STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366430	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein Gahanna	402 Liberty Way Gahanna, OH 43230

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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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 43064 Based on observation, interview, and medical record review the facility failed to ensure a full set of utensils and napkins was provided for all residents in houses 400 (#8, #11, #14, #18, #20, #21, #32, #34, #38) and 404 (#6, #9, #19, #22, #24, #28, #33, #35, #40, #45), additionally the facility failed to ensure a dignified dining experience for Resident #19. This affected 19 residents (#6, #8, #9, #11, #14, #18, #19, #20, #21, #22, #24, #28, #32, #33, #34, #35, #38, #40, #45) observed for dining. The facility census was 50. Findings include: 1. Interview on 09/09/24 at 11:31 A.M. with Resident #33 revealed the facility did not provide appropriate silverware for meals. She reported she in the past had been given a fork to eat applesauce with. Observation on 09/10/24 at 12:40 P.M. of the lunch meal in building 404 revealed residents were served a sandwich, a bowl of soup, and orange segments. All residents (#6, #9, #19, #22, #24, #28, #33, #35, #40, and #450 were only provided a spoon for utensils. One resident (#40) was observed using her spoon to cut up her sandwich. Interview on 09/10/24 after the 12:40 P.M. observation with Dietitian #150 verified the observation. He indicated the residents could ask for additional utensils but should not have to. 2. Observation on 09/09/24 at 12:08 P.M. revealed Resident #19 sitting at the dining room table, multiple residents around her were eating their meals, she had no food in front of her. At 12:21 P.M., Resident #19 was provided food after all the other residents had finished their meals at the table. Observation on 09/12/24 at 8:10 A.M. revealed Resident #19 at the dining room table without food in front of her. Another resident was seated next to her eating breakfast. At 8:31 A.M. the other resident had finished her meal and left; Resident #19 was still sitting at the table without food. Observation at 8:49 A.M. revealed another resident was seated next to Resident #19 at the table eating, a third resident at the table was served breakfast at that time. Observation at 8:57 A.M. revealed Resident #19 was still sitting at the dining room table without food. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/12/24 at 8:57 A.M. with the Administrator verified Resident #19 remained at the table. She had been unaware that Resident #19 had not had breakfast yet. However, she verified with Diet Tech #123 that they were working on preparing Resident #19's meal. 32654 3. On 09/09/24 from 11:00 A.M. to 11:25 A.M. of the lunch meal revealed State tested Nursing Assistant (STNA) #119 prepared the resident's lunch of potato soup, turkey sandwich with lettuce and tomato and mandarin oranges. Further observation revealed all nine residents (#8, #11, #14, #18, #20, #21, #32, #34, and #38) residing in the house received only a spoon to consume their lunch with and was not offered a full set (knife, spoon and fork) of utensils. Further observation revealed all nine resident had not been offered or received a napkin or condiments for their meal. On 09/09/24 at 11:25 A.M., interview with STNA #119 verified the residents only received a spoon for the lunch meal and no napkin and condiments. STNA #119 revealed the house did not have a full set of utensils for each resident residing in the house. This deficiency represents noncompliance investigated under Complaint Number OH00156905.

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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 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 record review and staff and family interviews, the facility failed to ensure one resident (#25) was provided bathing per her preference. This affected one (Resident #25) of six residents reviewed for activities of daily living (ADL). The facility census was 50. Findings Include: Review of the medical record for Resident #25 revealed an initial admitted [DATE] with the diagnoses including but not limited to congestive heart failure, hyperlipidemia, hypothyroidism, chronic kidney disease, atrial fibrillation, hypertension, gastro-esophageal reflux disease, macular degeneration and protein calorie malnutrition. Review of the plan of care dated 03/22/24 revealed the resident had a self-care deficit and/or physical mobility performance deficit related to activity intolerance, fatigue, impaired balance and weakness. Interventions included the resident requires moderate assistance of one staff for dressing, showering and personal hygiene. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the mood and behavior revealed the resident had not rejected any care. Review of the resident's task list revealed no assigned day for scheduled showers. Review of the resident's shower documentation from 08/16/24 to 09/09/24 revealed the resident had received two showers on 08/16/24 and 09/02/24. On 09/09/24 at 2:12 P.M., interview with Resident #25's family member revealed the resident only received one shower a week and she would like more. On 09/16/24 at 9:50 A.M., interview with the Interim Director of Nursing (IDON) verified the resident had only two shower in the past 30 days as preferred and bed baths on 08/23/24, 08/30/24 and 09/06/24. This deficiency represents non-compliance investigated under Complaint Number OH00156906 and Complaint Number OH00156905.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on record review, staff interview and facility policy review, the facility failed to ensure one resident's (#31) physician was notified of vital signs outside of the physician ordered parameters. This affected one (Resident #31) of 24 sampled residents reviewed. The facility census was 50. Findings Include: Review of the medical record for Resident #31 revealed an initial admitted [DATE] with the latest readmission of 09/05/24 with the diagnoses including but not limited to cellulitis of left upper limb, cardiomyopathy, hypertension, ulcerative colitis, cerebrovascular accident with left sided hemiplegia, anemia, severe protein calorie malnutrition, hyperlipidemia, congestive heart failure, presence of cardiac pacemaker, anxiety disorder and major depressive disorder. Review of the plan of care dated 03/18/22 revealed the resident had an altered cardiovascular status related to CHF, hypertension, hyperlipidemia, CVA and presence of pacemaker. Interventions included administer medications as ordered, daily weight with special instructions to notify heart failure clinic if weight gain of two pounds in a 24 hour period or five pounds in one week. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the resident's monthly physician orders for September 2024 identified orders dated 10/17/22 blood pressure twice daily with the special instructions to contact heart failure clinic if systolic blood pressure is less than 100 or greater than 135 and 11/22/22 check oxygen saturation rate and heart rate twice daily with the special instructions to contact the heart failure clinic if heart rate is less than 60 or greater than 85. Review of the resident's Medication Administration Record (MAR) for August 2024 revealed the resident's pulse was greater than 85 on 08/05/24, 08/06/24, 08/07/24, 08/08/24, 08/09/24, 08/10/24 and 08/31/24. Further review of the MAR revealed the resident's systolic blood pressure was greater than 135 on 08/03/24, 08/17/24 and 08/18/24. Review of the medical record revealed no documented evidence the physician at the heart failure clinic was notified of the vital signs outside the specified parameters as physician ordered. On 09/10/24 at 1:00 P.M., interview with Interim Director of Nursing (IDON) verified the physician at the heart failure clinic was not notified of the vital signs outside the specified parameters as physician ordered. Review of the facility policy titled, Notification of Change in Condition, last revised on 11/22/21 revealed the facility will immediately inform the resident, consult with the resident's physician, Nurse Practitioner (NP) or clinical nurse specialist and if known notify the resident's representative when there is a significant change in the resident's physical, mental or psychosocial status.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on record review and staff interview, the facility failed to ensure one resident's (#31) required resident information for emergency transfer was documented in the resident's medical record and provided for the receiving facility. This affected one (Resident #31) of three residents reviewed for hospitalization . The facility census was 50. Findings Include: Review of the medical record for Resident #31 revealed an initial admitted [DATE] with the latest readmission of 09/05/24 with the diagnoses including but not limited to cellulitis of left upper limb, cardiomyopathy, hypertension, ulcerative colitis, cerebrovascular accident with left sided hemiplegia, anemia, severe protein calorie malnutrition, hyperlipidemia, congestive heart failure, presence of cardiac pacemaker, anxiety disorder and major depressive disorder. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the progress note dated 09/01/24 revealed the resident's left arm was extremely swollen. The Nurse Practitioner (NP) was notified and ordered the resident to be transported to a local emergency department (ED). Review of the change in condition evaluation dated 09/01/24 revealed the evaluation was blank. Review of the progress note dated 09/01/24 at 4:00 P.M. revealed the resident was admitted to the local acute care hospital. On 09/10/24 at 1:00 P.M., interview with Interim Director of Nursing (IDON) verified the resident's change in condition evaluation was not completed and the facility had no documented evidence the acute care hospital was provided written documentation detailing the resident's change in condition.

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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** 47059 Based on medical record review and staff interview, the facility failed to ensure all resident Pre-Admission Screening and Resident Review (PASARR) documents were accurate to resident current conditions and diagnoses. This affected one (Resident #7) three residents reviewed for PASARR documents. The census was 50. Findings include: Review of the medical record revealed Resident #7 was admitted on [DATE] with diagnoses that included chronic respiratory failure, major depressive disorder, anxiety disorder, and hypertension. On 06/14/23 additional diagnoses of psychotic disorder with delusions and other hallucinations were added. Review of the PASARR provided on 09/10/24 revealed it was completed on 03/20/23 by the facility. The PASARR indicated there was no mental diagnoses. There have been no other PASARR forms completed since additional mental health diagnoses of psychotic disorder with delusions and other hallucinations were added on 06/14/23. Interview on 09/16/24 at 11:45 A.M. with social worker #139 confirmed Resident #7's admission PASARR did not contain any mental health diagnoses and a new PASARR was not completed after additional mental health diagnoses were added on 06/14/23.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47059 Based on record review and staff interviews the Preadmission Screening And Resident Review (PASARR) did not reflect all mental health diagnoses for two residents (Resident #7 and #28) out of three residents reviewed for PASARR accuracy. The facility census was 50. Findings include: 1. Review of the medical record revealed Resident #7 was admitted on [DATE] with diagnoses that included chronic respiratory failure, major depressive disorder, anxiety disorder, and hypertension. Review of the PASARR provided on 09/10/24 revealed it was completed on 03/20/23 by the facility. The PASARR indicated there was no mental health diagnoses. There have been no additional PASARR forms completed. Interview on 09/16/24 at 11:45 A.M. with social worker #139 confirmed Resident #7's admission PASARR did not contain any mental health diagnoses. 2. Review of the medical record revealed Resident #28 was admitted on [DATE] with diagnoses that included senile degeneration of the brain, dementia, atherosclerotic heart disease and bipolar disorder (all dated 07/05/22) Review of the PASARR provided on 09/10/24 revealed it was completed on 07/05/22 by another facility. The PASARR indicated there were no mental health diagnoses. There have been no additional PASARR forms completed. Interview on 09/16/24 at 11:45 A.M. with social worker #139 confirmed Resident #28's admission PASARR did not contain any mental health diagnoses.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47059 Based on medical record review and staff interview, the facility failed to ensure all significant mental health changes were communicated to the state mental health agency. This affected one (Resident #7) of three residents reviewed for PASRR documents. The census was 50. Findings Include: Review of the medical record revealed Resident #7 was admitted on [DATE] with diagnoses that included chronic respiratory failure, major depressive disorder, anxiety disorder, and hypertension. On 06/14/23 additional diagnoses of psychotic disorder with delusions and other hallucinations were added. Review of the PASARR provided on 09/10/24 revealed it was completed on 03/20/23 by the facility. The PASARR indicated there was no mental diagnoses. There have been no other PASARR forms completed since additional mental health diagnoses of psychotic disorder with delusions and other hallucinations were added on 06/14/23. Interview on 09/16/24 at 11:45 A.M. with social worker #139 confirmed Resident #7's admission PASARR did not contain any mental health diagnoses and a new PASARR was not completed after additional mental health diagnoses were added on 06/14/23.

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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 - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 three (#31, #32, and #52) of 24 sampled residents reviewed for careplans. The facility census was 50. Findings Include: 1. Review of the medical record for Resident #31 revealed an initial admitted [DATE] with the latest readmission of 09/05/24 with the diagnoses including but not limited to cellulitis of left upper limb, cardiomyopathy, hypertension, ulcerative colitis, cerebrovascular accident with left sided hemiplegia, anemia, severe protein calorie malnutrition, hyperlipidemia, congestive heart failure (CHF), presence of cardiac pacemaker, anxiety disorder and major depressive disorder. Review of the plan of care dated 03/18/22 revealed the resident has an altered respiratory status/difficulty breathing related to CHF and seasonal allergies. Interventions included administer medications as ordered, elevate head of bed when difficulty breathing while lying flat. Further review revealed no intervention addressing the resident's oxygen use. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the mood and behavior revealed the resident displayed no behaviors including rejection of care. The assessment indicated the resident had not received oxygen therapy. Review of the resident's monthly physician orders for September 2024 identified orders dated 11/22/22 check oxygen saturation rate and heart rate twice daily with the special instructions to contact the heart failure clinic if heart rate is less than 60 or greater than 85, 02/23/23 change oxygen tubing weekly and 07/26/24 oxygen every shift to keep oxygen saturation above 95%. On 09/10/24 at 1:00 P.M., interview with the Interim Director of Nursing (IDON) verified the facility had not developed a comprehensive plan of care addressing the resident's oxygen use. 2. Review of the medical record for Resident #32 revealed an initial admitted [DATE] with the latest readmission of 07/06/24 with the diagnoses including but not limited to sepsis, urinary tract infection, atrial flutter, hypothyroidism, hyperlipidemia, anxiety disorder, functional dyspepsia, osteoarthritis, vitamin D deficiency, benign prostatic hyperplasia with lower urinary tract symptoms, chronic pain syndrome, retention of urine, diverticulosis of intestine, obstructive and reflux uropathy, bipolar disorder, major depressive disorder, dementia with behavioral disturbances, intellectual disabilities and hypertension. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The assessment indicated the resident was always incontinent of both bowel and bladder. Review of the resident's monthly physician orders for September 2024 identified no orders related to the resident's indwelling urinary catheter placement. Review of the resident's medical record revealed no documented evidence a comprehensive plan of care was completed addressing the resident's indwelling urinary catheter usage. On 09/11/24 at 12:15 P.M. observation of State tested Nursing Assistant (STNA) #119 and #183 provide catheter care for the resident #32 revealed the resident was yelling out he was backed up. The resident was taken to his room and ambulated with two maximal assists and a front wheeled walker to the bathroom. The resident was assisted onto the toilet where he was continent of a large formed stool. STNA #119 cleansed the resident's rectal area with disposable wipes from the front to back. The resident was ambulated to his bed and assisted into bed. STNA #119 pulled the resident's pants down, obtained the required supplies, washed her hands, obtained a soapy washcloth and cleansed the resident's groins and shaft of penis using a different section of the cloth. The STNA then obtained a clean soapy wash cloth and cleansed the tip of the resident's penis in a circular motion. She then used a different section of the cloth and cleansed the catheter tubing in a circular motion outward. The STNA then rinsed and dried in the same manner. The STNA then applied the resident's incontinence brief and positioned the resident to comfort. On 09/12/24 at 2:38 P.M., interview with the Interim Director of Nursing (IDON) verified the lack of physician orders and comprehensive care plan addressing the resident's indwelling catheter usage. 43064 3. Review of Resident #52's medical record revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, hypertension, nontraumatic intracerebral hemorrhage, anxiety, chronic kidney disease, and gastro-esophageal reflux disease without esophagitis. Review of Resident #52's Minimum Data Set (MDS) 3.0 dated 07/26/24 revealed the resident was rarely or never understood. Review of Resident #52's plan of care dated 07/31/24 revealed the resident had a self-care deficit related to an impaired ability to perform or complete activities of daily living (ADL) for herself such as feeding, dressing, bathing, and toileting related to cerebrovascular disease. There were no interventions indicated and the plan of care did not further address ADL needs. Review of Resident #52's physician order dated 07/23/24 revealed an order for Sertraline (an antidepressant) 50 milligrams (mg). Review of Resident #52's plan of care on 09/10/24 revealed it did not address Resident #52's antidepressant use. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/10/24 at 1:01 P.M. with interim Director of Nursing (IDON) verified there was no care plan for antidepressants. She additionally verified the plan of care did not address what level of assistance Resident #52 needed with her ADL's. 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. This deficiency represents noncompliance investigated under Complaint Number OH00156905.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on record review and staff interview, the facility failed to ensure quarterly care conferences were conducted and the required interdisciplinary team (IDT) members were present at care conferences. This affected two residents (#25 and #34) of 24 sampled residents. The facility census was 50. Findings Include: 1. Review of the medical record for Resident #34 revealed an initial admitted [DATE] with the latest readmission of 02/09/24 with the diagnoses including but not limited to cerebrovascular accident with left sided hemiplegia, benign prostatic hyperplasia, chronic kidney disease, diabetes mellitus, chronic obstructive pulmonary disease (COPD), sickle cell trait, epilepsy, adjustment disorder with depressed mood, contracture of right and left knee, gastro-esophageal reflux disease, gout, allergic rhinitis, insomnia, dysphagia, vascular dementia, hypertension, hearing loss, unilateral inguinal hernia and major depressive disorder. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the medical record revealed the last care conference held was on 05/21/24 at 3:13 P.M. The entry was documented by the Administrator as being the only staff member in attendance. On 09/16/24 at 10:35 A.M., interview with Licensed Social Worker (LSW) #139 verified the facility had not conducted the required care conference since 05/21/24. The LSW verified not all required IDT members were present for the care conference, including nursing. 2. Review of the medical record for Resident #25 revealed an initial admitted [DATE] with the diagnoses including but not limited to congestive heart failure, hyperlipidemia, hypothyroidism, chronic kidney disease, atrial fibrillation, hypertension, gastro-esophageal reflux disease, macular degeneration and protein calorie malnutrition. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the medical record revealed the last care conference held was on 05/28/24. On 09/16/24 at 10:35 A.M., interview with LSW #139 verified the required members of the IDT team had not attended the care conference held on 05/28/24, including nursing. This deficiency represents non-compliance investigated under Complaint Number OH00156905.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on record review and staff interview, the facility failed to complete a discharge summary that included a recapitulation of the resident's stay. This affected one resident (#54) of one resident revived for discharge. The facility census was 50. Findings Included: Review of the closed medical record for Resident #54 revealed an initial admitted [DATE] with the diagnoses including compression fracture of T11-T12, metabolic encephalopathy, hypertension, hyperlipidemia, hypothyroidism, anxiety disorder, major depressive disorder and pressure ulcer Stage II buttocks. The resident was discharged to an assisted living facility on [DATE]. Review of the resident's admission screen and baseline care plan dated [DATE] revealed the resident was alert and oriented to person only on admission. The assessment indicated the resident was confused. Review of the resident's quarterly MDS assessment dated [DATE] revealed the resident had no cognitive deficit. Review of the plan of care dated [DATE] revealed the resident was to discharge to prior level of care. Review of the resident's progress notes revealed no documentation of the resident's discharge or facility the resident was discharged to. Review of the resident's discharge physician orders failed to identify an order to discharge the resident to an assisted living facility. Review of the resident's discharge instructions dated [DATE] revealed the instructions were partially filled out and not signed by the resident/family or nurse. On [DATE] at 1:52 P.M. interview with the Licensed Nursing Home Administrator (LNHA) revealed the facility had faxed all information to the assisted living facility the resident was discharging to. The facility provided no evidence the receiving facility had received a completed discharge summary or a recapitulation of the resident's stay.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation, interview, and medical record review the facility failed to ensure Resident #52 received assistance at meals as needed, and failed to ensure routine shaving, nail care, and/or showers were provided for Resident #25, #32, #35, and #45. This affected five residents (#25, #32, #35, #45, and #52) of six residents reviewed for activities of daily living. The facility census was 50. Findings include: 1. Review of Resident #45 revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, paroxysmal atrial fibrillation, adult failure to thrive, major depressive disorder, unspecified dementia, chronic kidney disease stage four, and hypertension. Review of Resident #45's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed severely impaired cognition. Resident #45 required substantial or maximal assistance for bathing and set up or clean up assistance for personal hygiene. Review of Resident #45's plan of care dated 06/19/23 revealed she had an activity of daily living self-care or physical mobility performance deficit related to diagnoses. Interventions included one to two staff assistance with transfers, therapy as ordered, and supervision or limited assistance with personal care. Review of Resident #45's bathing information from 08/12/24 to 09/10/24 revealed she received a bath or shower on 08/17/24, 08/20/24, 08/31/24, 09/02/24, and 09/03/24. Observation on 09/09/24 at 11:53 A.M. and 1:52 P.M. revealed Resident #45 (who was a female) had significant facial hair on her chin and under her nose. Additionally, her hair was noted to be greasy and matted in the back and on the top. Observation on 09/16/24 at 10:35 A.M. revealed Resident #45's facial hair remained, and her hair continued to be greasy and matted. Interview on 09/16/24 at 10:35 A.M. with Resident #45 revealed her facial hair was bothering her and she wanted a shower. Interview on 09/16/24 at 10:40 A.M. with Agency Aide #155 verified Resident #45 needed shaved and her hair was greasy. 2. Review of Resident #35's medical record revealed an admitted [DATE] with diagnoses including Alzheimer's disease, osteoporosis, hypertension, anxiety disorder, and major depressive disorder. Review of Resident #35's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed severely impaired cognition. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #35's plan of care dated 10/06/22 revealed she had an activity of daily living self-care or physical mobility performance deficit related to weakness. Interventions included wearing glasses, assistance with bathing or showering, and supervision or limited assistance by one staff with personal hygiene. Review of Resident #35's tasks revealed she was to receive a shower on Monday's and Thursday's. Review of Resident #35's bathing documentation from 08/12/24 to 09/10/24 revealed she received a bath or shower on 08/15/24, 08/19/24, 09/02/24, and 09/09/24. Interview on 09/16/24 at 3:06 P.M. with Interim Director of Nursing (IDON) verified Resident #35 did not receive showers as scheduled. 3. Review of Resident #52's medical record revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, hypertension, nontraumatic intracerebral hemorrhage, anxiety, chronic kidney disease, and gastro-esophageal reflux disease without esophagitis. Review of Resident #52's Minimum Data Set (MDS) 3.0 dated 07/26/24 revealed the resident was rarely or never understood. She required substantial or maximal assistance with eating. Review of Resident #52's occupational therapy discharge summary dated 08/14/24 revealed she required partial or moderate assistance with meals. Review of Resident #52's occupational therapy evaluation dated 09/10/24 revealed she required substantial to maximal assistance with meals. Observation on 09/10/24 at 8:45 A.M. with Interim Director of Nursing (IDON) revealed Resident #52 feeding herself, she had piled pureed biscuits, eggs, and gravy into a cup of applesauce. Interview on 09/11/24 at 9:07 A.M. with IDON verified that Resident #52 was supposed to receive assistance with meals and had not received this at breakfast on 09/10/24. 32654 4. Review of the medical record for Resident #25 revealed an initial admitted [DATE] with the diagnoses including but not limited to congestive heart failure, hyperlipidemia, hypothyroidism, chronic kidney disease, atrial fibrillation, hypertension, gastro-esophageal reflux disease, macular degeneration and protein calorie malnutrition. Review of the plan of care dated 03/22/24 revealed the resident had a self-care deficit and/or physical mobility performance deficit related to activity intolerance, fatigue, impaired balance and weakness. Interventions included the resident requires moderate assistance of one staff for dressing, showering and personal hygiene. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The assessment indicated the resident's vision was highly impaired and did not wear corrective lenses. Review of the mood and behavior revealed the resident had not rejected any care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the September 2024 activity calendar revealed manicures in all five houses were scheduled on 09/04/24 at 10:30 A.M. On 09/09/24 at 12:30 P.M., observation of Resident #25 revealed her nails were long, jagged and had chipped nail polish. On 09/12/24 at 11:44 A.M., interview with Interim Director of Nursing (IDON) verified the lack of nail care leaving the resident's long and jagged with chipped nail polish. Resident #25 stated it had been approximately one month since staff had last provided nail care leaving some nails with no nail polish at all. 5. Review of the medical record for Resident #32 revealed an initial admitted [DATE] with the latest readmission of 07/06/24 with the diagnoses including but not limited to sepsis, urinary tract infection, atrial flutter, hypothyroidism, hyperlipidemia, anxiety disorder, functional dyspepsia, osteoarthritis, vitamin D deficiency, benign prostatic hyperplasia with lower urinary tract symptoms, chronic pain syndrome, retention of urine, diverticulosis of intestine, obstructive and reflux uropathy, bipolar disorder, major depressive disorder, dementia with behavioral disturbances, intellectual disabilities and hypertension. Review of the plan of care dated 01/30/24 revealed the resident had a self-care deficit related to physical mobility, dementia, intellectual disabilities and level of assistance varies daily. Interventions included check nail length, trim and clean on bath days and as necessary and the resident requires one extensive assist with personal hygiene. Review of the resident's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the task list revealed the staff was to offer assistance with shaving and resident had his own personal electric razor. Review of the resident's shower documentation from 08/11/24 to 09/11/24 revealed the resident was scheduled every Wednesday and Saturday for showers. Further review revealed the resident was not provided the scheduled shower on 08/14/24, 08/24/24, 08/31/24, 09/01/24, 09/07/24 and 09/11/24. On 09/09/24 at 10:59 A.M., observation of Resident #32 revealed the resident had long jagged nails and several days of long facial hair. On 09/10/24 at 8:43 A.M., observation of Resident #32 revealed the resident's nails remained long and jagged. Resident #32's facial hair remained long and unshaven. On 09/12/24 at 10:31 A.M interview with State tested Nursing Assistant (STNA) #112 verified the resident had not received his showers, his nails were long and jagged and had not received routine shaving. This deficiency represents non-compliance investigated under Complaint Number OH00156906 and Complaint Number OH00156905.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47059 Based on medical record review, resident and staff interview, and observation, the facility failed to assess, implement, and deliver an individualized activity program for six residents (Resident #19. #22, #32, #34, #35, and #51) of six residents reviewed for activities. The facility census was 50. Findings include: 1. Review of the medical record revealed Resident #51 was admitted on [DATE] with diagnoses that included displaced intertrochanteric fracture of right femur, chronic obstructive pulmonary disease, major depressive disorder, and dementia. Review of Resident #51's admission Minimum Data Set (MDS) revealed she is moderately cognitively intact with a brief interview for mental status (BIMS) score of 10/15. Resident #51 has no impairment of range of motion in her upper or lower extremities and uses a wheelchair for mobility. Review of the plan of care for Resident #51 initiated on 07/29/24 revealed the plan included the need to identify the resident's preferences for individual and group activities but the individualization was not addressed. Observation on 09/09/24 at 11:19 A.M., 1:58 P.M., and 2:49 P.M., revealed Resident #51 in a chair in the common area. There was no music, television, or other forms of entertainment. Observation on 09/10/24 at 8:41 A.M., 12:37 P.M., and 2:45 P.M., reveled Resident #51 in a chair in the common area. There was no music, television or other form of entertainment. Staff were near by but not interacting with her. Observation on 09/11/24 at 8:55 A.M., 11:15 A.M., and 3:45 P.M., reveled Resident #51 sitting in chair in common room. There were no activities, no music, and no TV in the area. Observation on 09/12/24 at 9:27 A.M. revealed Resident #51 sitting in her wheelchair interacting with speech therapist for initial evaluation. Interview on 09/12/24 at 9:27 A.M. with State tested Nursing Assistant (STNA) #134 confirmed Resident #51 has a coloring book and it is kept in her room. Resident #51 is in the common room most of the day and there is TV on sometimes. STNA #134 confirmed Resident #51 could not see the TV from where she sits. The planned activities are only in one house and if the residents are interested in the activity, we have to take them if they are able. There is only one activities person so the aids in the house do activities, cook and serve meals, and take care of the residents in the house. Interview on 09/11/24 at 2:30 P.M. with the Director of Nursing (DON) the only activities documented in Resident #51's chart in the last 14 days were watching TV or listening to music with the exception of one craft or coloring on Sunday 09/08/24. The activity log has one documented 1:1 activity on 07/31/24. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	32654 2. Review of the medical record for Resident #32 revealed an initial admitted [DATE] with the latest readmission of 07/06/24 with the diagnoses including but not limited to sepsis, urinary tract infection, atrial flutter, hypothyroidism, hyperlipidemia, anxiety disorder, functional dyspepsia, osteoarthritis, vitamin D deficiency, benign prostatic hyperplasia with lower urinary tract symptoms, chronic pain syndrome, retention of urine, diverticulosis of intestine, obstructive and reflux uropathy, bipolar disorder, major depressive disorder, dementia with behavioral disturbances, intellectual disabilities and hypertension. Review of the plan of care dated 01/21/23 revealed the resident's preferences are identified and listed under approaches. Interventions included resident/family were aware they can personalize the resident's room, resident prefers to assist in choosing own clothing, resident prefers to nap during the day, resident generally prefers the following activities: watching television, listening to music, looking at book/pictures of farm equipment and tractors, visits from family/guardian, one on one visits with staff. Review of the resident's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The assessment indicated it was somewhat important to the resident to listen to music, be around pets and participate in his favorite activities. Review of the resident's medical record revealed no documented evidence a activity assessment was completed. Review of the activity participation record for July 2024 revealed no documented evidence the resident was provided any activities. Review of the activity participation record for August 2024 revealed the resident was provided activities on 08/12/24 and 08/13/24. Review of the August 2024 activity calendar revealed activities did not occur in each of the five houses daily. Activities were scheduled in the 400 house (house the resident resides in) were on 08/01/24, 08/05/24, 08/06/24, 08/12/24, 08/13/24, 08/21/24, 08/23/24 and 08/27/24. Further review of the activities calendar for August 2024 revealed no activities were scheduled after 1:30 P.M. On the weekends it was indicated that the aides were to complete one on one visits. The Olympics was listed on 08/03/24 and 08/10/24. Additional weekend activities included hanging out on the patio on 08/17/24, 08/24/24, and 08/31/24, and coffee, snacks and conversations on Sundays. Review of the activity participation record for September 2024 revealed the resident was not provided any activities from 09/01/24 to 09/16/24. Review of the September 2024 activity calendar revealed activities did not occur in each of the five hoses daily. Activities scheduled in the 400 house were on 09/04/24, 09/06/24, 09/10/24, 09/13/24 and 09/16/24. Further review of the activities calendar from 09/01/24 to 09/15/24 revealed only one activity (a football game) was scheduled after 2:30 P.M. Weekend activities for 09/01/24, 09/08/24, and 09/15/24 included aide one on one visits and coffee and chit chat. Weekend activities for 09/07/24 included one on one visits, hanging out on the patio, and a football game, and on 09/14/24 the activities were one on one visits and hanging out on the patio. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/10/24 at 9:55 A.M., observation of the resident revealed he was sitting in his Broda chair in the dining room with no activities in progress. On 09/09/24 at 11:00 A.M., observation of Resident #32 revealed he was sitting in his Broda chair in dining room. No activities were observed in progress and the resident was staring out the window. On 09/10/24 at 3:00 P.M., observation of the resident revealed he was sitting in his Broda chair staring out the window. No activities were observed in progress. On 09/11/24 at 9:18 A.M., observation of the resident revealed he was sitting in his Broda chair at the dining room table with his eyes closed. No activities were observed in progress. On 09/11/24 at 10:38 A.M., observation of the resident the staff moved the resident to the lounge opposite of the television and reclined the resident back in his Broda chair. On 09/11/24 at 12:15 P.M., observation the resident's room during catheter care revealed the resident has a large vinyl record collection and movies. The resident had a television he could play the movies on. Interview with the resident during the observation revealed he liked to listen to music. On 09/16/24 at 3:59 P.M., interview with the Licensed Nursing Home Administrator (LNHA) and the Activity Coordinator (AC) #138 revealed she was the only activity staff for all five houses. AC #138 verified a comprehensive activity assessment was not completed for the resident and the resident was not provided individual or one on one activities. 3. Review of the medical record for Resident #34 revealed an initial admitted [DATE] with the latest readmission of 02/09/24 with the diagnoses including but not limited to cerebrovascular accident with left sided hemiplegia, benign prostatic hyperplasia, chronic kidney disease, diabetes mellitus, chronic obstructive pulmonary disease (COPD), sickle cell trait, epilepsy, adjustment disorder with depressed mood, contracture of right and left knee, gastro-esophageal reflux disease, gout, allergic rhinitis, insomnia, dysphagia, vascular dementia, hypertension, hearing loss, unilateral inguinal hernia and major depressive disorder. Review of the plan of care dated 03/27/19 revealed the resident had little or no activity involvement related to resident wishes not to participate. Interventions included establish prior level of activity involvement and interests by talking with the resident/caregivers and/or family on admission and as needed, explain the importance of social interaction, leisure activity time and encourage to participate, the resident needs a variety of activity types and locations to maintain interests, resident needs assistance/escort to activity functions, the resident prefers the following television channels, news channel, game shower channels, sports channels and movies, especially on [NAME] Classic Movie channel, history channel and buckeye football, invite/encourage the resident's family members to attend activities with resident in order to support participation, modify daily schedule for Resident #34 as needed to accommodate activity participation, modify daily scheduled, treatment plan as needed to accommodate activity participation as requested by the resident, monitor/document for impact of medical problems on activity level, remind the resident that he may leave activities any time and is not required to stay for the entire activity and the resident's preferred activities are watching television, listening to music and having visitors. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record revealed the last care conference held was on 05/21/24 at 3:13 P.M. Social service summary included a discussion of the Milestone program and Music and Memory. The entry documented the resident's daughter was excited for the program to begin. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the medical record revealed the last activity assessment completed was on 01/10/24. Review of the activity participation record for August 2024 revealed the resident was provided activities any activities from 08/01/24 to 08/31/24. Review of the August 2024 activity calendar revealed activities did not occur in each of the five houses daily. Activities were scheduled in the 400 house (house the resident resides in) were on 08/01/24, 08/05/24, 08/06/24, 08/12/24, 08/13/24, 08/21/24, 08/23/24 and 08/27/24. Further review of the activities calendar for August 2024 revealed no activities were scheduled after 1:30 P.M. On the weekends it was indicated that the aides were to complete one on one visits. The Olympics was listed on 08/03/24 and 08/10/24. Additional weekend activities included hanging out on the patio on 08/17/24, 08/24/24, and 08/31/24, and coffee, snacks and conversations on Sundays. Review of the activity participation record for September 2024 revealed the resident was not provided any activities from 09/01/24 to 09/16/24. Review of the September 2024 activity calendar revealed activities did not occur in each of the five hoses daily. Activities scheduled in the 400 house were on 09/04/24, 09/06/24, 09/10/24, 09/13/24 and 09/16/24. Further review of the activities calendar from 09/01/24 to 09/15/24 revealed only one activity (a football game) was scheduled after 2:30 P.M. Weekend activities for 09/01/24, 09/08/24, and 09/15/24 included aide one on one visits and coffee and chit chat. Weekend activities for 09/07/24 included one on one visits, hanging out on the patio, and a football game, and on 09/14/24 the activities were one on one visits and hanging out on the patio. On 09/09/24 11:03 A.M., observation of the resident revealed he was quiet at bedrest with his television on. On 09/09/24 at 2:47 P.M., interview with Resident #34's family member revealed the facility does not do in room activities for those residents who cannot go to another house. The family member indicated one on one visits were not being provided. On 09/09/24 at 2:20 P.M., observation of Resident #34 revealed he was quiet at bedrest with his television on. No activities were provided in the resident's room. On 09/10/24 at 3:20 P.M., observation of Resident #34 revealed he was remained in his room with the television on. No activities were provided in the resident's room. On 09/16/24 at 3:59 P.M., interview with the Licensed Nursing Home Administrator (LNHA) and the Activity Coordinator (AC) #138 revealed she was the only activity staff for all five houses. AC #138 verified a comprehensive activity assessment was not completed for the resident and the resident was not provided individual or one on one activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	43064 4. Review of Resident #19's medical record revealed an admitted [DATE] with diagnoses including metabolic encephalopathy, dementia, mixed hyperlipidemia, type two diabetes mellitus, absence epileptic syndrome, insomnia, dysphagia, hypertension. and muscle weakness. Review of Resident #19's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed she was rarely or never understood. A staff assessment was done for her activity preferences, Resident #19 preferred listening to music, being around pets, doing things with groups of people, and participating in favorite activities. Review of Resident #19's activities assessments revealed the last one was completed on 08/11/23. It was somewhat important for the resident to listen music, be around groups of people, complete favorite activities, go outside when the weather was good, and participating in religious services. Review of Resident #19's plan of care on 09/10/24 revealed activities preferences were not addressed. Review of the activity log from 08/01/24 to 09/09/24 revealed Resident #19 attended music on 08/12/24 and church services on 09/04/24 Review of Resident #19's activities from 08/12/24 to 09/9/24 revealed she watched television on 08/16/24, 08/17/24, 08/18/24, 08/19/24, 08/20/24, 08/25/24, 08/29/24, 08/31/24, 09/01/24, 09/02/24, 09/03/24, 09/04/24, 09/06/24, and 09/07/24. Resident #19 listened to music on 08/12/24, 08/13/24, 08/14/24, 08/15/24, 08/19/24, 08/21/24, 08/22/24, 08/23/24, 08/26/24, 08/27/24, 08/28/24, 08/30/24, 09/01/24, 09/03/24, 09/04/24, 09/05/24, 09/08/24, and 09/09/24. Additionally, on 09/09/24 Resident #19 watched or observed people. Review of the activities calendar for August 2024 revealed no activities were scheduled after 1:30 P.M. On the weekends it was indicated that the aides were to complete one on one visits. The Olympics was listed on 08/03/24 and 08/10/24. Additional weekend activities included hanging out on the patio on 08/17/24, 08/24/24, and 08/31/24, and coffee, snacks and conversations on Sundays. Review of the activities calendar from 09/01/24 to 09/15/24 revealed only one activity (a football game) was scheduled after 2:30 P.M. Weekend activities for 09/01/24, 09/08/24, and 09/15/24 included aide one on one visits and coffee and chit chat. Weekend activities for 09/07/24 included one on one visits, hanging out on the patio, and a football game, and on 09/14/24 the activities were one on one visits and hanging out on the patio. Observation on 09/09/24, 09/10/24, and 09/11/24 revealed no group or formal activities occurring in the house Resident #19 resided in. Observation on 09/09/24 at 10:50 A.M., 11:11 A.M., 12:08 P.M., 1:51 P.M., 2:45 P.M., and 3:46 P.M. revealed Resident #19 sitting at the dining room table with a fidget blanket in front of her. There were no other forms of entertainment. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 09/10/24 at 10:50 A.M. revealed Resident #19 sitting at the dining room table with a fidget blanket. Observation at 2:40 P.M. revealed Resident #19 sitting at the dining room table with no entertainment. Observation on 09/11/24 at 10:30 A.M. revealed Resident #19 sitting at the dining room table with a fidget blanket. Observation at 11:00 A.M., 11:51 A.M., and 12:17 P.M. revealed Resident #19 in the dining room with no entertainment. Observation at 2:42 P.M. revealed Resident #19 at the kitchen counter with a fidget blanket. Interview on 09/11/24 at 2:42 P.M. with State tested Nursing Aide (STNA) #171 verified there had been no activities in the building this week during her shift. She reported she did not know what was being done for activities for residents. She reported residents had complained that there was not enough to do or enough variety. She verified Resident #19 had spent most of her time in the dining room with only a fidget blanket to entertain her. She reported there had been an Amazon echo in the building to play music with but that disappeared. Interview on 09/16/24 at 3:59 P.M. with Activities Coordinator #138 and the Administrator revealed Activities Coordinator #138 was the only activities personnel although the Chaplin generally helped with activities as well. One on one activities were supposed to occur with residents who did not leave their rooms or did not participate in group activities. The Chaplin additionally helped complete one on one visits. Activities Coordinator #138 reported the aides were supposed to be completing activities on the weekend and throughout the day and documenting them in the electronic medical record. She verified they were not documenting activity participation. Activities Coordinator #138 verified Resident #19 did not have an activities plan of care or an assessment within the last year. 5. Review of Resident #22's medical record revealed an admitted [DATE] with diagnoses including dementia, type two diabetes mellitus, bipolar disorder, chronic kidney disease stage four, dysphagia, major depressive disorder, and muscle weakness. Review of Resident #22's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed impaired cognition. Review of Resident #22's plan of care revised 06/29/23 revealed his preferences had been identified and listed under approaches. Approaches included watching television, visits with family, drawing and sketching, church and bible study. Review of Resident #22's activities assessments revealed the last one was on 06/16/23 and it was unfinished. The assessment indicated that it was somewhat important for Resident #22 to listen to music he liked, keep up with news, do things with groups of people, do favorite activities, go outside, and participate in religious activities. Review of the activities log from 08/01/24 to 09/09/24 revealed on 08/07/24 Resident #22 participated in worship and bible study and one on one visits, on 08/08/24 he participated in yoga, on 08/12/24 he participated in music, on 08/14/24 he had a one on one visit, on 08/26/24 he did coloring and had a one on one visit, on 09/03/24 he did bingo, and on 09/04/24 he participated in church services. Resident #22 did not have any weekend activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #22's activity documentation from 08/13/24 to 09/09/24 revealed he watched tv on 08/13/24, 08/14/24, 08/16/24, 08/17/24, 08/18/24, 08/19/24, 08/20/24, 08/22/24, 08/23/24, 08/25/24, 08/26/24, 08/27/24, 08/28/24, 08/29/24, 08/30/24, 09/01/24, 09/02/24, 09/03/24, 09/04/24, 09/05/24, 09/07/24, 09/08/24, and 09/09/24. Resident #22 listened to music on 08/15/24, 08/18/24, 08/19/24, 08/21/24, 09/04/24, and 09/09/24. Resident #22 watched and observed people on 09/03/24 and 09/06/24. Resident #22 completed puzzles on 09/03/24. Resident #22's additional activities included chatter bag on 08/21/24 and 08/25/24, music and memory on 08/25/24 and 09/01/24, music theory on 08/15/24, and reminiscing on 08/17/24, 09/05/24, and 09/06/24. Other than watching television or listening to music, Resident #22 only had weekend activities on 8/17/24, 8/25/24, and 09/01/24. Review of the activities calendar for August 2024 revealed no activities were scheduled after 1:30 P.M. On the weekends it was indicated that the aides were to complete one on one visits. The Olympics was listed on 08/03/24 and 08/10/24. Additional weekend activities included hanging out on the patio on 08/17/24, 08/24/24, and 08/31/24, and coffee, snacks and conversations on Sundays. Review of the activities calendar from 09/01/24 to 09/15/24 revealed only one activity (a football game) was scheduled after 2:30 P.M. Weekend activities for 09/01/24, 09/08/24, and 09/15/24 included aide one on one visits and coffee and chit chat. Weekend activities for 09/07/24 included one on one visits, hanging out on the patio, and a football game, and on 09/14/24 the activities were one on one visits and hanging out on the patio. Observation on 09/09/24, 09/10/24, and 09/11/24 revealed no group or formal activities occurring in the house Resident #22 resided in. Observation on 09/09/24 at 10:56 A.M. 12:12 P.M., 1:51 P.M. and 2:45 P.M. revealed Resident #22 in front of the television. Observation on 09/10/24 at 10:50 A.M. and on 09/11/24 at 11:00 A.M. 11:51 A.M. and 12:17 P.M. revealed Resident #22 at the dining room table without entertainment. Interview on 09/16/24 at 3:59 P.M. with Activities Coordinator #138 reported she believed they were doing activities with Resident #22 but not documenting it. It was verified that Resident #22's activities assessment was over a year old. 6. Review of Resident #35's medical record revealed an admitted [DATE] with diagnoses including Alzheimer's disease, osteoporosis, hypertension, anxiety disorder, and major depressive disorder. Review of Resident #35's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed severely impaired cognition. Review of Resident #35's plan of care dated 11/28/22 revealed her preferences were identified and listed under approaches. Her approaches included personalizing her own room, napping during the day, and her preference for social groups, listening to music, watching TV and one on one visits with family and staff. Review of Resident #35's activity assessments revealed the last one was completed on 09/27/22 it indicated that the resident found it very important to read, do group activities, and do favorite activities. It was somewhat important to keep up with the news and go outside. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the activities log from 08/01/24 to 09/09/24 revealed Resident #35 was not offered any activities. Review of Resident #35's activities from 08/14/24 to 09/09/24 revealed she watched television on 08/15/24, 08/17/24, 08/18/24, 08/20/24, 08/22/24, 08/23/24, 08/25/24, 08/26/24, 08/31/24, 09/01/24, 09/03/24, 09/04/24, 09/05/24, 09/06/24, 09/07/24, 09/08/24 and 09/09/24. Resident #35 Listened to music on 08/17/24, 08/18/24, 08/19/24, 08/20/24, 08/21/24, and 08/28/24. Resident #35 Read on 08/14/24, 08/15/24, 08/16/24, 08/19/24, 08/21/24, 08/24/24, 08/27/24, 08/29/24, 08/30/24, 09/02/24, and 09/03/24. Resident #35 had a one on one or family visit on 08/31/24 and 09/05/24. Review of the activities calendar for August 2024 revealed no activities were scheduled after 1:30 P.M. On the weekends it was indicated that the aides were to complete one on one visits. The Olympics was listed on 08/03/24 and 08/10/24. Additional weekend activities included hanging out on the patio on 08/17/24, 08/24/24, and 08/31/24, and coffee, snacks and conversations on Sundays. Review of the activities calendar from 09/01/24 to 09/15/24 revealed only one activity (a football game) was scheduled after 2:30 P.M. Weekend activities for 09/01/24, 09/08/24, and 09/15/24 included aide one on one visits and coffee and chit chat. Weekend activities for 09/07/24 included one on one visits, hanging out on the patio, and a football game, and on 09/14/24 the activities were one on one visits and hanging out on the patio. Observation on 09/09/24, 09/10/24, and 09/11/24 revealed no group or formal activities occurring in the house Resident #35 resided in. Interview on 09/16/24 at 3:59 P.M. with Activities Coordinator #138 and the Administrator revealed reported Resident #35's daughter visited often and resident #35 did not sit down to attend activities often. They verified there was no evidence that the resident was refusing or had been asked to attend activities.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review, staff interview and facility policy review, the facility failed to identify, assess and monitor skin conditions for two residents (#19 and #31) and failed to ensure one resident's (#48) wound treatments were completed as physician ordered. This affected three of three residents reviewed for skin conditions. Additionally, the facility failed to ensure one resident's (#11) Thromboembolism-Deterrent (TED) hose were applied as physician ordered. This affected one of one residents revived for edema. The facility census was 50. Findings Included: 1. Review of the medical record for Resident #11 revealed an initial admitted [DATE] with the latest readmission of [DATE] with diagnoses including but not limited to hypertensive heart disease with heart failure, asthma, pain, chronic obstructive pulmonary disease (COPD), chronic respiratory failure, severe morbid obesity, vitamin D deficiency, pancytopenia, obstructive sleep apnea and gastro-esophageal reflux disease. Review of the plan of care dated [DATE] revealed the resident had CHF, with hypertensive hear disease. Interventions included don knee high TED hose to bilateral legs as ordered, give cardiac medications as ordered, monitor/document/report as needed any signs/symptoms of CHF, monitor vital signs as directed, notify the physician of significant abnormalities, oxygen via nasal prong at two to four liters continuous and weight monitoring as directed. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive impairment. Review of the resident's monthly physician orders for [DATE] identified orders dated [DATE] knee high TED hose on in the morning for edema and off at bedtime. Review of the [DATE] Treatment Administration Record (TAR) revealed the facility nurse documented the TED hose were in place on [DATE] and [DATE]. On [DATE] at 2:44 P.M., observation of Resident #11 revealed the resident had no TED hose on. On [DATE] at 2:50 P.M., observation of Resident #11 revealed she had no TED hose in place. Interview with the resident at the time of the observation revealed the nurse measured her legs for the TED hose but never did come back with them. The resident stated the nurse measured her legs two or three weeks ago. On [DATE] at 2:55 P.M., interview with Licensed Practical Nurse (LPN) #180 verified the resident's TED hose were not in place as physician ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the medical record for Resident #31 revealed an initial admitted [DATE] with the latest readmission of [DATE] with the diagnoses including but not limited to cellulitis of left upper limb, cardiomyopathy, hypertension, ulcerative colitis, cerebrovascular accident with left sided hemiplegia, anemia, severe protein calorie malnutrition, hyperlipidemia, congestive heart failure, presence of cardiac pacemaker, anxiety disorder and major depressive disorder. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident had skin tears. Review of the Nurse Practitioner (NP) progress note dated [DATE] at 12:29 P.M. revealed the resident was being seen for fatigue and left upper extremity swelling. The progress note also documented the resident had no new skin issues. Review of the weekly skin observation dated [DATE] revealed the resident had a skin tear to the left buttocks and a rash to the right buttocks and coccyx. Review of the change in condition evaluation dated [DATE] revealed the evaluation was blank. Review of the progress note dated [DATE] revealed the resident's left are was extremely swollen. The NP was notified and ordered the resident to be transported to a local emergency department (ED). Review of the progress note dated [DATE] at 4:00 P.M. revealed the resident was being admitted to the local acute care hospital. Review of the hospital history and physical (H&P) dated [DATE] revealed the resident was admitted to the acute care hospital with left axilla redness and left upper extremity cellulitis. The resident present to the ED with pain, redness, weeping in left axilla/breast fold that was not responding to topical therapy. The resident was started on the antibiotic Vancomycin in the ED. Topical Miconazole and Fluconazole 150 mg weekly for four weeks was also added. Wound and blood cultures were also obtained. The H&P documented erythema, weeping and tenderness to the left axilla/upper arm/breast and knee folds. Review of the Infectious Disease Physician's progress noted dated [DATE] revealed the reason for the consult was cellulitis to the left axilla and back. The progress note documented the resident had a large erythema to the left back, left axilla and part of the chest. The physician ordered CT scan to rule out abscess, continue current treatment with Vancomycin, Miconazole and Fluconazole. The physician also ordered to keep area clean/dry and offloading. Review of the medical record revealed no documented evidence the resident's large erythema to the left back, left axilla and part of the chest and cellulitis was identified, monitored and treatment implemented prior to the transfer to the ED. Review of the resident's monthly physician orders for [DATE] identified orders dated [DATE] blood pressure twice daily with the special instructions to contact heart failure clinic if systolic blood pressure is less than 100 or greater than 135 and [DATE] check oxygen saturation rate and heart rate twice daily with the special instructions to contact the heart failure clinic if heart rate is less than 60 or greater than 85. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Medication Administration Record (MAR) for [DATE] revealed the resident's pulse was greater than 85 on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. Further review of the MAR revealed the resident's systolic blood pressure was greater than 135 on [DATE], [DATE] and [DATE]. Review of the medical record revealed no documented evidence the physician at the heart failure clinic was notified of the vital signs outside the specified parameters as physician ordered. On [DATE] at 11:56 A.M., interview with Resident #31 revealed she was recently hospitalized due to cellulitis to her back and left underarm. Resident #31 revealed she had reported the rash getting worse however, the nurse did not address the worsening of the rash. On [DATE] at 1:00 P.M., interview with the Interim Director of Nursing (IDON) verified the lack of documentation of the resident's cellulitis and large erythema to the left back, left axilla and part of the chest. The IDON also verified the physician at the heart failure clinic was not notified of the vital signs outside the specified parameters as physician ordered. 43064 3. Review of the medical record for Resident #48 revealed an admitted [DATE] with a discharge date of [DATE] her diagnoses included cellulitis of right toe, contracture of left ankle, spastic diplegic cerebral palsy, difficult traumatic brain injury with loss of consciousness, and presence of cerebrospinal fluid drainage. Review of Resident #48's quarterly MDS 3.0 assessment dated [DATE] revealed she had moderately impaired cognition. Review of Resident #48's physician order dated [DATE] to [DATE] revealed an order for under her right big toe to clean the wound with normal saline, pat dry, pack with four-by-four gauze and secure daily. Review of Resident #48's [DATE] Medication Administration Record (MAR) revealed wound care was not completed on [DATE], [DATE], [DATE], [DATE], and [DATE]. Interview on [DATE] at 12:07 P.M. with Interim Director of Nursing (DON) verified there was no evidence would care was completed on five days in August. 4. Review of Resident #19's medical record revealed an admitted [DATE] with diagnoses including metabolic encephalopathy, dementia, mixed hyperlipidemia, type two diabetes mellitus, absence epileptic syndrome, insomnia, dysphagia, hypertension. and muscle weakness. Review of Resident #19's comprehensive Minimum Data Set assessment dated [DATE] revealed she was rarely or never understood. Review of Resident #19's progress note dated [DATE] revealed the nurse was sitting by the table when she heard Resident #19 hit her head on the floor. Staff was standing by her and the resident was assisted to the sitting position. She was assessed and sent to the emergency room . Resident #19 returned from the hospital later that day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #19's after visit summary dated [DATE] from the hospital revealed a small bruise was noted to the right forearm and a hematoma without laceration to the right scalp. Review of Resident #19's progress note dated [DATE] revealed she had returned from the hospital and her vitals were assessed. There was no indication of skin concerns. Review of Resident #19's forms and assessments revealed from [DATE] to [DATE] revealed no indication of a readmission assessment. Review of Resident #19's weekly skin evaluation dated [DATE] revealed no skin concerns. Review of Resident #19's progress note dated [DATE] revealed Resident #19 had a bruise on her right lower arm four to five centimeters that could be from her fall the previous week. Interview on [DATE] at 11:28 A.M. and 2:35 P.M. with the Interim Director of Nursing (DON) verified skin assessments were not completed following Resident #19's return to the hospital. She additionally verified that Resident #19's bruise to her right arm was noted in the hospital notes and not indicated by the facility until [DATE]. She additionally verified the hematoma she sustained during the fall was not monitored. This deficiency represents noncompliance investigated under OH00156905.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation, interview, and medical record review the facility failed to ensure fall interventions were in place for Resident #8, #19, #25, #28, and #52 and failed to ensure sufficient fall documentation and neurological checks were completed for Resident #19 and #110. Additionally, the facility failed to ensure Resident #48 was not left unsupervised. This affected seven residents (#8, #19, #25, #28, #48, #52, and #110) of nine residents reviewed for accidents. The facility census was 50. Findings include: 1. Review of Resident #52's medical record revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, hypertension, nontraumatic intracerebral hemorrhage, anxiety, chronic kidney disease, and gastro-esophageal reflux disease without esophagitis. Review of Resident #52's Minimum Data Set (MDS) 3.0 dated 07/26/24 revealed the resident was rarely or never understood. Review of Resident #52's plan of care dated 07/31/24 revealed she was at risk for falls related to cerebrovascular accident and weakness. Interventions included anticipating and meeting needs, ensuring call light in reach, bed in low position, education on safety reminders, encouraging to participate in activities, and staff to offer toileting and peri care upon rising. Review of Resident #52's progress note dated 08/05/24 revealed the resident was found on the floor with no injuries. The intervention was frequent rounding and a floor mat on the floor. Review of Resident #52's fall investigation form dated 08/05/24 revealed the resident had an unwitnessed fall in her room. She rolled out of bed and was found on her stomach. The bed was locked, and the resident had been noted resting in bed within the last hour. Written under the additional comments section was mat to floor Observation on 09/09/24 at 1:59 P.M. revealed Resident #52 was in her bed. The bed was not in the lowest position and there was no mat next to her bed. Observation revealed no mat in her room. Observation on 09/10/24 at 8:45 A.M. and 2:45 P.M. revealed Resident #52 was in her bed, and there was no fall mat in place. No mat was observed in her room. Interview on 09/10/24 at 2:47 P.M. with Agency Aide #161 verified there was no fall mat in place or in the residents room. She was unaware the resident required one. 2. Review of Resident #110's medical record revealed an admitted [DATE] revealed diagnoses including but not limited to hemothorax, multiple fractures of ribs to the right side, encephalopathy, type two diabetes mellitus, chronic kidney disease stage three, benign prostatic hyperplasia without lower urinary tract symptoms, aphasia, and peripheral vascular disease. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #110's progress note dated 09/07/24 revealed the aide alerted the nurse that Resident #110 was found on the floor on a mat. He was assessed with no injuries noted. Review of Resident #110's neurological checks from 09/07/24 to 09/08/24 revealed only one was completed. Review of Resident #110's change of condition note dated 09/08/24 revealed he was sent to the hospital and returned after less than 24 hours. Review of Resident #110's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed it was in progress. Resident #119 was rarely or never understood. Interview on 09/11/24 at 11:28 A.M. with Interim Director of Nursing (DON) revealed the timeline for neurological checks was not lining up and she was reaching out to the nurse who worked on 09/08/24 to determine what happened. Review of Resident #110's progress note created 09/12/24 but effective 09/08/24 revealed the nurse went to the room to check on the resident and found him on the floor on his mat. A large bruise was noted on the elders left hip. An order was given to send the resident to the hospital. Interview on 09/16/24 at 9:51 A.M. with the Interim DON verified she had spoken to the nurse from 09/08/24 and it was revealed he had an additional fall on that day that had not been documented. She verified neurological checks were not completed as they should have been for either fall. 3. Review of Resident #19's medical record revealed an admitted [DATE] with diagnoses including metabolic encephalopathy, dementia, mixed hyperlipidemia, type two diabetes mellitus, absence epileptic syndrome, insomnia, dysphagia, hypertension. and muscle weakness. Review of Resident #19's comprehensive Minimum Data Set assessment dated [DATE] revealed she was rarely or never understood. Review of Resident #19's plan of care dated 08/07/23 revealed the resident was at risk for falls related to impaired cognition and history of falls. Interventions included five P's (pain, position, potty, pathway, and possessions) every 2 hours added 08/01/24, mat to floor beside bed when in bed, bed in lowest position while in bed, anticipating and meeting needs, being sure the call light is within reach, educating resident about safety reminders and what to do if a fall occurs, ensure footwear when ambulating or mobilizing in wheelchair, providing a safe environment, keeping area clutter free, doing activities that minimize the potential for falls while providing diversion and distraction, and staff to offer toileting and peri care upon rising, before and after meals, at bedtime, and as needed. Review of Resident #19's progress notes dated 04/23/24 revealed no indication of a fall. Review of Resident #19's fall review form for her 04/23/24 revealed it was not indicated when it was completed or who completed it. It was noted that the resident was found on the floor in the common area beside the recliner. There was not indication if previous interventions were in place. Purposeful rounding was written on the form with no explanation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #19's neurological check list's from 4/23/24 to 04/27/24 revealed only five of 17 neurological checks were completed Review of Resident #19's progress note dated 04/24/24 revealed the fall report and current interventions had been reviewed. Increased rounding when the resident was in the recliner was thought to be an appropriate intervention. Review of Resident #19's progress note dated 04/30/24 revealed the nurse was sitting by the table when she heard Resident #19 hit her head on the floor. Staff was standing by her and the resident was assisted to the sitting position. She was assessed and sent to the emergency room . Resident #19 returned from the hospital later that day. Review of Resident #19's after visit summary dated 04/30/24 from the hospital revealed a CT scan was completed, and no concerns were noted she was diagnosed with a closed head injury. Review of Resident #19's fall audit for her 04/30/24 fall revealed the audit itself was undated. It was not indicated if the interventions were in place and functioning properly. It was not indicated that an evaluation of the interventions occurred. The care plan was updated with new interventions that included purposeful rounding. Review of Resident #19's progress note dated 05/01/24 revealed the fall report and current interventions were reviewed. The nurses immediate intervention was to send the resident to the hospital for further evaluation due to hitting her head. This was appropriate for the current situation. Upon return from the hospital the resident was placed on additional intervention to increase rounding while in the chair. Review of Resident #19's progress note dated 05/30/24 revealed at 8:00 A.M. the nurse was notified that the elder was sitting on the floor. Upon arrival, she was noted sitting up with legs stretched in front of her, bed in low position, and floor mat in place. Interventions included educating the aides to complete purposeful rounding on the resident. Review of Resident #19's fall audit for her 05/30/24 fall revealed the audit itself was undated. It was indicated that neurological checks were completed when needed and the care plan was updated with new interventions including 'purposeful rounding.' Review of Resident #19's progress note dated 05/31/24 revealed the fall report and current interventions were reviewed, purposeful rounding was deemed to be an appropriate intervention. Review of Resident #19's progress note dated 08/01/24 revealed the resident was noted sitting on the floor with legs stretched out in front of her, arms on her side, wheelchair by her and unlocked. The aide reported 'it all happened so fast, I was cleaning the floor when all of a sudden noted elder up and sat on the floor immediately'. The resident was assessed with no injury noted. The aide was educated to toilet the resident after each meal. Review of Resident #19's progress note dated 08/02/24 revealed a fall investigation summary was completed. On 08/01/24 the resident sat on the floor while the aide was picking something up off the floor. The wheelchair was unlocked and the resident did not hit her head. She stood up and sat next to the wheelchair. The new intervention was 5 P's rounding every two hours. (continued on next page)

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	366430	A. Building B. Wing	09/18/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #19's fall investigation form for her 08/01/24 fall revealed she was transferring unassisted in the common area. She was noted to be sitting on the floor She had previously been sitting in her chair. She was toileted after her fall and the last time she had been seen was as she was falling. The investigation was unsigned. Written on the bottom was to toilet the resident after meals. Review of Resident #19's tasks on 09/11/24 revealed there was no indication of 5 P's or purposeful rounding. Interview on 09/11/24 at 11:28 A.M. with the Interim Director of Nursing (DON) verified neurological checks were not completed according to policy. She additionally verified there was no signature or date for the 04/23/24 fall investigation. Additionally, she verified there had been no progress note for the 04/23/24 fall and no indication if previous interventions had been in place. The details of the 04/23/24 fall were not indicated including when the last time the resident was seen. Interim DON reported that on 04/30/24 the resident was sent to the hospital because she hit her head and was on a blood thinner. She verified that the fall audit was indicated and that it was not indicated if interventions were in place at the time of the fall. The Interim DON verified purposeful rounding was the intervention even though the facility staff was already supposed to be doing purposeful rounding. She verified the intervention for the 05/30/24 fall was educating the aides to complete purposeful rounding which would indicate they were not doing so at the time of her fall. Additionally, the 05/30/24 fall audit was undated, and the intervention was once again purposeful rounding. The Interim DON verified the 08/01/24 fall investigation was undated, and the aide was educated to toilet the resident after each meal, which means a previous intervention had not been in place prior to her fall. She additionally verified purposeful rounding and the 5P's were the same thing and should have been in the tasks so the aides were aware of it. Review of the policy 'Neurological Assessment' revised 03/19/21, revealed a neurological assessment was to be initiated for any obvious head trauma, unwitnessed fall in which a head injury may occur, a seizure, or acute changes in mental status. The first assessment was to be completed as soon as possible and then every 15 minutes four times, every 30 minutes two times, every hour two times, every four hours five times, and every eight hours for 24 hours. Neurological assessments were to be completed for a minimum of 48 hours from the time of initiation. 4. Review of the medical record for Resident #48 revealed an admitted [DATE] with a discharge date of [DATE] her diagnoses included cellulitis of right toe, contracture of left ankle, spastic diplegic cerebral palsy, difficult traumatic brain injury with loss of consciousness, and presence of cerebrospinal fluid drainage. Review of Resident #48's quarterly MDS 3.0 assessment dated [DATE] revealed she had moderately impaired cognition. Review of Resident #48's physician order revised 07/11/24 revealed the resident had an appointment on 08/2/24 at 11:00 A.M. with orthopedic one in Columbus. Review of Resident #48's progress notes revealed no notes on 07/14/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/16/24 at 12:29 P.M. with the Interim Director of Nursing (DON) revealed Resident #48's family had been texting appointments to facility staff the day before the appointment. Resident #48 had a lot of appointments, so they did this very often. She reported an appointment for 08/22/24 was accidently put in as 07/22/24 and she was sent out to an appointment that she did not have. She reported it was transportations fault the resident was left alone. She reported that she would expect transportation to wait for someone to be checked in prior to leaving a resident alone. Interview on 09/16/24 at 12:35 P.M. and 12:51 P.M. with [NAME] Transportation Employee #154 revealed Resident #48 was picked up at the facility at 10:30 A.M. and arrived to the appointment at 11:08 A.M. He reported they returned at 11:55 A.M. to pick the resident up and he had no documentation to indicate problems. He reported if a resident was confused facility staff or family would come on transportation or they would be told that family would meet them at the appointment. He reported if a resident was unaccompanied, it would be assumed they were appropriate to be alone. Interview on 09/18/24 at 9:17 A.M. with Resident #48's family verified Resident #48 had been left alone in orthopedic one's building on 07/22/24. She reported Resident #48 texted her to let her know she was alone and the family immediately checked the resident's cell phone reception to verify this. She reported the resident had been left on the first floor when the physical therapy office she usually saw was on the second floor. Resident #48's family member called the physical therapy office and asked someone to go get the resident and then called the facility and transportation to come get the resident. Resident #48's family member reported family attended most of Resident #48's appointments to ensure she did not go alone. 32654 5. Review of the medical record for Resident #8 revealed an initial admitted [DATE] with the diagnoses including but not limited to cerebral atherosclerosis, aphasia, diffuse traumatic brain injury, dementia, spastic hemiplegia with left sided, seizures, polyneuropathy, chronic respiratory failure, dysphagia, hypertension and basal cell carcinoma of skin. Review of the plan of care dated 01/24/24 revealed the resident was at risk for falls related to hemiplegia/decreased mobility and weakness. Interventions included anticipate and meet needs, keep needed items in reach, mat on the floor on the right side of the bed. Review of the resident's monthly physician orders for September 2024 identified no orders related to fall interventions. On 09/09/24 at 10:55 A.M., observation of Resident #8 revealed she was quiet at bedrest and the resident's fall mat was leaned against the wall behind the head of her bed. State tested Nursing Assistant (STNA) #103 verified the fall mat was not in place. On 09/10/24 at 8:44 A.M., observation of the resident's fall interventions revealed no fall mat in the resident's room. On 09/10/24 at 1:00 P.M., interview with the Interim Director of Nursing (IDON) verified the fall mat was present in the resident's room and implemented per plan of care. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Review of the medical record for Resident #25 revealed an initial admitted [DATE] with the diagnoses including but not limited to congestive heart failure, hyperlipidemia, hypothyroidism, chronic kidney disease, atrial fibrillation, hypertension, gastro-esophageal reflux disease, macular degeneration and protein calorie malnutrition. Review of the plan of care dated 01/17/24 revealed the resident was at risk for falls related to decreased mobility. Interventions included anticipate and meet needs, ensure call light/pendent is within reach and encourage resident to use it for assistance needs, educate the resident/family/caregivers about safety reminders and what to do if a fall occurred, ensure resident is wearing shoes when ambulating or mobilizing in wheelchair, keep area clutter free, therapy evaluation and treatment as needed, purposeful rounding and staff to offer toileting and peri-care upon rising, before and after meals, bedtime and as needed. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The assessment indicated the resident's vision was highly impaired and did not wear corrective lenses. Review of the progress note dated 07/03/24 at 6:37 P.M. revealed the resident was found on the floor on her left side with her feet towards the nightstand. The resident was observed not having shoes/footwear in place. Review of the medical record revealed no documented evidence the facility implemented to ensure the resident had footwear in place. Review of the progress note dated 07/07/24 at 9:30 A.M. revealed the STNA alerted the nurse the resident lost balance during transfer and was guided to the floor. The facility implemented ensure resident had proper shoes in place. Review of the resident's Quality Assurance (QA) Fall Review Form dated 07/07/24 revealed the resident was lowered to the floor during transfer and lost balance. The form indicated the resident had no shoes/footwear in place during transfer. The form indicated the resident had a fall on 07/03/24 with no shoes on. The immediate intervention was education on proper footwear in place. On 09/16/24 at 11:37 A.M., interview with the Interim Director of Nursing (IDON) verified Resident #25's fall investigation on 07/03/24 did not contain an intervention implemented to address the lack of non-skid footwear in place. Review of the Falls Investigation Form dated 07/03/24 at 10:20 A.M. revealed the resident was in her room and tried to self transfer resulting in a fall. The resident was found lay on the floor on her left side. The form documented the resident was not wearing footwear during self-transfer attempt. The facility implemented education to the resident to use call pendent for assistance and every two hour purposeful rounds. 47059 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Review of records revealed Resident #28 was admitted on [DATE] with diagnoses that included senile degeneration of the brain, dementia, atherosclerotic heart disease, dysphagia, osteoarthritis, and bipolar disorder. Review of the quarterly minimum data set (MDS) dated [DATE] revealed Resident #28 is significantly cognitively impaired with a brief interview for mental status (BIMS) score of 04/15. Resident #28 has no impairment of range of motion in the upper or lower extremities and uses a wheelchair for mobility. Physician orders include falls mat beside bed. Care planned falls risk interventions include falls mat beside bed, scoop low-air mattress to bed, call pendent in reach, bed in lowest position, and purposeful rounding every 2 hours. Observation on 09/09/24 at 11:10 A.M., 1:54 P.M., and 2:46 P.M., and on 09/10/24 at 12:03 P.M. revealed Resident #28 in her bed, her bed was not in the lowest position and a fall mat was not in place. Observation on 09/10/24 at 12:53 PM revealed Resident #28 was sitting up in bed with a scoop low air mattress. Wearing pendent to call for help if needed. Falls mat was in place but the bed was not in the lowest position. Observation on 09/12/24 at 9:25 A.M. revealed resident lying on right side with a scoop low air mattress in place. Falls mat in room but not beside bed. Bed not in lowest position. Interview on 09/12/24 at 9:30 A.M. with LPN #158 confirmed bed was not in lowest position and falls mat was not next to bed. This deficiency represents non compliance investigated under Complaint Number OH00156905 and OH00156906.

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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 observation, record review and staff interview, the facility failed to ensure the timely assessment and treatment of a urinary tract infection (UTI) for one resident (#22). This affected one of one reviewed for UTI. Additionally, the facility failed to ensure one resident (#32) had physicians orders for the use of an indwelling urinary catheter. This affected one (#32) of two residents reviewed for catheter use. The facility census was 50. Findings Include: 1. Review of the medical record for Resident #32 revealed an initial admitted [DATE] with the latest readmission of 07/06/24 diagnoses included sepsis, urinary tract infection, benign prostatic hyperplasia with lower urinary tract symptoms, retention of urine, obstructive and reflux uropathy, dementia with behavioral disturbances, intellectual disabilities and hypertension. Review of the resident's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The assessment indicated the resident was always incontinent of both bowel and bladder. Review of the resident's monthly physician orders for September 2024 identified no orders related to the resident's indwelling urinary catheter placement. Review of the resident's medical record revealed no documented evidence a comprehensive plan of care was completed addressing the resident's indwelling urinary catheter use. On 09/12/24 at 2:38 P.M., interview with the Interim Director of Nursing (IDON) verified the lack of physician orders addressing the resident's indwelling catheter use. 43064 2. Review of Resident #22's medical record revealed an admitted [DATE], diagnoses included dementia, type two diabetes mellitus, bipolar disorder, chronic kidney disease stage four, dysphagia, major depressive disorder, and muscle weakness. Review of Resident #22's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed impaired cognition. Review of Resident #22's Certified Nurse Practitioner (CNP) note dated 07/09/24 revealed therapy reported the resident had been more lethargic this morning and they thought he might have a urinary tract infection (UTI). Resident #22 denied any increased fatigue, suprapubic or flank pain, dysuria, urgency, frequency, or fever. No orders were placed. (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 #22's progress note dated 07/10/24 revealed therapy reported increased fatigue and confusion to the provider. The provider assessed the resident and ordered a urinary analysis (UA) and blood work. The order was placed, and laboratory samples would be in the next day for pick up and draw. Review of Resident #22's physician order dated 07/10/24 to 07/11/24 revealed an order for urinary analysis and blood work for UTI symptoms. Review of Resident #22's laboratory collected and reported 7/11/24 revealed a urine specimen had not been collected. Review of Resident #22's progress note dated 07/13/24 revealed the resident complained of nausea and stomach pain at a four out of 10. The physician was notified and ordered stat laboratory test, urinary analysis culture and sensitivity. The order was entered and the urine specimen was collected. Review of Resident #22's physician order dated 07/13/24 revealed an order for urinary analysis and culture and sensitivity stat for infection. Review of Resident #22's progress note dated 07/14/24 revealed the nurse followed up with the laboratory regarding the specimen collected. The laboratory reported they had nobody to pick it up yesterday and would send someone out by midnight to complete the stat laboratory pick up. Review of Resident #22's progress note dated 07/15/24 revealed the laboratory was called and confirmed the results were pending. Review of Resident #22's laboratory tests collected on 07/15/24 and reported 7/18/24 revealed abnormal urine in the following areas protein, white blood cell, epithelial cell, bacteria, hyaline casts, amorphous, and mucous. A urinary culture was indicated and completed. Escherichia coli (E. coli) was noted in the urine. Review of Resident #22's progress note dated 07/16/24 revealed partial UA results were back and the blood work. A culture was indicated and pending at that time. The nurse practitioner was notified of the initial results and recommended waiting for the culture results prior to any new orders. Review of Resident #22's progress note dated 07/17/24 revealed the residents urinary culture remained pending at that time. The laboratory called and stated the final culture would be complete the next day. The resident complained of abdominal pain and was assessed by the provider. A new order was placed for Macrobid (antibiotic)100 milligrams (mg) twice a day for five days for urinary tract infection. Review of Resident #22's physician order dated 07/17/24 to 07/22/24 revealed an order for Macrobid 100 mg one capsule twice a day for five days for UTI. Interview on 09/16/24 at 9:51 A.M. with Interim Director of Nursing (DON) verified the timeline for Resident #22's UTI and treatment. She reported they were having problems with the laboratory being willing to complete stat orders. She verified if that was the case stat labs should not be ordered or the resident should be sent to the hospital. Interim DON was unaware why the initial UA was incomplete.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation, interview, and record review, the facility failed to ensure Resident #19, #22, and #32 had reasonable access to fluids, failed to offer Resident #34 food purchased and brought in by family, and failed to offer Resident #25 ice cream following dinner as care planned. This affected four residents (#19, #22, #32, and #34) of ten residents reviewed for nutrition and hydration. The facility census was 50. Findings include: 1. Review of Resident #19's medical record revealed an admitted [DATE], diagnoses included metabolic encephalopathy, dementia, mixed hyperlipidemia, type two diabetes mellitus, absence epileptic syndrome, insomnia, dysphagia, hypertension. and muscle weakness. Review of Resident #19's comprehensive Minimum Data Set assessment dated [DATE] revealed she was rarely or never understood. The resident required partial or moderate assistance with eating. Review of Resident #19's plan of care dated 08/02/24 revealed she was at risk for changes to nutrition and hydration due to health status, diagnosis of dysphagia, use of mechanically altered diet, use of thickened liquids, use of oral nutrition supplement, and history of significant weight changes. Interventions included encouraging the resident to drink fluids when given medications, encouraging to drink fluids and eat snacks between meals, offering food and fluids she likes, helping at meals and snacks by cueing or assisting as needed, monitoring oral intake, monitoring skin and wound reports, offering the diet that my doctor has ordered, offer supplement as ordered. Review of Resident #19's nutritional screen dated 08/02/24 revealed she needed 1055 to 1266 milliliters (ml) of fluid a day. Review of Resident #19's fluid intake from 08/13/24 to 09/09/24 revealed on 08/13/24 and 08/14/24 she had 620 ml, on 08/15/24 she had 1300 ml, on 08/16/24 she had 240 ml, on 08/17/24 she had 720 ml, on 08/18/24 she had 1030 ml, on 08/19/24 and 08/20/24 she had 600 ml, on 08/21/24 she had 740 ml, on 08/22/24 she had 990 ml, on 08/23/24 she had 680 ml, on 08/25/24 she had 740 ml, on 08/26/24 she had 480 ml, on 08/27/24 she had 120 ml, on 08/28/24 she had 360 ml, on 08/29/24 she had 480 ml, on 08/30/24 she had 240 ml, on 08/31/24 she had 1050 ml, on 09/01/24 she had 800 ml, on 09/02/24 she had 960 ml, on 09/03/24 she had 620 ml, on 09/05/24 she had 1030 ml, on 09/06/24 she had 740 ml, on 09/07/24 she had 750 ml, on 09/08/24 she had 730 ml, and on 09/09/24 she had 860 ml. Observation on 09/09/24 at 10:50 A.M., 11:11 A.M., 12:08 P.M., 1:51 P.M., 2:45 P.M., and 3:46 P.M. revealed Resident #19 sitting at the dining room table without fluids. Observation on 09/10/24 at 10:50 A.M., 11:51 A.M., and 2:40 P.M., revealed Resident #19 in the dining room or television room without fluids. Observation on 09/11/24 at 10:30 A.M., 11:00 A.M., 11:51 A.M., and 12:17 P.M. revealed Resident #19 at the dining room table without fluids. Observation at 2:42 P.M. revealed the resident at the counter in the dining room without fluids. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/11/24 at 2:42 P.M. with State tested Nursing Aide (STNA) #171 verified Resident #19 did not have access to fluids. She verified the resident could give herself fluids but was likely to knock them over. She reported she gave the resident fluids at times but there was no set parameters. 2. Review of Resident #22's medical record revealed an admitted [DATE], diagnoses included dementia, type two diabetes mellitus, bipolar disorder, chronic kidney disease stage four, dysphagia, major depressive disorder, and muscle weakness. Review of Resident #22's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed impaired cognition. The resident required set up or clean up assistance with meals. Review of Resident #22's plan of care dated 07/12/24 revealed the resident was at malnutrition or dehydration risk due to health status, areas of skin impairment, use of therapeutic diet, and regular meal refusals. Interventions included encouraging the resident to eat and drink by offering foods and fluids, encourage the resident to eat calorically dense foods, helping at meals and snack time, monitor oral intake, monitor skin and wound reports, observing for signs of dehydration, offer the diet that my doctor has ordered, and offering medications that doctor as ordered. Review of Resident #22's nutritional screen dated 04/30/24 revealed his estimated fluid needs were 2,300 to 2,500 ml a day. Review of Resident #22's fluid intake from 08/17/24 to 09/09/24 revealed on 08/18/24 he had 920 ml, on 08/19/24 he had 840 ml, on 08/20/24 he had 720 ml, on 08/21/24 he had 740 ml, on 08/22/24 he had 940 ml, on 08/23/24 he had 1030 ml, on 08/25/24 he had 790 ml, on 08/26/24 he had 480 ml, on 08/27/24 he had 240 ml, on 08/28/24 he had 480 ml, on 08/29/24 he had 480 ml, on 08/30/24 he had 240 ml, on 08/31/24 he had 500 ml, on 09/01/24 he had 1050 ml, on 09/02/24 he had 960 ml, on 09/03/24 he had 740 ml, on 09/04/24 he had 1100 ml, on 09/05/24 he had 1,140 ml, on 09/06/24 he had 740 ml, on 09/07/24 he had 750 ml, on 09/08/24 he had 740 ml, and on 09/09/24 he had 920 ml. Observation on 09/09/24 at 10:56 A.M., 12:12 P.M., 1:51 P.M. and 2:45 P.M. revealed Resident #22 in the common area with no fluids in reach. Observation on 09/10/24 at 10:50 A.M. revealed Resident #22 in the dining room without fluids and at 11:51 A.M. he was in the common area without fluids. Observation on 09/11/24 at 11:00 A.M., 11:51 A.M., and 12:17 P.M., revealed Resident #22 in the dining room without fluids, at 2:42 P.M. he was observed in the common area without fluids. Interview on 09/11/24 at 2:42 P.M. with STNA #171 verified Resident #22 did not have fluids available to him. She reported sometimes he asked for fluids and they would be provided. 32654 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the medical record for Resident #32 revealed an initial admitted [DATE] with the latest readmission of 07/06/24, diagnoses included sepsis, urinary tract infection, atrial flutter, hypothyroidism, hyperlipidemia, anxiety disorder, functional dyspepsia, osteoarthritis, vitamin D deficiency, benign prostatic hyperplasia with lower urinary tract symptoms, chronic pain syndrome, retention of urine, diverticulosis of intestine, obstructive and reflux uropathy, bipolar disorder, major depressive disorder, dementia with behavioral disturbances, intellectual disabilities and hypertension. Review of the plan of care dated 01/21/23 revealed the resident was at possible nutrition/dehydration risk due to health status, low total protein levels, use of therapeutic diet, elevated body mass index (BMI), currently edentulous without appliance status and history of significant weight changes. Interventions included diet as ordered, encourage to drink fluids and eat snacks between meals and during activities as appropriate, encourage to eat and drink by offering foods and fluids the resident likes, encourage calorically dense foods, encourage to eat in the main dining room, encourage to eat plenty of protein, assist resident at meals and snacks by cueing or assisting as needed, offer substitute if the resident does not like what is served, if resident consumed less than 50% of meal offer a substitute, medication as ordered, monitor intake and document negative findings and observe for signs/symptoms of dehydration. Review of the resident's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the resident's monthly physician orders for September 2024 identified orders dated 05/11/23 regular diet no added salt and Ensure two times daily for nutritional supplement, 06/17/24 encourage fluids every shift. Review of the resident's nutritional progress note dated 06/20/24 at 4:04 P.M. revealed the resident's estimated caloric intake was 2365 to 2649, estimated protein 95 to 114 grams and estimated fluids 2365 to 2649 ml/24 hours. Review of the resident's fluid intakes from 08/14/24 to 09/11/24 revealed the resident normally consumed 640 milliliters (ml) to 1080 ml in 24 hours period. On 09/09/24 at 11:00 A.M., observation of Resident #32 revealed the resident was sitting in his Broda chair in the dining room. Further observation revealed no fluids were available to the resident. On 09/09/24 at 3:39 P.M., observation of Resident #32 revealed the resident remained at the dining room table with no fluids available. On 09/10/24 at 9:55 A.M., observation of Resident #32 revealed he was sitting in his Broda chair in the dining room with no fluids present for the resident. On 09/10/24 at 3:00 P.M., observation of Resident #32 revealed the resident remained at the dining room table with no fluids available. On 09/11/24 at 9:18 A.M., observation of Resident #32 revealed he was sitting in his Broda chair with his eyes closed. Further observation revealed no fluids were available for the resident. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/12/24 at 10:15 A.M., observation of the resident revealed he was sitting at the dining room table with no fluids available. On 09/12/24 at 10:31 A.M., interview with State tested Nursing Assistant (STNA) #112 verified the resident was only offered fluids at meals and had no fluids readily available between meals. 4. Review of the medical record for Resident #34 revealed an initial admitted [DATE] with the latest readmission of 02/09/24, diagnoses included cerebrovascular accident with left sided hemiplegia, benign prostatic hyperplasia, chronic kidney disease, diabetes mellitus, chronic obstructive pulmonary disease (COPD), sickle cell trait, epilepsy, adjustment disorder with depressed mood, contracture of right and left knee, gastro-esophageal reflux disease, gout, allergic rhinitis, insomnia, dysphagia, vascular dementia, hypertension, hearing loss, unilateral inguinal hernia and major depressive disorder. Review of the plan of care dated 07/10/18 revealed the resident was at risk for changes to nutrition/hydration related to health status, use of therapeutic diet, use of mechanically altered diet, history of skin impairment, hemiplegia, history of weight changes, high body mass index (BMI), use of oral nutritional supplement, variable dependence needed with feeding, approved by family and resident to mix pureed food together as preference at meals, refuses to drink water, often only wants to eat sweet potatoes, family stocks food in kitchen and resident's personal mini refrigerator with foods outside of the resident's diet texture despite education. Interventions included encourage to drink all fluids during medications, encourage to eat and drink by offering food and fluids the resident likes, encourage to eat calorically dense foods, encourage to eat in the main dining room, encourage to eat plenty of protein, assist at meals and snack time by cuing and assisting as needed, if the resident does not like what is being served at meal or snack, offer a substitute, if the resident eats less than 50% of meal offer a substitute, if intakes decrease encourage family and friends to being in food and fluids they like, may puree food altogether, observe for signs/symptoms of dehydration, off the diet as ordered, medications as ordered, therapy evaluation and treatment as ordered and review weights, skin, labs and intakes routinely and as available and report changes as needed. 09/09/24 at 11:20 A.M., observation of State tested Nursing Assistant (STNA) #119 revealed the STNA offer the resident his lunch meal and the resident refused the meal. Further observation revealed the STNA failed to offer the resident sweet potatoes as care planned or food from his refrigerator in his room.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on observation, interview, and medical record review the facility failed to ensure Resident #52's tube feeding formula was appropriately labeled and dated after opening. This affected one resident of one resident reviewed for tube feeding. The facility census was 50. Findings include: Review of Resident #52's medical record revealed an admitted [DATE], diagnoses included type two diabetes mellitus, hypertension, nontraumatic intracerebral hemorrhage, anxiety, chronic kidney disease, and gastro-esophageal reflux disease without esophagitis. Review of Resident #52's Minimum Data Set (MDS) 3.0 dated 07/26/24 revealed the resident was rarely or never understood. She had no significant weight changes. Resident #52 received 51% or more of her calories from her feeding tube. Review of Resident #52's physician order dated 07/22/24 revealed she had enteral feeding. With each new bottle the formula container, syringe, and administration set were to be labeled with resident's name, date, time, and nurse's inititals. Observation on 09/10/24 at 8:40 A.M. revealed on Resident #52's bedside table was a bottle of Glucerna that had been opened and use. There was no open date or indication of who opened the bottle. Interview on 09/10/24 at 8:45 A.M. with interim Director of Nursing (DON) verified the bottle was opened and undated. Interview on 09/10/24 at 8:51 A.M. with Licensed Practical Nurse # 177 revealed Resident #52 was temporarily receiving bolus tube feeds and they were pulling the boluses out of the bottle. The facility had no policies related to tube feeding.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review, staff interview and facility policy review, 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 residents (#11, #21, #31, #38) of four residents reviewed for respiratory care. The census was 50. Findings Include: 1. Review of the medical record for Resident #11 revealed an initial admitted [DATE] with the latest readmission of 01/12/24, diagnoses included hypertensive heart disease with heart failure, asthma, chronic obstructive pulmonary disease (COPD), chronic respiratory failure, and obstructive sleep apnea. Review of the plan of care dated 01/12/24 revealed the resident had an alteration in respiratory status related to COPD, asthma and chronic respiratory failure. Interventions included elevate head of bed due to difficulty breathing when lying flat, monitor for shortness of breath, chest pain or change in condition, monitor oxygen saturation rate, monitor respiratory status, oxygen as ordered and provide emotional support as needed. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive impairment. The assessment indicated the resident had not received oxygen therapy. Review of the resident's monthly physician orders for September 2024 identified orders dated 04/12/24 oxygen two to four liters as needed for COPD, keep oxygen saturation rate greater than 90%. On 09/09/24 10:22 A.M., observation of the resident revealed she had oxygen at two liters per nasal cannula in place. Further observation revealed the oxygen nasal cannula tubing was dated with white paper tape 08/15/24 at 6:00 A.M. On 09/09/24 at 10:40 A.M., interview with Registered Nurse (RN) #173 verified the resident's oxygen nasal cannula had not been changed weekly as per facility policy. 2. Review of the medical record for Resident #21 revealed an initial admitted [DATE] with the latest readmission of 04/03/24, diagnoses included Alzheimer's disease, major depressive disorder, osteoporosis, chronic pain syndrome, hypertension, anemia and delusional disorder. Review of the plan of care dated 09/19/23 revealed the resident had an altered respiratory status/difficulty breathing related to decline in activities of daily living (ADL) status following fall with hip fracture. Interventions included elevate the head of bed when having difficulty breathing while lying flat, monitor for signs/symptoms of respiratory distress, oxygen at one to two liters per nasal prongs, humidified oxygen, change aerosol and oxygen tubing as ordered and oxygen saturation rate every shift. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a severe cognitive deficit. The assessment indicated the resident received oxygen therapy. Review of the resident's physician orders for September 2024 identified orders dated 09/14/23 change aerosol tubing/mask weekly, change oxygen tubing weekly when in use, elevate head of bed unless contraindicated, 12/16/23 oxygen saturation rate every shift and 09/10/24 humidified oxygen at one to two liters per minute as needed to maintain oxygen saturation rate above 90% as needed. Review of the resident's September 2024 Treatment Administration Record (TAR) revealed the staff nurse documented the resident's oxygen tubing was changed on night shift on 09/08/24. On 09/09/24 at 9:40 A.M., observation of the resident revealed no date on the nasal cannula tubing or humidification to the oxygen concentrator. On 09/09/24 at 10:50 A.M., interview with Registered Nurse (RN) #173 verified the resident's oxygen nasal cannula had not been changed weekly as physician ordered and the resident's oxygen was not humidified as physician ordered. 3. Review of the medical record for Resident #31 revealed an initial admitted [DATE] with the latest readmission of 09/05/24, diagnoses included congestive heart failure (CHF), presence of cardiac pacemaker, anxiety disorder and major depressive disorder. Review of the plan of care dated 03/18/22 revealed the resident has an altered respiratory status/difficulty breathing related to CHF and seasonal allergies. Interventions included administer medications as ordered, elevate head of bed when difficulty breathing while lying flat. Further review revealed no intervention addressing the resident's oxygen use. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident had no received oxygen therapy. Review of the resident's monthly physician orders for September 2024 identified orders dated 02/23/23 change oxygen tubing weekly, 05/17/24 head of bed elevated to alleviate/prevent shortness of breath when lying flat and 07/26/24 oxygen every shift to keep oxygen saturation above 95%. On 09/09/24 at 11:41 A.M., observation of the resident's oxygen nasal cannula tubing revealed no date. On 09/09/24 at 3:48 P.M., interview with the Interim Director of Nursing (IDON) verified the resident's nasal cannula tubing was not dated. 4. Review of the medical record for Resident #38 revealed an initial admitted [DATE] with the latest readmission of 12/16/23, diagnoses included chronic respiratory therapy, congestive heart failure (CHF), obesity, hypertension, chronic obstructive pulmonary disease (COPD), atrial fibrillation and chronic pain. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the plan of care dated 07/31/23 revealed the resident had altered respiratory status/difficulty breathing related to COPD, respiratory failure, CHF, atrial fibrillation and seasonal allergies. Interventions included administer medications as ordered, elevate head of bed when having difficulty breathing while lying flat, monitor for signs/symptoms of respiratory distress and oxygen at three liters per nasal cannula. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated the resident had no cognitive impairment. The assessment indicated the resident received oxygen therapy. Review of the resident's monthly physician orders for September 2024 identified orders dated 09/14/23 change aerosol tubing/mask weekly, elevate head of bed unless contraindicated, change oxygen tubing weekly, Ipratropium (medication used to open up airways)-Albuterol (medication used to relax the airways) 0.5-2.5 milligrams (mg)/3 milliliters (ml) with the special instructions one pre-mixed vial via nebulizer three times daily for COPD, nurse may give medication to resident for resident to self administer, 11/12/23 oxygen air delivery at three liters every shift and humidified oxygen at two to four liters continuous to maintain oxygen saturation rate above 92%, oxygen saturation rate every shift. Review of the resident's September 2024 Treatment Administration Record (TAR) revealed the facility nurse initialed the resident's aerosol tubing/mask was changed on night shift on 09/08/24. On 09/09/24 at 10:39 A.M. observation of the resident revealed the resident's oxygen tubing had no date, the resident's nebulizer mask was laying on top of the refrigerator and the mask was noted to be dusty and dirty with no date. On 09/09/24 at 10:40 A.M., interview with Registered Nurse (RN) #173 verified the resident's oxygen nasal cannula and nebulizer aerosol mask had not been changed weekly as physician ordered. Review of the facility policy titled, Equipment Change Schedule & Disinfection Process, dated 01/04/24 revealed an equipment change schedule and disinfection process provides a schedule for changing disposable equipment at regular intervals as determined by manufacturers recommendations and local community standards. The nasal cannula was to be changed every seven days or as needed if soiled, date and initial tubing and provide a set up bag with room number, date and initials. Bubble humidification will be replaced every seven days or as needed. The nebulizer will be changed every seven days or as needed if soiled, date and initial the tubing and provide a set up bag with room number, date and initials.

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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** 43064 Based on record review and staff interview the facility failed to ensure pharmacy recommendations were addressed by the physician and followed through by facility staff for one, (Resident #35) and failed to have evidence of the pharmacist's recommendations for one, (Resident #22). This affected two residents (#22 and #35) of five residents reviewed for un-necessary medications. The facility census was 50. Findings include: 1. Review of Resident #35's medical record revealed an admitted [DATE] with diagnoses including Alzheimer's disease, osteoporosis, hypertension, anxiety disorder, and major depressive disorder. Review of Resident #35's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed severely impaired cognition. Review of Resident #35's pharmacist recommendation dated 02/20/24 revealed the resident was on Cholecalciferol (vitamin) daily and an annual Vitamin D laboratory test result could not be located. The pharmacist recommended obtaining a Vitamin D level on the next convenient lab day. The physician addressed this and recommended an order for Vitamin D level laboratory test to be completed on 03/05/24. Review of Resident #35's medical record revealed the laboratory test were not completed on 03/05/24. Review of Resident #35's pharmacist recommendation dated 05/15/24 revealed the resident had an order for Hydroxyzine (medication used for itching, nausea and anxiety) 25 milligrams (mg) every eight hours as needed for anxiety. The pharmacist recommended reviewing the order and indicating the length of the therapy for the order. The physician addressed this on 05/30/24 and indicated he disagreed but would add a note to justify the need. Review of Resident #35's medical record revealed the physician did not add a note addressing continued need for the medication. Review of Resident #35's pharmacist recommendation dated 08/05/24 revealed Resident #35 was on Seroquel (antipsychotic medication) 25 mg twice a day for anxiety disorder or depression. The pharmacist recommended correcting the diagnosis in the system so the effectiveness of the medication and side effects could be appropriately monitored. The pharmacist recommended Seroquel 25 mg twice a day with severe depression with hallucinations. The physician addressed it on 08/13/24 writing 'stable on this dose'. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #35's pharmacist recommendation dated 08/05/24 revealed Resident #35 had an order for Hydroxyzine 25 mg one capsule by mouth every eight hours as needed for anxiety, it had no stop date. The pharmacist recommended considering either discontinuation, adding a stop date, or updating to scheduled dosing. On 08/13/24 the physician indicated they disagreed but did not provide a reason. Interview on 09/11/24 at 11:28 A.M. and on 09/12/24 at 7:59 A.M. with interim Director of Nursing (DON) verified Resident #35's vitamin D level was not completed as recommended until July 2024. She additionally verified the physician did not follow up with a note addressing his 05/30/24 recommendation. Interim DON additionally verified the physician did not provide a reason to decline the recommendations made for the Hydroxyzine 25 mg on 08/05/24 and did not appropriately address the recommendation o 08/05/24 for the Seroquel and provide a diagnosis that would allow the medications side effects to be monitored in the system. 2. Review of Resident #22's medical record revealed an admitted [DATE] with diagnoses including dementia, type two diabetes mellitus, bipolar disorder, chronic kidney disease stage four, dysphagia, major depressive disorder, and muscle weakness. Review of Resident #22's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed impaired cognition. Review of Resident #22's pharmacy reviews for 10/05/23, 11/03/23, and 12/08/23, revealed the pharmacist report needed to be viewed for recommendations from the prescriber for Resident #22. Review of Resident #22's medical record revealed no evidence of the pharmacists recommendations for 10/05/23, 11/03/23, and 12/08/23. Interview on 09/16/24 at 9:51 A.M. with the Interim DON verified she was unable to locate the recommendations the pharmacist provided on the listed dates.

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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** 32654 Based on medical record review and staff interview, the facility failed to ensure residents were appropriately monitored as ordered when administered medications. This affected one (Resident #38) of four residents reviewed for respiratory care. The facility census was 50. Findings Include: Review of the medical record for Resident #38 revealed an initial admitted [DATE] with the latest readmission of 12/16/23 with diagnoses including but not limited to chronic respiratory therapy, congestive heart failure (CHF), hypertension, atrial fibrillation and chronic pain. Review of the plan of care dated 07/31/23 revealed the resident had an altered cardiovascular status related to arrhythmia, CHF, hypertension and atrial fibrillation. Interventions included administer medications as ordered. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated the resident had no cognitive impairment. Review of the resident's monthly physician orders for September 2024 identified orders dated 07/19/23 Metoprolol (medication used to improve blood flow and decrease blood pressure by relaxing blood vessels and slowing the heart rate) 25 milligrams (mg) by mouth twice daily for hypertension with the special instructions to hold for systolic blood pressure of less than 100 and/or heart rate less than 60. Review of the resident's July 2024 Medication Administration Record (MAR) revealed no documented evidence the resident's blood pressure or pulse was obtained prior to administering the medication Metoprolol 25 mg by mouth twice daily for hypertension with the special instructions to hold for systolic blood pressure of less than 100 and/or heart rate less than 60. Review of the resident's August 2024 Medication Administration Record (MAR) revealed no documented evidence the resident's blood pressure or pulse was obtained prior to administering the medication Metoprolol 25 mg by mouth twice daily for hypertension with the special instructions to hold for systolic blood pressure of less than 100 and/or heart rate less than 60. Review of the resident's September 2024 Medication Administration Record (MAR) revealed no documented evidence the resident's blood pressure or pulse was obtained prior to administering the medication Metoprolol 25 mg by mouth twice daily for hypertension with the special instructions to hold for systolic blood pressure of less than 100 and/or heart rate less than 60 on 09/01/24, 09/02/24, 09/03/24, 09/04/24, 09/05/24, 09/06/24, 09/07/24, 09/08/24 and 09/09/24 morning dose. On 09/09/24 at 3:50 P.M., interview with Interim Director of Nursing (DON) verified the resident's blood pressure and pulse was not obtained prior to the administration of the medication Metoprolol 25 mg by mouth twice daily.

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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** 32654 Based on observation, medical record review and staff interview, the facility failed to secure and store medications appropriately. This affected one (#38) of two residents observed during medication administration. The facility census was 50. Findings Include: Review of the medical record for Resident #38 revealed an initial admitted [DATE] with the latest readmission of 12/16/23, diagnoses included chronic obstructive pulmonary disease (COPD), chronic respiratory therapy, congestive heart failure, hypertension, atrial fibrillation and chronic pain. Review of the plan of care dated 09/14/23 revealed the resident had a physician's order for unsupervised, self-administration of the nebulizer treatments. Interventions included assess ability to safely self administer medications on admission/readmission, quarterly, with change in medication orders and with significant changes in condition, discuss medications with each supervised administration, demonstrate correct administration as required, review each medication as necessary and review medication self-administration with resident to reassess abilities. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated the resident had no cognitive impairment. The assessment indicated the resident received oxygen therapy. Review of the resident's monthly physician orders for September 2024 identified orders dated 09/14/23 change aerosol tubing/mask weekly, elevate head of bed unless contraindicated, change oxygen tubing weekly, Ipratropium (medication used to dilate airways)-Albuterol (medication used to relax airways) 0.5-2.5 milligrams (mg)/3 milliliters (ml) with the special instructions one pre-mixed vial via nebulizer three times daily for COPD, nurse may give medication to resident for resident to self administer. Review of the medical record revealed no self-administration of medication assessment to determine if the resident was capable of self-administration of medication Ipratropium-Albuterol 0.5-2.5 mg/3 ml. On 09/09/24 at 10:39 A.M., observation of the resident's nebulizer machine sitting on a tray on the resident's refrigerator revealed three individual use vials of Ipratropium-Albuterol 0.5-2.5 mg/3 ml. Further review revealed no original packaging or directions for the use of the medications. On 09/09/24 at 10:44 A.M., interview with Registered Nurse (RN) #173 verified the Ipratropium-Albuterol 0.5-2.5 mg/3 ml. was stored unsecured in the resident's room without a physician's ordered to keep at bedside. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/09/24 at 3:50 P.M., interview with the Interim Director of Nursing (DON) verified the resident had no self-administration medication assessment to determine the resident's ability to self-administer the Ipratropium-Albuterol 0.5-2.5 mg/3 ml. The DON also verified the resident had no physician's order to leave the Ipratropium-Albuterol 0.5-2.5 mg/3 ml at bedside.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, interview, medical record review, and review of facility menus the facility failed to ensure the menu was followed for Resident #19 and the facility failed to ensure a planned menu was in place for residents on a puree and mechanically altered diet. This had the potential to affect all 11 residents on a puree and mechanically altered diet (#8, #9, #17, #19, #24, #29, #34, #40, #50, #52, and #100). The facility census was 50. Findings include: 1. Review of Resident #19's medical record revealed an admitted [DATE], diagnoses included dementia, dysphagia, and muscle weakness. Review of Resident #19's comprehensive Minimum Data Set assessment dated [DATE] revealed she was rarely or never understood. Review of Resident #19's physician orders dated 08/05/23 revealed an order for pureed texture diet with slightly thick liquids. Review of the menu for the lunch meal on 09/09/24 revealed residents were to receive three ounces of beans and [NAME], cornbread, tossed salad with dressing, and diced peaches. Observation on 09/09/24 at 12:21 P.M. of the lunch meal revealed Resident #19 was served mashed potatoes and a beverage. Interview on 09/09/24 at 12:31 P.M. with State tested Nursing Assistant (STNA) #156 verified Resident #19 received only mashed potatoes for her lunch meal. She reported that Resident #19 was on a puree diet and could not eat the food items that were on the menu for the day. 2. Review of facility menus for September 2024 revealed there was one menu for a regular diet. Review of the International Dysphagia Diet Standardization Initiative (IDDSI) diet guides for soft and bite sized diet, moist and minced diet, and pureed diet, revealed the guides explained the texture requirements and indicated the foods that should be avoided on the diets. There was no indication of what the avoidable foods should be replaced with. Interview on 09/16/24 at 1:08 P.M. with Dietitian #150 and Diet Tech #123 verified there were 11 residents on a puree and mechanically altered diet (#8, #9, #17, #19, #24, #29, #34, #40, #50, #52, and #100) and there was no menu for residents on soft and bite sized diet, minced and moist diet, or puree diet. They reported those diets were to receive the same food items as the regular menu. However, they verified that was not accurate as some items (corn, crackers, etc.) could not be made appropriate for textured diets. In those cases, the aides would need to substitute the item based on the IDDSI posting. Both the Dietitian #150 and Diet Tech #123 verified the posting only stated the foods they should avoid without explaining what an equivalent replacement would be.

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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. 32654 Based on observation and staff interview, the facility failed to ensure puree food items were cooked and brought back up to temperature following the completion of puree method. This affected two of two residents residing in the 400 house. The census was 50. Findings included: Review of the facility's menu for house 400 revealed the scheduled meal on 09/10/24 for the lunch meal was potato soup, deli sandwich with lettuce, tomato and onion, orange sections and milk. On 09/10/24 at 11:10 A.M., State tested Nursing Assistant (STNA) #119 was observed to prepare the lunch menu for house 400. STNA #119 opened a can of carrots and placed contents into a blender and pureed the carrots to the appropriate consistency. Interview at the time of the observation revealed the house had two residents (#8 and #34) who received a pureed diet. The STNA then placed the pureed carrots into two bowls and served them to resident #8 and #34. On 09/20/24 at 11:14 A.M., interview with STNA #119 verified the carrots were not heated, seasoned or brought back to temperature after being pureed.

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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 observations, interview, medical record review, and review of diet guides the facility failed to ensure Resident #40 was served food appropriate for a soft and bite sized texture diet and Resident #52 was served food appropriate for a pureed texture diet. This affected two residents (#40 and #52) of five residents on a puree diet and three residents on a soft and bite sized diet. The facility census was 50. Findings include: 1. Review of Resident #40's medical record revealed an admitted [DATE], diagnoses included diastolic heart failure, dysphagia, and nutritional anemia. Review of Resident #40's physician order dated 06/18/24 revealed an order for a soft and bite sized diet with no added salt and a half portion of dessert. Observation of on 09/10/24 at 12:40 P.M. of the lunch meal revealed Resident #40 was served a whole sandwich with lunch meat and tomato, soup, and orange segments. She was observed taking several bites of the sandwich. Interview on 09/10/24 at 12:47 P.M. with Dietitian #150 verified Resident #40 was on a soft and bite sized diet and should have received puree bread with ground meats, pureed carrots, soup, and applesauce. Review of the menu for 09/10/24 lunch meal revealed residents were to receive deli sandwiches with lettuce, tomato, and onion, potato soup, and orange segments. There was no soft and bite sized diet menu. Interview on 09/16/24 at 1:08 P.M. with Dietitian #150 and Diet Tech #123 verified there was no soft and bite sized diet menu. They were to follow the regular menu and substitute items that were not appropriate for the texture. Review of the International Dysphagia Diet Standardization Initiative (IDDSI) diet guide for soft and bite sized diet revealed the texture was soft, tender, and moist. The ability to 'bite off' a piece of food is not required, the bite sized pieces should not be bigger than 1.5 centimeters (cm) by 1.5 cm, and foods could be mashed or broken down with pressure from fork. Meat should be cooked tender and chopped, if it could not be served soft and tender it should be served as minced and moist. Vegetables were to be steamed and boiled with final size no bigger than 1.5 cm by 1.5 cm. 2. Review of Resident #52's medical record revealed an admitted [DATE], diagnoses included type two diabetes mellitus, hypertension, and gastro-esophageal reflux disease without esophagitis. Review of Resident #52's physician order dated 07/23/24 revealed an order for a pureed texture diet. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/10/24 at 8:45 A.M. revealed Resident #52 eating breakfast. The food in front of her appeared to have chunks of egg and meat. Interview on 09/10/24 at 8:45 A.M. with the Interim Director of Nursing (DON) verified Resident #52's meal appeared to have chunks of food. Interview on 09/10/24 at 8:51 A.M. with Agency Aide #155 verified the food did not appear appropriately pureed as she noted pieces of egg and meat. Review of the menu for 09/10/24 breakfast revealed residents were to receive a biscuit, country gravy, scrambled eggs, and applesauce. There was no puree menu. Review of the IDDSI diet guide for pureed food revealed the texture did not require chewing, should be smooth with no lumps, and be able to hold its shape on a spoon.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review and staff interview, the facility failed to ensure one resident (#32) was provided the physician ordered adaptive equipment for meals. This affected one of nine residents reviewed for nutrition. The facility census was 50. Findings Include: Review of the medical record for Resident #32 revealed an initial admitted [DATE] with the latest readmission of 07/06/24, diagnoses included osteoarthritis, vitamin D deficiency, chronic pain syndrome, major depressive disorder, dementia with behavioral disturbances, intellectual disabilities and hypertension. Review of the plan of care dated 01/21/23 revealed the resident was at possible nutrition/dehydration risk due to health status, low total protein levels, use of therapeutic diet, elevated body mass index (BMI), oral nutritional supplement usage, currently edentulous without appliance status and history of significant weight changes. Interventions included diet as ordered, encourage to drink fluids and eat snacks between meals and during activities as appropriate, encourage to eat and drink by offering foods and fluids the resident likes, encourage calorically dense foods, encourage to eat in the main dining room, encourage to eat plenty of protein, assist resident at meals and snacks by cueing or assisting as needed, offer substitute if the resident does not like what is served, if resident consumed less than 50% of meal offer a substitute, medication as ordered, monitor intake and document negative findings and observe for signs/symptoms of dehydration. Review of the resident's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the resident's monthly physician orders for September 2024 identified orders dated 07/29/24 Kennedy cup (a spill proof handled cup with a lid and straw) for all meals. Review of the State tested Nursing Assistant (STNA) task list revealed the resident had an order for a Kennedy cup at all meals. On 09/10/24 at 11:20 A.M., observation of the resident revealed he was served the scheduled meal and was given a cup of juice with a straw in a regular drinking glass. The resident also had a bottle of chocolate ensure with a straw. Further observation revealed no Kennedy cup provided to the resident for the drinks served with the meal. On 09/11/24 at 11:30 A.M., observation of the resident revealed the resident was given the schedule meal along with a large glass of juice in a regular drinking glass. Further observation revealed no Kennedy cup provided to the resident for the drink served with the meal. On 09/11/24 at 11:57 A.M., interview with STNA #183 revealed the only lidded cup the house had was for another resident the family provided. STNA #183 verified the resident was not provided the physician ordered adaptive equipment used for drinking at all meals.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43064 Based on observation, interview, and review of facility policy the facility failed to ensure foods were stored in a sanitary manner and failed to ensure foods were labeled, dated, stored appropriately, and not kept past the expiration dates. This had the potential to affect 50 of 50 residents in the facility. Findings include: Observation on 09/09/24 from 8:28 A.M. to 9:00 A.M. revealed the following concerns: In house 403 there were hot dog buns dated 09/02/24 and 09/08/24 and a rotisserie chicken for the resident in 511 dated 08/27/24. 511 also had two unidentifiable food items that were not dated. In the refrigerator there was a bag of frozen peas that was open to air and undated. The freezer in the kitchen and the refrigerator in the pantry were full of food debris and stains. In House 401 there were two packages of cheddar slices poorly wrapped in foil and exposed to air. There was half an onion and half a tomato cut open and unwrapped, both items were in a drawer that was filled with food debris. Both refrigerators and freezers in the kitchen and pantry were unclean. In House 400 there was a box of instant potatoes open to air with no open date and a bottle of ketchup with a broken lid, exposing the ketchup to air. In House 402 the oven vents had a thick black build up. Additionally, there were two packages of bread dated 09/03/24 and one package of hot dog buns dated 09/04/24. Both refrigerators were noted to be unclean, and the refrigerator in the pantry had a large food stain in the bottom. In House 404 the oven vents had a thick black build up. Additionally, there was a mashed potato container labeled for Resident #9 dated 08/29/24, an open bowl of pears undated, two boxes of instant potatoes that were open to air and undated, and four packages of bread dated 08/25/24, 08/26/24, 09/06/24, and 09/07/24. Interview on 09/09/24 from 8:28 A.M. to 9:00 A.M. with Diet Tech #123 verified the observations. She reported the housekeepers or aides were supposed to clean the refrigerators regularly. Diet Tech #123 reported she believed the oven vents were supposed to be cleaned by maintenance. Review of the policy 'Food Storage Policy and Procedure' revised May 2013, revealed when frozen foods are removed to thaw, they are labeled with the date and the word 'thaw' is put on the label. Review of the policy 'Resource for families' revealed if food is brought into the community for residents they should be labeled and dated to monitor for food safety. Food in unmarked or unlabeled containers should be marked with the current date the food item was stored. This deficiency represents non-compliance investigated under Complaint Number OH00157282.

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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 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 (#11 and #31) of 24 sampled residents. The facility census was 50. Findings Include: 1. Review of the medical record for Resident #11 revealed an initial admitted [DATE] with the latest readmission of 01/12/24, diagnoses included hypertensive heart disease with heart failure, asthma, pain, chronic obstructive pulmonary disease (COPD), chronic respiratory failure, severe morbid obesity, vitamin D deficiency, pancytopenia, obstructive sleep apnea and gastro-esophageal reflux disease. Review of the plan of care dated 01/12/24 revealed the resident had an alteration in respiratory status related to COPD, asthma and chronic respiratory failure. Interventions included elevate head of bed due to difficulty breathing when lying flat, monitor for shortness of breath, chest pain or change in condition, monitor oxygen saturation rate, monitor respiratory status, oxygen as ordered and provide emotional support as needed. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive impairment. The assessment indicated the resident had not received oxygen therapy. Review of the resident's monthly physician orders for September 2024 identified orders dated 04/12/24 oxygen two to four liters as needed for COPD and keep oxygen saturation rate greater than 90%. Review of the resident's September 2024 Medication Administration Record (MAR) reflected the resident had not utilized the as needed oxygen. On 09/09/24 at 10:22 A.M., observation of Resident #11 revealed the resident was sitting in her recliner with her legs elevated with oxygen via nasal cannula on. On 09/09/24 at 2:44 P.M., observation of Resident #11 revealed the resident's oxygen remained on via nasal cannula. On 09/10/24 at 2:50 P.M observation of Resident #11 revealed the resident was sitting in her recliner with her legs elevated with oxygen via nasal cannula on. On 09/11/24 at 2:35 P.M., interview with the Interim Director of Nursing (IDON) verified the resident's medical record failed to reflect the resident's use of the as needed oxygen the resident was utilizing on a daily basis. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #31 revealed an initial admitted [DATE] with the latest readmission of 09/05/24 diagnoses included cellulitis of left upper limb, cardiomyopathy, hypertension, ulcerative colitis, cerebrovascular accident with left sided hemiplegia, anemia, severe protein calorie malnutrition, hyperlipidemia, congestive heart failure, presence of cardiac pacemaker, anxiety disorder and major depressive disorder. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The assessment indicated the resident had skin tears. Review of the Nurse Practitioner's (NP) progress note dated 08/27/24 at 12:29 P.M. revealed the resident was being seen for fatigue and left upper extremity swelling. The progress note also documented the resident had no new skin issues. Review of the weekly skin observation dated 08/29/24 revealed the resident had a skin tear to the left buttocks and a rash to the right buttocks and coccyx. Review of the change in condition evaluation dated 09/01/24 revealed the evaluation was blank. Review of the progress note dated 09/01/24 revealed the resident's left arm was extremely swollen. The NP was notified and ordered the resident to be transported to a local emergency department (ED). Review of the progress note dated 09/01/24 at 4:00 P.M. revealed the resident was being admitted to the local acute care hospital. Review of the hospital history and physical (H&P) dated 09/01/24 revealed the resident was admitted to the acute care hospital with left axilla redness and left upper extremity cellulitis. The resident present to the ED with pain, redness, weeping in left axilla/breast fold that was not responding to topical therapy. The resident was started on the antibiotic Vancomycin in the ED. Topical Miconazole (anti-fungal)and Fluconazole (anti-Fungal) 150 mg weekly for four weeks was also added. Wound and blood cultures were also obtained. The history and physical (H&P) documented erythema, weeping and tenderness to the left axilla/upper arm/breast and knee folds. Review of the Infectious Disease Physician's progress noted dated 09/03/24 revealed the reason for the consult was cellulitis to the left axilla and back. The progress note documented the resident had a large erythema to the left back, left axilla and part of the chest. The physician ordered CT scan to rule out abscess, continue current treatment with Vancomycin, Miconazole and Fluconazole. The physician also ordered to keep area clean/dry and offloading. Review of the medical record revealed no documented evidence the resident's large erythema to the left back, left axilla and part of the chest and cellulitis was identified, monitored and treatment implemented prior to the transfer to the ED. On 09/09/24 at 11:56 A.M., interview with Resident #31 revealed she was recently hospitalized due to cellulitis to her back and left underarm. Resident #31 revealed she had reported the rash getting worse however, the nurse did not address the worsening of the rash. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/10/24 at 1:00 P.M., interview with the Interim Director of Nursing (DON) verified the lack of documentation of the resident's cellulitis and large erythema to the left back, left axilla and part of the chest. The DON also verified the resident's change in condition assessment was blank.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review, staff interview and policy review the facility failed to ensure enhanced barrier precautions (EBP) were in place for five residents (Resident #32, #52, #45, #110, #45 and #1) of seven residents reviewed for enhanced barrier precautions. The facility failed to ensure an isolation room contained appropriate bins for staff to place soiled laundry and to dispose of soiled personal protective equipment (PPE) for one resident,(Resident #10) of one reviewed for transmission-based precautions. The facility failed to provide evidence the infection control policies and procedures are reviewed annually. This had the potential to affect all 50 residents in the facility as each home of the facility had residents who were not in enhanced barrier precautions who had physician orders to have enhanced barrier precautions implemented in their care. The facility census was 50. Findings Include: 1. Review of the medical record for Resident #32 revealed an initial admitted [DATE] with the latest readmission of 07/06/24, diagnoses included sepsis, urinary tract infection, benign prostatic hyperplasia with lower urinary tract symptoms, retention of urine, obstructive and reflux uropathy. Review of the resident's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The assessment indicated the resident was always incontinent of both bowel and bladder. Review of Resident #32's monthly physician orders for September 2024 identified no orders related to the resident's indwelling urinary catheter placement. Review of the resident's medical record revealed no documented evidence a comprehensive plan of care was completed addressing the resident's indwelling urinary catheter usage. On 09/11/24 at 12:15 P.M. observation of catheter care provided by State tested Nursing Assistant (STNA) #119 and #183 for Resident #32 revealed the resident was yelling out he was backed up. The resident was taken to his room and ambulated with two maximal assists and a front wheeled walker to the bathroom. The resident was assisted onto the toilet where he was continent of a large formed stool. STNA #119 cleansed the resident's rectal area with disposable wipes from the front to back. The resident was ambulated to his bed and assisted into bed. STNA #119 pulled the resident's pants down, obtained the required supplies, washed her hands, obtained a soapy washcloth and cleansed the resident's groins and shaft of penis using a different section of the cloth. The STNA then obtained a clean soapy wash cloth and cleansed the tip of the resident's penis in a circular motion. She then used a different section of the cloth and cleansed the catheter tubing in a circular motion outward. The STNA then rinsed and dried in the same manner. The STNA then applied the resident's incontinence brief and positioned the resident to comfort. The STNA's failed to don a gown during the catheter care. The STNA's verbalized the gown is only worn while emptying the catheter collection bag. The STNA's verified the lack of implementing the personal protective equipment for Enhanced Barrier Precautions (EBP). 43064 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Review of Resident #52's medical record revealed an admitted [DATE], diagnoses included type two diabetes mellitus, chronic kidney disease, and gastro-esophageal reflux disease without esophagitis. Review of Resident #52's Minimum Data Set (MDS) 3.0 dated 07/26/24 revealed the resident was rarely or never understood. Review of Resident #52's physician order dated 07/22/24 revealed the resident required enhanced barrier precautions (EBP). Meaning staff needed gloves and gowns with care and treatment. Review of Resident #52's physician order dated 09/06/24 revealed the resident required enteral feed every shift related to transient cerebral ischemic attack. Observation on 09/09/24 at 12:35 P.M. and 1:59 P.M. revealed Resident #52 who had a tube feed did not have EBP in place. There was no personal protective equipment (PPE) or signs noted by or in Resident #52's room. Interview on 09/09/24 at 12:35 P.M. with State tested Nursing Aide (STNA) #127 verified Resident #52 was not on EBP. Interview on 09/10/24 at 8:45 A.M. with the interim Director of Nursing (DON) verified Enhanced Barrier precautions had not been in place on 09/09/24. 3. Review of Resident #110's medical record revealed an admitted [DATE], diagnoses included benign prostatic hyperplasia without lower urinary tract symptoms, aphasia, and peripheral vascular disease. Review of Resident #110's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the assessment was not complete but in progress. Resident #110 was coded as rarely or never understood. Review of Resident #110's plan of care initiated 09/06/24 and revised on 09/09/24 revealed he had an indwelling catheter related to urinary retention and was at risk for complications. Interventions dated 09/06/24 included checking tubing for kinks, monitoring and documenting intake and output according to facility policy, monitoring for pain due to catheter, and monitoring for discomfort on urination and frequency. Interventions dated 09/09/24 included EBP and monitoring for signs of urinary tract infection. Review of Resident #110's physician order dated 09/06/24 revealed an order for urinary catheter 18 french gauge for urinary retention. Observation on 09/09/24 at 12:35 P.M. and 1:59 P.M. revealed Resident #110 who had a urinary catheter did not have EBP in place. There was no PPE or signs noted by or in Resident #110's room. Interview on 09/09/24 at 12:35 P.M. with State tested Nursing Aide (STNA) #127 verified Resident #110 was not on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. Review of Resident #45 revealed an admitted [DATE], diagnoses included type two diabetes mellitus, paroxysmal atrial fibrillation, adult failure to thrive, major depressive disorder, unspecified dementia, chronic kidney disease stage four, and hypertension. Review of Resident #45's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed severely impaired cognition. Resident #45 had a diabetic foot ulcer. Review of the plan of care revised 06/03/24 revealed Resident #45 had a diabetic ulcer of the left foot related to diabetes. Interventions included carefully drying between toes but not applying lotion, monitoring the wound on an ongoing basis, monitoring for signs of infection, and treatment documentation to include measurement of each area of skin breakdown. EBP was added as an intervention on 01/03/24. Observation on 09/09/24 at 11:53 A.M. of Resident #45 revealed EBP were not in place. There was no PPE or signs noted by or in Resident #45's room. Interview on 09/09/24 at 12:31 P.M. with STNA #156 verified Resident #45 did not have EBP in place. 47059 5. Record review for Resident #1 revealed the resident was admitted on [DATE], diagnoses included neuromuscular dysfunction of the bladder, and urinary retention. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was cognitively intact and had no signs of psychosis or behaviors noted. Resident #1 had an indwelling catheter. Review of physician orders for Resident #1 revealed orders for a foley catheter to continuous straight drain to be changed every month, the catheter bag to be changed every seven days, and catheter patency checked, and catheter care done every shift. There was also an order for enhanced barrier precautions, gown and gloves with treatment and/or care dated 11/16/2023. Review of the September 2024 treatment administration record revealed the urinary catheter care and treatment was documented as completed as ordered. Observation on 09/09/24 at 10:30 A.M. revealed Resident #1 was resting quietly in bed with foley catheter drainage bag covered and hanging from the bed frame at the foot of the bed. Resident #1 had no signage or personal protective equipment at the entrance to her room indicating she was in enhanced barrier precautions. Interview on 09/09/24 at 12:30 P.M. with State tested Nursing Assistant (STNA) #185 confirmed lack of EBP in use for Resident #1. STNA #185 stated she had no idea what enhanced barrier precautions were and when the surveyor explained EBP, STNA #185 stated there are no residents on EBP in this building currently. Interview on 09/16/24 at 11:00 A.M. with the Director of Nursing (DON) who was the facilities infection preventionist confirmed the staff were educated on EBP and stated they would be re-educated because residents were not in EBP at the start of the survey on 09/09/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366430	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein Gahanna	402 Liberty Way Gahanna, OH 43230

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of procedure Isolation Precautions Process Dated 08/01/2022 revealed enhanced barrier precautions (EBP) are used for resident with infection or colonization with a multidrug resistant organism when contact precautions do not apply, wounds, and/or indwelling medical devices. Gowns and gloves should be worn during high-contact resident care including dressing, bathing, changing linens, transferring, providing hygiene, toileting, device care, and wound care. Signage will be place at the entry to the resident's room indicating to see the nurse prior to entry and the nurse will provide appropriate personal protective equipment instruction. 6. Record review revealed Resident #10 was admitted [DATE]. On 09/09/24 Resident #10 tested positive for SARS-CoV -2 (COVID-19). Resident #10 was immediately put in droplet precautions on 09/09/24. Review of annual Minimum Data Set (MDS) dated [DATE] revealed Resident #10 was cognitively intact had no range of motion impairment in upper or lower extremities, required assistance for mobility, activities of daily living and used a wheelchair. Interview on 09/10/24 at 8:40 A.M. with Resident #10 revealed she had not been feeling well since 09/09/24 when she tested positive for COVID-19. She expressed concern and confusion to being so sick since she had received all of her vaccinations. Observation on 09/10/24 at 8:46 A.M. revealed upon exiting Resident #10's room there was only a regular trash can at the door (no isolation trash or red bags) and there was no isolation linen hamper in her room. Interview on 09/10/24 at 09:45 A.M. with STNA#127 confirmed the regular trash is what is used for the isolation personal protective equipment, STNA #127 stated I don't think we have any other trash cans. Interview on 09/10/24 09:50 A.M. with STNA #152 confirmed there were no isolation bins for used personal protective equipment or soiled linen from Resident #10's room. Review of procedure Isolation Precautions Process Dated 08/01/2022 revealed guidelines for signage and use of personal protective equipment when the resident is suspected or confirmed to be colonized with an infectious agent. It does not address disposal of personal protective equipment or handling of potentially infectious linen. 7. Review of the following Infection control policies and procedures revealed there was no evidence the policies and procedures were reviewed annually. Documents reviewed included: Policy Stewardship Plan last revision date 12/04/19 listed UTI protocol, C-Diff Protocol, Handwashing, Indwelling Catheter use, and Immunization Vaccination Policies as items that are reviewed annually and as needed to promote antibiotic stewardship and prevention protocol awareness. Policy Infection Prevention and Control Program last revision dated 11/05/21 outlined the purpose of the program and referred to other policies and procedures that support the programs intent. Procedure Isolation Precautions Process last revision date 08/01/22 revealed the definitions for transmission-based precautions, standard precautions, and enhanced barrier precautions with indications for use of each. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Policy COVID - 19 Resident Vaccination Policies and Procedures last review date 09/30/22 outlined obtaining and administering vaccine for residents. Procedure Influenza and Pneumococcal Immunization last revision date 06/19/19 outline the process for administering and documenting administration of the vaccines to residents. Interview on 09/16/24 at 11:00 A.M. with the Director of Nursing (DON) who is also the infection preventionist confirmed the above were the current policies and procedures in place at the facility, the facility had no local infection control committee and all policies and procedures are reviewed and revised at the corporate level.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 43064 Based on observation and interview the facility failed to ensure Resident #45's room was maintained in a clean and homelike manner and failed to ensure appropriate water temperature and water drainage for Resident #33. The facility census was 50. Findings include: 1. Observation on 09/09/24 at 11:53 A.M. and 2:44 P.M. and on 09/16/24 at 10:35 A.M. revealed Resident #45's bed was against the wall and a couple inches below the window. The window ledge was observed to have unidentifiable splatters and was chipped in several spots. Interview on 09/16/24 at 10:35 A.M. with Agency Aide #155 verified the observation. 2. Interview on 09/09/24 at 11:00 A.M. with Resident #33 revealed her sink was not draining appropriately. She additionally reported the water did not get hot and made it difficult to wash her face. Observation on 09/09/24 at 11:00 A.M. revealed Resident #33's bathroom sink filled up quickly without draining and the water was lukewarm after running it for several minutes. Observation on 09/16/24 at 11:15 A.M. with Maintenance #157 revealed Resident #33's bathroom sink filled up quickly without draining. After running the water for over three minutes the temperature had only reached 91.1 degrees Fahrenheit. Interview on 09/16/24 at 11:15 A.M. with Maintenance #157 verified Resident #33's water temperature was not hot enough and the sink was not draining appropriately.