no daily chronicle provided. Resident was laying in the dark with bed low to the ground and mattress pads on both sides. No television or music was playing and resident was laying looking up at the ceiling. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 10/28/24 at 10:08 A.M. with Licensed Practical Nurse (LPN) #492 confirmed resident did not have a chronicle (newsletter) and confirmed he was in bed without any activities going on. Interview on 10/28/24 around 2:00 P.M. with Activity Director (AD) #464 revealed she started 07/2024 and was informed residents activity preferences should be assessed during quarterly and significant change MDS assessments. She confirmed Resident #55 had several significant change and quarterly MDS assessments where activity preferences were not assessed. AD revealed she was told when she started she was told Resident #55 liked to lay in bed and revealed he was unable to communicate his preferences. AD acknowledged resident was able to communicate with thumbs up and down and could answer basic questions. AD confirmed Resident #55's care plan stated laying in bed and watching television were preferred activities which did not match his assessed preferences. She revealed they have several activities done by volunteers and had no staff on weekends from activities. Interview on 10/28/24 at 2:48 P.M. with Activity Director #464 confirmed she took attendance for resident activities, but had no attendance documented for Resident #55. 49039 2. Review of the medical record for Resident #100 revealed an admitted [DATE] with diagnoses of hemiplegia, acute respiratory failure, displaced intertrochanteric fracture of left femur, type two diabetes mellitus, chronic kidney disease, metabolic encephalopathy and encounter for palliative care. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated that Resident #100 was severely cognitively impaired, experienced impairments in both upper and lower extremities, depended entirely on staff for all activities of daily living, and exhibited no behaviors that significantly intrude on the privacy or activities of others. Review of Section F-Preferences for Routine and Activities revealed Resident #100 was not assessed for preferences. Review of the care plan dated 09/10/24 indicated that Resident #100 has impaired cognitive function/thought processes due to a diagnosis of cerebrovascular accident, with interventions including encouraging family involvement, engaging in simple, structured activities that avoid overly demanding tasks, and providing a homelike environment. The care plan also indicated that Resident #100 has deficits in activities of daily living, self-care, mobility, and functional ability due to activity intolerance, fatigue, and pain, with interventions such as providing activities that promote extremity use: crafts, balloons, volleyball, ball toss, and parachute activities, while encouraging the resident to participate as fully as possible in each interaction. The care plan notes that Resident #100 is at risk for mood changes related to depression and anxiety, with interventions that include assisting in developing a meaningful activity program and encouraging opportunities for exercise and personal choice activities. The care plan highlights potential for decreased activity participation, involvement, and social isolation due to communication deficits, with interventions that include encouraging attendance and participation in activities and explaining the importance of social interaction. Observation on 10/21/24 at 1:30 P.M. revealed that Resident #100's door was closed; prior to opening it, the surveyor could hear audible yelling of help, help . Upon entry, the resident requested assistance with water. Observation of the resident's room showed that curtains were closed, the television was off, and no common articles or personal items were nearby. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/23/24 at 9:17 A.M. revealed Resident #100 was lying in bed without stimulating activities; the television was on the opposite side of the room. Interview on 10/23/24 at 10:44 A.M. with Registered Nurse (RN) #247 revealed Resident #100 was yelling in his room, had none of his personal belongings at bedside and was laying in bed with the television on the far left side playing out of his vision. Interview on 10/23/24 at 4:24 P.M. with the administrator requesting a record of an activity log for Resident #100 could not be supplied since he had engaged in any facility activities. Observation on 10/23/24 at 5:06 P.M. revealed Resident #100 was continuously yelling for water; upon entering the room, the television was off, and the resident was inconsolable. Interview on 10/28/24 at 2:45 P.M. with Leisure Services (LS) #600 confirmed the facility lacks activities for residents who typically do not leave their rooms or require one-on-one assistance with activities. LS #600 informed this surveyor the resident is provided with daily chronicles for an activity but confirmed that no additional activities have been provided in accordance with the care plan and resident's preferences. LS #600 confirmed activities were routinely documented in the task folder in resident records. Review of recreation one-on-one visits in the task folder from 10/28/24 to 09/29/24 showed no documented visits. Review of Recreation Programs dated 11/30/23 revealed the programs are designed to encourage maximum individual participation and are geared to the individuals residents needs they are scheduled seven days a week, including one evening per week, and residents are given an opportunity to contribute. The programs consist of individual, small and large group activities that are designed to meet the needs and interests of each 'resident to include resident preferences.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. 31404 Based on staff interviews and record review, facility failed to ensure the Activity Director met minimum qualifications for the position. This had potential to affect all facility residents. Facility census was 99. Findings include: Interview on 10/28/24 around 2:00 P.M. with Activity Director (AD) #464 revealed she started 07/2024 and received about a day and a half of training. She revealed she had no prior history working in long term care or with activities or recreation. Interview on 10/28/24 at 2:48 P.M. with Activities Director #464 revealed she was working on a certification course for activities. She revealed the facility paid for the course and it should take about six months to complete. AD revealed she was on module five but was unable to show any evidence of any modules being completed and was unable to show a certificate of completion. Activity Director revealed from her knowledge, her hire was not conditional related to the certificate/training's being completed. Interview on 10/28/24 at 3:30 P.M. with Human Resources #506 acknowledged Activity Director #464 should not have been hired without meeting the minimum criteria for the position. Review of employee record for Activity Director #464 revealed resident had been enrolled in the course. The document did not say when AD was enrolled and did not provide update on status of what coursework had been completed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on observations, medical record review, resident and staff interviews, and facility policy review, the facility failed to follow physician orders for three residents (Residents #37, 43, and 51), failed to ensure medications were available for administration as ordered for one resident (Resident #62), and failed to promptly initiate timely treatment for one resident's (Resident #68) malfunctioning percutaneous endoscopic gastrostomy (PEG) tube. This affected five residents (Residents #37, 43, 51, 62, and 68) of 27 residents reviewed for quality of care concerns. The facility census was 99. Findings Include: 1. Review of the medical record Resident #37 revealed an admitted on 04/22/22. Medical diagnoses included chronic respiratory failure, history of falling, repeated falls, anxiety disorder, major depressive disorder, mood (affective) disorder, and need for assistance with personal care. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment revealed Resident #37 had mildly impaired cognition and scored an 11 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #37's primary language was Spanish. Resident #37 required supervision or touching assistance with showering/bathing and ambulation. The resident required partial assistance from staff for toileting. Review of the Medication Administration Record (MAR) dated October 2024 revealed Resident #37 had an order for Daily Weight Notify Physician (MD) with two pound weight gain in 24 hours and document refusals one time a day with a start date on 07/16/24. Resident #37's recorded weights included: 10/02/24 251 pounds (#), 10/03/24 253.4 # (+2.4 #), 10/16/24 244 #, 10/17/24 246 # (+2 #), 10/20/24 247.8 #, and 10/21/24 249.8 # (+2 #). There were no weights recorded from 10/07/24 through 10/14/24 (eight days) with the listed reason other-see notes. Review of the progress notes dated from 10/01/24 through 10/24/24 revealed there was not any evidence the physician was notified of two pound weight gains on 10/03/24, 10/17/24, or 10/21/24 as ordered. Notes dated 10/08/24 at 6:16 A.M., 10/09/24 at 6:11 A.M., 10/11/24 at 5:51 A.M., 10/12/24 at 6:26 A.M., 10/13/24 at 6:45 A.M., and 10/14/24 at 6:16 A.M. revealed Resident #37's weight was not able to be obtained due to the weight machine providing inaccurate readings. Interview on 10/24/24 at 2:51 P.M. with Licensed Practical Nurse (LPN) #453 confirmed there was no evidence Resident #37's physician was notified of the weight fluctuations as listed above as ordered. LPN #453 also confirmed Resident #37 did not receive daily weights from 10/07/24 through 10/14/24 (eight days) due to the facility's weight machine not working properly. 2. Review of the medical record for Resident #43 revealed an admitted on 07/18/18. Medical diagnoses included wedge compression fracture of third lumbar vertebra, spinal stenosis, dementia, essential primary hypertension, and personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #43 had impaired cognition and scored eight out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #43 required supervision to substantial assistance from staff to complete Activities of Daily Living (ADLs). Review of the Medication Administration Record (MAR) dated September 2024 revealed Resident #43 had a physician order for Amlodipine Besylate Oral Tablet 10 milligrams (mg) with instructions to give one tablet by mouth one time daily for hypertension (high blood pressure). The physician was to be notified of a systolic blood pressure over 140, a diastolic blood pressure over 80, and/or a heart rate over 80 with a start date on 09/04/24. Resident #43 had a blood pressure or heart rate outside of the parameters daily from 09/04/24 through 09/30/24, except for 09/27/24. Review of the Medication Administration Record (MAR) dated October 2024 revealed Resident #43 continued with the same physician order as above for Amlodipine Besylate. Resident #43 had a blood pressure and/or a heart rate outside of the parameters daily, except on 10/01/24, 10/02/24, 10/08/24, 10/16/24 and 10/18/24. Review of the progress notes dated from 09/03/24 through current revealed there was no evidence the physician was notified of Resident #43's blood pressures and/or heart rates as indicated in the physician order on any of the dates listed above. Interview on 10/23/24 at 11:23 A.M. with Unit Manager (UM) #267 confirmed Resident #43's was not notified when her blood pressure and/or heart rate was outside of the indicated parameters as indicated in the physician's order on the dates noted above in September or October 2024. 3. Review of the medical record for Resident #51 revealed an initial admitted on 12/18/20 and a readmitted on 01/10/24. Medical diagnoses included dementia, Bipolar Disorder, hypertensive heart failure, schizoaffective disorder, and chronic kidney disease. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #51 had mildly impaired cognition and scored 11 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #51 required varied assistance from staff to complete Activities of Daily Living (ADLs) ranging from supervision to partial or moderate assistance. Review of the Medication Administration Record (MAR) dated September 2024 revealed Resident #51 had a physician order for Hydrochlorothiazide Capsule 12.5 milligrams (mg) with instructions to give two capsules two times daily for hypertension and to notify the physician of a systolic blood pressure over 140, a diastolic blood pressure over 80, and/or a heart rate over 80. The order had a start date on 08/29/24 and a discontinue date on 09/05/24. Resident #51's blood pressure and/or heart rate was outside of the provided parameters one time on 09/01/24, 09/03/24, 09/05/24, and twice on 09/02/24 and 09/04/24. Review of the Medication Administration Record (MAR) dated October 2024 revealed Resident #51 had a physician order for Carvedilol Tablet 12.5 milligrams (mg) with instructions to give one tablet by mouth two times daily for hypertension (high blood pressure). The medication was to be held for a systolic blood pressure less than 110 or a heart rate less than 60. There was no evidence of Resident #51's heart rate being checked prior to administering the medication. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/28/24 at 12:03 P.M. with Clinical Regional Registered Nurse (CRRN) #605 confirmed there was no evidence Resident #51's physician was notified when the resident's blood pressure and/or heart rate were outside of the parameters as indicated in the Hydrochlorothiazide medication order. CRRN #605 also confirmed there was no evidence Resident #51's heart rate was not monitored or recorded when Carvedilol medication was administered as indicated in the physician order. 4. Review of the medical record for Resident #62 revealed an admitted on 12/27/23. Medical diagnoses included aftercare following joint replacement surgery, human immunodeficiency virus disease, type II diabetes mellitus without complications, obesity, generalized muscle weakness, and abnormalities of gait and mobility. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #62 had intact cognition and scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #62 was independent with completing Activities of Daily Living (ADLs). Review of the Medication Administration Record (MAR) dated October 2024 revealed Resident #62 did not receive Hydroxyzine Pamoate Capsule 50 milligrams (mg) in the afternoon on 10/16/24, the morning on 10/17/24, the afternoon or evening on 10/23/24, or the morning on 10/24/24 as ordered. Resident #62 did not receive the initial dose of Refresh P.M. Ophthalmic Ointment on 10/24/24 as ordered. Resident #62 did not receive weekly injection of Ozempic Subcutaneous Solution Pen 8 mg/3 milliliters (mL) on Friday, 10/18/24 as ordered. Resident #62 did not receive Dextran 70-Hypromellose Ophthalmic Solution 0.1-0.3% eye drops on 10/24/24 or at 9:00 A.M. on 10/25/24 as ordered. Review of Med Pass Notes dated 10/18/24 through 10/24/24 revealed Hydroxyzine Pamoate, Refresh P.M. Ophthalmic Ointment, Ozempic, and Dextran Hypromellose Ophthalmic Solution eye drops were pending delivery from the pharmacy and were not available for administration to Resident #62 as ordered. Interviews on 10/23/24 at 5:10 P.M. and 10/24/24 at 9:00 A.M. with Resident #62 revealed he felt was not receiving his medications as ordered consistently. Resident #62 stated several nurses have indicated the facility did not have various medications available for administration or the medication was still pending delivery from the pharmacy. Resident #62 stated he did not receive eye medications consistently or his weekly Ozempic injection. Resident #62 could not recall exact dates when he did not receive all of his medications as ordered but stated it has been going on for awhile and has happened this month too. Interview on 10/28/24 at 3:41 P.M. with the Director of Nursing (DON) confirmed Resident #62 did not receive the above medications on the above dates due to the medications pending delivery from the pharmacy and were not available to be administered to Resident #62. 36648 5. Review of the medical record for Resident #68 revealed an admitted [DATE] with no cognitive deficits. Diagnoses included diabetic II hypertension, hyperlipidemia and status post exploratory laparoscopy on 8/23/2024 with extensive lysis of additions, segmental small bowel resection with anastomosis and serosal repair of cecum. Complicated with persistent partial small bowel. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/22/24 at 10:30 A.M. of Resident #69 with the Director of Nursing revealed the resident had a peg tube coming out of her abdomen. The tube extended from her abdomen to a collection measuring box that was inside a wash basin. The tube was filled with a dark brown substance and had an odor coming from the wash basin. The tube had two connecting sections wrapped in a pink adhesive tape . The first section of the tube closest to the abdomen was wrapped with pink tape securing the connection between the gastric tube and the tubing for the collection system, and the second area wrapped in pink tape was the connection into the collection measuring box . Resident #68 remains in bed , because the tube continues to leak, and she can't carry the box and basin around when ambulating. Interview on 10/22/24 at 10:30 A.M. with Resident #68 revealed she has been losing weight and does not know why. She has been in the facility for over three weeks, and she wants to go home. She is no longer receiving physical therapy and must stay in her room all day because she has the tube running out of her abdomen to a box that sits in a wash basin to keep it off the floor. No one has had her out of her bed or addressed the tube coming out of her stomach. Interview by telephone on 10/22/24 at 10:45 A.M. with Resident #68 sister revealed she is very concerned about her sister, she seems to be depressed, losing weight and no one has updated her or Resident #68 on her condition and when she can go home. She has not been out of her room because of the tube coming out of her stomach. She can't move , no one has taken her out of her room. Interview on 09/22/24 at 10:40 A.M. with the DON revealed the resident was admitted to the facility with this tube. The tube was placed into the resident abdomen by the Cleveland Clinic when she experienced complications with her small bowel resection. They have received no information on what kind of drainage system it is and what it is for. She knew that the tube had been leaking and she has been unable to get any one to address the problem. She sent the resident to the hospital on 10/16/24, but they sent her back to the facility the same day with no new orders. She confirmed she contacted a local GI specialist however, no one has contacted her back . Review of Resident #68 medical record revealed the tube extending from her abdomen is a gravity drainage system to collect drainage from her segmental small bowel resection with anastomosis and serosal repair of cecum. Review of the Physician Progress note for visit on 10/17/24 revealed Resident #68 was extremely upset about no one doing anything for her excessive drainage in/around venting PEG tube. The hospital staff reported the tubing was fine. Physician explained a gastroenterologist (GI) specialist has been contacted about exchanging the tube. A return call is expected from the GI physician office. Review of Resident #68 Nurses Progress Notes orders from 10/18/24 to 10/22/24 revealed no indication a GI doctor has been contacted regarding Resident #68 tube. Review of Resident #68 physician orders from 09/24/24 to 10/22/24 revealed no indication a GI doctor has been contacted or given orders for Resident #68 tube. Review of the Hospital's Emergency Discharge summary for Resident #68 revealed she was seen for redness and pain around her peg site. Recommended clindamycin for suspected cellulitis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the After Visit Summary from the hospital dated 10/16/24 revealed the resident was seen for a wound check due to redness and pain around the PEG site. She received an order for Clindamycin 150 mg take 3 capsules by mouth every 8 hours for 7 days for a diagnosis of cellulitis of other specified site. After surveyor intervention on 10/22/24 Resident #68 was transferred to the hospital for peg tube. Regional Registered Nurse #605 documented in Resident #28 medical record on 10/22/24 at 11:07 A.M. the reason for transfer was because the welfare and needs of the resident cannot be met at the facility. Resident #68 did not return to the facility. Review of the facility policy, Medication Administration-General Guidelines, revised 12/2019, revealed the facility policy stated, Medications are administered as prescribed in accordance with good nursing principles and practices. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration). Medications are administered in accordance with written orders of the prescriber. If a medication with current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility are searched. If the medication cannot be located after further investigation, the pharmacy is contacted, or medication removed from the night box/emergency kit. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. This deficiency substantiates Complaint Numbers OH00158889, OH00158796, OH00158801, OH00158339, OH00158922, OH00158521 and OH00159075.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on observation, record review, staff interview and review of the facility policy, the facility failed to develop and implement a comprehensive and individualized skin integrity program to ensure identification, interventions and treatments were initiated upon identification of the wound. This affected two (Resident #40 and #4) residents. Additionally, the facility failed to change a malfunctioning mattress timely for Resident #5. This affected three residents (Resident #40, #4, and #5) out of three residents reviewed for skin integrity. The facility census was 99. Findings Include: 1. Review of the medical record for Resident #40 revealed an admitted [DATE] with diagnoses not limited to intracapsular fracture of left femur, urinary tract infection, peripheral vascular disease, metabolic encephalopathy, history of transient ischemic attack, traumatic brain injury and dementia. Review of Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #40 had a memory problem, was severely cognitively impaired, exhibited inattention, disorganized thinking, required partial/moderate assistance with bed mobility and toileting, and required setup or cleanup assistance with wheeling 50 feet. MDS section M - Skin condition revealed the resident had no ulcers, wounds, or skin problems. Review of quarterly skin assessment dated [DATE] revealed that Resident #40 was at moderate risk of skin breakdown. It was noted that the resident's sensory perception was very limited, the skin was occasionally moist, the resident was chairfast, had very limited mobility, and presented a potential problem with friction and shear. Review of progress note dated 04/17/24 revealed Resident #40 was identified with a skin impairment described as an arterial ulcer to the left heel. The wound was noted to have softness, and treatment was in place with notification to the wound team and family. Review of Weekly Ulcer/Wound documentation dated 04/17/24 revealed Resident #40 had skin impairment risk factors related to incontinence and peripheral vascular disease, with interventions for pressure ulcer/injury care and offloading heels. This documentation identified a wound on the left heel measuring 4.0 centimeters (cm) x 3.5 cm x unable to determine (UTD), with no open area, and notifications were made to the physician and family, including comments for marathon as treatment. A review of the Weekly Ulcer/Wound documentation completed on 04/24/24 revealed no significant change in wound size. Review of physician orders dated 04/23/24 for Resident #40 revealed left heel treatments were initiated with marathon cover and foam dressing every three days. Review of the treatment administration record (TAR) for Resident #40 dated 04/01/24 to 04/30/24 revealed an order for treatment to the left heel: apply marathon and cover with foam dressing every night shift every three days. The TAR indicated that the first treatment was not documented as completed until 04/23/24, which noted a delay since the wound was identified on 04/17/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/28/24 at 5:06 P.M. with Licensed Practical Nurse (LPN) #998 confirmed she was the first nurse to identify the skin impairment; at that time, the resident was not complaining of any pain. LPN #998 confirmed the resident was routinely receiving offloading of his heels and had an air mattress in place to prevent skin impairment as well as the new ulcer from opening. LPN #998 informed the wound nurse practitioner immediately upon identification of the wound, who directed staff to begin marathon/med honey with bordered foam dressing to prevent the opening of the skin issue; LPN #998 denied placing the order for the wound treatments. Telephone interview on 10/29/24 at 4:04 P.M. with the wound Nurse Practitioner (NP) confirmed he was informed of Resident #40's wound in a timely manner, with an order to implement marathon and bordered foam dressing to provide additional cushioning and prevent the skin impairment from progressing into an open area. He was not made aware that an order for treatments had not been placed for 7 days after the area was identified. He was notified 2-3 weeks after the initial identification of the potential skin area had opened, leading to a decision to change treatment measures to prevent deterioration in the wound. The wound NP confirmed the resident was at high risk for arterial issues due to the diagnosis of PVD. Once the wound was identified, the facility completed a blood flow test to his extremities, which showed impaired output to his leg, placing him at increased risk of skin issues. The wound NP denied significant deterioration based on wound measurements completed after the facility failed to complete dressing changes for 7 days. Email interview on 10/30/24 at 9:33 A.M. with Clinical Regional Registered Nurse (RN) #605 confirmed that evidence of wound treatments was not available to support that treatments were begun before 04/23/24. The Clinical Regional RN confirmed treatment orders were not put in place timely but denied causing deterioration in the wound. The Clinical Regional RN also confirmed that interventions were in place prior to wound identification, which included offloading heels, Prafo boots, and a pressure redistribution mattress. 2. Review of the medical record for Resident #5 revealed an admitted [DATE] with diagnoses of spina bifida, osteomyelitis of vertebra sacral and sacrococcygeal region, paraplegia, stage 4 and stage 3 pressure ulcers, type two diabetes mellitus and noncompliance with other medical treatment and regimen due to unspecified reason. Review of Minimum Data Set (MDS) 3.0 assessment for Resident #5 completed 10/03/24, revealed the resident had moderate cognitive impairment, demonstrated inattentive behavior, had bilateral impairments in lower extremities, required substantial/maximal assistance with daily living activities, and presented with two stage three ulcers and one stage four ulcer. Review of hospice service note dated 10/15/24 revealed Resident #5 mattress appeared flat and was beeping; troubleshooting was attempted with no success, and both hospice and the director of nursing were notified to order a new mattress. Review of progress notes dated 10/16/24 and 10/23/24 revealed Resident #5 refused weekly wound assessments by the wound nurse practitioner. Review of Treatment Administration Record from 10/2024 for Resident #5 showed multiple refusals to complete routine dressing changes as ordered. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/22/24 at 8:08 A.M. revealed an audible, consistent beeping coming from Resident #5's room. Upon entering, a low-pressure warning was displayed on the special air mattress screen. The resident declined to provide additional information about the issue. During this observation, an interview with the hospice aide confirmed ongoing problems with the low air pressure mattress with no consistent resolution. Observation on 10/22/24 at 5:15 P.M. confirmed the error message remained illuminated on the screen, with continuous audible beeping. Interview on 10/22/24 at 5:14 P.M. with Registered Nurse Minimum Data Set (MDS) Nurse #441 confirmed that the mattress was malfunctioning and that a work order would need to be placed. She stated she would ensure a work order was submitted for mattress replacement. Observation on 10/23/24 at 11:36 A.M. confirmed that the bed continued to beep with the same error message. Interview on 10/23/24 at 11:36 A.M. with Unit Manager (UM) #999 confirmed that the bed was not functioning correctly and that the resident had refused to switch mattresses on several occasions. UM #999 indicated that there was no documentation supporting attempts to change the mattress, along with noted refusals. Review of progress notes from 10/15/24 to 10/22/24 indicated no attempts were made to address the mattress issue, nor were there any documented refusals from the resident. Review of order slip dated 10/23/24 indicated that a replacement mattress was ordered but subsequently canceled on 10/23/24 at 10:00 A.M. due to the patient ' s refusal. No additional order slips were received for the initial issue identified on 10/15/24. Review of admission assessment and baseline care plan for Resident #5, dated 09/23/24, revealed the resident was at moderate risk for skin breakdown. Interventions included a pressure-reducing mattress for the bed, a pressure-reducing cushion for the chair, heel elevation, turning and repositioning every two hours, monitoring skin every shift, and treatment per physician orders. Review of care plan dated 08/18/23 found Resident #5 was resistant/noncompliant with treatment and care, including activities of daily living, wound care, and changing the mattress when it was not functioning properly. Interventions included allowing flexibility in the daily routine to accommodate mood, preferences, and customary habits. If the resident resisted care, staff were instructed to leave and return later, inform them of upcoming activities, and offer options for flexibility. Review of care plan dated 05/29/24 revealed Resident #5 was at risk for changes in skin integrity due to generalized weakness, impaired mobility, and noncompliance. Current skin integrity issues were identified on the coccyx, left buttocks, and left lateral ischium. Interventions included providing a low air loss mattress for the bed with bolsters, educating the resident and family about causes of skin breakdown, and conducting weekly skin assessments. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of wound notes dated 10/09/24 revealed Resident #5 had a deteriorating stage three pressure ulcer on the left lateral ischium measuring 4.03 centimeters (cm) x 6.53 cm x 1 cm. Additionally, a stage three pressure ulcer was noted on the center lateral coccyx, measuring 9.11 cm x 15.48 cm x 5 cm. The clinician emphasized the importance of offloading, turning, repositioning, and dressing changes to promote wound healing, noting that the resident's compliance was poor due to underlying conditions. Interview on 10/28/24 at 1:28 P.M. with the Director of Nursing confirmed that Resident #5's mattress was not functioning properly on 10/15/24. She could not provide documentation for a replacement mattress order prior to the surveyor's intervention or a work order being placed to resolve the issue. The Director stated that hospice was responsible for ordering the replacement mattress and had not provided an update until 10/23/24. Review of skin care management policy dated 11/30/23 revealed that residents with identified skin breakdown will have pressure reduced utilizing lifting devices, proper positioning, and the use of positioning devices, will receive treatments as ordered, and care plans will be updated as needed. 31404 3. Record review of Resident #4 revealed an admitted [DATE]. The resident was sent to the hospital on 10/23/24. Resident #4 with pertinent diagnoses of: pneumonitis due to inhalation of food and vomit, acute respiratory failure with hypoxia, pneumonia, sepsis, type two diabetes mellitus with diabetic peripheral angiopathy, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, ventricular fibrillation, hypertensive heart disease with heart failure, Alzheimer's disease, dementia without behavioral disturbance, anxiety disorder, encounter for attention to gastrostomy, metabolic encephalopathy, mild cognitive impairment, isocheimic cardiomyopathy, anemia, atherosclerosis, peripheral vascular disease, old myocardial infarction, weakness, personal history of sudden cardiac arrest, personal history of malignant neoplasm of ovary, personal history of urinary infections, major depressive disorder, presence of cardiac pacemaker, and overactive bladder. Review of the 10/10/24 admission Minimum Data Set (MDS) assessment revealed the resident is moderately cognitively impaired. The resident required substantial maximal assistance for roll left and right, sit to lying, and lying to sit. The resident was always incontinent of bowel and bladder. Review of the pre admission hospital records dated 10/03/24 revealed Resident #4 had a pressure injury to the right heel, pressure injury to the right leg posterior, and a pressure injury to the right foot lateral distal. There was no measurements in the hospital records. Review of Resident #4 facility admission assessment dated [DATE] revealed pressure ulcers to the right lower leg rear, right heel, and bottom of foot. There was no wound measurements completed or description of the wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 10/09/24 weekly ulcer wound documentation initial assessment revealed wound #1 was to the right anterior foot and measured 2 centimeters (cm's) in length by 2.2 cm's in width by 0.1 cm in depth they said it was an arterial ulcer. Wound #2 was identified as a diabetic neuropahtic ulcer to the right lateral foot measuring 6 cms in length by 5.4 cms in width by 0.1 cms in depth. Wound #3 was a vascular ulcer to the right posterior lower leg measuring 6.7 cms in length by 14.1 cms in width by undetermined depth. These were the same wounds from the hospital just categorized as non pressure by the facility. Review of the medical record on 10/22/24 revealed there was no Physician Orders for wound dressing changes or evidence wound dressing changes were completed from 10/03/24 until 10/07/24. An order was put in on 10/07/24 for wound dressing changes. Interview with Licensed Practical Nurse (LPN) #504 on 10/24/24 at 2:41 P.M. revealed Resident #4 did not have wound dressing changes or orders in the record until 10/07/24. Interview with LPN #504 on 10/24/24 at 2:43 P.M. revealed Resident #4 was admitted on Thursday 10/03/24 and she was not here and the wounds didn't get seen until Sunday 10/07/24. She stated she doesnt know if there were orders on the continuity of care from the hospital, but his chart should of been audited on the weekend within 24 hours. Review of skin care management policy dated 11/30/23 revealed that residents with identified skin breakdown will have pressure reduced utilizing lifting devices, proper positioning, and the use of positioning devices, will receive treatments as ordered, and care plans will be updated as needed.

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	366418	A. Building B. Wing	10/31/2024

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Legacy Dublin	4075 West Dublin-Granville Road Dublin, OH 43017

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 36648 Based on observations, interviews and policy review the facility failed to enforce the smoking policy to ensure resident safety. This affected three (Resident #92, #94, and #213) residents who were observed smoking and had the potential to affect all residents in the facility. Additionally, the facility failed to ensure fall preventions were in place for one resident (Resident #37) and failed to obtain neurological checks as scheduled after a fall for one resident (Resident #43) out of six residents reviewed for falls. The facility census was 99. Findings include: 1. Review of the medical record for Resident #92 revealed an admitted [DATE] with mild cognitive deficits. Diagnoses included muscle abscess and muscle weakness. Review of Resident #92's care plan revealed Resident #92 is to go off the premises when he wants to smoke. Review of Resident # 92's Smoking evaluation dated 10/21/24, determined he is safe to smoke independently/unsupervised if he follows the facility's smoking rules. 2. Review of the medical record for Resident #94 revealed an admitted [DATE] with mild cognitive deficits. Diagnoses included alcohol cirrhosis , portal hypertension , and heptadic failure. Review of Resident #94's care plan revealed Resident #94 is non-complaint with the facility's non-smoking policy. Review of Resident #94's Smoking evaluation dated 10/20/24 revealed Resident # 94 is not safe to smoke independently , she does not follow the smoking policy and will attempt to vape inside her room. 3. Review of the medical record for Resident # 213 revealed an admitted [DATE] with severe cognitive deficits . Diagnoses included pneumonia, chronic obstructive pulmonary disease and malignant neoplasm of the left breast. Review of Resident #213's Smoking Evaluation dated 10/17/24 determined the resident is an unsafe smoker and cannot smoke independently/unsupervised. During the entrance conference on 10/21/24 at 9:43 A.M. with the Administrator and the Director of Nursing. It was confirmed the facility is a non-smoking facility and residents who wish to smoke must be off the facility property when smoking. Observation on 10/22/24 at 7:00 A.M. revealed Resident #92 , Resident #94 and Resident #213 were outside of the building smoking a cigarette less than 25 feet near the facility main entrance / door way. Admission Coordinator # 508 was with the residents. There were no ashtrays , no fire extinguisher or fire proof blanket to ensure safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy titled Non-Smoking Policy dated 06/08/2022 . Revealed the facility is non-smoking and informs all prospective residents and/or their responsible party of the non-smoking policy prior to admission. The purpose of the policy is to ensure the facility meets the Federal and State regulations and guidelines regarding the resident's right to be informed of the non-smoking policy. 41266 4. Review of the medical record for Resident #37 revealed an admitted on 04/22/22. Medical diagnoses included chronic respiratory failure, history of falling, repeated falls, anxiety disorder, major depressive disorder, mood (affective) disorder, and need for assistance with personal care. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment revealed Resident #37 had mildly impaired cognition and scored an 11 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #37's primary language was Spanish. Resident #37 required varied amounts of assistance ranging from set up assistance to substantial assistance from staff to complete Activities of Daily Living (ADLs). Review of fall investigations on 06/01/23, 08/19/24, and 08/20/24 revealed Resident #37 had experienced unwitnessed falls in the bathroom. Review of the fall investigation dated 08/20/24 at 5:40 P.M. revealed Resident #37 had an unwitnessed fall in the bathroom. Interventions already in place included items within reach, nonskid footwear, bedside commode, and low bed. Review of the care plan dated 08/16/24 revealed Resident #37 was at risk for falls due to impaired balance. Interventions included call light accessible when in room, evaluate effectiveness of medications, commonly used articles were kept within easy reach, non-slip footwear, reinforce need to call for assistance, remove clutter from environment, and a reminder sign to call for assistance written in the resident's primary language (Spanish). The care plan did not include the fall intervention of a bedside commode as indicated in the fall investigation. Observations on 10/22/24 at 10:21 A.M. and 10/24/24 at 6:04 P.M. of Resident #37's room revealed there was not a bedside commode provided to Resident #37. Interview and observation on 10/24/24 at 6:04 P.M. with Licensed Practical Nurse (LPN) #495 of Resident #37's room confirmed a bedside commode was not present in the room. Interview on 10/28/24 at 9:54 A.M. with the Director of Nursing (DON) confirmed Resident #37 should have had a bedside commode provided as a fall intervention due to the resident experienced multiple falls in the bathroom. The DON confirmed Resident #37 did not have a bedside commode present but after surveyor intervention, one was provided to the resident. 5. Review of the medical record for Resident #43 revealed an admitted on 07/18/18. Medical diagnoses included spinal stenosis thoracolumbar region, unspecified dementia, wedge compression fracture of third lumbar vertebra (07/03/23), age-related osteoporosis without current pathological fracture, post-traumatic headache (10/08/24), low back pain (10/08/24), and repeated falls (10/08/24). The acute fracture of Resident #43's T12 vertebra was not listed as a diagnosis. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #43 had impaired cognition and scored eight out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #43's primary language was Chinese. Resident #43 used a walker for ambulation. Resident #43 required setup or clean-up assistance with ambulation. Resident #43 received scheduled pain medication but did not receive as needed (PRN) pain medications or any non-medication interventions for pain. Resident #43 had frequent pain during the review period and reported a pain level of five out of ten where ten was the worst pain possible. Resident #43 had one fall with major injury since admission/readmission or prior assessment. Review of the fall investigation dated 10/07/24 at 9:27 A.M. revealed Resident #43 had an unwitnessed fall in her room on 10/06/24. The resident reported having new onset head and back pain. Certified Nurse Practitioner (CNP) #700 ordered the resident to be sent out to the hospital for further evaluation. Neurological assessments were initiated. Review of the progress notes revealed a late entry note dated 10/07/24 at 10:35 A.M. revealed UM #267 was notified by Resident #43 of complaints of head and right buttock pain. Resident #43 stated she had an unwitnessed fall in her room on 10/06/24 while attempting to move a chair. CNP #700 was notified and ordered for Resident #43 to be transferred to the hospital for further evaluation. Per the Wong-Baker FACES pain scale (a non-verbal pain scale), Resident #43 had a pain level of three to four (described as hurts a little more). Pain was noted to be new since the resident's fall. (This late entry note was created on 10/11/24 at 8:59 A.M. for an effective date on 10/07/24 (four days after the incident occurred by UM #267). Review of the Neurological Evaluation Flow Sheet dated 10/07/24 revealed Resident #43 had neurological assessments completed at 9:15 A.M., 9:45 A.M., 10:15 A.M., 10:45 A.M., and 11:50 A.M. (Resident #43 was then transferred out to the hospital.) Interview on 10/23/24 at 11:30 A.M. with Unit Manager (UM) #267 revealed neurological checks should be completed every 15 minutes for an hour, every 30 minutes for two hours, every hour for four hours, and every eight hours for 72 hours. Interview on 10/24/24 at 12:04 P.M. with the Director of Nursing (DON) confirmed neurological checks should be completed every 15 minutes for an hour, every 30 minutes for two hours, every hour for four hours. And every eight hours for 72 hours. The DON confirmed the neurological assessments completed on Resident #43 did not include every 15 minute checks. Review of the facility policy, Neurological Assessment, reviewed 11/30/23, revealed the policy stated, Neurological checks are to be performed: Day 1 every 15 minutes for one hour, every 30 minutes for 1.5 hours, every hour for two hours, and every four hours for two hours. Day 2: every shift. Day 3: every shift. Review of the facility policy, Falls-Clinical Protocol, reviewed 11/30/23, revealed the facility policy stated, for an individual who has fallen, staff will attempt to define possible causes. Based on the assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. This deficiency represents non-compliance investigated under Complaint Numbers OH00158922, OH00158796, OH00158801, and OH00159064.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404 Based on staff and resident interview, record review,and policy review, the facility failed to ensure orders for indwelling urinary catheters were in place for Resident #88 and #100. This affected two Residents (#88 and #100) of two reviewed for indwelling urinary catheters. The facility census was 99. Findings include: 1. Record review of Resident #88 revealed an admitted [DATE] with pertinent diagnoses of: type two diabetes mellitus with diabetic peripheral angiopathy, pressure ulcer of sacral region stage four, rheumatic mitral stenosis, anemia, peripheral vascular disease, encounter for attention to colostomy, lactose intolerance, weakness, acquired absence of right and left leg above knee, nicotine dependence, obstructive and reflux uropathy, hyperlipidemia, depression, hyperkalemia, presence of urogenital implants, and sepsis. Review of the 09/27/24 quarterly Minimum Data Set (MDS) assessment revealed the resident is cognitively intact and does not use and mobility devices to aid in mobility. The resident required substantial to maximal assistance for rolling left to right, sit to lying, lying to sitting onside of bed. The resident has an indwelling catheter and an ostomy appliances. Interview with Resident #88 on 10/21/24 at 11:57 A.M. revealed he does not think his indwelling urinary catheter has been changed since he has been here. Review of the medical record on 10/21/24 revealed no current orders for care, treatment, or placement of Resident #88 indwelling urinary catheter. Interview with Clinical Regional Registered Nurse (CRRN) #605 on 10/28/24 at 2:24 PM verified there was no orders for catheter care or to have a catheter until 10/22/24. 49039 2. Review of the medical record for Resident #100 revealed an admitted [DATE] with diagnoses of hemiplegia, acute respiratory failure, displaced intertrochanteric fracture of left femur, type two diabetes mellitus, chronic kidney disease, metabolic encephalopathy and encounter for palliative care. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #100 was severely cognitively impaired, experienced impairments in both upper and lower extremities, depended entirely on staff for all activities of daily living, had a indwelling catheter present, and was always incontinent of bowel. Review of physician orders dated 10/23/24 revealed Foley catheter care every shift and as needed for routine care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of care plan dated 09/12/24 revealed Resident #100 exhibits an alteration in elimination related to constipation with interventions of assist with toileting when resident requests, check resident if he is incontinent, monitor for changes in urine appearance, amount, odor and clarity and provide pad or briefs as indicated. Resident requires enhanced barrier precautions related to Foley catheter with no interventions on catheter care noted. Review of admission assessment and baseline care plan dated 08/29/24 revealed Resident #100 has a indwelling catheter with no interventions found for bowel and bladder. Review of the treatment administration record (TAR) for Resident #100 revealed on 10/23/24 Foley catheter two times per day was implemented. Review of the Medical record for Resident #100 revealed no evidence catheter care was provided routinely between 08/29/24 to 10/23/24. Interview on 10/23/24 at 10:44 A.M. with Registered Nurse (RN) #247 confirmed resident #100 has catheter and it was observed full. The urine was noted to be slightly discolored. Interview on 10/28/24 at 1:28 P.M. with the Director of Nursing (DON) confirmed routine catheter care was not started until 10/23/24 per the TAR. The DON confirmed staff should provide catheter care two times per day with documentation supporting the task was completed. Review of catheter care policy dated 11/30/23 revealed the purpose of this task is to prevent infection and reduce irritation.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47059 Based on observations, resident, family, and staff interviews, record reviews, and review of facility policies, the facility failed to ensure the residents who were at nutrition and/or hydration risk were provided with adequate assistance with meal and fluid intake, weights were obtained and monitored, and meal and fluid intakes were consistently documented. This affected six residents (Residents #4, #15, #55, #58, #68, and #100) of 12 residents reviewed for nutrition and hydration during the annual survey. The facility census was 99. Findings include: 1. Record review for Resident #15 revealed the resident was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, quadriplegia, constipation, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 08/13/24 revealed Resident #15 had mildly impaired cognition. Resident #15 was totally dependent on staff for eating. The resident had a significant weight loss while not on prescribed weight-loss regimen. Review of the care plan, revised 01/11/24, revealed Resident #15 was at risk for altered nutritional status as the resident was unable to feed self and needs total feeding assistance. Interventions included to feed all meals and encourage adequate intake of protein, calories and fluid. Offer snacks and feed them to her three times a day between meals. Resident #15 was at risk for fluid imbalance related to reliance on staff for fluids. Interventions included to encourage fluid intake between meals and monitor for signs and symptoms of dehydration. Review of the nutrition notes revealed on 07/03/24, Resident #15 was noted on 06/06/24 to weigh 152.4 pounds and on 07/02/24 weight 158.4 for a 3.9% weight gain and weight was considered stable and monitoring will continue monthly. On 08/20/24, Resident #15's weight was noted on 08/19/24 to be 146.4 pounds and resident was to continue nutritional supplements and monitor weight monthly. On 09/13/24, there was a weight warning from 09/07/24 weight of 145.2 pounds was triggering a 10 percent weight loss in the past 180 days. No new orders continue encouraging meal consumption and nutritional supplements. On 10/15/24, the note indicated Resident #15 weight 141.6 pounds on 10/14/24 triggering significant weight loss or 10% change in the last 180 days (2.5% loss in the last 30 days). At this time house supplemental shakes three times a day were added and on 10/22/24 this was changes to Boost Breeze three times a day to add additional calories and protein to Resident #15s diet. Review of the documentation for amount of meal eaten for 10/2024 revealed there was no documentation present for breakfast, lunch, or dinner on 10/04/24, 10/05/24, 10/06/24, 10/13/24, 10/16/24, 10/22/24, 10/23/24, and 10/25/24. There was no documentation of the amount of the breakfast and lunch meal consumed on 10/01/24, 19/02/24, 10/03/24, 10/09/24, 10/17/24, and 10/18/24. Review of the documentation for the amount of fluids consumed for 10/2024 revealed on day shift there were no fluids documented as consumed on 10/04/24, 10/05/24, 10/26/24, 10/13/24, 10/16/24, 10/22/24, 10/23/24, and 10/25/24. There we no fluids documented consumed on night shift for 10/01/24 through 10/09/24, 10/12/24, 10/24/24, 10/17/24, 10/19/24 through 10/23/24, and 10/26/24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the documentation for nutritional supplements consumed revealed nursing documented they were given three times a day as ordered from 10/16/24 to 10/28/24. The state tested nursing assistant (STNA) documentation for the days documented in October 2024 stated response not required or not applicable with the exception of 10/10/24 at 2:27 P.M. response was refused. Observation on 10/21/24 at 11:46 A.M. of Resident #15 resting quietly in bed with half consumed cup of chicken broth and full cup of water. There were no straws in the cups and Resident #15 stated the cups were from her breakfast tray. The STNA left to get straws and hasn't been back yet. There was no nutritional supplement included in her tray. Observation on 10/28/24 at 12:13 P.M. of Resident #15 revealed a regular lunch tray with STNA #482 assisting her with eating. STNA #482 confirmed Resident #15 consumed her sandwich and half of her salad. Resident #15 did not want her brownie. STNA #482 confirmed Resident #15 did not receive a dietary supplement with her lunch tray. Interview on 10/28/24 at 12:30 P.M. with Licensed Practical Nurse (LPN) #267 confirmed the fluid and meal intakes were not recorded daily. The nutritional supplements were documented as given but there was no documentation of the volume consumed. Interview on 10/28/24 at 1:25 P.M. with Registered Dietitians (RD) #384 and #610 confirmed the nurses were documenting nutritional supplements were consumed by Resident #15 three times a day. The STNA documentation does not reflect consumption three times a day. When the STNA documents response not required or Not Applicable it means the supplement did not come on the meal tray. RD #384 and #610 confirmed meal and dietary supplement intakes were not documented three times a day every day. 36648 2. Review of the medical record for Resident #68 revealed an admitted [DATE]. Diagnoses included diabetic mellitus type II, hypertension, hyperlipidemia and segmental small bowel resection with anastomosis and serosal repair of cecum. Resident #68 was discharged to the hospital on 10/22/24. Review of Resident #68's physician orders on 09/27/24 to 10/22/24 revealed she was receiving Total Parenteral Nutrition (TPN) (a method of nutrition that delivers nutrients directly into a vein to treat malnourishment and other conditions) Electrolytes Intravenous Concentrate (parenteral electrolytes) use 1, 700 milliliter (ml)l intravenously one time a day for TPN order. In addition, she was ordered a clear liquids diet regular texture with Jello, fruit juice, broth for each meal tray. On 10/04/24, she was ordered a frozen nutritional treat (a high calorie nutritional supplement) at lunch and dinner. Review of Resident #68's weight history revealed on admission (09/24/24), she weighed 215 pounds. On 10/14/24, she weighed 205.6 pounds . In 19 days, she lost 9.4 pounds a total 4.37 % of body weight. There were no other weights recorded in Resident #68's medical record. Review of the nutritional assessment dated [DATE] revealed the resident utilized TPN and oral intake with nutritional supplements to meet her caloric needs. There was no further documentation to reflect Resident #68's nutritional status was monitored after 09/27/24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/22/24 at 10:30 A.M. with Resident #68 revealed she has been losing weight and does not know why. She has been in the facility for over three weeks, and she wants to go home. Telephone interview on 10/22/24 at 10:45 A.M. with Resident #68's sister revealed she was very concerned about her sister. Resident #68 seemed to be depressed, losing weight and no one has updated her or Resident #68 on her condition and when she can go home. Interview on 10/28/24 at 1:35 P.M. with Registered Nurse (RN) #384 and Registered Dietitian (RD) #610 confirmed on admission, resident weights were to be completed once a week for four weeks and then once a month. RN #384 and RD #610 confirmed Resident #68 was only weighed twice during her stay at the facility from 09/24/24 to 10/22/24. They verified the physician, and the dietician were not notified of Resident #68's weight loss while receiving daily TPN. They also verified there was no follow-up on Resident #68's nutritional status after the initial nutritional assessment was completed on 09/27/24 and verified there should have been. 31404 3. Record review of Resident #4 revealed an admitted [DATE]. Diagnoses included pneumonitis due to inhalation of food and vomit, acute respiratory failure with hypoxia, pneumonia, sepsis, type two diabetes mellitus with diabetic peripheral angiopathy, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, hypertensive heart disease with heart failure, Alzheimer's disease, dementia without behavioral disturbance, metabolic encephalopathy, and anemia. Resident #4 was sent to the hospital on 10/23/24. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 was moderately cognitively impaired. Review of the hospital pre-admission record revealed Resident #4 had a weight on 10/03/24 of 157 pounds. Review of a physician order dated 10/04/24 revealed Resident #4 was to receive nothing by mouth. Resident #4 was to nutrition and hydration through tube feedings. Review of Resident #4's medical record from 10/03/24 to 10/23/24 revealed there was no documented weights from admission on 10/03/24 or weekly until 10/22/24 for Resident #4. Interview with Clinical Regional Registered Nurse (CRRN) #605 on 10/24/24 at 11:48 A.M. verified there was no weights for Resident #4 from admission on 10/03/24 or weekly until 10/22/24. CRRN #605 verified the facility policy states monthly weights instead of weekly weights for the first month as per current professional standards. Interview with Registered Dietitian (RD) #528 on 10/24/24 at 11:58 A.M. stated the procedure was for weights to be completed upon admission and then weekly for a a month. RD #528 stated Resident #4 was at a high risk for weight loss due to eating nothing by mouth and being on a tube feed. RD #528 stated she requested weights for Resident #4 but they were never completed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility weight monitoring policy dated 11/30/23 revealed resident weights will be obtained within 24-72 hours of admission and recorded in the weight record log. Weights will be obtained monthly. Weekly weights will also be monitored if requested by dietician/physician. 49039 4. Review of the medical record for Resident #100 revealed an admitted [DATE]. Diagnoses included hemiplegia, acute respiratory failure, type II diabetes mellitus, chronic kidney disease, metabolic encephalopathy, and encounter for palliative care. Review of the admission Minimum Data Set MDS (3.0) assessment dated [DATE] revealed Resident #100 was severely cognitively impaired, had an impairment on bilateral upper and lower extremities, and was dependent on staff for all activities of daily living including eating. Review of the admission assessment and baseline care plan dated 08/29/24 revealed Resident #100 was at risk for weight alteration with interventions of offer snacks and fluids between meals. Review of the care plan dated 09/03/24 revealed Resident #100 was at risk of altered nutritional status as evidence by mechanically altered diet, altered intakes and at risk for weight loss. Interventions included to encourage adequate food intake, record residents' food/fluids after each meal, and monitor for dehydration. The care plan dated 09/05/24 identified Resident #100 at risk for falls with intervention to have commonly used articles within easy reach. Review of the Nutritional assessment dated [DATE] revealed Resident #100 was not on a fluid restriction and required a mechanically altered diet. The plan identified Resident #100 had altered intakes, with dietary following residents intakes, and there were reports of swallowing problems. Review of the hospital record dated 09/05/24 revealed Resident #100 was noted to have dry mucous membranes and mildly elevated lactic acid likely corresponding with mild dehydration. Review of Resident #100's fluid intake during the night from 09/29/24 to 10/28/24 revealed inconsistent intakes were recorded. Nights noted with measured intakes were 10/04/24, 10/06/24, 10/10/24, 10/11/24, 10/12/24, 10/14/24, 10/20/24, 10/27/24, and 10/28/24. There were 21 nights with no measured fluid intake for Resident #100. Observation and interview on 10/21/24 at 1:30 P.M. revealed Resident #100's door was closed and heard audible yelling of help, help . Upon entry to Resident #100's room, the resident requested assistance with water. Observation of the resident's room revealed three stryrofoam cups across the room and out of the resident's reach. Wound Care Nurse (WCN) #504 confirmed the water was out of reach for the resident. WCN #504 confirmed a bedside table was not in the resident's room to place a cup of water on so it would remain in reach for the resident. Observation 10/23/24 at 9:17 A.M. revealed Resident #100 had a bedside table present in his room, however it was located at the end of the bed out of resident's reach. On top of the bedside table, there was a cup of fresh water labeled 10/23/24. (continued on next page)

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	366418	A. Building B. Wing	10/31/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/23/24 at 5:08 P.M. with State tested Nursing Assistant (STNA) #333 revealed Resident #100 was in her room and Resident #100 stated she was excessively thirsty. STNA #333 provided a cup of fresh water to Resident #333 where he was able to pull the straw to his mouth and drink without assistance. STNA #333 confirmed the water was far out of the resident's reach to drink freely and did not know why he did not have water nearby at all times. Observation on 10/23/24 at 5:06 P.M. revealed Resident #100 was continuously yelling for water; upon entering the room, the bed side table was at the end of the bed with water out of reach. 5. Review of the medical record for Resident #58 revealed an admitted [DATE] with diagnoses of Alzheimer's disease, major depressive disorder, adult failure to thrive, and metabolic encephalopathy. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #58 had a memory problem, was severely cognitively impaired, had a bilateral impairment on upper extremities and was dependent on staff assistance with eating and exhibited no swallowing difficulties. Review of Resident #58's physician orders dated 09/26/24 revealed an order for soft and bite size texture diet with a down grade in diet noted on 10/09/24 to pureed texture. Review of the nutritional assessment completed 10/02/24 revealed Resident #58's hospital weight was 161 pounds indicating an overweight body mass index (BMI). Assessment revealed diagnosis of adult failure to thrive with note of resident has no had weight or height taken in facility. The weight and height from hospital was used to calculate nutritional needs. Review of the care plan dated 10/02/24 revealed Resident #58 was at risk for nutritional decline and altered nutritional status as evidenced by BMI, advanced age, mechanically altered diet, diagnoses of dementia, Alzheimer's disease, and adult failure to thrive. Resident #15 required total dependence on nursing staff for feeding assistance. Interventions included to encourage adequate oral intake, feed at all meals, monitor and record the resident's food intake after each meal. Review of Resident #58's weight summary from 08/29/24 to 10/25/24 revealed there were no weights recorded in these two months. Review of Resident #58's meal intake record from 08/29/24 to 10/25/24 of intakes reported at or below 75% which indicated a potential nutritional deficit were noted on 09/29/24, 09/30/24, 10/01/24, 10/03/24, 10/04/24, 10/06/24, 10/07/24, 10/10/24, 10/11/24, 10/12/24, 10/13/24, 10/14/24, 10/16/24, 10/21/24, 10/25/24, 10/26/24, and 10/27/24. Interview on 10/28/24 at 10:05 A.M. with Registered Nurse (RN) #384 confirmed new admission should have a weight result within 48 hours of admission then weekly for the first four weeks of admission. RN #384 confirmed weights were not available for review for Resident #58 as required per weights policy and nursing staff was not notified this needed to be completed. 44070 6. Review of the medical record for Resident #55 revealed an admitted [DATE]. Diagnoses included cerebrovascular disease, diabetes mellitus, cerebrovascular disease, cognitive communication deficit, dysphasia, muscle weakness, and adjustment disorder. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 was cognitively impaired and required set up assistance from staff with eating, partial moderate assistance for personal hygiene, and substantial/maximum assistance for bed mobility. Review of the plan of care dated 01/30/23 revealed Resident #55 was at risk for altered hydration with interventions including thickened liquids per physician order and report changes related to signs of fluid deficit or overload. Review of Resident #55's physician orders dated 09/04/24 revealed an order for honey thickened liquids. Observation on 10/21/24 at 2:40 P.M. revealed Resident #55's bed was low to the ground with mattress pads on both sides for fall interventions. Resident #55 was laying flat on his back staring up at the ceiling. Resident #55 did not have any drinks within reach and no drinks were observed to be in his room. Observations on 10/22/24 at 1:10 P.M. and 2:45 P.M. revealed Resident #55 had no drink within reach. On 10/24/24 at 2:30 P.M., Resident #55 was lying in a low bed with no drink within reach. Observation and interview on 10/28/24 at 10:08 A.M. with Licensed Practical Nurse (LPN) #492 confirmed Resident #55 did not have any drink within reach. LPN #492 stated Resident #55 required thickened liquids and she had provided a cup of thickened liquid during medication pass. LPN #492 showed the cup was in the trash and confirmed it was a small dixie size cup. LPN #492 confirmed Resident #55 did not have access to anything to drink upon observations and staff should be passing fluids in the morning. Review of the facility's undated policy titled Hydration revealed residents shall be provided fluids to promote hydration. Each resident shall be provided fluids at each meal and regular times throughout the day. Fluids shall be provided at meals, medication pass, activities, at bedside and upon request. Review of the facilities policy titled Weight Monitoring with last review date of 11/20/23 revealed all in-house residents are weighed monthly by the 15th day of the month. Reweights well be obtained within 48 hours if a five pound or more difference is noted from the previous weight. The interdisciplinary team will be made aware of a weight change of five percent in one month or 10 percent in six months. This deficiency represents non-compliance investigated under Complaint Number OH00158889 and OH00158801.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on medical record review, review of a fall investigation, resident and staff interviews, and facility policy review, the facility failed to effectively manage one resident's (Resident #43) pain following an unwitnessed fall which resulted in a T12 spinal fracture. Actual harm occurred on 10/07/24 when Resident #43 reported head, neck, and low back pain to Unit Manager (UM) #267. Resident #43 reported an unwitnessed fall occurred in her room on 10/06/24. Resident #43 received scheduled pain medications at 8:04 A.M. Certified Nurse Practitioner (CNP) #700 assessed Resident #43 on 10/07/24 at approximately 9:00 A.M. The resident reported 10 out of 10 pain where 10 is the worst pain possible and was visibly crying while ambulating with her walker. CNP #700 ordered Resident #43 to be transported to the hospital for further evaluation via non-emergency transportation. Resident #43 did not receive any non-pharmacological interventions or pain medication. Resident #43 arrived at the hospital at 12:39 P.M. (almost four hours after being evaluated by CNP #700) with severe low back pain. A Computed Tomography (CT) scan of Resident #43's thoracic and lumbar spine confirmed Resident #43 sustained an acute fracture of the T12 vertebrae (a type of vertebral fracture that occurs when the T12 vertebrae in the thoracic spine collapses or shrinks when too much pressure is applied to the spine from major or minor trauma and can affect lower body functions). This affected one (Resident #43) out of four residents assessed for pain. The facility census was 99. Findings Include: Review of the medical record for Resident #43 revealed an admitted on 07/18/18. Medical diagnoses included spinal stenosis thoracolumbar region, unspecified dementia, wedge compression fracture of third lumbar vertebra (07/03/23), age-related osteoporosis without current pathological fracture, post-traumatic headache (10/08/24), low back pain (10/08/24), and repeated falls (10/08/24). The acute fracture of Resident #43's T12 vertebra was not listed as a diagnosis. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #43 had impaired cognition and scored eight out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #43's primary language was Chinese. Resident #43 used a walker for ambulation. Resident #43 required setup or clean-up assistance with ambulation. Resident #43 received scheduled pain medication but did not receive as needed (PRN) pain medications or any non-medication interventions for pain. Resident #43 had frequent pain during the review period and reported a pain level of five out of ten where ten was the worst pain possible. Resident #43 had one fall with major injury since admission/readmission or prior assessment. Review of the Medication Administration Record (MAR) dated October 2024 revealed Resident #43 received two scheduled Tylenol 325 milligrams (mg) tablets, one scheduled Oxycodone Hydrochloride (HCl) 5 mg tablet, and one scheduled Gabapentin 400 mg capsule (for nerve pain) at 8:04 A.M. on 10/07/24. No additional scheduled pain medications were administered. The pain level indicated was 0. Resident #43 had the following PRN pain medications ordered: Acetaminophen 325 mg two tablets every four hours for pain, Lidocaine Patch 4% apply to affected area topically every 24 hours for pain, and Oxycodone HCl 5 mg every six hours for pain. Resident #43 was not administered any PRN pain medications on 10/07/24. There was no evidence non-pharmacological interventions had been attempted to manage Resident #43's pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the pain levels dated 10/07/24 revealed Resident #43 had a pain level of zero at 8:04 A.M. recorded by PRN Licensed Practical Nurse (LPN) #701. There was no additional pain levels recorded until 2:50 P.M. (two hours after Resident #43 had already been transported to the hospital). Review of the facility Fall Review assessment dated [DATE] at 10:35 A.M. and completed by LPN #701 revealed Resident #43 had new pain at a level of hurts a little more on the Wong-Baker FACES pain scale (a non-verbal pain scale) due to head and right buttock pain. The assessment was completed by UM #267. Review of the progress notes revealed a late entry note dated 10/07/24 at 10:35 A.M. revealed UM #267 was notified by Resident #43 of complaints of head and right buttock pain. Resident #43 stated she had an unwitnessed fall in her room on 10/06/24 while attempting to move a chair. CNP #700 was notified and ordered for Resident #43 to be transferred to the hospital for further evaluation. Per the Wong-Baker FACES pain scale (a non-verbal pain scale), Resident #43 had a pain level of three to four (described as hurts a little more). Pain was noted to be new since the residents ' fall. (This late entry note was created on 10/11/24 at 8:59 A.M. for an effective date on 10/07/24 (four days after the incident occurred by UM #267). On 10/07/24 at 10:50 A.M., CNP #702 assessed Resident #43 related to a chief complaint of: fall/hit head on the floor/right buttocks. The resident was assessed at the nurse's station where Resident #43 told the interpreter she fell on [DATE], hit her head and right buttocks on the floor. Resident #43 was crying in pain, noted to be 10 out of 10 pain on a pain scale where 10 was the worst pain possible. CNP #702 notified CNP #700. CNP #700 arrived on-site at the facility and ordered Resident #43 to be transferred to the hospital for further evaluation. Review of CNP #700's progress note, dated 10/07/24 and signed at 12:18 P.M., revealed Resident #43 was assessed due to an acute fall from 10/06/24 with complaints of headache along with right thigh, leg, and back pain. Resident #43 was crying in pain. Resident #43 already received a scheduled dose of Oxycodone with no relief. Resident #43's Power of Attorney (POA) was contacted and requested the resident be transferred to the hospital for further evaluation. Resident #43 was noted to be alert and oriented. There was noted tenderness to Resident #43's right hip, thigh, and lower back. Review of hospital records dated 10/07/24 revealed Resident #43 arrived at the hospital at 12:39 P.M. and was admitted at 12:43 P.M. for severe low back pain. An interpreter was used during the examination. Resident #43 fell on [DATE] at the facility and ever since had been experiencing excruciating pain along her right low back and right buttock. The resident denied having any other localized pain and was still ambulatory. Resident #43's blood pressure was elevated at 143/73, and she had a pulse of 100. A CT scan of Resident #43's thoracic and lumbar spine confirmed an acute fracture of T12 vertebral body without significant body height loss or retropulsion. Treatment options were discussed and due to Resident #43 being neurologically intact without any red flag signs or symptoms, urgent spine surgery was not warranted. Recommended continuing supportive measures for her T12 vertebral body fracture including a multimodal pain regimen and physical/occupational therapies as well as consideration for a Lumbar-Sacral Orthosis (LSO) or Thoracolumbar Sacral Orthosis (TLSO) (back braces) to be worn when out of bed for comfort. Resident #43 was discharged back to the facility on [DATE]. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #43's care plan revealed a revision date on 10/21/24 (the same day surveyors entered the survey). Resident #43 was at risk for pain related to psychological distress (the focus area was initiated on 10/21/24). Interventions included administer pain medication per physician order, assess for pain, if experiencing pain rate pain per [NAME]-BAKER FACES PAIN SCALE and document/report complaints and non-verbal signs of pain, evaluate the effectiveness of pain interventions, and offer change in position and assistance as needed. An interview on 10/23/24 at 11:02 A.M. with UM #267 revealed Resident #43 reported complaints of head and back pain to her on 10/07/24 after a fall in her room occurred on 10/06/24 that was unwitnessed. The facility's nurse practitioner (CNP #702) as well as CNP #700 assessed Resident #43. UM #267 estimated the resident first complained of pain between 9:00 A.M. and 10:00 A.M. on 10/07/24 and was transferred out to the hospital within 20 to 30 minutes of being assessed. However, upon further review of the resident's hospital records, UM #267 confirmed Resident #43 did not arrive at the hospital until 12:39 P.M. (nearly four hours after being assessed). UM #267 confirmed Resident #43 did not receive any PRN pain medications or pain patch. UM #267 confirmed there was no evidence of any non-pharmacological interventions attempted. UM #267 confirmed there was no evidence of additional monitoring of Resident #43's pain level between when Resident #43 was assessed by CNP #702 and CNP #700 and when the resident was transferred to the hospital. Interviews on 10/23/24 at 3:51 P.M. and 10/24/24 at 9:29 A.M. via telephone with CNP #700 confirmed she assessed Resident #43 in the facility on the morning of 10/07/24. CNP #700 estimated the time of her assessment to have taken place around 9:00 A.M. CNP #700 confirmed Resident #43 was ambulatory but was observed crying and complaining of head, neck, and back pain at a severe level. CNP #700 ordered Resident #43 to be transferred out to the hospital for further evaluation due to concerns of uncontrolled pain levels and possible head injury. CNP #700 confirmed she did not feel the resident required emergent transport and agreed non-emergent transportation was appropriate. CNP #700 thought Resident #43 had been transported within 30 to 45 minutes of her assessment and was not aware Resident #43 did not arrive at the hospital until almost 1:00 P.M. (approximately four hours later). CNP #700 confirmed had she been aware of the delayed transport, she would have ordered an additional dose of Oxycodone be administered to Resident #43 as well as close monitoring until the resident was able to be transported. An interview on 10/24/24 at 1:38 P.M. with PRN LPN #701 via telephone confirmed she cared for Resident #43 during day shift on 10/07/24. LPN #701 stated when she entered Resident #43's room to administer morning medications, she noticed the resident to be visibly upset and was pointing at her leg area. LPN #701 stated she reported her observations to UM #267 and indicated she felt they needed to figure out what was going on because of the language barrier. UM #267 assessed Resident #43 and was able to determine that the resident had a fall in her room on 10/06/24 that was unwitnessed. The CNP (CNP #700) was notified and arrived on-site to assess Resident #43 around 9:00 A.M. she thought. CNP #700 ordered for Resident #43 to be transferred to the hospital for further evaluation due to uncontrolled pain and a possible head injury. LPN #701 stated Resident #43 was supposed to be picked up within 30 to 45 minutes but was not transported until around 12:30 P.M. for unknown reasons. LPN #701 confirmed Resident #43 was still able to ambulate but did appear to have pain. LPN #701 confirmed she had not attempted any non-pharmacological interventions, did not administer any PRN pain medications, did not notify CNP #700 of the delayed transport, and could not recall when or if she had completed another pain assessment on Resident #43. LPN #701 stated she felt Resident #43 was okay because she was still able to ambulate. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy, Pain Assessment and Management, reviewed 11/30/23, revealed the policy indicated, Pain Management was defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals. Conduct a comprehensive pain assessment upon admission to the facility, post fall, and the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. Observe the resident (during rest and movement) for physiological and behavioral (non-verbal) signs of pain. Ask the resident if he/she is experiencing pain. Attempt non-pharmacological interventions prior to administering medication. Review the medication administration record to determine how often the individual requests and receives pain medication, and to the extent the administered medications relieve the resident's pain. This deficiency represents non-compliance investigated under Complaint Number OH00158407.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47059 Based on record review and staff interviews the facility failed to identify and care plan residents with Post Traumatic Stress Syndrome (PTSD) to include non-pharma logical interventions to eliminate or mitigate triggers that may cause re-traumatization. This had the potential to effect one resident (#15) of one resident reviewed for diagnosis of PTSD. The census was 99. Findings include: Record review for Resident #15 revealed Resident #15 was admitted to the facility on [DATE] and had diagnoses including chronic obstructive pulmonary disease, seizures, quadriplegia, constipation, schizophrenia, anxiety disorder, post-traumatic stress disorder, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 08/13/24, revealed Resident #15 had mildly impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 11/15. Resident #15 was noted to have a diagnosis of PTSD and resident assessed to be totally dependent on staff for bed mobility, transfers, toileting and eating. Review of the social service admission assessment dated [DATE] in section D. Trauma the questions Have you experienced or witnessed a traumatic event in your life? and would you like to speak with a mental health professional? were both answered no so no additional assessment or care planning were initiated. Review of the nursing admission assessment dated [DATE] had no indications a trauma assessment was performed. Review of Resident #15's Care Plan last updated 09/13/24 revealed the diagnoses of PTSD was not addressed in the Care Plan. Interview on 10/28/24 at 2:18 P.M. with Regional Registered Nurse (RN) #605 confirmed there is a diagnoses of post-traumatic stress disorder (PTSD) and there is no mention of PTSD in the admission assessment or on the care plan for Resident #15.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47059 Based on record review and staff interviews the facility failed to ensure pharmacy recommendations were addressed by the physician, including rational for not following recommendations. This affected two residents (Resident #11 and #15) out of five residents reviewed for un-necessary medications. The facility census was 99. Findings include: 1. Review of Resident #11's medical record revealed an admitted [DATE] with diagnoses that included: chronic obstructive pulmonary disease, pyogenic arthritis, Type 2 diabetes mellitus, bipolar disorder, chronic kidney disease, hypertension, attention-deficit hyperactivity disorder, anxiety disorder, major depressive disorder, mood disorder, presence of artificial knee joint and infection of the surgical site infection right knee, and migraines. Review or Resident #11's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #11 was cognitively intact and received insulin, antipsychotics, antianxiety, antidepressant, antibiotic, opioid, and hypoglycemic medications all with indications present. Review of the monthly medication reports from pharmacy revealed: On 01/18/24 the pharmacists noted Resident #11 had a current active order that read Oxycodone 10 mg every four hours as needed and Oxycodone 20 mg every four hours as needed. Please provide more clear direction for the nursing staff - please include a desired pain scale for each medication. On 01/24/24, provider documented disagree with no further instructions. On 01/18/24 the pharmacist recommended per guidelines for managing psychotropic drug therapy, the following medications are due for annual evaluation for continued use: Buspirone 30 milligrams twice a day. On 01/24/24 the Physician disagreed because reduction likely to impair resident's function and/or cause an increase in behaviors. The physician did not complete the form and identify diagnoses/symptoms or behaviors. On 02/13/24 the pharmacist indicated there was a current active order for Insulin Glargine 100 units/milliliter - inject 30 units subcutaneous per day. Please verify if this patient is allergic to Glargine and consider discontinuing their current active order if appropriate. If not a true allergy, please update their profile accordingly. There is an undated handwritten note stating not a true allergy per certified nurse practitioner. As of 10/23/24 the resident's chart continues to list Insulin Glargine as an allergy. On 07/22/24 the pharmacist recommended per guidelines for managing psychotropic drug therapy, the following medications are due for annual evaluation for continued use: Bupropion Extended Release 150 milligrams daily and Venlafaxine Extended Release 450 milligrams at bedtime. On 07/25/24 the Physician disagreed because reduction likely to impair resident's function and/or cause an increase in behaviors. The physician did not complete the form and identify diagnoses/symptoms or behaviors. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/24/24 at 11:00 A.M. with Licensed Practical Nurse (LPN) #267 confirmed there are no parameters indicating when to give oxycodone for pain. LPN # 267 also verified the allergies listed in the electronic medication record indicate Resident #11 is allergic to Insulin Glargine and is receiving Insulin Glargine. LPN # 267 verified Resident #11's monthly medication review for 02/13/24 indicated the patient's profile listed an allergy to Insulin Glargine and recommended either discontinuing the order or updating the patient profile. An undated note stated the nurse practitioner indicated it was not a true allergy. The patient profile has not been updated. LPN #267 verified the physician checked disagree on the monthly medication review forms but did not complete the second part of the form as indicated in the instructions. 2. Record review for Resident #15 revealed Resident #15 was admitted to the facility on [DATE] and had diagnoses including chronic obstructive pulmonary disease, seizures, quadriplegia, constipation, schizophrenia, anxiety disorder, post-traumatic stress disorder, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 08/13/24, revealed Resident #15 had mildly impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 11/15. Resident #15 received antipsychotic, antianxiety, antidepressant, anticoagulant, and antibiotic medications given with indications noted. Review of the monthly medication reports from pharmacy revealed: On 09/19/24 the pharmacist noted it is recommended for a patient taking an anti-psychotic medication to have a lipid panel drawn every 6 months and the resident is currently overdue. On 09/24/24 the physician disagreed with no explanation, that portion of the form was left blank. Interview on 10/24/24 at 11:00 A.M. with LPN #267 confirmed the physician checked disagree on the monthly medication review forms but did not complete the second part of the form as indicated in the instructions.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47059 Based on medical record review, review of facility policy, and staff interviews, the facility failed to ensure residents who received multiple as needed pain medications had parameters in place to ensure pain medications were administered appropriately. This affected two (Residents #11 and #15) of five residents reviewed for unnecessary medications. The facility census was 99. Findings include: 1. Review of Resident #11's medical record revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, pyogenic arthritis, chronic kidney disease, and migraines. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #11 was cognitively intact. Review of Resident #11's current pain medications dated 10/2024 revealed orders for Oxycodone (treats moderate to severe pain) 10 milligrams (mg) every four hours as needed for pain and acetaminophen (treats minor aches and pain) 325 mg tablets give two tablets every four hours as needed for pain. There were no parameters in place for the as needed pain medications. Review of of Resident #11's medication administrations records (MAR) from 09/01/24 to 10/31/24 revealed Resident #11 received Oxycodone 10 mg every four hours as needed for pain was administered one to four times a day, everyday, from 09/01/14 through 10/31/24 with documented pain scores (zero is no pain and ten is most severe pain) ranging from two to eight. Tylenol 325 mg tablets was administered every four hours as needed for pain on 10/19/24 at 6:32 P.M. for a pain level of five. Interview on 10/24/24 at 11:00 A.M. with Licensed Practical Nurse (LPN) #267 confirmed there were no parameters for Resident #11 indicating when to give Oxycodone or acetaminophen for pain. 2. Record review for Resident #15 revealed Resident #15 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, quadriplegia, and constipation. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 08/13/24, revealed Resident #15 had mildly impaired cognition. Review of Resident #15's current pain medications orders dated 10/2024 revealed orders for Norco tablet (Hydrocodone-acetaminophen) (treats moderate to severe pain) 5-325 milligrams (mg) give one tablet every 12 hours as needed for pain and acetaminophen (treats minor aches and pain) 325 milligram tablets give two tablets every four hours as needed for pain. Review of Resident #15's medication administration record (MAR) from 10/01/24 through 10/31/24 revealed Norco 5-325 mg every 12 hours as needed for pain was administered multiple days in October 2024 for pain scores ranging from a three to an eight on a numerical pain scale (zero was no pain, ten is most severe pain). Tylenol 325 mg tablets give two tablets as needed every six hours for pain was administered on 10/15/24 at 11:30 P.M., 10/19/24 at 12:37 P.M., and 10/22/24 at 6:36 P.M. with no pain score documented. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/23/24 at 3:35 P.M. with Regional Registered Nurse (RRN) #605 revealed expectations of the nurse are if the resident has more than one as needed (PRN) pain medication, she would expect the nurse to use nursing judgement to determine the least strongest medication that would meet the patient's needs. She would also expect the nurse to ask the resident which pain medication they want for the level of pain they are experiencing. Interview on 10/24/24 at 11:00 A.M. with Licensed Practical Nurse (LPN) #267 confirmed there were no parameters for Resident #15 indicating when to give Norco or acetaminophen for pain. Review of the policy titled Pain Assessment and Management last review date 11/20/23 revealed the expectation to assess for pain based on verbal and non-verbal cues as part of the pain assessment. Review the medications administration record to determine how often the individual requests and receives pain medication, and to what extent the administered medications relieve the resident's pain.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on observation, resident and staff interview, and record review, the facility failed to ensure dental services and follow up were provided timely to a resident. This affected one (Resident #22) of one resident reviewed for dental services. The facility census was 99. Findings include Review of the medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included multiple sclerosis, failure to thrive, weakness, chronic pain, and diabetes mellitus. Review of the progress note dated 02/14/22 revealed Resident #22 saw the dentist with exam recommending extractions of #4, #5, #6, #7, #8, #9, 11, #12, and #13 and have dentures made and a plan would be discussed with the resident once clearance from 360 dental. The progress notes revealed on 04/22/22, a care conference was held and Resident #22 stated he wanted teeth extractions, which he had declined a few weeks prior. The progress note dated 04/25/22 revealed a call was made to schedule extractions with 360 care. On 04/28/22, a follow up from 360 dentist informed social services that extractions would need to be referred out. Resident received oral surgery referral and the resident shall be updated. On 05/02/22, Resident #22 was informed this date related to extractions. Resident informed 360 cannot do the extractions and was agreeable to them being referred out to different providers. On 05/10/22, a dental referral was made for extractions for Dental Clinic #1. On 05/24/22, a call to the Dental Clinic #1 and left message. The facility shall continue to reach office while also looking for other dental offices. On 08/08/22, an appointment for Dental Clinic #2 for 09/01/22 at 1:00 P.M. and the resident stated he wanted to get the extractions done. A second note this date stated Dental Clinic #2 requested radiology x-rays to be sent via email. On 08/31/22, social services reminded Resident #22 of his appointment at Dental Clinic #2 for tomorrow (09/01/22) and informed him it would be a long appointment. On 09/01/22, Resident #22 was seen in the hallway when he should have been at his appointment. Resident #22 informed social services transportation could not locate the building and blamed social services. Resident #22 also stated they would not see him due to not having any information. Social Services informed the resident he had all paperwork he needed in the packet provided by facility. There was no further documentation regarding rescheduling the teeth extraction appointments or follow up to a dentist until 2024. Review of the physician orders for 04/22/24 revealed an order for dentist referral for two teeth extractions. There was no follow up noted in the medical record for Resident #22 to see a dentist after the physician order was made from 04/22/24 to 10/21/24. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 was cognitively intact. Review of the plan of care dated 10/21/24 revealed no dental care plan or any mention of dental needs. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 10/21/24 at 2:35 P.M. with Resident #22 revealed he had teeth that needed to be pulled. Resident #22 used his hand and easily wiggled his two front teeth. Resident #22 stated it had been a while since he saw a dentist. Interview on 10/23/24 at 4:10 P.M. with Social Services Director #520 confirmed a social service aide was assisting in arranging dental service follow up for Resident #22 and confirmed the facility had no evidence of resident being rescheduled and receiving the dental services he needed after he missed the 2022 appointment. Social Services Director #520 also confirmed she had no knowledge of a physician order being placed 04/2024 and confirmed Resident #22 had no follow up or social service intervention since then for dental services. Review of the facility notice titled Dental Services dated 11/30/23 revealed residents shall receive services in accordance with assessment and plan of care. Routine and emergency services shall be provided through a contract with a local dentist, a referral to resident's preferred dentist, referral to community dentist and referral to other healthcare organization that provide dental services. Social Services shall be responsible for assisting in making dental appointments and transportation arrangements as necessary.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 36648 Based on resident and staff interviews, observations, and review of the facility policy, the facility failed to ensure the residents were offered snacks in the evening. This affected Resident #1, #11, and #34 and had the potential to affect 96 residents who received food from the kitchen. The facility census was 99. Findings include: Interviews with Residents #1, #11 and #34 during the Resident Council meeting on 10/23/24 at 10:30 A.M. revealed the residents were not receiving snacks. Interview on 10/23/24 at 2:00 P.M. with the Director of Dietary Services (DDS) #512 and the Regional Dietary Manager #610 stated they do not prepare a snack cart for each unit. It was the responsibility of the nurses and or the state tested nursing aides (STNA) when a resident request a snack in between meals, they were to retrieve a snack in the nutrition rooms or from the kitchenette in each units dining room. DDS #512 stated she goes to the units and dining rooms routinely to ensure there was a supply of snacks. Observation and interview on 10/23/24 at 4:09 P.M. with STNA #610 revealed the second floor nutrition room had no available snacks for residents. There was milk in the refrigerator. Observation of the kitchenette in the dining room revealed saltines and graham crackers were available snacks for the residents. STNA #610 does ask each of her residents she was taking care of if they like a snack per their choice. However, it is understood if the resident wants a snack, they must ask an employee to get it for them. This was how they of it on the night shift. Observation and interview on 10/23/24 at 4:00 P.M. with Registered Nurse (RN) #247 revealed Unit One nutrition room had no snacks available. The refrigerator had two sandwiches in the refrigerator wrapped with no date or names. RN #247 was unsure if the STNAs routinely pass snacks to residents day or evening. He has an STNA who will go get a snack if a resident asks for one. There was no staff who offer snacks routinely to the residents. Review of facility policy titled Snacks dated 10/2022 revealed snacks and beverages will be provided as identified in the individual plans of care. Bedtime (a.k.a. HS) snacks will be provided for all residents. Additional snacks and beverages will be available upon request for all residents who want to eat at non-traditional times. Snacks will be assembled, labeled, and dated in accordance with the individual plan of care for each resident and those items will be delivered to patient areas in a timely manner. The Dining Services Department will assessable and deliver to each unit the individually planned snack items and bulk items to be offered at bedtime. Nursing Services is responsible for delivering the individual snacks to the identified residents and for offering evening snacks to all other residents. This deficiency represents non-compliance investigated under Complaint Number OH00158339.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36648 Based on observations, staff interviews, and policy review, the facility failed to ensure the kitchen and nutrition rooms were maintained in a sanitary manner. This had the potential to affect 96 residents who the facility identified to receive food from the kitchen. The facility census was 99. Findings include: Observations of the kitchen on 10/21/24 from 9:35 A.M. to 9:50 A.M. with Dietary Director of Services (DDS) #512 and Regional Director of Dietary #600 revealed throughout the kitchen area, there were knats flying around the entry way into the kitchen and in the dry storage area. This was verified by the DDS #512. Observation of the ice machine located in the kitchen revealed the shoot where the ice cubes travel to cups contained a black speckled substance when wiped with a clean white napkin. This was verified by Regional Director of Dietary #600. In the dry storage area, the area around the baseboards behind and under the shelves were covered with a dark brown, black, spotted and specks substances like dirt in the entire parameter of the room. In the kitchen area, there were two large 100 pound bins with lids. Inside of the bins, there were two open bags of cane sugar, two bags of brown sugar and a bag of corn meal, and the five bags were not dated when opened. Each bin lid had dry substance like particles on it. This was verified by Dietary Director of Services #512. Observation on 10/23/24 at 4:00 P.M. with Registered Nurse (RN) #247 of Unit One nutrition room revealed the stand alone refrigerator freezer was not working . The temperature was 58 degrees Fahrenheit. The ice packs inside the freezer were thawed. The ice machine shoot where the ice cubes travel to cups contained a black speckled substance when wiped with a clean white napkin. RN #247 verified the freezer was not working and the ice machine was dirty inside. Observation on 10/23/24 at 4:09 P.M. with State tested Nursing Aide (STNA) #610 of the second floor nutrition room revealed several dirty trays with Styrofoam containers of food sitting on the counters on top of each other. The ice machine shoot where the ice cubes travel to cups contained a black speckled substance when wiped with a white clean napkin. STNA #610 verified the dirty trays sitting on the counter and the ice machine was dirty inside. Review of the facility's undated policy titled Food Preparation and Storage Policy revealed food items will be prepared to conserve maximum nutritive value, develop and enhance flavor and keep free of harmful organisms and substances. Review of the facility policy titled Environment dated 09/2017 revealed all food contact surfaces will be cleaned and sanitized after each use. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Food Storage: Cold Foods dated 02/2023 revealed all foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. This deficiency represents non-compliance investigated under Complaint Numbers OH00159075, OH00158889, and OH00158801.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on record review, review of the Centers for Disease Control and Prevention (CDC) guidance, staff interviews, and observations, the facility failed to ensure a comprehensive water management plan was in place for the prevention of Legionella, failed to follow proper infection control techniques during wound dressing changes, failed to utilize Enhanced Barrier Precautions for a resident with an indwelling medical device, and failed to complete tuberculosis test per the facility assessment. This affected two residents (#4 and #102) and had the potential to affect all 99 residents residing in the facility. Findings include: 1. Review of facilities Water Management Program Plan dated 01/26/18 revealed the facility must establish a water management team. The team consists of the facility administrator, maintenance director and infection preventionist. Review of the facilities Waterborne Pathogens Plan dated 09/04/24 revealed risk factors associated with Legionella bacteria are water flow, disinfection and water temperatures. Review of the facilities What Clinicians Need to Know about Legionnaires' disease dated 11/30/23 revealed the facility follows the water management program with the Center for Disease Control and Prevention (CDC). Interview on 10/28/24 at 4:24 P.M. with Maintenance Director (MD) #514 denied the presence of a facility water management team that conducts regular meetings. MD #514 confirmed his responsibility for the general maintenance and upkeep of the water management plan, which included monitoring water temperatures and flushing dead areas. MD #514 was unable to provide documentation about the water flow system, including the intake points and the distribution from boilers/heaters to resident rooms. Additionally, when asked about his training in infection control and Legionella management, he indicated that while he had basic knowledge of the procedures, however he was unaware of any additional requirements. Review of the CDC's Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings dated 06/24/21 revealed the facility needs to actively identify and manage hazardous condition that support growth and spread of Legionella. Developing and maintaining a water management program requires staff but is not limited to is to establish a water management program team, describe the buildings water systems using text and flow diagrams and make sure the program is running as designed and is effective. The plan notes it is extremely important that the facility reviews the elements of your program at least once per year. A water management program team is important to obtain certain skills such as knowledge of Legionella, ability to identify control location and implement corrective actions, ability to confirm program performance and communicate regularly about the program. Describing the water system includes include details such as where the building connects the municipal water supply, how water is distributed, and where water heaters or boilers are located. 31404 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Record review of Resident #4 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus with diabetic peripheral angiopathy, Alzheimer's disease, dementia without behavioral disturbance, and peripheral vascular disease. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 was moderately cognitively impaired. Review of the pre-admission hospital records dated 10/03/24 revealed Resident #4 had a pressure injury to the right heel, pressure injury to the right leg posterior, and a pressure injury to the right foot lateral distal. Review of Resident #4's physician order dated 10/21/24 revealed an order for the right anterior foot, to cleanse with saline pat dry, apply medihoney to wound bed, cover with abdominal pad wrap with kerlix, as needed for wound care. Observation on 10/23/24 at 9:35 A.M. of Resident #4's wound dressing change revealed Wound Clinic Nurse (WCN) #733 cleaning three of the resident's wound. Wound Clinic Nurse #733 used wound cleanser on the wounds and cleaned all three wounds with the same gauze. Wound Nurse Practitioner #777 then debrided the wound on Resident #4's lateral foot without cleaning the contaminated area. Interview with Wound Clinic Nurse #733 on 10/23/24 at 9:44 A.M. verified she cleaned Resident #4's wound with the same wound wash and gauze. She verified cleaning the right calf area then right heel and finally the right lateral foot last. Wound Clinic Nurse #733 stated she turned the gauze over between cleaning the areas. 3. Review of the facility's 2024 Tuberculosis Risk Assessment worksheet revealed baseline testing is completed with a two step tuberculin skin test for health care workers. Review of State tested Nurse Aide (STNA) #315's personnel file revealed STNA #315 was hired on 07/02/24 and they only had a one step tuberculin test upon hire. There was no second tuberculin test completed. Review of State tested Nurse Aide (STNA) #900 personnel file revealed STNA #315 was hired on 07/30/24 and they had no evidence of any tuberculin test being completed prior to hire. Interview with Human Resources (HR) #506 on 10/28/24 at 3:00 P.M. verified STNA #315 only had a one step Tuberculin test upon hire and they needed two steps. HR #506 verified STNA #900 had no evidence of any tuberculin test being completed prior to hire. 47059 4. Review of Resident #102's medical record revealed the resident was readmitted on [DATE]. Diagnoses included type I diabetes mellitus and encounter for attention to gastrostomy. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #102 had intact cognition and had a gastric tube (g-tube) in place. Review of the physician's orders for Resident #102 revealed an order to flush the gastric tube with 200 milliliters of water twice a day. Orders for gastric tube feeding stopped 09/20/24 and gastric tube site care and enhanced barrier precautions were discontinued 10/01/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 10/24/24 at 2:40 P.M. of incontinence care for Resident #102 performed by State tested Nursing Assistant (STNA) #309 revealed no concerns with incontinence care. Resident #102 had a gastric tube in place and STNA #309 did not use enhanced barrier precautions. Interview on 10/24/24 at 2:55 P.M. with the Director of Nursing (DON) confirmed Resident #102 has a g-tube in place and was not in enhanced barrier precautions. The DON stated Resident #102 was eating now and not using the g-tube for any nutrition except the twice a day flush with water, so Resident #102 does not need to be in enhanced barrier precautions anymore. Review of the facility policy titled Enhanced Barrier Precautions last revision dated 11/20/23 revealed enhanced barrier precautions utilizing a minimum of gown and gloves for any high-contact resident care should be used for any resident with wounds or an indwelling medical device. High-contact care is considered to be dressing, bathing/showering, transferring, providing hygiene, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube or tracheostomy), and wound care. Review of the CDC guidelines for Application and Duration of Enhanced Barrier Precautions dated 06/28/24 and found at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html# revealed Enhanced Barrier Precautions should be used for residents with a wound or indwelling medical device, even if the resident is not known to be infected or colonized with a multi drug resistant organism. Enhanced Barrier Precautions are currently recommended to be used broadly, in all units across the whole facility, for residents who meet these criteria.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on record review, staff interviews, and facility policy review, the facility failed to follow guidance within their antibiotic stewardship program to ensure antibiotics were ordered appropriately. This affected two (Resident #10 and Resident #163) of three residents reviewed for antibiotic usage. The facility census was 99. Findings include: Review of facilities antimicrobial stewardship program mission statement dated 11/30/23 revealed the facility ensures that antibiotic medications are only used when truly necessary, and when prescribed, will be the best medication at the correct dose for the appropriate length of treatment. Our goal is to help reduce growing antibiotic resistance. 1. Review of the medical record for Resident #10 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, peripheral vascular disease, chronic gastritis, and urinary incontinence. Review of the care plan dated 11/30/23 revealed Resident #10 had bladder incontinence due to impaired mobility with interventions of monitor for signs and symptoms of urinary tract infection (UTI) such as burning on urination, flank pain, hematuria, difficulty voiding, change in mental status, change in behavior, fever, change in color, clarity and odor of urine. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #10 was severely cognitively impaired, exhibited no behaviors, required substantial/maximal assistance with toileting, and was always incontinent or urine and bowel. Review of Resident #10's body temperature summary from 09/17/24 to 10/11/24 revealed no temperatures were marked as abnormal or high. Review of the Nurse Practitioner note dated 09/30/24 revealed the physician saw Resident #10 for noted weakness and family's request. Laboratory results and x-ray completed the previous week were noted normal. Family requested to start antibiotic for suspected UTI since the resident was incontinent, refusing a straight catherization due to pain and discomfort. To prevent illness and complication, the family insisted to start on antibiotic as it was previously done. Additional plan to encourage oral hydration as able. Review of Resident #10's physician orders with a start date of 09/30/24 and end date of 10/10/24 revealed an order for Macrobid (antibiotic) oral capsule 100 milligrams by mouth two times a day for UTI for 10 days. Review of the Medication Administration Record (MAR) revealed the first dose of Macrobid began on 09/30/24 in the evening and an end date of 10/10/24. It was noted Resident #10 refused morning dosage on 10/06/24, 10/08/24 and 10/10/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366418	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Dublin	4075 West Dublin-Granville Road Dublin, OH 43017

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medical record revealed no diagnosis of UTI when Macrobid was started, and no evidence was found supporting an increase in incontinence, frequency, or urgency beyond the resident's current baseline of incontinence. No declined in orientation or mental state was observed. Review of the facilities infection control log from 09/19/24 to 09/24/24 revealed Resident #10 was prescribed Macrobid as a preventative treatment for a UTI with no labs ordered or completed with an identified organism. Interview on 10/28/24 at 4:42 P.M. with Registered Nurse (RN) #384 confirmed Resident #10's medical record did not contain evidence supporting the order for Macrobid. RN #384 confirmed Resident #10 was prescribed an antibiotic without following Mcgreer's criteria as required per the antibiotic stewardship program. 2. Review of the medical record for Resident #163 revealed an admitted [DATE]. Diagnoses included cystitis without hematuria, pyuria, and history of urinary tract infections (UTI). Review of the five-day Minimum Data Set (MDS) 3.0 assessment completed 07/18/24 revealed Resident #163 was cognitively intact, with no behaviors, was dependent on staff for toileting and was frequently incontinent of urine and bowel. Review of the hospital discharge summary dated 07/11/24 revealed Resident #163 was admitted to the hospital/prior to facility admission due to acute uncomplicated cystitis, and found resident had 10 days of persistent dysuria, painful urination and generalized weakness. Hospital record note history of klebsiella UTI with resistance to Macrobid. Review of Resident #163's body temperature summary from 07/11/24 to 07/22/24 revealed no abnormal temperatures. Review of Resident #163's physician orders dated 07/12/24 to 07/14/24 revealed an order for Macrobid (antibiotic) 100 milligrams (mg) by mouth one time a day for prophylactic infection. On 07/15/24, the physician extended the order of Macrobid 100 mg, administer one capsule two times per day from 07/15/24 to 07/22/24 for UTI. On 07/22/24, the physician ordered for ampicillin one capsule by mouth two times a day for UTI, with a start date of 07/22/24 and end date of 08/01/24. Review of the 72-hour antibiotic time out dated 07/14/24 for Resident #163 revealed Macrobid 100 mg as antibiotic prescribed from hospital discharge, the resident does not meet Loeb minimum criteria as the resident exhibited no symptoms. Review of the facilities infection control log from 07/03/24 to 07/12/24 revealed Resident #163 was prescribed Macrobid for prophylaxis pertaining to UTI with urine result for compatibility. The infection control log from from 07/15/24 to 07/23/24 revealed Resident #163 was prescribed ampicillin due to UTI caused by escheria coli. Interview on 10/28/24 at 4:42 P.M. with Registered Nurse (RN) #384 confirmed Resident #163's initial order for Macrobid was not appropriate. Review of the hospital records found the patients prophylactic antibiotic needed discontinued since it did not meet any criteria for use and had a history of resistance. Once the antibiotic was discontinued, an order for a urine culture and sensitivity was completed to ensure Resident #163 received an appropriate antibiotic. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facilities Antibiotic Stewardship Program Policy dated 11/30/23 revealed the facility utilizes McGeer's definitions of infection to determine appropriate infectious diagnoses and treatment. The facility implements training to staff to emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects residents and the overall community.

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on record review, resident and staff interview, review of facility policy, and observations, the facility failed to ensure they had a functional call light system and call lights were kept within reach. This affected two (Residents #31 and #55) of three residents reviewed for call light systems. The facility census was 99. Findings include: 1. Review of the medical record for Resident #31 revealed an admitted [DATE]. Diagnoses included chronic kidney disease, depression, bilateral osteoarthritis of knee and bed confinement status. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #31 was cognitively impaired, had bilateral impairments in the lower extremities, was dependent on staff for all activities of daily living, and was incontinent of urine. Review of the care plan dated 02/20/24 revealed Resident #31 was at a fall risk due to impaired mobility and incontinence. Interventions included to explain and remind the resident of non-compliance with ambulation and transfers and reinforce needs to call for assistance. Review of the facilities work orders dated 07/28/24 to 10/22/24 revealed no requests were placed for Resident #31's call light system repair. Observation and interview on 10/21/24 at 1:57 P.M. with Resident #31 revealed a bell was at the bedside. Resident #31 stated it was his alternative to a call light. His call light system had not been functioning for over a month. At this time, the resident was observed ringing his call bell. Observation on 10/22/24 at 2:27 P.M. in Resident #31's room revealed when the call light was pressed, a light illuminated on the call light box on the wall. However, upon exiting the room, the light above the door was not illuminated, and the main nurses' station did not receive a call from the resident's room. Interview on 10/22/24 at 5:18 P.M. with Registered Nurse (RN) #441 confirmed Resident #31's call light does not function properly. RN #441 stated Resident #31 received a bell to ring when he required assistance. RN #441 confirmed a request for a repair would be placed for maintenance to resolve the issue. Interview on 10/23/24 at 5:45 P.M. with Maintenance Director (MD) #514 confirmed the call light system was not functioning properly in Resident #31's room. MD #514 stated he had no record of staff members submitting a request for replacement. MD #514 confirmed there had been persistent call light issues in Resident #31's room for the past three weeks. To resolve the call light issue, a replacement of the affected unit would be necessary. A temporary and appropriate solution for the malfunctioning call light system was to provide the affected resident with a bell. 44070 (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #55 revealed an admitted [DATE]. Diagnoses included cerebrovascular disease, diabetes mellitus, cerebrovascular disease, cognitive communication deficit, dysphasia, muscle weakness, and adjustment disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 was cognitively impaired and required substantial/maximum assistance for bed mobility. Review of the plan of care dated 10/23/23 revealed Resident #55 was at risk for falls with interventions for bed in lowest position, floor bed and mattresses to both sides and provide clip for call light. Observation on 10/21/24 at 2:40 P.M. revealed Resident #55 activated his call light. The call light lit up to the wall, but did not light up in the hallway and had no audible alert. Continuous observation from 2:40 P.M. to 3:25 P.M. revealed Resident #55's call light was not answered. Observation and interview on 10/21/24 at 3:28 P.M. with State tested Nursing Aide (STNA) #807 confirmed she had not been alerted to the call light for Resident #55. She revealed the light should activate above the door in the hallway and also stated they had a screen at the nurse's station where all call lights would show up once activated. STNA #807 confirmed Resident #55's call light did not activate above the door or on the screen. STNA #801 confirmed Resident #55's call light was not working correctly. Interview on 10/22/24 at 5:45 P.M. with Maintenance Director (MD) #514 revealed knowledge of call lights breaking. MD #514 stated the facility had a system similar to hospital bed remote that activated call lights while also working as a television remote. They remotes break easily and were slow to get repair parts. MD #514 stated the facility staff informed him that morning (10/22/24) of the broken call light for Resident #55 and acknowledged he cannot start the process to fix anything if staff do not tell him. Review of the facility policy titled Call Light dated 06/08/22 revealed facility shall respond to resident call for assistance and assure the call system was in working order. The equipment included a bedside call light in functioning order. For bedside lights, a light and sound shall appear and be heard over the door of the resident room. This deficiency represents non-compliance investigated under Complaint Number OH00158407, OH00158922, and OH00158801.