STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366424	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein New Albany	6690 Liberation Way New Albany, OH 43054

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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. 50008 Based on observation, medical record review, staff interview, and facility policy review, the facility failed to provide residents with a dignified dining experience. This affected one (#46) of two residents reviewed for dignity. The facility census was 52. Findings include: Review of the medical record revealed Resident #46 was admitted to facility on 06/08/24 with diagnoses that included cerebral infarction, arteriovenous malformation of cerebral vessels, and chronic motor or vocal tic disorder. Review of a Minimum Data Set (MDS) assessment on 06/13/24 revealed Resident #46 needed substantial to maximal assistance with eating. Observation on 08/14/24 at 9:01 A.M. revealed State tested Nurse Aide (STNA) #196 was standing while feeding Resident #46 his breakfast meal in his bed. Interview with STNA #196 on 08/14/24 at 9:01 A.M. confirmed STNA #196 was standing while feeding Resident #46. STNA #196 stated that on some occasions, Resident #46 had asked her to sit down while feeding him. Review of a facility document for senior lifestyle neighborhood standards for dining, approved 11/13/07 and revised 04/2013, revealed the meal is intended to be a time for quiet relaxed dining and conversation. This will be achieved by each elder sitting in a dining room chair unless care planning states otherwise.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation, resident and staff interview, medical record review, and review of invoices, the facility failed to ensure residents had a means to contact staff members of needs and services that were individualized to the resident's needs. This affected one (#102) of one resident reviewed for call lights. The facility census was 52. Findings include: Review of the medical record for Resident #102 revealed an admitted [DATE] with diagnoses including quadriplegia, type two diabetes mellitus, depression, atherosclerosis of other arteries, osteoarthritis, spinal stenosis, paroxysmal atrial fibrillation, and neuromuscular dysfunction of the bladder. Review of Resident #102's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #102 had moderately impaired cognition. Interview on 08/12/24 at 11:55 A.M. with Resident #102 revealed she was quadriplegic but could move her head. She reported the facility had not provided a call light for her to use and because of this she had to yell out when she needed help. Observation on 08/12/24 at 11:55 A.M. revealed Resident #102 did not have a call light or pendent. Observation on 08/13/24 at 10:05 A.M. revealed Resident #102 yelling out for help. State tested Nurse Aide (STNA) #190 told the resident she would be with her in a moment. Interview on 08/13/24 at 10:26 A.M. with STNA #190 verified Resident #102 did not have a call light that worked for her due to her quadriplegia. She reported the resident mostly yelled out to get assistance, although she believed at times the resident would use voice activation to turn the volume up on her television to get the staff's attention. Interview on 08/14/24 at 8:19 A.M. with Maintenance #146 revealed he was unsure where at what stage the process was at for getting Resident #102 a means to notify staff of her needs. Interview on 08/14/24 at 4:59 P.M. with Regional Nurse #300 revealed she believed an order had already been placed for a call light for Resident #102. Review of the invoice provided on 08/19/24 at 8:00 A.M. by Regional Nurse #300 revealed an order was placed for a call cord pad on 08/15/24. Interview on 08/19/24 at 9:15 A.M. with Regional Nurse #300 verified a call light for Resident #102 was ordered on 05/15/24 after surveyor inquiry.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, resident and staff interview, and medical record review, the facility failed to ensure residents were provided the right to chose their eating utensils to promote a homelike dining experience. This affected one (#21) of one residents reviewed for choices. The facility census was 52. Findings Include: Review of the medical record for Resident #21 revealed an initial admitted [DATE] with the diagnoses including but not limited to dementia, colostomy, diabetes mellitus, hypertension, obstructive reflux uropathy, morbid obesity, malignant neoplasm of colon, and osteoarthritis. Review of Resident #21's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of Resident #21's current plan of care revealed no care plan indicating the resident was not able to have a table knife at meals. Review of Resident #21's monthly physician orders for August 2024 identified orders dated 06/10/24 for the resident to receive a regular diet, half portion desserts, and easy to chew solids. Further review revealed no physician order indicating the resident was unable to have a table knife with meals. Review of Resident #21's progress notes revealed no indication the resident was not permitted a table knife with meals. On 08/12/24 at 9:20 A.M., interview with Resident #21 revealed she does not receive a table knife with her meals and had difficulty using a spoon and fork to cut up her food. Observation of Resident #21 during the interview revealed she was was eating at the dining room table and had no table knife with her meal. On 08/12/24 at 12:33 P.M., observation of Resident #21 during the lunch meal revealed she was not offered a table knife for the lunch meal. On 08/13/24 at 3:55 P.M., interview with State tested Nurse Aide (STNA) #154 revealed the residents in House 100 are not offered table knives with meals. STNA #154 revealed only two (#14 and #21) residents should receive table knives with meals. On 08/19/24 at 12:10 P.M., observation of Resident #21 revealed she was eating lunch and had no table knife with her meal. On 08/19/24 at 12:28 P.M., interview with STNA #350 verified the residents of the house are not offered a table knife because the residents have dementia.

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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** 47569 Based on resident funds account review, medical record review, and staff interview, the facility failed to ensure residents were assisted with spending down their resident trust accounts once the balance reached $200 less than the Medicaid allowable limit. This deficient practice affected one resident (#43) of four residents reviewed for personal funds. The facility census was 52. Findings Include: Review of the medical record for Resident #43 revealed an admitted [DATE] with a diagnosis of Alzheimer's disease with late unset. Resident #43 had dual payer sources consisting of Medicaid and a commercial insurance. Review of Resident #43's document for resident fund management authorization and agreement to handle resident funds form dated 9/01/23, revealed the resident's account type was marked as non-transferable account which included no automatic transfer of deposits to pay for care cost. The form was signed by Resident #43's Power of Attorney (POA). Review of Resident #43's account statement dated 01/02/24 to 08/02/24 revealed several debits and credits on the account activity with the account balance as of 08/02/24 of $11,582.10, which exceeds the allowable amount under Medicaid assistance of $2,000.00 for personal funds while admission to the facility. Review of Resident #43's resident funds balance notification letters dated 08/19/24, 04/04/24, and 05/29/24 addressed to Resident #43 revealed the letters were not signed by either the facility representative or marked by Resident #43 acknowledgement of receipt. There were no receipts of delivery available to review, and there was not a plan of spending down Resident #43's personal funds account to the allowable amount for Medicaid assistance. Interview on 08/19/24 at 2:10 P.M. with Business Office Manager (BOM) #184 confirmed Resident #43's account balance did exceed the allowable amount in a personal funds account for residents receiving Medicaid assistance and there was not a plan in place for Resident #43 to spend down the exceeded amount. BOM #184 also confirmed there were no receipts of delivery or receipt available to review for the resident fund balance notification letters.

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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** 50008 Based on observation, medical record review, review of maintenance logs, and staff interview, the facility failed to maintain a safe and homelike environment. This affected two (#31 and #36) of nine residents reviewed for environment. The facility census was 52. Findings include: 1. Review of the medical record revealed Resident #36 was admitted on [DATE] with diagnoses that included autistic disorder, heart failure, epilepsy, lack of coordination, insomnia, and anxiety. Observation on 08/13/24 at 3:41 P.M., 08/14/24 at 4:32 P.M., and 08/19/24 at 1:09 P.M. revealed Resident #36's room wall had paint chips missing from the wall in an area measuring seven inches long by eight inches wide, and the window frame next to Resident #36's bed had chipped wood along the bottom sill, exposing jagged sharp wood splinters. Interview with State tested Nurse Aide (STNA) #77 on 08/15/24 at 2:57 P.M. confirmed that the bottom window sill next to Resident #36's bed was jagged and sharp. STNA #77 stated if there are maintenance requests for repairs, she would directly message Maintenance Director (MD) #146 and inform him about the repairs needed. Interview with STNA #132 on 08/15/24 at 3:00 P.M. confirmed that the paint was peeling and the window sill was jagged and sharp in Resident #36's room. STNA #132 stated that she would put in a work order with MD #146 on 08/15/24. Interview with MD #146 on 08/19/24 at 1:17 P.M. revealed he had not received a work order for any repairs needed in Resident #36's room. MD #146 revealed the paint on the wall was missing next to Resident #36's bed where the hand rail pushed against the wall. MD #146 confirmed the window sill was damaged and contained exposed, splintered, and sharp wood next to Resident #36's bed. 2. Review of Resident #31's medical record revealed admitted [DATE] with diagnoses including dementia, anxiety, osteoarthritis, major depressive disorder, and history of falls. Observation on 08/12/24 at 9:26 A.M. of Resident #31's room revealed a missing wood trim from the bottom of the window frame approximately four feet in length, exposing the dry wall with gauges and dry wall material exposed. There is a sharp jagged edge noted to the remaining broken wooden trim. The bed was located directly below the window and within reach of the broken wood trim and exposed dry wall. Review of the maintenance request logs dated 06/12/24 to 08/14/24 revealed a request to fix the missing wooden window trim for Resident #31 dated 08/12/24. Interview on 08/12/24 at 12:10 P.M. with the Regional [NAME] President of Clinical #303 confirmed the missing wooden window trim, exposed dry wall material, and the exposed sharp jagged edges of the remaining piece of the window frame with the bed located under the window in Resident #31's room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47569

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on observation, medical record review, staff interview, and facility policy review, the facility failed to insure residents were free from physical restraints. This deficient practice affected one (#31) of one residents reviewed for physical restraints. The facility census was 52. Findings Include: Review of Resident #31's medical record revealed an admitted [DATE] with diagnoses including dementia, anxiety, osteoarthritis, major depressive disorder, and history of falls. Resident #31 required assistance from staff for transfers and activities of daily living (ADLs) tasks and used a wheelchair for mobility. Resident #31 had impaired cognition and could be redirected during times of agitation. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had delusions, was always incontinent of urine and bowel, and was at risk for skin impairment. Resident #31 had a Brief Interview of Mental Status (BIMS) score of zero out of 15 reflecting severely impaired cognition. Review of the fall investigations for Resident #31 on 09/02/23 at 7:40 A.M. revealed Resident #31 had a fall while attempting to independently ambulate with a walker to the dining room and was observed lying on the floor with the walker. No injuries were assessed. The intervention for this fall was for a therapy evaluation and for staff to assist Resident #31 to the dining room for all meals. On 03/23/23 at 11:30 A.M. Resident #31 had a fall in her room and was observed lying on the floor on her left side, no injuries were assessed. The intervention for this fall was to keep Resident #31 in the common area of House 100 while awake for closer supervision by staff. Observations on 08/12/24 at 10:18 A.M. revealed Resident #31 sitting in a wheelchair, with the foot pedals in place, which was pushed up under the counter top of the kitchen with an activity busy hands book and a baby doll lying on the counter top in front of Resident #31. The wheelchair brakes were not engaged. At 11:25 A.M., Resident #31 was still sitting in the wheelchair, with foot pedals in place, up under the counter top of the kitchen waiting for the lunch meal. At 3:59 P.M. revealed Resident #31 continued to sit in the wheelchair up under the counter top of the kitchen watching staff prepare the supper meal. Interview on 08/12/24 at 4:00 P.M. with State tested Nurse Aide (STNA) #13 revealed the staff had Resident #31 sitting at the counter because she liked to talk to the staff and watch what the staff are are doing. Resident #31 used to use a walker and could walk back and forth to her room. Resident #31 came back from a recent hospital stay and she could not walk very well and now she was in the wheelchair. Resident #31 was able to move the wheelchair around by herself and liked to take care of her babies while she was sitting at the counter. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Observations on 08/13/24 at 8:40 A.M. revealed Resident #31 sitting in a wheelchair, with the foot pedals in place, pushed up under the counter top of the kitchen with a baby doll sitting beside the breakfast meal dishes in front of Resident #31. At 10:41 A.M., Licensed Practical Nurse (LPN) #186 removed Resident #31 from the kitchen area and took Resident #31 in the wheelchair to her room for treatment administration and returned Resident #31 to the kitchen area and pushed her up under counter top in the wheelchair at 10:50 A. M. Resident #31 was agitated and grabbed the baby doll from the counter and started rocking with the baby doll. At 11:43 A.M. Resident #31 continued to sit in the wheelchair up under the counter top waiting for the lunch meal to be served, the wheelchair brakes were not engaged. At 3:01 P.M. Resident #31 was sitting in the wheelchair, with the foot pedals in place, pushed up under the dining room table with the baby doll and the activity busy hands book. The wheelchair brakes were in engaged. Several staff members were present in the kitchen and dining room area, with no one checking on Resident #31 or the brakes on the wheelchair. Observations on 08/14/24 at 8:06 A.M. revealed Resident #31 sitting in the wheelchair, with the foot pedals in place, pushed up under the counter top of the kitchen with the brakes not engaged. Resident #31 was eating the breakfast meal. The baby doll and activity busy hands book were not visible on the counter. At 4:33 P.M., Resident #31 was sitting in the wheelchair, with the foot pedals in place, up under the counter top of the kitchen holding the baby doll with the activity busy hands book sitting on the counter in front of Resident #31. Observations on 08/15/24 at 8:50 A.M. revealed Resident #31 sitting in the wheelchair, with the foot pedals in place, pushed up under the counter top of the kitchen. The wheelchair brakes were engaged on the wheelchair and Resident #31 was finishing eating the breakfast meal. The baby doll and the activity busy hands book were noted to be sitting on the dining room table. Observation at 11: 40 A.M. revealed Resident #31 was sitting in the wheelchair, with the foot pedals in place, without the baby doll or the activity busy hands book in front of her on the counter. The wheelchair brakes continued to be engaged. At 2:49 P.M. Resident #31 was sitting in the wheelchair pushed up under the counter top. Resident #31 was asking for the baby doll, which was still lying on the dining room table, and none of the staff members present retrieved the baby doll for Resident #31. Interview on 08/15/24 at 3:17 P.M. with LPN #186 confirmed Resident #31 does sit in the wheelchair pushed up under the counter or the dining room table for close supervision by staff due to previous falls when the resident was attempting to ambulate independently. LPN #186 stated that Resident #31 being seated there in the wheelchair with the foot pedals in place prohibited Resident #31 from standing up from the wheelchair or self-propelling the wheelchair around the common area and hallways of the house. Review of the facility's policy titled, Restraint, dated 09/18/02 revealed the long-term care facility has a goal to achieve a restraint free environment.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on medical record review and staff interview, the facility failed to ensure Pre-admission Screening and Resident Review (PASARR) evaluations were updated upon determination or newly evident or possible serious mental disorders. This affected one (#4) of one reviewed for PASARR. The facility census was 52. Findings Include: Review of the medical record for Resident #4 revealed an initial admitted [DATE] with the latest readmission of 02/26/24, and with the diagnoses including but not limited to bipolar disorder, morbid obesity, hypertension, dementia with anxiety, peripheral vascular disease, polyarthritis, cataracts, alcohol dependence with alcohol induced dementia, generalized muscle weakness, difficulty in walking, mixed incontinence, hyperlipidemia, low back pain, sensorineural hearing loss, osteoarthritis, dermatitis, and insomnia. A diagnoses of anxiety disorder was added on 04/24/23. Review of Resident #4's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of Resident #4's medical record revealed no evidence a significant change PASSAR evaluation was completed following the new diagnosis of anxiety disorder on 04/24/23 until 04/10/24. On 08/19/24 at 9:47 A.M., interview with Regional Nurse #300 verified Resident #4's significant change PASARR was not completed in a timely manner.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50008 32654 Based on observation, medical record review, staff interview and facility policy review, the facility failed to develop a comprehensive plan of care to address resident needs and conditions as required. This affected four (#13, #26, #35, and #42) of 25 sampled residents reviewed. The facility census was 52. Findings Include: 1. Review of the medical record for Resident #13 revealed an initial admitted [DATE] with the latest readmission of 08/8/24. Diagnoses including but not limited to acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), Parkinson's disease, restlessness and agitation, anxiety disorder, major depressive disorder, seizures, hypertension, hyperlipidemia, insomnia, dementia, and atrial fibrillation. Review of Resident #13's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors, however had wandering behaviors. The assessment indicated the resident was always incontinent of bowel and frequently incontinent of bladder. Review of Resident #13's monthly physician orders for August 2024 identified an order dated 08/10/24 to apply Xeroform dressing, absorbent pad, and Kerlix to the right forearm every morning until healed. Review of Resident #13's plan of care revealed no care plan addressing the wound to the resident's right forearm. On 08/12/24 at 10:59 A.M., observation of Resident #13 revealed a dry and intact dressing to the resident's right forearm. On 08/19/24 at 11:34 A.M., interview with the Director of Nursing (DON) verified the resident had no care plan addressing the wound to the resident's right forearm. 2. Review of Resident #42's medical record revealed an initial admitted [DATE] with the latest readmission of 02/16/24. Diagnoses included but not limited to Parkinson's disease, vascular dementia, abnormalities of gait and mobility, hypercholesterolemia, major depressive disorder, obstructive sleep apnea, benign neoplasm of peripheral nerves and autonomic nervous system, spinal stenosis, cervical disc disorder, adult failure to thrive, hypothyroidism, progressive supranuclear ophthalmoplegia and vitamin D deficiency. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the plan of care dated 12/01/23 revealed Resident #42 was incontinent of bladder related to dementia. Interventions included the resident used disposable briefs and were changed frequently and as needed, cleanse peri-care with each incontinence episode, check as required for incontinence care, wash, rinse and dry perineum, change clothing as needed after each episode and monitor for signs/symptoms of urinary tract infection (UTI). Review of the bowel and bladder screen dated 04/02/24 revealed Resident #42 was frequently incontinent of both bowel and bladder. Review of Resident #42's functional abilities and goals dated 04/02/24 revealed the resident required substantial/maximal assistance with toileting and dressing. Review of Resident #42's quarterly MDS assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors, including rejection of care. The assessment indicated the resident was always incontinent of both bowel and bladder and was not on a toileting program. Review of Resident #42's monthly physician orders for August 2024 identified and order dated 01/22/24 wear thrombo-embolic deterrent (TED) hose daily every shift for deep vein thrombosis (DVT) prevention, may removed for bathing/hygiene, on in morning and off at bedtime. Review of the current plan of care revealed no care plan addressing Resident #42's incontinence of bowel or thrombo-embolic deterrent (TED) hose use. On 08/19/24 at 11:40 A.M., interview with the Director of Nursing (DON) verified there was no comprehensive plan of care developed to address Resident #42's bowel incontinence and TED hose use. 3. Review of the medical record for Resident #26 revealed an admitted [DATE] with diagnoses including cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type two diabetes mellitus, major depressive disorder, peripheral vascular disease, and hypothyroidism. Review of Resident #26's comprehensive MDS 3.0 assessment dated [DATE] revealed Resident #26 had intact cognition. Review of Resident #26's physician order dated 02/02/24 revealed an order for the diuretic Lasix oral tablet 20 milligrams (mg) one time a day every other day for edema related to hypertension. Review of Resident #26's plan of care on 08/15/24 revealed no care plan related to diuretics or hydration. Interview on 08/15/24 at 1:55 P.M. with Regional Nurse #300 verified Resident #26 did not have a plan of care related to potential fluid imbalance related to diuretics. 4. Review of the medical record revealed Resident #35 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular disease, type II diabetes mellitus, dementia, anemia, and polyosteoarthritis. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #35's MDS 3.0 assessment dated [DATE] revealed the resident had an unhealed unstageable pressure ulcer (obscured full-thickness skin and tissue loss) that was not present on admission. Review of Resident #35's care plan revealed he developed a deep tissue injury (DTI) on 06/24/24 to his right heel. Review of the wound evaluation dated 07/16/24 revealed Resident #35 had a stage four pressure ulcer (full-thickness skin and tissue loss) to the right heel. A care plan for a stage four pressure ulcer to the right heel was initiated on 08/13/24. The care plan had been silent for identifying the stage four pressure ulcer from its identification as a stage four pressure ulcer on 07/16/24 through 08/13/24. An interview with Regional MDS Nurse #307 on 08/14/24 at 3:33 P.M. confirmed Resident #35 had a stage four pressure ulcer to his right heel on 07/16/24, but that the care plan for the stage four pressure ulcer was not initiated until 08/13/24. Review of the facility policy titled, Comprehensive Care Planning Policy, dated 11/13/17, revealed the interdisciplinary team would develop, implement and evaluate the comprehensive person centered plan of care which includes measurable objectives and timeframes to meet a resident's medical, nursing and mental/psychosocial needs that are identified in the comprehensive assessment. 43064

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	366424	A. Building B. Wing	08/21/2024

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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** 43064 Based on observation, resident and staff interview, medical record review, and facility policy review, the facility failed to thoroughly assess residents for activity preferences, provide activities of resident interest, and failed to ensure activities were completed as planned. This affected three (#6, #42, and #103) of five residents reviewed for activities. The facility census was 52. Findings include: 1. Review of the medical record for Resident #103 revealed an admitted [DATE] with diagnoses including quadriplegia, type two diabetes mellitus, depression, atherosclerosis of other arteries, osteoarthritis, spinal stenosis, paroxysmal atrial fibrillation, and neuromuscular dysfunction of the bladder. Review of Resident #103's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #103 had moderately impaired cognition. Review of Resident #103's plan of care revealed activities and activities preferences were not addressed. Review of Resident #103's activity screening dated 07/23/24 revealed the resident found it to be somewhat important to attend entertainment events, to go outside when the weather was good, do outdoor tasks, be around animals, keep up with the news, watch movies with other people, listen to music she liked, and have books, newspapers, or magazines. It was also somewhat important to participate in favorite hobbies which included travel, making afghans, and other crafts. Resident #103 found it very important to watch or listen to television. It was indicated it was unknown if Resident #103 participated in group activities or one-on-one activities. Review of Resident #103's activities from 08/01/24 to 08/14/24 revealed Resident #103 participated in watching television or movies every day. Her only other activity was a family or one-on-one visit on 08/11/24. Review of the facility activity tracker from 07/19/24 to 08/14/24 revealed no additional activity documentation for Resident #103. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the activities calendar for August 2024 revealed coffee and chronicles was listed every day. Additional activities included; on 08/01/24 chapel at 2:00 P.M. and hot fudge sundaes at an unknown time, on 08/02/24 Bingo at 2:30 P.M. and movie and popcorn night at 6:00 P.M., it was indicated it was national coloring book day, on 08/03/24 Hawaiian island word search and a major league baseball game, on 08/04/24 manicures and a famous birthdays puzzle with no times listed, on 08/05/24 Bingo at 2:30 P.M. and the Olympics without a time, on 08/06/24 visits with [NAME] (a dog) at 11:00 A.M. and spa day with no time listed, on 08/07/24 bingo at 2:30 P.M. and popsicles and Olympics without a time, on 08/08/24 board games without a time and chapel at 2:00 P.M., on 08/09/24 the Olympics without a time and movie and popcorn night at 6:00 P.M., On 08/10/24 random trivia without a time and a major league baseball game, on 08/11/24 manicures and an IQ puzzle without a time and the Olympic closing ceremony, on 08/12/24 coloring and peach pie day without a time, on 08/13/24 ladies lunch out and music at 2:00 P.M., and on 08/14/24 Elvis (Presely) music all day and Bingo at 2:30 P.M. Interview on 08/12/24 at 11:55 A.M. with Resident #103 revealed she had not had anyone in activities come to visit or do activities with her. She reported she had been up in her chair during activities before, but it was always BINGO and crafts, which she was physically unable to do. Resident #103 reported she would love to be told about and participate in activities with music and trivia. Observation on 08/13/24 at 10:02 A.M., 11:30 A.M., 3:04 P.M., and 3:21 P.M. revealed Resident #103 watching television. Observation on 08/14/24 throughout the day revealed no Elvis music playing in the house Resident #103 resided in. Subsequent observations of Resident #103 at 8:30 A.M., 9:20 A.M. and 10:00 A.M. revealed she was watching television. Interview on 08/19/24 at 10:07 A.M. with Activities Coordinator #29 revealed she was the only activities personnel. She worked 8:30 A.M. to 5:00 P.M. Monday through Friday and had Thursday's off. She reported she did not come in to complete weekend activities, but the nurse aides were supposed to complete activities with the residents. The nurse aides were also supposed to have coffee and review the Chronicle with residents every day. She reported it was hit or miss on if the nurse aides were able to complete activities. Activities Coordinator #29 verified on 08/14/24, Elvis music was not playing all day, and she reported she played it during BINGO. She reported she did have musicians scheduled that she would ensure Resident #103 was invited to and would work with nurse aides to make sure the resident was up in her chair for activities. Activities Coordinator reported she knew the nurse aides struggled with Resident #103's television at times but could not list any other activities for the resident. 2. Review of the medical record for Resident #42 revealed an initial admitted [DATE] with and readmission of 02/16/24. Diagnoses including major depressive disorder, Parkinson's disease, spinal stenosis, vascular dementia, cervical disc disorder, adult failure to thrive, and obstructive sleep apnea. Review of Resident #42's plan of care revised 01/27/24 revealed the resident preferred to be out in the common area and participate in some activities. Interventions included encouraging the resident to participate in group activities and preferring to nap in the day. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #42's activity assessment dated [DATE] revealed the resident found it to be somewhat important to play games, take care of plants, watch sports, listen to music he likes, use the computer, and have books, newspapers, or magazines to read. He found it to be very important to be involved in cooking and to watch or listen to television. The assessment did not address what kind of television, music, or books, he liked. Review of Resident #42's activities from 08/01/24 to 08/13/24 revealed watching and observing occurred twice on 08/01/24, once on 08/02/24, 08/05/24, 08/06/24, 08/07/24, and on 08/08/24, twice on 08/12/24, and once on 08/13/24. Television occurred once on 08/02/24 and 08/03/24, twice on 08/04/24, once on 08/06/24, 08/07/24, 08/09/24, 08/11/24, and 08/13/24. Listening to music occurred on 08/08/24 and Bible study occurred on 08/10/24. The resident refused activities on 08/05/24, 08/09/24, 08/10/24, and 08/11/24. Review of the facility activity tracker from 08/01/24 to 08/13/24 revealed Resident #42's additional activities included a visit with a dog on 08/01/24. Review of the activities calendar for August 2024 revealed coffee and chronicles was listed every day. Additional activities included: on 08/01/24 chapel at 2:00 P.M. and hot fudge sundaes at an unknown time, on 08/02/24 Bingo at 2:30 P.M. and movie and popcorn night at 6:00 P.M., it was indicated it was national coloring book day, on 08/03/24 Hawaiian island word search and a major league baseball game, on 08/04/24 manicures and a famous birthdays puzzle with no times listed, on 08/05/24 Bingo at 2:30 P.M. and the Olympics without a time, on 08/06/24 visits with [NAME] (a dog) at 11:00 A.M. and spa day with no time listed, on 08/07/24 bingo at 2:30 P.M. and popsicles and Olympics without a time, on 08/08/24 board games without a time and chapel at 2:00 P.M., on 08/09/24 the Olympics without a time and movie and popcorn night at 6:00 P.M., On 08/10/24 random trivia without a time and a major league baseball game, on 08/11/24 manicures and an IQ puzzle without a time and the Olympic closing ceremony, on 08/12/24 coloring and peach pie day without a time, on 08/13/24 ladies lunch out and music at 2:00 P.M., and on 08/14/24 Elvis music all day and Bingo at 2:30 P.M. Observation on 08/12/24 at 9:36 A.M. revealed Resident #42 at the dining room table, no activities were observed. Observation on 08/13/24 at 9:56 A.M. and 11:05 A.M. revealed Resident #42 at the dining room with no activities Observation on 08/14/24 throughout the day revealed no Elvis music playing in the house Resident #42 resided in. Resident #42 was observed without activities at 8:15 A.M., 10:30 A.M., and 12:21 P.M. Interview on 08/19/24 at 10:07 A.M. with Activities Coordinator #29 verified the activities assessment or care plan did not provide details on the kinds of activities Resident #42 enjoyed. Activities Coordinator #29 verified that on 08/14/24, Elvis music was not playing all day, she reported she played it during BINGO. 3. Review of the medical record for Resident #6 revealed an admitted [DATE] with diagnoses including bipolar disorder, type two diabetes mellitus, cerebral infarction, chronic pain syndrome, rheumatoid arthritis, adult failure to thrive, fibromyalgia, and chronic pain. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #6's comprehensive MDS 3.0 assessment dated [DATE] revealed Resident #6 had intact cognition. Review of Resident #6's medical record revealed an activities assessment had not been completed in the previous year. Review of Resident #6's plan of care dated 09/29/22 revealed Resident #6 enjoyed many activities and programs but needed continuous encouragement, reminders, and motivation. Interventions included personalizing own room, preferring naps during the day, and enjoying the following activities: listening to classical/opera music, reading, enjoying family visits with dogs and attending activities of her choosing. Review of Resident #6's activities from 08/01/24 to 08/13/24 revealed music, reading, or television occurred on every day. Review of the facility activity tracker from 08/01/24 to 08/13/24 revealed Resident #6's additional activities included; Bible study on 08/01/24, BINGO on 08/02/24 and 08/07/24, visits with a dog on 08/06/24, and ladies lunch out on 08/12/24. Review of the activities calendar for August 2024 revealed coffee and chronicles was listed every day. Additional activities included: on 08/01/24 chapel at 2:00 P.M. and hot fudge sundaes at an unknown time, on 08/02/24 Bingo at 2:30 P.M. and movie and popcorn night at 6:00 P.M., it was indicated it was national coloring book day, on 08/03/24 Hawaiian island word search and a major league baseball game, on 08/04/24 manicures and a famous birthdays puzzle with no times listed, on 08/05/24 Bingo at 2:30 P.M. and the Olympics without a time, on 08/06/24 visits with [NAME] (a dog) at 11:00 A.M. and spa day with no time listed, on 08/07/24 bingo at 2:30 P.M. and popsicles and Olympics without a time, on 08/08/24 board games without a time and chapel at 2:00 P.M., on 08/09/24 the Olympics without a time and movie and popcorn night at 6:00 P.M., On 08/10/24 random trivia without a time and a major league baseball game, on 08/11/24 manicures and an IQ puzzle without a time and the Olympic closing ceremony, on 08/12/24 coloring and peach pie day without a time, on 08/13/24 ladies lunch out and music at 2:00 P.M., and on 08/14/24 Elvis music all day and Bingo at 2:30 P.M. Interview on 08/12/24 at 10:18 A.M. with Resident #6 revealed she mostly stayed in her room because the facility did not have activities that she was interested in. Observation on 08/14/24 throughout the day revealed no Elvis music playing in the house Resident #6 resided in. Interview on 08/19/24 at 10:07 A.M. with Activities Coordinator #29 verified on 08/14/24 Elvis music was not playing all day, she reported she played it during BINGO. Activities Coordinator #29 verified Resident #6's annual assessment had not been completed. She was unaware Resident #6 was uninterested in the activities that were scheduled, she reported at times Resident #6's pain prevents her from going to activities. Review of the policy titled, Engagement and Activity, dated April 2013, revealed the goal was to create a home where persons living in the home have choice and excellent quality of life and care coupled with providing an environment rich in meaningful engagement experiences. It was everyone's responsibility to engage the residents in all facets of life.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation, staff interview, and medical record review, the facility failed to adequate assess and provide treatments for non-pressure skin injuries, and facility to provide treatment as ordered to prevent edema. This affected three (#13, #42, and #102) of 25 medical records reviewed for care. The facility census was 52. Findings include: 1. Review of the medical record for Resident #102 revealed an admitted [DATE] with diagnoses including adult failure to thrive, hypertensive heart disease with heart failure, acute respiratory failure with hypoxia, and restlessness and agitation. Review of Resident #102's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed severely impaired cognition. Resident #102 had an indwelling catheter. Review of Resident #102's progress note dated 08/03/24 revealed Resident #102 obtained a skin tear following her daughter transferring her. The nurse assessed the area and identified a small skin tear to the left shin measuring 2.0 centimeters (cm) long by 0.2 cm wide by 0.1 cm deep. The area was cleansed with wound cleanser, patted dry, and Xeroform was applied followed by Kerlix. An order was placed for daily treatment until the area was resolved. Review of Resident #102's physician order dated 08/04/24 revealed an order for the skin tear to her left shin. The area was to be cleansed with wound cleanser, patted dry, covered with Xeroform, and then a clean dry dressing. Review of Resident #102's treatment administration record (TAR) for August 2024 revealed the treatment to her left shin was not completed on 08/05/24, 08/08/24, and 08/09/24. Review of Resident #102's medical record from 08/04/24 to 08/13/24 revealed no additional measurements of Resident #102's skin tear. Interview on 08/14/24 at 3:08 P.M. with Licensed Practical Nurse (LPN) #186 revealed she was the wound nurse and revealed they did not complete measurements on skin tears. LPN #186 reported the nursing staff are supposed to monitor skin tears during dressing changes, and verified the missing wound documentation and treatments for Resident #102. 2. Review of the medical record for Resident #13 revealed an initial admitted [DATE] with diagnoses including but not limited to acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), Parkinson's disease, restlessness and agitation, anxiety disorder, major depressive disorder, seizures, hypertension, hyperlipidemia, insomnia, dementia, atrial fibrillation, cerebrovascular accident (CVA) with left sided hemiplegia, diverticulitis, dysphagia, and spinal stenosis. Review of Resident#13's comprehensive MDS assessment dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident had no skin issues. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #13's plan of care revealed no care plan addressing the wound to the resident's right forearm. Review of Resident #13's monthly physician orders for August 2024 identified an order dated 08/10/24 to apply Xeroform dressing, absorbent pad and Kerlix to the right forearm every morning until healed. Review of Resident #13's progress note dated 08/10/24 at 3:49 P.M. revealed a new order for Xeroform, absorbent pan, and Kerlix to the right forearm daily until healed was obtained. Review of the medical record revealed no documented evidence of the type of wound, how the wound occurred, or an assessment of the wound to Resident #13's right forearm. On 08/12/24 at 10:59 A.M., observation of Resident #13 revealed a dry and intact dressing to the resident's right forearm. On 08/19/24 at 11:27 A.M., observation of Resident #13 revealed the resident was observed having no dressing to the wound to the upper right forearm. The wound was triangle shaped with a yellowish dried coating to the wound. On 8/14/24 at 3:08 P.M., interview with LPN #186 revealed she was the facility's wound nurse. LPN #186 revealed facility nurses text her to let her know of wounds, and stated the wound doctor does not see skin tears unless there are concerns. LPN #186 stated staff monitor the areas during dressing changes, but they do not complete dimensions for skin tears. On 08/19/24 at 11:20 A.M., interview with the Director of Nursing (DON) verified Resident #13's medical record contained no documentation evidence of the type of wound, how the wound occurred, or an assessment of the wound to the resident's right forearm. On 08/19/24 at 11:34 A.M., interview with the DON verified Resident #13 had no dressing to the wound to his right forearm as physician ordered. 3. Review of Resident #42's medical record revealed an initial admitted [DATE] with the latest readmission of 02/16/24. Diagnoses including but not limited to Parkinson's disease, vascular dementia, abnormalities of gait and mobility, hypercholesterolemia, major depressive disorder, obstructive sleep apnea, benign neoplasm of peripheral nerves and autonomic nervous system, spinal stenosis, cervical disc disorder, adult failure to thrive, hypothyroidism, progressive supranuclear ophthalmoplegia, and vitamin D deficiency. Review of Resident #42's functional abilities and goals dated 04/02/24 revealed the resident required substantial/maximal assistance with toileting and dressing. Review of Resident #42's quarterly MDS assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors, including rejection of care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #42's monthly physician orders for August 2024 identified an order dated 01/22/24 wear to wear thrombo-embolic deterrent (TED) hose daily every shift for deep vein thrombosis (DVT) prevention may removed for bathing/hygiene, on in morning and off at bedtime. Review of Resident #42's August 2024 treatment administration record (TAR) revealed the facility nurse initialed off the TED hose were on in the morning and removed on 08/12/24 and 08/13/24. On 08/12/24 at 2:01 P.M., observation of Resident #42 revealed the resident had edema to bilateral legs, no TED hose were observed on. On 08/13/24 at 9:56 A.M., observation of Resident #42 revealed the resident was sitting at the dining room table and the resident was observed as having no TED hose on. On 08/13/24 at 11:46 A.M., interview with Registered Nurse (RN) #148 verified Resident #42 had an order for TED hose and the TED hose were not in place as physician ordered. RN #148 also verified the resident had no TED hose in his room. 32654

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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** 43064 Based on resident and staff interview, medical record review, and review of a facility policy, the facility failed to ensure pressure ulcers were timely assessed and and monitored and failed to ensure treatments were administered as ordered. This affected one (#103) of six residents reviewed for pressure ulcers. The facility census was 52. Findings include: Review of the medical record for Resident #103 revealed an admitted [DATE] with diagnoses including quadriplegia, type two diabetes mellitus, depression, atherosclerosis of other arteries, osteoarthritis, spinal stenosis, paroxysmal atrial fibrillation, and neuromuscular dysfunction of the bladder. Review of Resident #103's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #103 had moderately impaired cognition. The resident had one unstageable pressure ulcer (obscured full-thickness skin and tissue loss) and one stage four pressure ulcer (full-thickness skin and tissue loss). Review of Resident #103's admission assessment dated [DATE] revealed Resident #103's wounds were not indicated or measured. Review of Resident #103's progress note dated 07/19/24 revealed the nurse noted dressings to the resident's coccyx and posterior right thigh and requested to complete dressing change and measurements and the resident asked for some time to rest first. The nurse indicated it would be done later. Review of Resident #103's medical record from 07/19/24 to 07/22/24 revealed no measurements or description of Resident #103's wounds. Review of Resident #103's physician orders dated 07/20/24 to 07/23/24 revealed an order for Santyl external ointment 250 units per gram (gm) to be applied to the coccyx and back of right thigh topically every day shift for wound care. Review of Resident #103's wound physician note dated 07/23/24 revealed Resident #103 had a stage four pressure ulcer to the coccyx that had present more than 375 days. The wound measured 7.0 centimeters (cm) long by 6.0 cm wide by 3.0 cm deep with a 42 cm surface area. Resident #103 additionally had an unstageable pressure ulcer to the right thigh that had been present for more than 47 days. The wound measured 4.0 cm long by 8.0 cm wide by 1.0 cm deep with a 32 cm surface area. The physician altered her treatment. Review of Resident #103's progress notes revealed Licensed Practical Nurse (LPN) #186 noted the resident had seen the wound doctor and repeated the measurements and treatment plan from the wound physician note. (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 Resident #103's physician order dated 07/24/24 to 07/31/24 revealed an order for Santyl external ointment 250 units per gm to be applied to the coccyx and back of the right thigh topically every day shift for wound care. Staff were to cleanse wounds with wound cleanser, pat the area dry, apply the santyl, then apply calcium alginate, and cover with a clean dry dressing. Review of Resident #103's wound physician note dated 07/30/24 revealed she had a stage four pressure ulcer to the coccyx that measured 7.0 cm long by 6.0 cm wide by 2.5 cm long with a 42 cm squared surface area. She additionally had an unstageable pressure ulcer to the right thigh measuring 4.0 cm long by 7.5 cm wide by 1.5 cm deep with a 30 cm squared surface area. Review of Resident #103's progress note dated 07/30/24 revealed LPN #186 noted the resident had seen the wound doctor and had no new orders. Review of Resident #103's physician order dated 08/01/24 revealed an order for Santyl external ointment 250 units per gm to be applied to the coccyx and right thigh topically every day shift for wound care. Staff were to cleanse the wounds with wound cleanser, pat the area dry, apply the santyl, then the calcium alginate, and cover with clean dry dressing. Review of Resident #103's medication administration record (MAR) from 08/01/24 to 08/12/24 revealed wound care was not completed on 08/02/24, 08/05/24, 08/08/24, 08/09/24, and 08/11/24. Review of Resident #103's wound physician note dated 08/06/24 revealed the resident's visit had been rescheduled as she was not available to round. Review of Resident #103's progress notes dated 08/06/24 revealed no indication of why she was unable to see the wound doctor and contained no measurements or description of her wounds. Review of Resident #103's medical record from 07/29/24 to 08/12/24 revealed no description or measurements of Resident #103's two pressure ulcers. Review of Resident #103's plan of care revised on 08/08/24 revealed Resident #103 had an actual and potential for skin breakdown related to decreased mobility, diabetes, incontinence, and pressure ulcer's including a stage four to the coccyx and unstageable to the right thigh. interventions included administering treatment as ordered, applying moisture barrier to perineal area and buttocks following incontinence, Betamethasone dipropionate gel as ordered, Enhanced barrier precautions, monitoring for infection at site, pressure reduction cushion to chair and mattress to bed, turning and repositioning frequently as needed, Vytone cream as ordered, weekly skin screening, and wound physician to see and treat Review of Resident #103's wound physician note dated 08/13/24 revealed the resident had a stage four coccyx wound measuring 8 cm long by 6 cm wide by 2 cm deep with a 48 cm squared surface area. Debridement was done to the right thigh, and it was determined to be a stage four pressure ulcer. The physician noted that the wound had not deteriorated but had been previously obscured by necrosis and had then revealed itself to be a stage four pressure ulcer measuring 3.5 cm long by 7.5 cm wide by 4.5 cm deep with a surface area of 26.25 cm squared. The physician noted that both areas had improved. (continued on next page)

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	366424	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #103's progress note dated 08/13/24 revealed LPN #186 indicated the resident had seen the wound doctor. She repeated the measurements and treatment recommendations from the wound doctor's notes. Review of Resident #103's assessments dated 07/20/24 to 08/12/24 revealed no additional wound assessments. Interview on 08/12/24 at 11:55 A.M. with Resident #103 revealed she came to this facility to get her pressure ulcers taken care of, however, she had concerns with the care she was getting. She reported the facility often missed wound care. Interview on 08/14/24 at 3:08 P.M. with LPN #186 revealed she was the facility's wound nurse. She reported if the wound physician did not visit a resident, measurements were not completed that week. LPN #186 verified Resident #103 was missing measurements for her wound upon admission and missing treatments in the MAR. She was unsure why Resident #103 was unavailable for the wound doctor on 08/06/24 and verified the resident had not been out of the facility. Review of the policy titled, Skin Care Management Procedure, dated 11/16/22, revealed upon admission a full skin assessment should be conducted within two to six hours of arrival. With each dressing change or at least weekly at minimum there should be documentation indicating the date observed, location and staging, size, depth, and the presence or extent of any undermining or tunneling. Documentation should also include any exudates and pain, description of the wound bed, wound edges, and surrounding tissue.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 32654 Based on medical record review, staff interview, and facility policy review, the facility failed to implement an effective intervention to reduce fall risk and determine effectiveness following a fall. This affected one (#4) of six residents reviewed for accidents. The facility census was 52. Findings Include: Review of the medical record for Resident #4 revealed an initial admitted [DATE] with the latest readmission of 02/26/24. Diagnoses including but not limited to bipolar disorder, morbid obesity, hypertension, dementia with anxiety, peripheral vascular disease, polyarthritis, anxiety disorder, cataracts, alcohol dependence with alcohol induced dementia, generalized muscle weakness, difficulty in walking, mixed incontinence, hyperlipidemia, low back pain, sensorineural hearing loss, osteoarthritis, dermatitis and insomnia. Review of the plan of care dated 05/25/18 revealed Resident #4 was at risk for falls related to history of falls. Interventions included anticipate and meet needs, assist resident to remove clutter prior to getting dressed, assist in wearing non-skid socks, slippers or shoes daily, ensure call light/pendent was within reach and encourage to use it for assistance as needed, encourage to participate in activities that promote exercise, physical activity for strengthening and improved mobility, ensure resident was wearing appropriate footwear when ambulating or mobilizing in wheelchair, keep room clutter free, keep needed items in reach, keep pathways clear, may need a wheelchair for long distance, provide front wheeled walker with a basket and keep within reach when in room, offer 120 milliliters (ml) four times a day to prevent urinary tract infection (UTI), provide verbal cues and instruction for posture technique and pace of walking the front wheeled walker, therapy evaluation as needed, and remind to use grab bars in the shower and beside the commode when sitting or rising from surfaces. Review of Resident #4's fall risk screening dated 12/22/23 revealed a score of 15 indicating the resident was at risk for falls. Review of Resident #4's fall investigation form dated 04/01/24 at 3:00 A.M. revealed the resident was found in her doorway sitting on the floor. The resident reported she was walking and fell . The resident had no non-skid footwear in place and the form documented the resident removed per herself. The facility implemented the intervention to offer 120 milliliters (ml) of fluid four times a day related to prior UTI. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 had a moderate cognitive deficit. On 08/19/24 at 10:18 A.M., interview with Regional Nurse #300 verified Resident #4's fall investigation on 04/01/24 did not contain an intervention implemented to address the lack of non-skid footwear in place or the resident removing interventions put in place to prevent falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility policy titled, Falls Management, dated 12/03/19 revealed to define a process that will assist residents across all levels of care to live the highest quality of life with dignity while incurring minimal risk of alls and injuries related to falls.

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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** 32654 Based on medical record review and staff interview, the facility failed to comprehensively assess a Resident #42's bowel and bladder function and implement interventions and/or a program to restore function and prevent further decline in bowel and bladder function. Additionally, the facility failed to ensure Resident #11 and #102, with urinary catheters received appropriate and timely care of the catheter as ordered. This affected three (#11, #42, and #102) of six residents reviewed for bowel and bladder status and urinary catheters. The facility census was 52. Findings include: 1. Review of Resident #42's medical record revealed an initial admitted [DATE] with the latest readmission of 02/16/24. Diagnoses including but not limited to Parkinson's disease, vascular dementia, abnormalities of gait and mobility, hypercholesterolemia, major depressive disorder, obstructive sleep apnea, benign neoplasm of peripheral nerves and autonomic nervous system, spinal stenosis, cervical disc disorder, adult failure to thrive, hypothyroidism, progressive supranuclear ophthalmoplegia, and vitamin D deficiency. Review of Resident #42's admission screen and baseline care plan dated 11/22/23 revealed the resident's bowel and bladder continence was not assessed on the admission screen. Review of the plan of care dated 12/01/23 revealed Resident #42 was incontinent of bladder related to dementia. Interventions included the resident used disposable briefs and were changed frequently and as needed, cleanse peri-care with each incontinence episode, check as required for incontinence care, wash, rinse and dry perineum, change clothing as needed after each episode and monitor for signs/symptoms of urinary tract infection (UTI). Further review of the plan of care revealed no care plan addressing the resident's incontinence of bowel. Review of Resident #42's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the mood and behavior section of the assessment revealed the resident displayed no behaviors, including rejection of care. The assessment indicated the resident was frequently incontinent of both bowel and bladder. Frequently incontinent of bowel was defined as two or more episodes with one continent episode in the seven day review period. Frequently incontinent of bladder was defined as seven or more incontinence episodes with at least one continent episode in the seven day review period. The assessment indicated a toileting program had not been implemented or trialed to improve or manage the resident's bowel and bladder incontinence. Review of the bowel and bladder screen dated 04/02/24 revealed Resident #42 was frequently incontinent of both bowel and bladder. Review of Resident #42's functional abilities and goals dated 04/02/24 revealed the resident required substantial/maximal (staff) assistance with toileting and dressing. (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 Resident #42's quarterly MDS assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the mood and behavior section of the MDS revealed the resident displayed no behaviors, including rejection of care. The assessment indicated the resident was always incontinent of both bowel and bladder. Always incontinent of bladder was defined as having all incontinent voids in the seven day review period. Always incontinent of bowel was defined as being incontinent for all bowel movements in the seven day review period. This assessment indicated a toileting program had not been implemented or trialed to improve or manage the resident's bowel and bladder incontinence. Review of Resident #42's monthly physician orders for August 2024 identified no orders related to bowel and bladder incontinence. Review of Resident #42's medical record revealed no documented evidence of a completed comprehensive bowel or bladder assessment following the decline on 07/02/24, evidence of comprehensive and individualized interventions to prevent the decline from occurring or evidence of any interventions being implemented to attempt to restore normal function for the resident. On 08/19/24 at 11:40 A.M., interview with the Director of Nursing (DON) verified the facility was unable to provide any assessments for Resident #42's bowel and bladder function following the assessed decline on 07/02/24. The DON verified she was unable to provide any documentation or evidence the facility attempted any interventions to attempt to restore normal function for the resident or to prevent Resident #42's decline in bowel and bladder status. 2. Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses including ulcerative colitis, hypertension, type two diabetes mellitus, neuromuscular dysfunction of the bladder, dysuria, and chronic pain. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition. Resident #11 had an indwelling catheter. Review of Resident #11's plan of care dated 12/06/23 revealed Resident #11 had an indwelling catheter related to neurogenic bladder. Removal was clinically contraindicated per physician she was followed by urology. Interventions included, for the indwelling catheter, positioning the catheter bag and tubing below the level of the bladder, changing the catheter as needed, checking the tubing for kinks, monitoring and documenting intake and output as per facility policy, monitoring for pain due to the catheter, monitoring for discomfort on urination, monitoring for signs of a UTI, urology consultation as needed, and urine output via urinary catheter. Review of Resident #11's physician order dated 10/17/23 revealed an order to provide catheter care each shift. Review of Resident #11's physician order dated 11/07/23 revealed an order to check urinary catheter patency each shift. Review of Resident #11's physician order dated 11/07/23 revealed an order to monitor urine output in milliliters (mls). (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 Resident #11's medication administration record (MAR) for July 2024 revealed checking urinary catheter patency was not completed in the morning on 07/18/24 and in the evening on 07/22/4 and 07/30/24. Resident #11's output was not monitored in the morning on 07/12/24, 07/14/24, 07/16/24, 07/18/24, 07/19/24, 07/25/24, and 07/31/24. Resident #11's output was not monitored in the evening on 07/08/24, 07/12/24, 07/15/24, 07/16/24, 07/22/24, 07/27/24, 07/29/24, and 07/30/24. Resident #11's catheter care was not completed in the morning on 07/18/24 and in the evening on 07/22/24, 07/29/24, and 07/30/24. Review of Resident #11's MAR for 08/01/24 to 08/12/24 revealed checking urinary catheter patency was not completed in the morning on 08/05/24 and 08/08/24. Resident #11's output was not monitored in the morning from 08/02/24 to 08/06/24, on 08/08/24, and 08/11/24. Resident #11's output was not monitored in the evening on 08/06/24. Resident #11's catheter care was not completed in the morning on 08/05/24 and 08/08/24. Interview on 08/15/24 at 2:18 P.M. with Regional Nurse #300 verified there was no evidence that catheter care, output monitoring, or checking urinary catheter patency was done for Resident #11 on the dates referenced in July and August 2024. 3. Review of the medical record for Resident #102 revealed an admitted [DATE] with diagnoses including adult failure to thrive, hypertensive heart disease with heart failure, acute respiratory failure with hypoxia, and restlessness and agitation. Review of Resident #102's comprehensive MDS 3.0 assessment dated [DATE] revealed severely impaired cognition. Review of Resident #102's plan of care revised 08/08/24 revealed Resident #102 had an indwelling catheter. Interventions included positioning the catheter bag and tubing below the level of the bladder and away from the room door, changing the catheter as ordered, checking the tubing for kinks frequently each shift, monitoring and documenting intake and output according to facility policy, monitoring pain or discomfort due to catheter, monitor for signs of discomfort on urination, and monitor and report to the physician signs of a UTI. Review of Resident #102's physician order dated 07/23/24 revealed an order to irrigate the catheter once a day. Review of Resident #102's physician order dated 07/24/24 revealed an order to monitor urine output in mls. Review of Resident #102's physician order dated 07/24/24 revealed an order to check urinary catheter patency every shift. Review of Resident #102's physician order dated 07/24/24 revealed an order to provide urinary catheter care every shift. (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 Resident #102's MAR for July 2024 revealed irrigating the catheter was not done on 07/29/24 and 07/30/24 and checking catheter patency was not done in the evening on 07/29/24 and 07/30/24. Resident #102's output was not monitored in the morning on 07/25/24 and 07/31/24 and in the evening on 07/24/24, 07/27/24, 07/29/24, and 07/30/24. Catheter care was not done in the evening on 07/29/24 and 07/30/24. Review of Resident #102's MAR for August 2024 revealed irrigating the catheter was not done on 08/06/24 and checking catheter patency was not done in the morning on 08/05/24 and 08/08/24. Resident #102's output was not monitored in the morning on 08/02/24, 08/03/24, 08/04/24, 08/05/24, 08/06/24, 08/07/24, 08/08/24, and 08/11/24. Resident #102's output was not monitored in the evening on 08/06/24 and 08/09/24. Resident #102's catheter care was not completed in the morning on 08/05/24 and 08/08/24. Interview on 09/15/24 at 9:20 A.M. with Regional Nurse #300 verified there was insufficient evidence to show catheter care was provided, output was monitored, and that staff was checking catheter patency for Resident #102 urinary catheter on the dates referenced in July and August 2024. 43064

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation, resident and staff interview, medical record review, and facility policy review, the facility failed to obtain resident weighs as ordered, failed to thoroughly assess Resident #103's nutritional status and contributing factors to nutritional deficits, and failed to provided double portioned food items as ordered to prevent malnutrition/weight loss. Additionally, the facility failed to ensure supplements were provided to Resident #20 as ordered and failed to re-weigh the resident following a significant change to the resident's weight per (facility) policy. Actual harm occurred on 08/14/24 when Resident #103 was identified to sustain a severe 8.8 percent (%) weight loss (16 pounds) since admission to the facility on [DATE] without evidence of comprehensive or individualized interventions being implemented to prevent or timely identify the weight loss. This affected two (#20 and #103) of six residents reviewed for nutrition. The facility census was 52. Findings include: 1. Review of the medical record for Resident #103 revealed an admitted [DATE] with diagnoses including quadriplegia, type two diabetes mellitus, depression, atherosclerosis of other arteries, osteoarthritis, spinal stenosis, paroxysmal atrial fibrillation, and neuromuscular dysfunction of the bladder. Review of Resident #103's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #103 had moderately impaired cognition. The resident had one unstageable pressure ulcer (obscured full-thickness skin and tissue loss) and one stage four pressure ulcer (full-thickness skin and tissue loss). Review of Resident #103's physician order dated 07/19/24 revealed an order for a regular diet with double meat portions. Review of Resident #103's physician order dated 07/20/24 revealed she was to get weekly weights for four weeks due to risk for malnutrition. Review of Resident #103's weights revealed on 07/20/24 she weighed 181 pounds and on 07/29/24 she weighed 177.8 pounds. Review of Resident #103's nutritional assessment dated [DATE] revealed the resident had reported her current body weight of 177.8 pounds as her usual body weight. She was totally dependent on staff for eating and consumed 51 percent (%) to 100% of her meals. The resident was on a regular diet with regular texture. Her estimated calorie needs were 2,000 to 2,240 calories, 80 to 96 grams of protein, and 2,400 milliliters of fluid. Her medications were reviewed, and no recommendations were given. Review of the assessment revealed no mention of Resident #103's wounds or diet order for double meat portions. Review of Resident #103's medication administration record (MAR) for July 2024 revealed her weekly weight was 181 pounds on 07/20/24 and marked as 'not applicable' on 07/27/24. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #103's meal intake records since admission revealed the resident consumed 0% to 25% of her meal on four occasions, 26% to 50% of her meal on 14 occasions, 51% to 75% of her meal on 23 occasions, and 76% to 100% of her meal on 28 occasions. Review of Resident #103's plan of care dated 08/02/24 revealed she was at risk for changes to nutrition and hydration due to past medical history and quadriplegia, she was to receive a regular diet with thin liquids. Interventions included educating the resident on the importance of adequate calorie intake, encouraging to her to drink fluids, encouraging to her to eat and drink by offering food and fluid she likes, encouraging calorically dense foods, encouraging her to eat plenty of protein, encouraging participating in menu planning, helping at meals and snack time by assisting as needed, and offering a substitute as needed. Review of Resident #103's MAR for 08/01/24 to 08/13/24 revealed no weekly weight was obtained on 08/03/24 and it was marked as 'not applicable' on 08/10/24. Review of Resident #103's weights revealed on 08/14/24 she weighed 165 pounds. This was a severe 8.8% (16 pounds) loss over less than thirty days. Interview on 08/12/24 at 11:55 A.M. with Resident #103 revealed she felt as though she had lost a lot of weight. She reported she did not think she got double portions of meat, and she would not eat them if she did. Resident #103 reported nobody spoke to her about her weight, but she would like ice cream to supplement her intake. Observation of the lunch meal on 08/13/24 beginning at 12:05 P.M. revealed Resident #103 received regular meat portions (tuna salad). Interview on 08/13/24 after the lunch observation at 12:40 P.M. with State tested Nurse Aide (STNA) #172 verified Resident #103 received a regular diet with regular portions, and reported Resident #103 was on a regular diet and had been for her entire stay. STNA #172 reported meals were prepared using the diet list hanging in the kitchen, which indicated she was a regular diet. Review of the diet list provided on 08/13/24 at 12:40 P.M. by STNA #172 revealed the diet list was dated 08/09/24 and Resident #103 was not listed as requiring double meat portions. Interview on 08/14/24 at 11:11 A.M. with Diet Technician #309 and Regional Diet Technician #305 revealed Diet Technician #309 was new to the building. They verified Resident #103 had an order for double meat portions. Diet Technician #309 verified she had completed the nutrition assessment dated [DATE]. The assessment did not address the double meat portions or Resident #103's wounds. The dietitian was to assess residents with pressure ulcers. Regional Diet Technician #305 revealed she had just introduced the new diet technician to the wound nurse so the wound nurse could update them on who has wounds. She verified Resident #103's wounds were not addressed in her assessment. The Diet Technicians additionally verified Resident #103's weekly weights were not completed as ordered. Interview on 08/19/24 at 2:12 P.M. with Regional Dietitian #311 verified he had not yet evaluated Resident #103 who had pressure ulcers. He was unaware Resident #103's most recent weight was a significant weight change. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the policy titled, Weight Policy, dated 12/02/21, revealed residents were to be weighed weekly for the first four weeks to establish a baseline weight. Monthly weights were to be taken by the fifth of the month and recorded in the electronic medical record. 2. Review of the medical record revealed Resident #20 was admitted to facility on 05/22/23 with diagnoses that included traumatic subdural hematoma, Parkinson's disease, heart failure, hemiplegia, hemiparesis, depressive disorder, and seizures. Review of Resident #20's MDS 3.0 assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 01, indicative of severe impairment for daily decision making. The MDS 3.0 assessment indicated Resident #20 received a substantial to maximal level of assistance with eating and had lost a significant amount of weight as of 07/02/24. Review of the nutrition progress note on 07/18/24 revealed that Resident #20 had lost a significant amount of weight, but that he was now stabilized, with a weight range of between 155 pounds to 158 pounds and accepting Ensure nutritional supplements three times daily. Further medical record review revealed on 07/29/24, Resident #20 had a weight of 158 pounds. Review of weight status revealed that on 08/05/24, Resident #20 had a weight of 150 pounds, indicative of an eight-pound weight loss, or a five percent significant weight loss, in seven days. As of 08/13/24, the medical record was silent for acknowledgment of the eight-pound weight loss. An interview on 08/14/24 at 9:10 A.M. with Regional Diet Technician #305 revealed the state tested nurse aides (STNAs) are responsible for distributing the Ensure nutritional supplements, and the nurses are responsible for recording the amount of Ensure consumed on the medication administration record. Interview with Regional Diet Technician #305 confirmed the facility did not follow their weight policy, which was to re-weigh residents with significant weight changes by the tenth day of the month. Regional Diet Technician #305 stated the facility would re-weigh Resident #20 on 08/14/24. On 08/14/24, Resident #20 was observed to not be offered his Ensure nutritional supplement. The Ensure was scheduled to be delivered to Resident #20 between the hours of 8:00 A.M. and 11:00 A.M. An interview with Resident #20 on 08/14/24 revealed that Resident #20 stated that he was hungry and wanted a snack. Resident #20 confirmed that he had not received Ensure nutritional supplement on 08/14/24. On 08/14/24 at 11:06 A.M., Resident #20 was observed to be weighed by STNA #45 and STNA #196. Resident #20's weight was observed to be 150 pounds, confirming the eight-pound weight loss identified on 08/05/24. An interview on 08/14/24 at 11:16 A.M. with STNA #45 confirmed that Resident #20 was not offered his Ensure supplement, which was scheduled to be delivered between 8:00 A.M. and 11:00 A.M. STNA #45 stated Resident #20 did not like Ensure nutritional supplement, so it was not offered. On 08/14/24 at 11:20 A.M., Resident #20 was observed to be served a fruit plate as a snack by STNA #45. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 08/14/24 at 12:59 P.M., Resident #20 was observed to be drinking chocolate flavored Ensure nutritional supplement, which was well accepted. There was an order for the second Ensure nutritional supplement of the day to be served between the hours of 12:00 P.M. and 3:00 P.M. Review of facility weight policy, created 12/02/21, revealed that the Food Coordinator, the Director of Nursing, and/ or the Dietitian or Diet Technician will request a reweigh for those persons with significant weight changes and or fluctuations of three to five pounds. The reweighs will be completed by the tenth of the month. If a significant weight change is noted, the dietitian or diet technician will then proceed with the following as appropriate: review current diet order, request weekly weights, speak with the resident at mealtime, evaluate the above data, make recommendations for interventions, and document the above in the medical record. 50008

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on observation, medical record review, and resident and staff interview, the facility failed to change and date oxygen tubing and supplies as ordered and failed to store respiratory equipment in a safe and sanitary manner. This affected four (#13, #42, #154, and #155) of seven residents reviewed for respiratory care. The census was 52. Findings Include: 1. Review of the medical record for Resident #154 revealed initial admitted [DATE] and re-admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), chronic respiratory failure, and other diseases of the bronchus. Resident #154 had intact cognition and required limited assist from staff for activities of daily living (ADLs) tasks and medication administration. Review of the respiratory care plan for Resident #154 dated 05/31/24 revealed oxygen used as ordered and breathing treatments as ordered. Review of the physician orders for Resident #154 revealed an order dated 08/02/24 to change oxygen tubing weekly every night shift every seven days, and an order dated 08/02/24 for humidified oxygen at five liters per minute continuous to maintain oxygen levels 90 percent (%) or greater. Review of medication administration record (MAR) for Resident #154 dated 08/02/24 to 08/12/24 revealed the order for humidified oxygen at five liters per minute to maintain oxygen levels at 90% or greater was marked as being administered as ordered. Review of treatment administration record (TAR) for Resident #154 dated 08/02/24 to 08/12/24 revealed the order for changing oxygen tubing weekly every night shift every seven days for maintenance was marked as being completed on 08/09/24. Observation on 08/12/24 at 11:43 P.M. revealed Resident #154 receiving oxygen therapy via nasal cannula, there was no date on the oxygen tubing to reflect that last time the tubing had been changed. Resident #154 stated she did not know when the staff changes the oxygen tubing. 2. Review of the medical record for Resident #155 revealed admitted [DATE] with diagnoses including acute respiratory failure, pleural effusion, and anxiety. Resident #155 had intact cognition and required assistance from staff for ADLs. Review of the respiratory care plan for Resident #155 dated 08/13/24 revealed oxygen therapy received as ordered. Review of the physician orders for Resident #155 revealed an order dated 08/02/24 for oxygen at four liters per minute continuous via nasal cannula to keep oxygen levels at 90% or greater, and an order dated 08/07/24 to change and date oxygen tubing weekly every night shift every seven days. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the MAR for Resident #155 dated 08/02/24 to 08/12/24 revealed the oxygen at four liters per minute continuous via nasal cannula to keep oxygen levels at 90% or greater had been marked as being completed by staff twice daily, and change and date oxygen tubing weekly every night shift every seven days for maintenance as having been changed on 08/07/24. Observation on 08/12/24 at 10:35 A.M. revealed Resident #155 siting at edge of bed with oxygen nasal cannula in place and the oxygen tubing attached to an oxygen concentrator sitting beside the day. There was no date noted on the oxygen tubing. Resident #155 stated she had only been at the facility a short time and did not know when the oxygen tubing was to be changed. Interview on 08/12/24 at 2:17 P.M. with Regional Registered Nurse #300 confirmed the oxygen tubing was not properly changed and dated for Resident #154 and Resident #155. 3. Review of the medical record for Resident #13 revealed an initial admitted [DATE]. Diagnoses including but not limited to acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), Parkinson's disease, restlessness and agitation, anxiety disorder, major depressive disorder, seizures, and hypertension. Review of the plan of care dated 05/30/23 revealed Resident #13 had COPD. Interventions included continuous oxygen at two liters as tolerated, elevate head of the bed due to shortness of breath, when out of bed keep upright in a chair during episodes of difficulty breathing, give supplements if needed to maintain adequate nutrition, give medications as ordered, monitor for anxiety, monitor for dyspnea, monitor for signs/symptoms of acute respiratory distress, monitor/report as needed any signs/symptoms of respiratory infection and occupational consult as ordered. Review of Resident #13's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors, however had wandering behaviors. The assessment indicated the resident received oxygen therapy. Review of Resident #13's monthly physician orders for August 2024 identified orders dated 01/05/24 for continuous oxygen at two liters and monitor oxygen saturation throughout the day, and on 04/23/24 to change aerosol tubing/mask every Tuesday for maintenance, change oxygen tubing weekly on Tuesday for maintenance. Review of the August 2024 treatment administration record (TAR) revealed the facility nurse initialed Resident #13's oxygen tubing was changed on 08/06/24 and 08/13/24, also the aerosol tubing/mask was changed on 08/06/24 and 08/13/24. On 08/12/24 at 10:59 A.M., observation of Resident #13 revealed the resident's oxygen tubing was dated 07/13/24 and the nebulizer delivery system was laying on the machine outside of a protective cover. On 08/12/24 at 11:17 A.M., Regional Nurse #300 verified Resident #13's oxygen nasal cannula was dated 07/12/24 and not changed as physician ordered. Regional Nurse #300 also verified the nebulizer delivery system was not in a protective cover. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 08/13/24 at 9:08 A.M., observation of Resident #13 revealed he was sitting in his recliner with legs elevated with oxygen in place. Further observation revealed the resident's oxygen nasal cannula was dated 07/13/24. 4. Review of Resident #42's medical record revealed an initial admitted [DATE] with the latest readmission of 02/16/24. Diagnoses included but not limited to Parkinson's disease, vascular dementia, abnormalities of gait and mobility, hypercholesterolemia, major depressive disorder, obstructive sleep apnea, benign neoplasm of peripheral nerves and autonomic nervous system, spinal stenosis, cervical disc disorder, and adult failure to thrive. Review of the plan of care dated 12/01/23 revealed Resident #42 had altered respiratory status/difficulty breathing related to sleep apnea. Interventions included to administer medications as ordered, monitor for side effects and effectiveness, elevate head of the bed when having difficulty breathing while lying flat, monitor for signs/symptoms of respiratory distress, and continuous positive airway pressure (CPAP) machine settings specified and delivered via mask nightly and with naps. Review of Resident #42's quarterly MDS assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of Resident #42's monthly physician orders for August 2024 identified the resident to sleep with CPAP at night and during naps for sleep apnea. On 08/13/24 at 9:56 A.M., observation of Resident #42's CPAP machine revealed the mask remained in the basket without a protective covering. On 08/12/24 at 11:17 A.M., Regional Nurse #300 verified Resident #42's CPAP machine mask was not in a protective covering. 32654

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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** 50008 Based on medical record review and staff interview, the facility failed to timely address pharmacy recommendations. This affected two (#5 and #26) of five residents reviewed for unnecessary medications. The facility census was 52. Findings include: 1. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses that included dementia without behavior disturbance, severe protein calorie malnutrition, chronic obstructive pulmonary disease, depression, and adult failure to thrive. Review of Resident #5's medication regimen review (MRR) by the pharmacist on 02/08/24 noted the resident had been using the antidepressant Remeron 7.5 milligrams mg for approximately six months without an attempted gradual dose reduction (GDR) or documented contraindication to a GDR. The request was made to the physician to consider a trial medication discontinuation. The physician responded on 05/03/24 indicating the physician disagreed, and a GDR was contraindicated. An interview on 08/14/24 at 3:30 P.M. with Regional Nurse #300 revealed that she would expect for the pharmacist recommendations to be addressed by the doctor within seventy-two hours. Interview with Regional Nurse #300 further revealed the MRR on 02/08/24 was not reviewed by the physician or his proxy until 05/03/24. 2. Review of the medical record for Resident #26 revealed an admitted [DATE] with diagnoses including cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type two diabetes mellitus, major depressive disorder, peripheral vascular disease, and hypothyroidism. Review of Resident #26's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #26 had intact cognition. Review of Resident #26's pharmacy recommendation dated 09/05/23 revealed the pharmacist noted the resident's hemoglobin A1C and the insulin the resident was ordered. The pharmacy recommended considering increasing the resident's Lantus insulin dose. The physician did not address this recommendation until 11/15/23, when they agreed to increasing it. Interview on 08/15/24 at 12:19 P.M. with Regional Nurse #300 verified Resident #26's pharmacy recommendation was not addressed by the physician timely. 32654 43064

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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** 43064 Based on medical record review and staff interview, the facility failed to residents were appropriately monitored as ordered when administered medications. This affected two (#102 and #103) of five residents reviewed for unnecessary medications. The facility census was 52. Findings include: 1. Review of the medical record for Resident #103 revealed an admitted [DATE] with diagnoses including quadriplegia, type two diabetes mellitus, depression, atherosclerosis of other arteries, osteoarthritis, spinal stenosis, paroxysmal atrial fibrillation, and neuromuscular dysfunction of the bladder. Review of Resident #103's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #103 had moderately impaired cognition. Review of Resident #103's plan of care dated 08/08/24 revealed Resident #103 had diabetes mellitus. Interventions included checking all of the body for breaks in skin, checking blood sugar as ordered, dietary consultation for nutritional regimen, discussing nutritional regimen, educating on importance of consistent diet, educate regarding medication and importance of compliance, monitor for signs of hypoglycemia or hyperglycemia, and provide medication that the doctor ordered. Review of Resident #103's physician order dated 07/20/24 revealed an order for the medication to treat diabetes Glipizide oral tablet 2.5 milligrams (mg) to be given one time a day for diabetes mellitus. The medication was to be held if blood sugar was less than 90 milligrams per deciliter (mg/dL). Review of Resident #103's medication administration record (MAR) from 07/20/24 to 08/13/24 revealed no evidence her blood sugar was assessed. Review of Resident #103's vitals from 07/20/24 to 08/13/24 revealed no evidence her blood sugar was assessed. Interview on 08/14/24 at 9:14 A.M. and 11:57 A.M. with Regional Nurse #300 verified she was unable to find any evidence Resident #103's blood sugar was monitored as ordered. 2. Review of the medical record for Resident #102 revealed an admitted [DATE] with diagnoses including adult failure to thrive, hypertensive heart disease with heart failure, acute respiratory failure with hypoxia, and restlessness and agitation. Review of Resident #102's comprehensive MDS 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #102's physician order dated 07/24/24 revealed an order for the blood pressure medication metoprolol succinate extended release 25 mg one time a day for hypertension. The medication was to be held for blood pressure less than 110 millimeters of mercury (mmHg) systolic blood pressure Review of Resident #102's MAR from 07/23/24 to 08/12/24 revealed Resident #102's blood pressure was not assessed prior to medication administration on 07/31/24, 08/05/24, 08/07/24, 08/08/24, and 08/11/24. Interview on 08/15/24 at 9:50 A.M. with Regional Nurse #300 verified Resident #102's blood pressure was not monitored as ordered. Regional Nurse #300 reported blood pressure monitoring should be attached to the order so staff would not miss it.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008 Based on medical record review and staff interview, the facility failed to ensure residents were free from significant medication errors. This affected one (#26) of five residents reviewed for unnecessary medications and one (#6) of one residents reviewed for pain management. The facility census was 52. Findings include: 1. Review of the medical record for Resident #26 revealed an admitted [DATE] with diagnoses including sepsis, cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type two diabetes mellitus, major depressive disorder, peripheral vascular disease, muscle weakness, and hypothyroidism. Review of Resident #26's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #26 had intact cognition. Review of Resident #26's physician order dated 12/03/22 revealed an order for the blood pressure medication losartan potassium 25 mg one tablet by mouth one time a day for hypertension to be held for blood pressure less than 110 over 60 millimeters of mercury (mmHg). Review of Resident #26's physician order dated 12/03/22 revealed an order for the blood pressure medication amlodipine besylate 10 mg one tablet by mouth one time a day for hypertension. The medication was to be held for blood pressure less than 110 over 60 mmHg. Review of Resident #26's physician order dated 07/12/24 revealed an order for the blood pressure medication metoprolol succinate extended-release (ER) 12.5 mg by mouth one time a day in the morning. The medication as to be held for blood pressure less than 110 over 60 mmHg. Review of Resident #26's medication administration record (MAR) for May 2024 revealed Resident #26's amlodipine besylate was administered outside of parameters on 05/04/24 and 05/23/24, her losartan potassium was administered outside of parameters on 05/04/24 and 05/23/24, and her metoprolol was administered outside of parameters on 05/04/24, 05/06/24, and 05/23/24. Interview on 08/15/24 at 1:55 P.M. with Regional Nurse #300 verified staff administered Resident #26's blood pressure medications outside of ordered parameters. 2. Review of the medical record for Resident #6 revealed an admitted [DATE] with diagnoses including bipolar disorder, type two diabetes mellitus, cerebral infarction, chronic pain syndrome, rheumatoid arthritis, adult failure to thrive, fibromyalgia, and chronic pain. Review of Resident #6's comprehensive MDS 3.0 assessment dated [DATE] revealed Resident #6 had intact cognition. Resident #6 reported frequent pain that effected sleep frequently and day to day activities occasionally. Over the last five days the resident's worst pain was moderate pain. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #6's plan of care dated 11/04/21 revealed Resident #6 had pain related to chronic pain syndrome and rheumatoid arthritis. Interventions included administering analgesia according to orders, anticipating need for pain relief, identifying previous pain history and management of that pain and impact on function, monitoring pain characteristics, notifying physician if interventions are unsuccessful or if current complaint is significant change from residents past experience, observing and reporting changes in usual routine, and providing the resident with reassurance that pain is time limited. Review of Resident #6's physician order dated 06/21/24 revealed an order for the narcotic pain medication Percocet 10-325 mg one tablet by mouth four times a day for pain and every 12 hours as needed for pain. Review of Resident #6's MAR for 08/01/24 to 08/12/24 revealed Resident #6 missed scheduled Percocet administrations. Further review revealed both the 8:00 A.M. and 4:00 P.M. doses were missed on 08/04/24. On 08/05/24, the 12:00 P.M. and 4:00 P.M. dose were missed, and on 08/06/24 the 4:00 P.M. dose was missed. Interview on 08/15/24 at 1:55 P.M. with Regional Nurse #300 verified the missing pain medication administration for Resident #6.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on observation, medical record review, and resident and staff interview, the facility failed to secure and store medications appropriately. This affected two (#25 and #44) of five residents observed during medication administration. The facility census was 52. Findings Include: 1. Review of the medical record for Resident #25 revealed admitted [DATE] with diagnoses including stomach cancer, adult failure to thrive, esophagus cancer, dysphalgia, and high blood pressure. Resident #25 required assistance from staff for activities of daily living (ADLs) tasks, medication administration, and personal hygiene care. Observation on 08/15/24 at 8:15 A.M., during medication administration for Resident #25, revealed several containers of opened medications sitting on the bedside table in the room including Flonase nasal spray 50 micrograms (mcg) dispensed from the pharmacy on 07/25/24 with expiration date 03/27, two bottles of Ofloxacin ear drops 0.3 percent (%) with one bottle's expiration date as 01/26 and the second bottle's expiration date as 03/25 (there was no open date observed on either bottle), and a bottle of liquid decongestant Mucinex medication with and expiration date 07/25 (there was no opened date observed). Interview on 08/15/24 at 8:25 with Licensed Practical Nurse (LPN) #59 confirmed the opened medication containers on the bedside table in Resident #25's room. LPN #59 removed the medications and secured them in the locked nurse's office until the medications could be returned to Resident #25's family member. 2. Review of the medical record for Resident #44 revealed an initial admitted [DATE] and a re-admitted [DATE] with diagnoses including high blood pressure, obstructive and reflux uropathy, and acute kidney stones. Resident #44 had intact cognition, had an indwelling neprophostomy tube, and required assistance from staff for personal hygiene tasks, transfers, and medication administration. Review of the physician orders for Resident #44 dated 08/01/24 to 08/15/24 revealed there were no orders for the application of Hydrocortisone cream 0.2%. Observation on 08/12/24 at 10:45 A.M. revealed on the beside table in Resident #44's room was an opened container of Hydrocortisone cream 0.2%. Observation on 08/15/24 at 8:40 A.M. revealed the same opened container of Hydrocortisone cream 0.2% sitting on the bedside table. Interview on 08/15/24 at 8:43 A.M. with Resident #44 revealed her ex-spouse brought in the container of Hydrocortisone cream 0.2% from home per request of Resident #44. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/15/24 at 9:00 A.M. with LPN #59 confirmed the opened container of Hydrocortisone cream 0. 2% sitting on the bedside table in Resident #44's room. LPN #59 removed the container and explained to Resident #44 the facility would need to get an order for the use of the medication and for the medication to be stored in the room.

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on review of the medical record, staff interview, and review of a facility policy, the facility failed to timely obtain laboratory values as ordered. This affected two (#13 and #39) of five residents reviewed for urinary tract infections (UTI). The facility census was 52. Findings include: 1. Review of the medical record for Resident #13 revealed an initial admitted [DATE] and readmitted [DATE] with diagnoses including acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, Parkinson's disease without dyskinesia, anxiety disorder, major depressive disorder, dementia, hemiplegia affecting left nondominant side, dysphagia, peripheral vascular disease, and epilepsy. Review of Resident #13's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he had a severe cognitive impairment. Review of Resident #13's progress note dated 08/10/24 at 2:36 P.M. revealed the nurse informed Family Nurse Practitioner (FNP) #313 of the resident's unusual behavior of being combative and increased in altered mental status. FNP #313 gave order for complete blood count (CBC) laboratory (labs) values, chest x-ray, comprehensive metabolic panel (CMP) lab values, and a urinary analysis (UA). Review of Resident #13's physician order dated 08/10/24 for a CBC lab, a chest x-ray, a CMP lab, and a urinary analysis. Review of Resident #13's progress noted dated 08/11/24 at 9:28 A.M. revealed the nurse called the lab regarding 'STAT' labs placed on 08/10/24 and, per the laboratory, they had no phlebotomist to send to collect the labs. The lab informed the nurse they would be collected on 08/12/24. Review of Resident #13's progress note dated 08/11/24 at 4:29 P.M. revealed the urine was collected via urinary hat and placed in lab specimen fridge. Review of Resident #13's labs revealed they were collected and reported on 08/12/24. Interview on 08/19/24 at 9:50 A.M. with the Director of Nursing (DON) verified Resident #13's labs were supposed to be STAT and had not been done immediately. 2. Review of the medical record for Resident #39 revealed an initial admitted [DATE] with the latest readmission of 02/06/24 with the diagnoses including cerebrovascular accident with left sided hemiplegia, pulmonary embolism, anemia, protein calorie malnutrition, bradycardia, hypertension, hypertension, hyperlipidemia, anxiety disorder, major depressive disorder, vascular dementia, gastro-esophageal reflux disease, dry eye syndrome, osteoarthritis, adult failure to thrive, slow transit constipation and sleep related leg cramps. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #39's comprehensive MDS assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the mood and behavior revealed the resident had delusions. The assessment indicated the resident was frequently incontinent of bowel and always incontinent of bowel. The assessment indicated the resident had two or more falls with no injury. Review of Resident #39's progress note dated 06/27/24 at 7:52 P.M. revealed the STAT urinalysis with culture and sensitivity (UA/C&S) was rescheduled for pick up by the laboratory. The entry indicated the night shift nurse was updated. Review of Resident #39's progress note dated 07/02/24 at 5:43 P.M. revealed the STAT UA/C&S ordered was collected and placed in the refrigerator for the laboratory to pick up. Further review revealed the results of the lab came back on 07/03/24. On 08/19/24 at 1:34 P.M., interview with Regional Nurse #300 verified the labs were not completed in a timely manner for Resident #39. Review of the facility policy titled, Laboratory Scheduling and Tests, dated 09/27/07, revealed it was the facility's policy to provide laboratory services as physician ordered to the residents. 32654

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008 Based on medical record review, staff interview, and policy review, the facility failed to report results of laboratory results in a timely manner. This affected two (#13 and #20) of 25 residents reviewed for laboratory values. The census was 52. Findings include: 1. Review of the medical record revealed Resident #20 was admitted to facility on 05/22/23 with diagnoses that included traumatic subdural hematoma, Parkinson's disease, heart failure, hemiplegia, hemiparesis, depressive disorder, and seizures. Review of Resident #20's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 01, indicative of severe impairment for daily decision making. Resident #20 received a substantial to maximal level of assistance with eating and had lost a significant amount of weight as of 07/02/24. Review of the nutrition progress note on 07/18/24 revealed Resident #20 lost a significant amount of weight, but that was now stabilized, with a weight range of between 155 pounds to 158 pounds and accepting the supplement Ensure nutritional supplements three times daily. Review of Family Nurse Practitioner (FNP) #313's progress note dated 08/16/24 revealed Resident #20 was seen by FNP #313 on 08/16/24 because of an eight-pound weight loss. FNP #313 added a new diagnosis of abnormal weight loss. Orders were made by FNP #313 to obtain a STAT comprehensive metabolic panel (CMP) and complete blood count (CBC) laboratory (labs) values on 08/16/24 related to weight loss. Review of Resident #20's STAT lab results revealed the lab collected the sample on 08/16/24 at 11:22 P.M. and the results were received by the facility on 08/17/24 at 3:13 A.M. Review of Resident #20's electronic medical record on 08/19/24 revealed that the progress notes were silent for receiving the STAT lab results from 08/16/24. Interview on 08/19/24 at 9:03 A.M. with Licensed Practical Nurse (LPN) #401 revealed LPN #401 was unaware of STAT labs that were drawn for Resident #20 on 08/16/24, nor was LPN #401 aware of the STAT lab results. Interview on 08/19/24 at 9:22 A.M. with LPN #401 revealed FNP #313 ordered STAT labs for Resident #20 on 08/16/24 and LPN #401 was unable to locate the lab results. LPN #401 confirmed the results of Resident #20's STAT labs had not been reported to FNP #313. Interview on 08/19/24 at 9:28 A.M. with Regional Nurse #300 revealed that she would expect STAT lab results to be reported to the physician or his proxy on the same date that the STAT labs were ordered. Regional Nurse #300 confirmed the results of the STAT labs for Resident #20 drawn on 08/16/24 have not been located. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/19/24 at 9:43 A.M. with the Director of Nursing (DON) confirmed Resident #20's STAT lab results from 08/16/24 were found on the printer. Director of Nursing #808 confirmed FNP #313 was notified of the STAT lab results on 08/19/24, even though the lab results were available on 08/18/24 at 3:13 A.M. 2. Review of the medical record for Resident #13 revealed an initial admitted [DATE] and readmitted [DATE]. Diagnoses including acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, Parkinson's disease without dyskinesia, anxiety disorder, major depressive disorder, dementia, hemiplegia affecting left nondominant side, dysphagia, peripheral vascular disease, and epilepsy. Review of Resident #13's comprehensive MDS 3.0 assessment dated [DATE] revealed he had a severe cognitive impairment. Review of Resident #13's progress note dated 08/10/24 at 2:36 P.M. revealed the nurse informed FNP #313 of the resident's unusual behavior of being combative and increased in altered mental status. FNP #313 gave order for a CBC lab, chest x-ray, CMP, and a urinary analysis (UA). Review of Resident #13's physician order dated 08/10/24 for a CBC lab , a chest x-ray, CMP lab, and a urinary analysis. Review of Resident #13's progress noted dated 08/11/24 at 9:28 A.M. revealed the nurse called the lab regarding STAT labs placed on 08/10/24 and, per the laboratory, they had no phlebotomist to send to collect the labs. The lab informed the nurse they would be collected on 08/12/24. Review of Resident #13's progress note dated 08/11/24 at 4:29 P.M. revealed the urine was collected via urinary hat and placed in lab specimen fridge. Review of Resident #13's labs revealed they were collected on 08/12/24 at 6:43 A.M. and reported on 08/12/24 at 9:32 P.M. Review of Resident #13's progress notes dated 08/12/24 to 08/15/24 revealed no evidence the physician was notified of the lab results. Review of Resident #13's progress note dated 08/16/24 at 1:10 P.M. revealed the nurse practitioner was notified of the lab results and put in an order in place. Interview on 08/19/24 at 9:50 A.M. with the DON verified Resident #13's lab results were not timely reported to the physician. Review of the facility policy titled, Laboratory Scheduling and Testing, dated 07/20/11, revealed laboratory serves were to be provided as ordered. 43064

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation, medical record review, staff interview, review of facility menu, and review of a dietary initiative, the facility failed to follow the menus and recipes for meals. This had the potential to affect all residents with the exception of Resident #8 who the facility identified as not eating anything my mouth. The facility census was 52. Findings include: 1. Review of the menu for 08/13/24 revealed residents were to receive tuna salad on croissant (one each), half a cup of mixed vegetables, five to eight crackers and cheese, one orange push pop, and milk. Observation in House #400 on 08/13/24 of the lunch meal at 11:17 A.M. revealed State tested Nurse Aide (STNA) #172 preparing tuna salad while not using any measuring utensils. Interview on 08/13/24 at 11:29 A.M. with STNA #172 revealed lunch would be tuna salad, crackers, cheese, and mixed vegetables. Observation on 08/13/24 at 12:05 P.M. revealed STNA #172 preparing resident meals. The meals included a small bowl of fruit, four to five slices of cheese, and five to eight crackers. STNA #172 then used a regular spoon to scoop tuna salad on to each of the resident plates. When she had prepared six plates, she reported she did not have enough for the last plate, she took tuna salad from some of the other plates and put it on the last plate. The resident's tuna salad portion varied from golf ball sized to a little bigger than a golf ball. All seven (#11, #14, #26, #33, #102, #103, and #104) residents were served this meal. Interview on 08/13/24 at the end of the 12:05 P.M. observation with STNA #172 revealed mixed berries were given instead of mixed vegetables because the residents had received mixed vegetables the previous night. She reported the meal called for croissants; however, the wrong croissants had been ordered so she did crackers instead. STNA #172 verified she had not used any measurements to portion the amount of tuna the residents received. STNA #172 reported she had not followed a recipe for tuna salad. There were some recipes in a book in the kitchen; however, she reported they could search for a recipe online or make it from memory if they knew how to make it. STNA #172 additionally verified that the residents did not receive dessert, and stated they would be given to the residents later and it would not be push pops as most residents did not like them. 2. Review of the menu for 08/14/24 revealed residents were to receive a half a cup of loaded potato soup, a soft pretzel with cheese, half a cup of green beans, half a cup of mixed berries, and milk. Observation in House #300 on 08/14/24 of the lunch meal at 12:47 P.M. revealed residents were served soup, berries, a pretzel, green beans, and juice. Residents were not provided milk or cheese. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 08/14/24 at 1:39 P.M. with STNA #126 verified residents were not given cheese with their pretzel. She additionally revealed residents only received milk at breakfast. 3. Review of the regular menu and the soft and bite sized menu from 08/02/24 to 08/19/24 revealed several instances of food being omitted from the soft and bite sized diet and not replaced. Review of the dinner menu for 08/04/24 revealed residents on a regular diet received beef stroganoff, steamed cauliflower, dinner roll, and chocolate cake. For dinner on 08/04/24 residents on a soft and bite sized diet received beef stroganoff, steamed cauliflower, and chocolate cake soaked in milk. Review of the lunch menu on 08/06/24 revealed residents on a regular diet received two chicken or beef tacos, chips and salsa, sweet roasted corn, and pineapples. For lunch on 08/06/24 residents on a soft and bite sized diet received ground beef with cheese and sour cream, half a baked potato with no skin, and pineapple chunks. Review of the lunch menu on 08/07/24 revealed residents on a regular diet received pepper steak, white rice, peppers and onions, and mandarin oranges. For lunch on 08/07/24 residents on a soft and bite sized diet received cream of mushroom soup, peppers and onions, and mandarin oranges. Review of the dinner menu on 08/09/24 revealed residents on a regular diet received stuffed green peppers, buttered noodles, Italian bread and pudding. For dinner on 08/09/24 residents on a soft and bite sized diet received stuffed green peppers, buttered noodles, and pudding. Review of the lunch menu on 08/14/24 revealed residents on a regular diet received loaded potato soup, soft pretzel with cheese, green beans, and mixed berries. For lunch on 08/14/24 residents on a soft and bite sized diet received loaded potato soup, green beans, and mixed berries. Review of the lunch menu on 08/16/24 revealed residents on a regular diet received chicken noodle soup, baguette or French bread, parmesan baked carrots, and blueberries. For lunch on 08/16/24 residents on a soft and bite sized diet received chicken noodle soup (broth only), steamed carrots, and strawberries. Review of the dinner menu on 08/16/24 revealed residents on a regular diet received goulash, sauteed zucchini and mushrooms, a dinner roll, and pudding. For dinner on 08/16/24 residents on a soft and bite sized diet received goulash, steamed zucchini and mushrooms, and pudding. Review of the lunch menu on 08/17/24 revealed residents on a regular diet received a shredded chicken quesadilla, black bean soup, fajita peppers and onions, and peaches. For lunch on 08/17/24 residents on a soft and bite sized diet received quesadilla chicken and cheese with no tortilla, steamed fajita peppers and onions, and peaches. Review of the dinner menu on 08/18/24 revealed residents on a regular diet received vegetable lasagna, garlic bread, green beans, and sugar cookies. For dinner on 08/18/24 residents on a soft and bite sized diet received vegetable lasagna, steamed green beans, and dessert of choice. Review of the lunch menu on 08/19/24 revealed residents on a regular diet received turkey burger sliders, tater tots, green beans, apple pie a la mode, and grapes. For lunch on 08/19/24 residents on a soft and bite sized diet received turkey burger sliders, tater tots, and green beans. Interview on 08/19/24 at 2:12 P.M. with Dietitian #311 revealed the menus provided were 'as served.' Residents on a soft and bite sized diet should always receive substitutions on things from the regular menu they are unable to eat. He reported the nurse aides knew how to use the fork test to determine what they could serve the residents. He verified the menu 'as served' was approved by him. He indicated residents on a soft and bite sized diet should always receive dessert. Review of the International Dysphagia Diet Standardization Initiative (IDDSI) description of the soft and bite sized diet (provided as facility policy) revealed food could be tested with the fork pressure diet to ensure it was soft and bite sized. To make sure food is soft enough press down on the fork until the thumbnail blanches to white, then lift the fork to see that the food is completely squashed and does not regain shape. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. On 08/13/24 at 11:53 A.M., observation of STNA #126 revealed she opened eight cans of tuna and placed it in a clear glass bowl. STNA #126 had no recipe to follow for preparing the tuna salad for lunch. She then cut up a large purple onion and placed in the tuna, then placed an unmeasured amount of mustard and mayonnaise in the bowl and mixed the tuna. Interview at the time of the observation with STNA #126 stated she used a recipe she got off Youtube for the meal. 5. Review of the medical record for Resident #23 revealed an initial admitted [DATE] with the diagnoses including but not limited to cerebral atherosclerosis, disorder of thyroid, anxiety disorder, dementia, diverticulosis of large intestine, slow transit constipation, anxiety disorder, chronic pain, osteoarthritis, hearing loss, and generalized muscle weakness. Review of Resident #23's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident had no known weight loss and was not receiving a mechanically altered diet. Review of the plan of care dated 07/15/24 revealed Resident #23 was receiving hospice care/comfort related to doesn't eat enough to prevent decline and declines tube feeding or intravenous therapy. Interventions included assist resident at meal and snack time as needed, communicate with hospice routinely and as needed, encourage to eat and drink by offering food and fluids that resident likes, encourage family to bring food and fluids in the resident likes, offer substitutes when does not like what is served, observe for signs/symptoms of dehydration, observe ability to feed herself at meals and recommend therapy screen as needed, observe intakes, weights, labs and skin condition routinely and report as needed, provide the diet as ordered and provide medications as ordered. Review of Resident #23's monthly physician orders for August 2024 identified an order dated 05/23/24 for a regular diet, soft and bite sized texture, thin liquid consistency with pleasure foods. Review of the facility's weekly menu revealed Resident #23 was to receive two sliders cut up without the bun, green beans, tator tots, and milk. Further review revealed the resident had no soft food to replace the apple pie or grapes. On 08/19/24 at 12:20 P.M., observation of STNA #350 preparing Resident #23's lunch meal revealed the resident was on a soft, bite size, finger food diet. The STNA opened a container of chicken salad and used a tablespoon and placed an unmeasured amount of the chicken salad on the resident's plate. The STNA then opened a box of bite size crackers and placed an unmeasured amount on the resident's plate. The STNA then opened an individual container of applesauce and placed on the resident's plate. The resident was given juice with her meal. STNA #350 verified during interview at the time of the observation they had not followed the menu and did give the resident what soft food was available in the house. 32654

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 43064 Based on observation and resident and staff interview, the facility failed to ensure appetizing food was served to the resident. This affected one (#39) of 11 resident residing in House #300. The facility census was 52. Findings include: Interview on 08/12/24 at 9:49 A.M. with Resident #39 revealed the facility's green beans always tasted awful, like they had come straight from the can. Observation in House #300 on 08/14/24 a 12:47 P.M. revealed State tested Nurse Aide (STNA) #126 was finishing preparing lunch. The residents were served soup, berries, a soft pretzel, green beans, and juice. After all meals were served at 1:39 P.M., a sample test tray was consumed. The green beans were noted to have no flavor and were rubbery. Interview on 08/14/24 at 1:39 P.M. with STNA #126 revealed the green beans had been warmed up from a can, and she only added a sprinkle of salt to the green beans because not everybody in the building liked pepper. 32654 47569

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation, medical record review, review of menus, staff interview, and review of a dietary initiative, the facility failed to ensure residents were served food items as ordered to meet their needs. This affected two (#33 and #102) of seven residents on a soft and bite sized diet. The facility census was 52. Findings include: Review of the medical record for Resident #33 revealed an admitted [DATE] with diagnoses including paranoid schizophrenia, centrilobular emphysema, auditory and visual hallucinations, and hyperlipidemia. Review of Resident #33's physician order dated 06/27/24 revealed an order for a regular diet with a soft and bite sized texture. Review of the medical record for Resident #102 revealed an admitted [DATE] with diagnoses including adult failure to thrive, hypertensive heart disease with heart failure, acute respiratory failure with hypoxia, and restlessness and agitation. Review of Resident #102's physician order dated 07/23/24 revealed an order for a regular diet with a soft and bite sized texture. Review of the lunch menu for 08/13/24 revealed residents on a soft and bite sized diet were to receive a scoop of tuna salad, mixed vegetables, cheese slice, and orange push-pops. Observation on 08/13/24 at 12:05 P.M. revealed State tested Nurse Aide (STNA) #172 was preparing resident meals. The meals included a small bowl of fruit, four to five slices of cheese, and five to eight crackers. STNA #172 then used a regular spoon to scoop tuna salad on to each of the resident's plates. All residents on a regular and soft and bite sized diet were served the same food. Resident #33 and Resident #102 were observed receiving these meals. Interview on 08/13/24 at the end of the 12:05 P.M. observation with STNA #172 verified residents on a soft and bite sized diet received crackers. Review of the International Dysphagia Diet Standardization Initiative (IDDSI) description of the soft and bite sized diet (provided as facility policy) revealed food could be tested with the fork pressure diet to ensure it was soft and bite sized. To make sure food was soft enough, press down on the fork until the thumbnail blanches to white, then lift the fork to see that the food was completely squashed and did not regain shape. Interview on 08/19/24 at 2:12 P.M. with Dietitian #311 stated nurse aides knew how to use the fork test to determine what they could serve the residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation review of food storage temperature logs, and staff interview, the facility failed food was stored in a safe and sanitary manner. This had the potential to affect all 51 residents receiving food from the facility. The facility identified Resident #8 as eating nothing by mouth. The census was 52. Findings include: 1. Observation on [DATE] from 9:06 A.M. to 9:49 A.M., in House #300, revealed food debris was noted in both the pantry refrigerator and the kitchen refrigerator. Observation of the refrigerator in the pantry revealed it felt warm and the sensor connected to it read 72 degrees Fahrenheit (F). State tested Nurse Aide (STNA) #126 pointed out the internal temperatures which indicated the refrigerator was 54 degrees F and the freezer was 24 degrees F. The refrigerator contained milk, eggs, cheese, coleslaw, and pasta salad. The freezer contained frozen vegetables, chicken, lasagnas, ground turkey, and pierogies, and these foods were starting to soften. Interview with STNA #126 at the time of the observation revealed the refrigerator was connected to a sensor and the dietitian received the results. STNA #126 initially reported the dietary staff came around and read the temperatures every morning, and later said everyone documented the temperatures in the log. STNA #126 was unable to find a filled in temperature log for House #300. STNA #126 had not checked temperatures that morning and was unsure how long the refrigerator had been down. 2. Observation on [DATE] from 9:06 A.M. to 9:49 A.M., in House #200, revealed expired foods were noted, including thousand island dressing dated [DATE], mozzarella cheese dated [DATE], hot dog buns dated [DATE], and sour cream dated [DATE] Interview with STNA #45 verified the foods were expired at the time of the observation. 3. Observation on [DATE] from 9:06 A.M. to 9:49 A.M., in House #100, revealed expired foods were noted, including chip dip dated [DATE], coleslaw dated [DATE], carrots dated [DATE], and hamburger buns dated [DATE]. Observation of the pantry refrigerator and freezer had food debris, splatter, and what appeared to be hair on the bottom of the shelf. Interview with STNA #63 verified the findings at the time of the observation. 4. Observation on [DATE] from 9:06 A.M. to 9:49 A.M., in House #500, revealed expired foods were noted, including wheat bread dated [DATE], coleslaw dated [DATE], burrito tortillas dated [DATE], two packages of flour tortillas dated [DATE] and [DATE], sandwich sauce dated [DATE], provolone cheese dated [DATE], and a container of swish cheese that was open, undated, and hardened. Interview with STNA #7 verified the findings at the time of the observation. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. Observation on [DATE] from 9:06 A.M. to 9:49 A.M., in House #400, revealed expired foods were noted, including bread dated [DATE], caramel topping dated [DATE], and ham dated [DATE]. Additionally, observation of the pantry refrigerator revealed a large liquid stain and other food debris. Interview with STNA #190 verified the findings at the time of the observation. STNA #190 indicated nurse aides were supposed to document food temperatures in a log kept in the kitchen; however, she was unable to find an [DATE] log. Refrigerator and freezer temperatures had not been obtained that morning. 47569

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on medical record review and staff interview, the facility failed to maintain a complete and accurate medical record. This affected two (#4 and #13) of 25 sampled residents. The facility census was 52. Findings Include: 1. Review of the medical record for Resident #4 revealed an initial admitted [DATE] with the latest readmission of 02/26/24. Diagnoses included bipolar disorder, morbid obesity, hypertension, dementia with anxiety, peripheral vascular disease, polyarthritis, generalized muscle weakness, and difficulty in walking. Review of the fall investigation form dated 04/01/24 at 3:00 A.M. revealed Resident #4 was found in her doorway sitting on the floor. The resident reported she was walking and fell . Review of Resident #4's medical record revealed the fall occurrence on 04/01/24 at 3:00 A.M. was not documented in the resident's medical record. On 08/19/24 at 10:18 A.M., interview with Regional Nurse #350 verified the 04/01/24 fall was not documented in Resident #4's medical record. 2. Review of the medical record for Resident #13 revealed an initial admitted [DATE]. Diagnoses included acute and chronic respiratory failure, chronic obstructive pulmonary disease, Parkinson's disease, restlessness and agitation, anxiety disorder, major depressive disorder, seizures, hypertension, hyperlipidemia, insomnia, dementia, and atrial fibrillation. Review of Resident #13's physician order dated 03/28/24 revealed an order for the supplement Ensure two times a day. Review of Resident #13's medication administration record (MAR) from 08/01/24 to 08/17/24 revealed the resident consumed 100 percent (%) of his supplement twice on 08/01/24, 08/10/24, 08/11/24, 08/12/24, 08/13/24, 08/15/24, 08/16/23, and 08/17/24; and once on 08/09/24 and 08/14/24. Further review revealed Resident #13 consumed 50% of his supplement twice on 08/02/24, 08/03/24, 08/05/24, 08/06/24, and 08/07/24; and once on 08/04/24 and 08/09/24. Resident #13 consumed 0% of his supplement once on 08/04/24. The resident refused his supplement once on 08/14/24. Review of Resident #13's Ensure intake as documented by the nurse aides revealed the resident consumed 100% of his supplement twice on 08/16/24 and once on 08/02/24, 08/04/24, 08/09/24, and 08/17/24. Resident #13 consumed 75% of his supplement twice on 08/03/24 and 08/15/24; and once on 08/02/24, and 08/18/24. The resident consumed 25% of his supplement once on 08/11/24. The resident was not available on 08/07/24 and 08/08/24. The resident refused once on 08/01/24, 08/04/24, 08/09/24, 08/10/24, 08/11/24, and 08/17/24. All other administrations were documented as 'not applicable.' (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/19/24 at 11:30 A.M. with the Director of Nursing (DON) verified Resident #13's supplement intake from the MAR and the nurse aide's documentation did not match. The DON reported the nurse aides' documentation should be the correct documentation as they were the ones who watched the residents and knew how much they consumed. Interview on 08/19/24 at 2:12 P.M. with Dietitian #311 revealed he believed the supplement documentation in the MAR should be the only and correct documentation. 43064

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on observation, medical record review, and staff interview, the facility failed to maintain infection control during a dressing change, failed to implement enhanced barrier precautions, and failed to maintain sanitary placement of a urinary catheter bag. This affected seven (#8, #11, #25, #102, #103, #154, and #155) of eight residents reviewed for infection control practices. The facility census was 52. Findings Include: 1. Review of the medical record for Resident #8 revealed an admitted [DATE] with the diagnoses including Down syndrome, obstructive sleep apnea, chronic respiratory failure, asthma, and stage four pressure injury to right buttock. Resident #8 was dependent for all care, personal hygiene needs, and administration of medications and treatments. Resident #8 had impaired cognition and required a wheelchair for mobility. Review of the physician orders for Resident #8 revealed an order dated 07/04/24 for a right ischial wound with instructions to change wound vacuum three times a week with continuous suction at 125 millimeters of mercury (mmHg) every day shift every Tuesday, Thursday, and Saturday for wound care until resolved. Observation on 08/15/24 at 2:40 P.M. revealed Licensed Practical Nurse (LPN) #59 completing a wound dressing change for Resident #8. LPN #59 gathered the supplies, including a pair of bandage scissors, and entered Resident #8 room. LPN #59 placed the supplies on the chair sitting in the corner across form the bed. LPN #59 assisted in repositioning Resident #8 onto her left side, changed gloves, washed hands, and donned a new pair of gloves. LPN #59 then removed the soiled dressing and placed in the trash can. LPN #59 removed gloves and then donned a new pair of gloves without washing hands prior to donning the new pair of gloves. LPN #59 removed the bandage scissors and a piece of green dressing foam, and began cutting the dressing foam with the scissors to fit the wound bed. The scissors were not cleaned prior to cutting of the dressing foam. LPN #59 completed the dressing change, removed the used supplies' packaging and trash, removed the gloves, and exited the room. Upon arrival to the medication cart, LPN #59 used hand sanitizer to cleanse hands and placed the bandage scissors back into the top drawer of the medication cart without cleaning the scissors. Interview on 08/15/24 at 3:10 P.M. with LPN #59 confirmed the bandage scissors were not cleaned prior to cutting the green dressing foam and LPN #59 did not wash hands between glove changes during the dressing change procedure for Resident #8. 2. Review of the medical record for Resident #25 revealed an admitted [DATE] with diagnoses including stomach cancer, adult failure to thrive, esophagus cancer, dysphasia, and high blood pressure. Resident #25 required assistance from staff for activities of daily living (ADL) tasks, medication administration, and personal hygiene. Resident #25 had impaired cognition, was hard of hearing, and received nutrition and medications via a peg tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician orders for Resident #25 revealed an order dated 08/06/24 for enhanced barrier precautions (EBP). Further review of Resident #25's treatment administration record (TAR) dated 08/06/24 to 08/15/24 revealed documentation of completion for the order of enhanced barrier precautions. Review of the medical record for Resident #154 revealed an initial admitted [DATE], and re-admitted [DATE], with diagnoses including chronic obstructive pulmonary disease, chronic respiratory failure, other diseases of the bronchus, and a wound requiring dressing changes. Resident #154 had intact cognition and required limited assist from staff for ADLs tasks and medication administration. Review of the physician orders for Resident #154 revealed an order dated 08/14/24 for EBP with instructions for gloves and gown to be worn with treatment and/or care. Review of the medical record for Resident #155 revealed an admitted [DATE] with diagnoses including acute respiratory failure, pleural effusion, sepsis, and anxiety. Resident #155 had intact cognition and required assistance from staff for ADLs tasks. Resident #155 received antibiotic medications via peripherally inserted central catheter (PICC) line located in the upper right arm. Review of the physician orders for Resident #155 revealed an order dated 08/12/24 for EBP with instructions for gloves and gown to be worn with treatment and or care related to PICC line. Observations on 08/12/24 from 9:15 A.M. to 10:50 A.M. revealed Resident #25, Resident #154, and Resident #155 did not have any signage or notification located on the outside door or inside the room for EBP and there was no personal protective equipment (PPE) available outside the rooms for staff or visitors to put on when entering the room. Interview on 08/12/24 at 11:30 A.M. with Regional Nurse #300 confirmed the lack of signage and notification for EBP and the lack of PPE for Resident #25, Resident #154, and Resident #155. 3. Review of the medical record for Resident #102 revealed an admitted [DATE] with diagnoses including adult failure to thrive, hypertensive heart disease with heart failure, acute respiratory failure with hypoxia, and restlessness and agitation. Review of Resident #102's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition and an indwelling catheter. Review of the plan of care revised 08/08/24 revealed Resident #102 had an indwelling catheter. Interventions included positioning catheter bag and tubing below the level of the bladder and away from room door, changing catheter as ordered, checking tubing for kinks frequently each shift, monitoring and documenting intake and output according to facility policy, monitoring pain or discomfort due to catheter, monitor for signs of discomfort on urination, and monitor and report to the physician signs of a urinary tract infection. Observation on 08/12/24 at 10:30 A.M. and 10:48 A.M. revealed Resident #102's catheter bag wrapped in a trash bag and hanging of her trash can. The trash can was observed to have trash inside it. Interview on 08/12/24 at 10:30 A.M. with Resident #102's family revealed the facility staff always placed the catheter bag on the trash can. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/12/24 at 10:50 A.M. with State tested Nurse Aide (STNA) #172 verified the catheter bag was hanging on the trash can. STNA #172 indicated the nurse would need to address whether or not this was appropriate. Interview on 08/12/24 at 11:11 A.M. with LPN #400 verified the catheter bag was hanging on the trash can, and reported this was because staff was unsure where else to hang it while she was up in her recliner. Observation on 08/13/24 at 11:38 A.M. revealed Resident #102's catheter bag remained hanging off the trash can. The trash bag and all trash had been removed from the bin. 4. Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses including ulcerative colitis, hypertension, type two diabetes mellitus, neuromuscular dysfunction of the bladder, dysuria, and chronic pain. Review of Resident #11's quarterly MDS)3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition and an indwelling catheter. Review of Resident #11's physician order dated 11/07/23 revealed an order for EBP. Staff were to use gloves and gowns with treatment or care. Review of the medical record for Resident #102 revealed an admitted [DATE] with diagnoses including adult failure to thrive, hypertensive heart disease with heart failure, acute respiratory failure with hypoxia, and restlessness and agitation. Review of Resident #102's comprehensive MDS 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition and an indwelling catheter. Review of Resident #102's physician order dated 07/25/24 revealed an order for EBP. Staff were to use gloves and gowns with treatment or care. Review of the medical record for Resident #103 revealed an admitted [DATE] with diagnoses including quadriplegia, type two diabetes mellitus, depression, atherosclerosis of other arteries, osteoarthritis, spinal stenosis, paroxysmal atrial fibrillation, and neuromuscular dysfunction of the bladder. Review of Resident #103's comprehensive MDS 3.0 assessment dated [DATE] revealed Resident #103 had moderately impaired cognition. Resident #102 had an indwelling catheter, a stage four pressure ulcer (full-thickness skin and tissue loss), and an unstageable pressure ulcer (obscured full-thickness skin and tissue loss). Review of Resident #103's physician order dated 07/29/24 revealed an order for EBP. Staff were to use gloves and gowns with treatment or care. Observation on 08/12/24 on five occasions from 10:18 A.M. to 2:00 P.M. revealed EBP were not in place for Resident #11, Resident #102, and Resident #103. All three residents were observed to have catheters in place. There were no signs indicating EBP and no PPE was observed in or around the rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/12/24 at 3:44 P.M. with STNA #172 revealed there was nobody in the house Resident #11, Resident #102, and Resident #103 resided in that required transmission-based precautions or EBP. Interview on 08/12/24 at 3:53 P.M. with Regional Nurse #300 verified Resident #11, Resident #102, and Resident #103 should be on EBP and were not. 43064

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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** 43064 Based on medical record review, staff interview, and policy review, the facility failed to ensure residents receiving antibiotics were properly assessed prior to implementation of antibiotic therapy and antibiotics appropriately prescribed. This affected three (#4, #11, and #39) of five residents reviewed for urinary tract infections (UTI). The facility census was 52. Findings include: Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses including ulcerative colitis, hypertension, type two diabetes mellitus, neuromuscular dysfunction of the bladder, dysuria, and chronic pain. Review of Resident #11's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition. Resident #11 had an indwelling catheter. Review of Resident #11's plan of care dated 12/06/23 revealed Resident #11 had an indwelling catheter related to neurogenic bladder. Removal was clinically contraindicated per the physician and the resident was followed by urology. Per the urologist, the facility was not to treat UTIs unless symptomatic due to constant infection related to catheter use. Interventions included indwelling catheter, positioning catheter bag and tubing below level of the bladder, changing the catheter as needed, checking the tubing for kinks, monitoring and documenting intake and output as per facility policy, monitoring for pain due to the catheter, monitoring for discomfort on urination, monitoring for signs of a UTI, urology consultation as needed, and urine output via urinary catheter. Review of Resident #11's plan of care revised 04/26/24 revealed Resident #11 had a chronic UTI related to catheter use. Interventions included giving antibiotic therapy as ordered, monitoring and reporting to the physician as needed for signs of UTIs, and family and caregiver teaching. Review of Resident #11's physician order dated 04/26/24 revealed an order for the antibiotic Bactrim DS tablet 800-160 milligrams (mg) one tablet by mouth two times a day for UTI prophylaxis. Review of Resident #11's progress notes from 4/20/24 to 4/30/24 revealed no notes related to beginning her Bactrim. Review of Resident #11's physician notes dated 04/30/24, 05/14/24, 05/28/24, and 06/04/24 revealed no documentation related to prophylactic use of Bactrim. Review of Resident #11's family nurse practitioner (FNP) notes dated 05/02/24, 05/2424, and 07/07/24 revealed the resident began prophylactic Bactrim. Review of Resident #11's CNP note dated 05/08/24 revealed no notes related to prophylactic use of Bactrim. Review of Resident #11 medical record from 04/26/24 to 08/14/24 revealed the 05/02/24 FNP note was the only time her prophylactic use of Bactrim was addressed. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/15/24 at 2:18 P.M. with Regional Nurse #300 verified Resident #11 was on a prophylactic antibiotic and was unable to find evidence the physician was evaluating its continued need. 2. Review of the medical record for Resident #4 revealed an initial admitted [DATE] with the latest readmission of 02/26/24. Diagnoses including but not limited to bipolar disorder, morbid obesity, hypertension, dementia with anxiety, peripheral vascular disease, polyarthritis, anxiety disorder, cataracts, alcohol dependence with alcohol induced dementia, generalized muscle weakness, difficulty in walking, mixed incontinence, hyperlipidemia, low back pain, sensorineural hearing loss, osteoarthritis, dermatitis, and insomnia. Review of the plan of care dated 11/27/18 revealed Resident #4 was at risk for urinary tract infections (UTI) due to personal history of UTI. Interventions included assist with managing adult brief as needed, dip urine as needed, encourage fluid intake, encourage routine peri-care and assist as needed, encourage voiding for every two to three hours to decrease bacteria in the bladder, medications as ordered, monitor for signs/symptoms of UTI, monitor elimination patterns and document negative findings, and provide resident/caregiver/family teach as needed for good hygiene practices. Review of Resident #4's progress note dated 02/15/24 at 6:10 P.M. revealed the facility received the results of the urinalysis and culture and sensitivity (UA/C&S). Further revealed of the resident's progress notes revealed no indication as why and when the UA/C&S was obtained. Review of the UA/C&S results dated 02/17/24 revealed Resident #4 had greater than 100,000 colony forming unit (CFU)/milliliter (ml) escherichia coli (E. coli) and a secondary colony of 10-15,000 CFU/mL escherichia coli. Further review revealed the secondary colony of escherichia coli was resistive to the prescribed antibiotic Bactrim double strength (DS). Review of Resident #4's discontinued physician orders identified orders dated 02/15/24 for the antibiotic Bactrim DS 800-160 milligrams (mg) by mouth twice daily for seven days for UTI and 02/22/25 Bactrim DS 800-160 milligrams (mg) by mouth twice daily for five days for UTI. Review of the acute care hospital discharge summary dated 02/26/24 revealed Resident #4 was diagnosed with falls, syncope, acute kidney injury, and UTI. The summary documented the Bactrim DS may have played a factor in the resident's high potassium level and the acute kidney injury. The Bactrim was discontinued, UA/C&S was repeated and the resident was started on the antibiotic Cephalexin 250 mg which was susceptible to both organisms on the C&S result dated 02/15/24. Review of Resident #4's readmission note dated 02/26/24 at 5:30 P.M. revealed the resident was readmitted to the facility following an acute care hospital stay for falls, syncope, acute kidney injury, and UTI. The resident was ordered Cephalexin 250 mg by mouth four times a day for four days for UTI. On 08/19/24 at 9:47 A.M., interview with Regional Nurse #300 verified another antibiotic would be more appropriate to treat the UTI and was unaware of Family Nurse Practitioner (FNP) #313 was ordering Bactrim DS for all UTI. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/19/24 at 3:00 P.M., interview with FNP #313 revealed if a resident was symptomatic she started the resident on Bactrim until the C&S came back. She said once it comes back she will change the antibiotic to what the organism was sensitive to. FNP #313 revealed she, Probably never saw the results of the C&S (for Resident #4), or she would have changed the antibiotic to one that was sensitive to both organisms in the urine. 3. Review of the medical record for Resident #39 revealed an initial admitted [DATE] with the latest readmission of 02/06/24. Diagnoses including cerebrovascular accident with left sided hemiplegia, pulmonary embolism, anemia, protein calorie malnutrition, bradycardia, hypertension, hypertension, hyperlipidemia, anxiety disorder, major depressive disorder, vascular dementia, gastro-esophageal reflux disease, dry eye syndrome, osteoarthritis, adult failure to thrive, slow transit constipation, and sleep related leg cramps. Review of Resident #39's comprehensive MDS assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the mood and behavior revealed the resident had delusions. The assessment indicated the resident was frequently incontinent of bowel and always incontinent of bowel. The assessment indicated the resident had two or more falls with no injury. Review of Resident #39's progress note dated 06/27/24 at 7:52 P.M. revealed a STAT UA/C&S was rescheduled for pick up by the laboratory. The entry indicated the night shift nurse was updated. Review of Resident #39's progress note dated 07/02/24 at 5:43 P.M. revealed the STAT UA/C&S ordered was collected and placed in the refrigerator for the laboratory to pick up. Review of Resident #39's UA/C&S results dated 07/03/24 revealed the resident had greater than 100,000 CFU/mL escherichia coli and 16-20,000 CFU/mL enterococcus faecalis identified in the urine. Further review of the C&S results revealed the 16-20,000 CFU/mL enterococcus faecalis was not sensitive to Bactrim DS 800-160 mg. Review of Resident #39's progress note dated 07/03/24 at 6:46 P.M. revealed FNP #313 ordered Bactrim DS twice daily for seven days for UTI. Review of the resident's discontinued physician orders identified an order dated 07/04/24 Bactrim DS 800-160 mg by mouth twice daily for seven days for UTI. Review of Resident #39's July 2024 medication administration record (MAR) revealed the Bactrim DS 800-160 mg was not started until 07/05/24. On 08/19/24 at 1:34 P.M., interview with Regional Nurse #300 verified another antibiotic would be more appropriate to treat Resident #39's UTI. On 08/19/24 at 3:00 P.M., interview with FNP #313 revealed if a resident was symptomatic she started the resident on Bactrim until the C&S came back. She said once it comes back she will change the antibiotic to what the organism was sensitive to. FNP #313 revealed she, Probably never saw the results of the C&S (for Resident #39), or she would have changed the antibiotic to one that was sensitive to both organisms in the urine. Review of the facility policy titled, Urinary Tract Infection, dated 09/07, revealed it was the facility's policy to provide appropriate care and services to prevent UTI in residents with or without catheters to the extent possible.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366424	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein New Albany	6690 Liberation Way New Albany, OH 43054

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 50008 Based on personnel record review and staff interview, the facility failed to provide 12 hours of annual in-services for state tested nurse aides (STNAs) as required. This affected two (STNA #45 and STNA #71) out of nine employee records reviewed. This had the potential to affect all 52 residents in the facility. The census was 52 residents. Findings include: 1. Review of STNA #45's personnel record revealed a hired date of 11/02/15. The personnel file for STNA #45 did not include proof of twelve hours of annual in-services for STNAs. An interview on 08/19/24 at 1:51 P.M. with Coach #200 confirmed STNA #45 did not have 12 hours of in-services on an annual basis. Coach #200 confirmed STNA #45 received one hour and 45 of in-services in a twelve-month period. 2. Review of STNA #71's personal file revealed a hire date 09/16/22. Further review revealed the required 12-hour yearly in-services for STNAs had not been completed for the last year. Interview on 08/19/24 at 1:09 P.M. with the Administrator revealed the facility used a system which was a computerized educational program to assign, complete, and track the completed assignments by each employee. The assigned training plans are uploaded and available to the employees monthly. The employees are notified by the cooperate human resource team and it was the employee's responsibility to completed the assigned in-services. Interview on 08/19/24 at 1:20 P.M. with Coach #200 confirmed Employee #71 had an incomplete training program for the last year. 47569