STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366434	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare Transitional Care of the Western Reserve	5000 Sowul Boulevard Stow, OH 44224

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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** 42733 Based on observation, resident interview and staff interview, the facility failed to ensure residents were not left in their rooms without visual or audio stimulation. This affected one resident (#62) of three residents reviewed for preferences. The facility census was 65. Findings include: Review of Resident #62's medical records revealed an admitted [DATE]. Diagnoses included stroke, muscle weakness and mobility abnormalities. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 had intact cognition and required partial assistance with personal hygiene and grooming. Observation on 08/12/24 at 10:18 A.M. revealed Resident #62 was in bed facing a blank wall. A television was observed on the opposite side of Resident #62's room that was not on. Interview with Resident #62 at time of observation revealed he was unable to turn to his left side to look at the television and stated he would at least like the television on to listen to. Concurrent interview with State tested Nursing Assistant (STNA) #404 confirmed the television was not in view of Resident #62 and was not turned on. STNA #404 stated he was unsure why the television was not on and, due to the placement of the bed, the television was not viewable for Resident #62. Observations on 08/13/24 at 8:18 A.M. and 08/14/24 at 9:36 A.M. revealed the television had not been turned on and Resident #62's bed was in the same position as previous observations. Resident #62 was observed in bed staring at a blank wall. Interview on 08/15/24 at 10:39 A.M. with Licensed Practical Nurse (LPN) #458 confirmed Resident #62's was in bed staring at a blank wall and the television was not on. LPN #458 stated she was unsure why the television was not on and stated Resident #62's bed should be able to be moved in order for Resident #62 to be able to view the television.

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 46195 Based on resident interview, observation, review of resident fund account records, staff interview and review of facility policy, the facility failed to ensure residents who had a financial account with the facility received quarterly statements as required. This affected five residents (#7, #31, #40, #48, and #57) of five residents reviewed for personal funds. The facility census was 65. Findings include: Interview on 08/12/24 at 11:14 A.M. with Resident #48 revealed she had a resident funds account at the facility. Resident #48 stated she had not received quarterly statements from the facility to show her account activity. Review of resident fund account records for five residents (#7, #31, #40, #48, and #57) revealed no evidence quarterly statements had been given over the past year to the resident and/or resident representative. Interview on 08/14/24 at 2:16 P.M. with Administrative Assistant (AA) #409 confirmed there was no evidence quarterly statements for Residents #7, #31, #40, #48, and #57 had been given to the resident and/or resident representative. AA #409 stated the facility's previous owner took the computer, which housed the statements, and the new owner had no access to the previous quarterly statements. Interview on 08/15/24 at 8:25 A.M. with Resident #48 revealed she had received a quarterly financial statement the previous night, which was the first time ever. Resident #48 stated the facility had her sign for her statement and was told it's a little bit late when she was handed the statement. Observation at the time of interview revealed the resident had been given a document titled Patient Fund PNA Quarterly Statement from 04/01/24 thru 06/30/14. Interview on 08/15/24 at 8:45 A.M. with AA #409 revealed corporate staff reached out to staff from the previous owner and they were able to get the quarterly financial statements from last quarter. The quarterly statements were hand delivered the night before to residents by the evening receptionist. AA #409 confirmed the quarterly statements should have been delivered at the beginning of the quarter (July) and had not been delivered until the evening of 08/14/24. Review of facility policy Accounting and Records of Resident Funds, revised April 2017, revealed individual accounting records were to be made available to the resident through quarterly statements and upon request.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 39969 Based on review of beneficiary notices and staff interview, the facility failed to ensure the appropriate beneficiary notices were provided at the end of Medicare services and failed to ensure beneficiary notices were provided timely. This affected three residents (#1, #47, and #169) of three residents reviewed for beneficiary notices. The facility census was 65. Findings include: 1. Review of the beneficiary notice list revealed Resident #1 discharged from Medicare services on 06/09/24 and remained in the facility. Review of the notices provided to Resident #1 revealed a Notice of Medicare Non-Coverage (NOMNC) was provided on 06/06/24. There was no evidence Resident #1 was provided the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN). 2. Review of the beneficiary notice list revealed Resident #47 discharged from Medicare services on 07/05/24 and remained in the facility. Review of the notices provided to Resident #47 revealed a NOMNC was provided on 07/02/24. The was no evidence Resident #47 was provided the SNFABN. 3. Review of the beneficiary notice list revealed Resident #169 discharged from Medicare services on 08/07/24 and discharged to home on 08/08/24. Review of the notices provided to Resident #169 revealed the NOMNC indicated last covered date for Medicare services was 08/07/24. Further review of the NOMNC revealed Resident #169 signed and dated receipt of the notice on 08/06/24. Interview on 08/13/24 at 3:24 P.M. and at 3:59 P.M. with Licensed Social Worker (LSW) #429 confirmed Resident #1 and Resident #47 were only provided the NOMNC and not the SNFABN notice as required when residents discharged from Medicare services and remained in the facility. LSW #429 further verified the NOMNC provided to Resident #169 was dated 08/06/24, with the last covered day being 08/07/24. LSW #429 stated the notice was provided to Resident #169 on 08/05/24, but the resident wrote the wrong date on the document. LSW #429 stated she told Resident #169 the date was wrong but confirmed there was no evidence to support the NOMNC had been provided at least two days prior to the end of services.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 42733 Based on staff interview and review of personnel files, the facility failed to ensure Nurse Aide Registry (NAR) checks were completed on employees upon hire. This had the potential to affect all resident residing in the facility. The facility census was 65. Findings include: 1. Review of Dietary Manager (DM) #444's personnel file revealed a hire date of 02/01/24. Further review revealed no evidence a NAR check was completed. 2. Review of State tested Nursing Assistant (STNA) #476's personnel file revealed a hire date of 07/30/24. Further review revealed no evidence a NAR check was completed. 3. Review of STNA # 478's personnel file revealed a hire date of 08/05/24. Further review revealed no evidence a NAR check was completed. Interview on 08/21/24 at 9:42 A.M. with Human Resources (HR) #403 revealed he had recently assumed the HR role. HR #403 stated he was unaware he was to check all employees against the NAR. HR #403 confirmed the facility had no evidence DM #444, STNA # 476 and STNA #478 had been checked on the NAR prior to employment.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on review of the Internet Quality Improvement and Evaluation System (iQIES) Minimum Data Set (MDS) 3.0 Validation Report and staff interview, the facility failed to ensure MDS assessments were submitted in a timely manner. This affected 11 residents (#7, #9, #13, #15, #21 #23, #24, #33, #39, #41, and #48) of 23 residents reviewed for MDS submission. The facility census was 65. Findings include: Review of the iQIES MDS Final Validation Report submitted on 08/09/24 at 2:22 P.M. revealed each of the following resident's MDS assessments were submitted more that 14 days late: Resident #7's quarterly MDS assessment dated [DATE] Resident #9's quarterly MDS assessment dated [DATE] Resident #13's quarterly MDS assessment dated [DATE] Resident #15's comprehensive MDS assessment dated [DATE] Resident #21's quarterly MDS assessment dated [DATE] Resident #23's quarterly MDS assessment dated [DATE] Resident #24's quarterly MDS assessment dated [DATE] Resident #33's quarterly MDS assessment dated [DATE] and discharge MDS assessment dated [DATE] Resident #39's quarterly MDS assessment dated [DATE] Resident #41's quarterly MDS assessment dated [DATE] Resident #48's quarterly MDS assessment dated [DATE] Interview on 08/20/24 at 12:46 P.M. with MDS Nurse #423 verified the above MDS assessments were submitted on 08/09/24 and were late. MDS Nurse #423 stated she had issues with the electronic health record and accessing iQIES. MDS Nurse #423 stated she informed her corporate office well in advance, sometime in the beginning of July, that she had issues with accessing to iQIES to timely submit the MDS assessments.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on medical record review and staff interview, the facility failed to ensure Minimum Data Set (MDS) assessments were accurately completed. This affected three residents (#24, #52, and #66) of 23 residents reviewed for accuracy of assessments. The facility census was 65. Findings include: 1. Review of the closed medical record for Resident #66 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included Nontraumatic subacute subdural hemorrhage, dementia, hypertension, pelvic and spinal fracture, muscle weakness and abnormalities of gait and mobility. Review of the discharge return not anticipated MDS assessment, dated 06/25/24, revealed Resident #66 had intact cognition and had a planned discharge to a short term general hospital. Review of the discharge summary completed on 06/25/24 at 12:59 P.M. revealed Resident #66 discharged on to assisted living (AL), accompanied by his son. Interview on 08/14/24 at 8:29 A.M. with MDS Nurse #423 verified the discharge MDS assessment dated [DATE] was not accurately coded. MDS Nurse #423 stated Resident #66 was admitted for a short term stay from an AL and discharged back to that AL. 46195 2. Review of the medical record for Resident #24 revealed an admitted [DATE]. Diagnoses included end stage renal disease, dependence on renal dialysis, and hypertensive heart and chronic kidney disease without heart failure with stage five chronic kidney disease or end stage renal disease. Review of Section O of the quarterly MDS assessment, dated 07/03/24, revealed the facility answered No to the resident receiving dialysis. Interview on 08/20/24 at 11:50 A.M. with MDS Nurse #423 confirmed Resident #24 received dialysis services. MDS Nurse #423 verified the MDS assessment had been coded incorrectly and should have been marked Yes in section O. 3. Review of the medical record for Resident #52 revealed an admitted [DATE]. Diagnoses included unspecified intellectual disabilities, mood disorder due to known physiological condition, impulse disorder, depression, unspecified abnormalities of gait and mobility and unsteadiness on feet. Review of an undated Incident Reassessment Summary revealed on 06/13/24 at 9:00 A.M. Resident #52 was agitated and went storming away with his walker and fell in the hallway. Review of Section J of the quarterly MDS assessment, dated 07/25/24, revealed the facility answered No to the question related to falls since admission or the prior assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #52's prior MDS assessments revealed an annual assessment was completed on 04/26/24. No further assessments had been completed between the annual assessment dated [DATE] and the quarterly assessment dated [DATE]. Interview on 08/20/24 at 12:45 P.M. with MDS Nurse #423 confirmed the MDS assessment, dated 07/25/24, had been inaccurately coded and further stated she had no access to the previous electronic medical record platform to determine if there had been any falls for Resident #52.

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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** 39969 Based on medical record review, resident interview, staff interview and review of facility policy, the facility failed to ensure care plans were updated timely and care conferences were held. This affected two residents (#44 and #7) of two residents reviewed for care planning. The facility census was 65. Findings include: 1. Review of the medical record for Resident #44 revealed an admitted [DATE]. Diagnoses included acute and chronic respiratory failure with hypercapnia, chronic obstructive pulmonary disease (COPD), morbid (severe) obesity, major depressive disorder and anxiety disorder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/02/24 revealed Resident #44 had intact cognition, had delusions, rejected care four to six days of the look back period and received antidepressants during the seven day look back period. Review of the physician orders for August 2024 revealed orders for Alprazolam (anti-anxiety) oral tablet 0.5 milligrams (mg), Trazodone HCl (antidepressant) oral tablet 50 mg and Duloxetine HCl (antidepressant) oral capsule delayed release particles 30 mg. Review of the care plan initiated on 07/25/24 revealed Resident #44 had a mood problem and anxiety was treated with Alprazolam. The goal section was incomplete. Further review revealed Resident #44 had a behavior problem related to. The care plan was incomplete, not indicating what the behavior problem was related to and the goal section was incomplete. Interview on 08/20/24 at 12:56 P.M. with MDS Nurse #423 revealed she completed some sections of the care plan, with Licensed Social Worker (LSW) #429 being responsible for other areas. MDS Nurse #423 stated she was not sure where LSW #429 was at with completing the care plan. Interview on 08/20/24 at 1:12 P.M. with LSW #429 revealed care plans were initiated by MDS Nurse #429. LSW #429 confirmed she was responsible for completing the sections related to mood/behaviors, code status and discharge planning. LSW #429 stated there was a change in the electronic medical records and the old care plans did not carry over to the new system. LSW #429 stated it was a lot for her to update all of the care plans and further stated she was behind. LSW #429 verified Resident #44's care plan was initiated on 07/25/24 but she had not updated it yet. 46195 2. Review of Resident #7's medical record revealed an admitted [DATE]. Diagnoses included hyperlipidemia, chronic kidney disease, unspecified dementia, moderate with mood disturbance, major depressive disorder, type two diabetes with diabetic chronic kidney disease, bipolar disorder, anxiety disorder and cognitive communication deficit. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS assessment, dated 07/03/24, revealed Resident #7 was moderately cognitively impaired and inattention was present and fluctuated. Resident #7 did not reject care. Interview on 08/12/24 at 10:27 A.M. with Resident #7 revealed the resident denied attending any care plan meetings. Further review of Resident #7's medical record from 09/01/23 through 08/20/24 revealed there was one documented care conference on 05/10/24, with nursing, the social worker and Resident #7's son present. Further review of the electronic medical record and the hard chart revealed no other documented care conferences in the medical record during the period reviewed. Interview on 08/29/24 at 3:22 P.M. with LSW #429 confirmed the only evidence of a care conference for Resident #7 from 09/01/23 though 08/20/24 was on 05/10/24. LSW #429 stated, according to her day planner, Resident #7 had care conferences on 11/03/23 and 02/02/24. A care conference, originally scheduled for 04/02/24, had been rescheduled for 05/10/24. LSW #429 stated a new care conference had not been scheduled for Resident #7. LSW #429 further stated she had yellowed out the care conferences scheduled in her day planner on 11/03/23 and 02/02/24 and assumed she documented them in the medical record. LSW #429 verified there was no evidence the care conferences occurred on 11/03/23 and 02/02/24. Review of the facility policy titled Care Planning-Interdisciplinary Team, revised September 2013, revealed a care plan was developed within seven days of the completion of the resident assessment (MDS). The resident, resident's family and/or the resident's legal representative/guardian or surrogate were encouraged to participate in the development of, and revision to, the resident's care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on medical record review, family interview, guardian interview, review of shower documentation and review of the facility policy and procedure, the facility failed to ensure showers were provided as scheduled for dependent residents. This affected two residents (#4 and #53) of seven residents reviewed for activities of daily living (ADLs). The facility census was 65. Findings include: 1. Review of the medical record for Resident #4 revealed an admitted [DATE]. Diagnoses included encephalopathy, Alzheimer's disease, and benign prostatic hyperplasia with lower urinary tract symptoms. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 had impaired cognition and was dependent on staff for showers and baths. Review of the care plan dated 08/08/24 revealed Resident #4 was at risk for self-care deficit for bathing, dressing, and feeding. Interventions included provide assistance with ADLs as needed. Review of shower sheet documentation revealed in June 2024, Resident #4 received showers on 06/14/24, 06/21/24 and 06/25/24. In July 2024, Resident #4 received showers on 07/09/24, 07/23/24, 07/24/24 and 07/30/24. In August 2024, Resident #4 received a shower on 08/06/24. A partial bed bath was documented on 08/09/24 and it was noted the resident refused a shower, partial bed bath was completed and would attempt again 08/10/24. Further review confirmed Resident #4 received a shower on 08/10/24. Interview on 08/12/24 at 4:30 P.M. with Resident #4's wife revealed the resident was to get showers every Tuesday and Friday but he was not getting them consistently. Resident #4's wife stated the resident preferred showers and his last shower was given after she complained. 2. Review of the medical record for Resident #53 revealed an admitted d of 04/24/24. Diagnoses included nontraumatic intracerebral hemorrhage, protein-calorie malnutrition, aphasia following nontraumatic intracerebral hemorrhage, quadriplegia, and anoxic brain damage. Review of the quarterly MDS assessment, dated 08/01/24, revealed Resident #53 had impaired cognition and was dependent on staff for all ADLs. Review of the care plan dated 08/08/24 revealed Resident #53 had an ADL self-care performance deficit related to disease process, quadriplegia, anoxic brain damage and traumatic brain injury. Interventions included the resident was totally dependent for showering/bathing with two staff assistance. Review of shower sheets documentation from 06/14/24 through 08/14/24 revealed Resident #53 received a shower on 06/14/24 and bed baths on 06/28/24, 07/24/24, 07/31/24 and 08/14/24. Interview on 08/12/24 at 1:36 P.M. with Resident #53's guardian revealed Resident #53 did not receive showers as scheduled. Resident #53's guardian stated he was told there were no records available regarding showers because the facility was fighting for records with the old company. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/15/24 at 1:42 P.M. with State tested Nurse Aide (STNA) #465 and STNA #487 verified showers were not provided as scheduled and further confirmed Resident #4 and Resident #53, who required total assistance with showers, had not received showers as scheduled. Review of facility policy titled Bath, Shower Room, revised February 2018, revealed the purpose of the procedure was to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Documentation included date and person providing the shower/tub bath and to document if the resident refused. Further review revealed to notify the charge nurse if the resident refused the shower/tub bath.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, resident interview, staff interview, medical record review and review of facility policy, the facility failed to ensure Intravenous (IV) dressings were changed per physician order and as needed. This affected one resident (#74) of one resident reviewed for IV dressings. The facility identified one resident with IV access. The facility census was 65. Findings include: Review of Resident #74's medical records revealed an admitted [DATE]. Diagnoses included osteomyelitis (bone infection) of the right ankle and foot and Methicillin Susceptible Staphylococcus Aureus (MRSA). Review of care plan dated 07/25/24 revealed Resident #74 was on IV medications related to osteomyelitis. Interventions included change IV dressing as ordered and indicated. Review of Resident #74's physician orders dated 08/06/24 revealed change IV dressing every seven days. Interview on 08/19/24 at 9:49 A.M. with Resident #74 revealed her IV dressing was to be changed every week and stated it was supposed to have been changed on 08/15/24. Resident #74 stated she has had IV lines in the past and was aware of the proper care of the line. Resident #74 stated she had asked the nurse (she believed was an agency nurse) to change the dressing on 08/15/24 and stated the nurse did not do it. Concurrent observation of Resident #74's IV line revealed the dressing was dated 08/17/24. The dressing was not intact and was rolled up on the top of the dressing near the insertion site, with a split gauze around the site. There was dried blood on the gauze. Continued observation revealed at 10:01 A.M., Licensed Practical Nurse (LPN) #492 entered Resident #74's room to administer her IV antibiotics. LPN #492 rolled down the top of the IV dressing and unclamped the IV line to administer the antibiotics, leaving the insertion site exposed. LPN #492 then exited Resident #74's room. Observation on 08/19/24 at 10:10 A.M. of Resident #74's IV dressing, with LPN #458, confirmed the IV dressing was not intact and the insertion site was exposed. LPN #458 stated the IV dressing was not appropriate for the IV and stated she would have the nurse change the IV dressing. Observation on 08/20/24 at 9:45 A.M. revealed Resident #74's dressing was the same as previous observation. LPN #458 confirmed the dressing was the same as the previous observation and stated the dressing was supposed to have been changed the previous day. LPN #458 stated she asked why the dressing had not been changed and was told the nurse was not sure how to change the dressing. Review of the facility policy titled Peripheral IV Dressing Changes, revised April 2016, revealed to change the IV dressing at least every 5-7 days and also if loosened or soiled.

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Altercare Transitional Care of the Western Reserve	5000 Sowul Boulevard Stow, OH 44224

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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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, medical record review, staff interview and review of facility policy, the facility failed to develop and implement a comprehensive pressure ulcer program for Resident #40 to prevent the development of a pressure ulcer and to ensure timely and necessary treatment was implemented. Actual harm occurred on 07/29/24 when Resident #40, who was cognitively impaired and dependent on staff for activities of daily living was identified to have an in-house acquired unstageable pressure ulcer (occurs due to prolonged pressure on a specific area of the skin resulting in the lack of blood and the wound cannot be properly staged until the layers of dead skin are removed) to his right leg. Following the development, the unstageable pressure ulcer deteriorated, resulting in debridement (procedure to remove dead, damaged, or infected tissue from a wound to improve healing) and the pressure ulcer was subsequently reclassified as a Stage IV (full thickness skin and tissue loss) pressure ulcer. Prior to the development, there was no evidence comprehensive, individualized and/or effective interventions were in place to prevent the development and/or to identify the pressure ulcer prior to it being unstageable. This affected one resident (#40) of two residents reviewed for pressure ulcer prevention and care. The facility census was 65. Findings include: Review of Resident #40's medical record revealed an admitted [DATE] with diagnoses including stroke with right sided weakness, right knee contracture, muscle weakness and aphasia (difficulty speaking). Review of Resident #40's care plan dated 07/16/24 revealed the resident was at risk for skin breakdown related to impaired mobility. Interventions included encourage soft heel protectors, dressing to area (area not identified) per orders, turn and reposition frequently when in bed and weekly wound management rounds. Further review revealed no interventions for pressure relieving devices, such as an air mattress or off-loading pressure points related to contractures. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40 had no cognition score due to the resident being rarely understood. The assessment revealed Resident #40 required extensive assistance from two staff for bed mobility and toileting and total dependence (from staff) for transfers. Review of a skin assessment dated [DATE] revealed Resident #40 had an abrasion to his right upper back with no other skin impairments noted. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a wound physician note dated 07/29/24 revealed Resident #40 had an unstageable pressure ulcer to his right leg that measured 6.5 centimeters (cm) in length by 3.9 cm width with 0.1 cm in depth with moderate amounts of serous drainage (clear, watery fluid that comes from a wound after tissue damage) and 80% eschar (necrotic tissue). The note indicated treatment included to apply Santyl (topical enzymatic agent that removed dead tissue from a wound and helped to heal faster and reduce the risk of infection) daily for 30 days, cover with a gauze dressing and to off-load the wound and reposition (resident) per facility protocol. Review of a wound physician note dated 08/05/24 revealed Resident #40's unstageable pressure ulcer measured 6.0 cm in length by 4.0 cm width with 0.1 cm depth with heavy serous drainage. No change in treatments was recommended at this time. Review of Resident #40's physician orders, dated 08/08/24, revealed to cleanse right lower extremity with normal saline (NS), apply Santyl and cover with a foam dressing daily. Further review revealed no current physician orders related to turning and repositioning, off-loading or pressure reliving interventions. Lastly, Resident #40 had no physician ordered wound treatments for the right leg wound prior to 08/08/24. Review of a wound physician note dated 08/12/24 revealed Resident #40's unstageable pressure ulcer measured 5.9 cm in length by 3.2 cm width with 0.2 cm in depth with heavy serous drainage. No change in treatments was recommended at this time. Observation on 08/15/24 at 2:24 P.M. of Resident #40, with State tested Nursing Assistant (STNA) #432 and Registered Nurse (RN) #407, revealed the resident was in bed on his right side. STNA #432 and RN #407 repositioned Resident #40 which revealed a large amount of greenish colored dried drainage on Resident #40's sheets, underneath his right leg. The foam dressing on Resident #40's right leg was dated 08/14/24. The dressing was saturated with a greenish and brownish colored drainage and a foul odor was detected. Concurrent interview with RN #407 confirmed the observations. RN #407 stated he was not aware of specific information regarding Resident #40's wound. RN #407 removed the soiled dressing, cleansed the area with NS and applied Santyl and a new foam dressing. Interview with STNA #432 at time of observation revealed she recalled Resident #40 having the wound a few weeks ago; however, she was unable to recall any specific information. Continued observation of Resident #40's wound revealed the outer area was reddened and had slough and eschar present. Resident #40 was not interviewable. Interview on 08/19/24 at 11:05 A.M. with Wound Physician (WP) #493 revealed she had only been treating Resident #40 for a few weeks. WP #493 stated she could not recall how she had been notified of Resident #40's wound to his right leg, but stated she had seen the resident and assessed the area on 07/29/24 during her wound rounds. WP #493 stated the wound was an unstageable pressure ulcer and she had ordered Santyl as a debridement agent. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Observation on 08/19/24 at 11:20 A.M., with WP #493, Licensed Practical Nurse (LPN) #458 and RN #407 revealed Resident #40's foam dressing was dated 08/18/24 and was saturated with a brownish colored drainage and a foul odor was detected. There was dried drainage on Resident #40's sheets, underneath his right leg. Interview with WP #493 at time of observation confirmed the odor and stated the drainage appeared to be heavier than she previously observed. WP #493 proceeded to surgically debride Resident #40's wound and stated after debridement the resident's wound was to be classified as a Stage IV pressure ulcer that measured 5.3 cm in length by 4.0 cm in width with 0.5 cm in depth. WP #493 had informed LPN #458 to continue the current treatment and add silver alginate (absorbent, antibacterial dressing to promote wound healing). A telephone interview on 08/19/24 at 1:27 P.M. with STNA #426 revealed she only worked on the weekends. The STNA stated a few weeks ago, on a Sunday, she and STNA #432 prepared Resident #40 for a shower and removed a foam boot from his right leg. STNA #426 stated, upon removal of the boot, she observed a large black area to Resident #40's right leg as well as black skin that had stuck to the boot. STNA #426 stated she had immediately informed RN #407 and he had looked at the area. STNA #426 stated she had cared for Resident #40 the previous day but was unable to recall if she removed the boot. STNA #426 stated Resident #40 was supposed to be turned at least every two hours and stated she would place a pillow between the resident's legs due to his contracture. Interview on 08/19/24 at 1:40 P.M. with RN #407 revealed an STNA (unable to recall her name) informed him on the weekend a few weeks ago that Resident #40 had an area to his leg. RN #407 stated he went to Resident #40's room and the resident had a boot on his right leg. RN #407 stated he removed the boot and observed an open area to Resident #40's right leg. RN #407 stated the area appeared to be reddened and dark purple in some areas. RN #407 stated he cleansed the area and placed a bandage over the wound. RN #407 revealed he did not notify the physician at that time because he was scheduled to work the next day, which was a Monday, and he was going to tell the wound nurse (Licensed Practical Nurse (LPN) #458) when she arrived on Monday. Interview on 08/19/24 at 2:18 P.M. with LPN #458 revealed she did not recalled RN #407 notifying her of Resident #40's wound on 07/29/24; however, she had observed the area during wound rounds with WP #493. LPN #458 stated she observed the wound to be an open area that was reddened with slough present. LPN #458 stated she was unaware Resident #40 did not have physician orders in place for pressure relieving interventions and stated the facility had recently changed computer programs and the orders were placed into the new computer system manually and it may have been missed. LPN #458 stated she had recently reviewed Resident #40's current physician orders and discovered the orders for the Santyl had not been in place (initially ordered on 07/29/24) and stated she had added the orders on 08/08/24 (10 days after the treatment was recommended). LPN #458 verified there was no evidence Resident #40's wound care treatments were provided as recommended (beginning on 07/29/24) due to the lack of physician orders in place. Review of facility undated policy titled Pressure Ulcer Prevention and Risk Identification revealed the physician and responsible party would be notified by the licensed nurse promptly of a newly identified skin area and a treatment would be initiated according to the physician order. Interventions would be implemented as indicated by the physician and as determined by the Interdisciplinary Team.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on medical record review, staff interview, dialysis center staff interview and review of facility policy, the facility failed to ensure ongoing communication and collaboration with the dialysis center. This affected one (#24) of one resident identified by the facility as receiving dialysis. The facility census was 65. Findings include: Review of the medical record for Resident #24 revealed an admitted [DATE]. Diagnoses included end-stage renal disease (ESRD) and dependence on dialysis, cognitive communication deficit and hypertensive heart and chronic kidney disease without heart failure, with stage five chronic kidney disease, or end stage renal disease. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/03/24, revealed Resident #24 was moderately cognitively impaired and exhibited disorganized behavior. Resident #24 was dependent on staff for toileting, showering and dressing and required substantial/maximal assistance from staff for mobility, including wheeling her manual wheelchair. Review of care plan dated 08/12/24 revealed Resident #24 received outpatient dialysis three times a week on Monday, Wednesday and Friday related to ESRD diagnosis. Interventions included to coordinate with dialysis regarding labs, diet, weight and medication as necessary; do not draw blood or take blood pressure in arm with graft; encourage resident to go for scheduled dialysis appointments; monitor/document/report to the physician any signs/symptoms of infection to access cite such as redness, swelling, warmth or drainage; monitor/document/report to the physician signs/symptoms of renal insufficiency such as changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds; and obtain vital signs and weight per protocol. Report significant changes in pulse, respirations and blood pressure immediately. Review of the medical record for Resident #24 from 05/29/24 to 08/14/24 revealed the dialysis center sent a communication form to the facility on [DATE], 05/31/24, 06/03/24, 06/05/24, 06/10/24 and 07/08/24. Further review revealed no additional communication forms during the reviewed period. Review of the communication form from the dialysis center revealed the form consisted of the following information: patient name; date; pre and post treatment blood pressure, temperature, and weight; the length of treatment; the length of post treatment bleed; lowest blood pressure during treatment and if symptomatic for the low blood pressure; highest blood pressure during treatment and if symptomatic for high blood pressure; if the resident was short of breath; if the resident had nausea or vomiting; if the resident was cramping; if the resident was complaining of pain and the location of the pain; medications administered during treatment; if the treatment had been completed without complications and any additional comments. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/15/24 at 12:51 P.M. with Dialysis Social Worker (DSW) #496 revealed the facility had sent no communication forms on Resident #24's dialysis treatment days. DSW #496 stated the dialysis center always sent a communication form back to the facility post treatment, either a paper copy sent with the resident or faxed directly to the facility. DSW #496 indicated the pre and post treatment communication was important information to identify any potential complications. Interview on 08/15/24 at 1:37 P.M. with Registered Nurse Supervisor (RNS) #407 revealed communication from dialysis generally came to the facility over the fax machine. RNS #407 confirmed there were missing communication forms for Resident #24, stating faxes sometimes got lost since faxes were sent to a different nurse's station. RNS #407 stated he would let dialysis know if there was a concern. RNS #407 confirmed the facility did not send a communication form to dialysis with any pre treatment information. Review of the facility policy titled End-Stage Renal Disease, Care of a Resident with, revised September 2010, revealed residents with ESRD will be cared for according to currently recognized standards of care.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on medical record review, observation, resident interview, staff interview and review of facility policy, the facility failed to ensure residents with a history of trauma were appropriately assessed to identify triggers to potentially minimize re-traumatization. This affected one resident (#48) of one resident reviewed for post-traumatic stress disorder (PTSD). The facility census was 65. Findings include: Review of medical record for Resident #48 revealed an admitted [DATE]. Diagnoses included postconcussional syndrome, bipolar disorder, acute respiratory failure with hypoxia, acute kidney failure, type two diabetes and anxiety disorder. Review of modification of the quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #48 was cognitively intact and had not exhibited any signs or symptoms of delirium, psychosis, or rejection of care. Resident #48 was either was independent or required setup/clean up assistance with activities of daily living (ADLs). Review of a Trauma Informed Care Observation 2019.10.15, dated [DATE], revealed Resident #48's son died by suicide. When asked what triggers reminded her of the event, the resident replied seeing pictures of son and thinking about her grandchildren. When asked how she would react when she was reminded of the event, Resident #48 indicated she would cry. Review of a psychology note, dated [DATE], revealed Resident #48 had a history of trauma related to the loss of her son when he was 25. The note indicated her son's death was very traumatic for her. Review of the printed care plan, dated [DATE] and located in the hard chart, revealed Resident #48 had trauma related to her son dying by suicide. Approaches included to identify triggers and coping strategies for each trigger. Further review revealed no triggers or coping strategies had been identified on the care plan. Review of the care plan, initiated [DATE] and located in the electronic medical record (EMR), revealed Resident #48 had a history of trauma, with potential for re-traumatization, related to the loss of her son by suicide. Interventions included to allow the resident choices and encourage decision making, consult the psychologist/psychiatrist, involve family/physician as appropriate and involve in plan of care as resident is able. The care plan did not identify or address triggers to the event or coping strategies. Interview on [DATE] at 11:25 A.M. with Resident #48 revealed speaking about her son, or suicide in general, were triggers for her. Resident #48 was observed to have tears in her eyes while talking about her son's death. Resident #48 stated she did not typically tell people about her son's death and further stated losing a child before a parent was not in the scheme of things. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 12:06 P.M. with State tested Nursing Assistance (STNA) #551 revealed she was unaware of any residents who had a trauma history. STNA #551 stated she did not know where to go to find out if a resident had a history of trauma, what triggers the resident may have, or what coping strategies should be used to minimize re-traumatization. Interview on [DATE] at 12:08 P.M. with STNA #404 revealed he had no experience with residents who had a trauma history, did not know what residents had a trauma history or what strategies should be implemented to minimize re-traumatization. Interview on [DATE] at 12:30 P.M. Licensed Social Worker (LSW) #429 revealed a trauma assessment would be completed upon admission, and triggers/interventions would be care planned. LSW #429 stated she would verbally tell staff of any trauma, triggers and coping strategies. LSW #429 confirmed, since there were so many agency staff in the building, there likely were staff who did not know what residents had a trauma history, what may trigger a traumatic event, or coping strategies. LSW #429 confirmed Resident #48 had an identified traumatic event and her care plan did not address the resident's triggers. Interview on [DATE] at 1:04 P.M. with [NAME] President of Clinical Services (VPCS) #552 revealed the facility was transitioning from and old EMR platform to a new EMR platform. VPCS #552 stated the facility had a printed trauma informed care plan in Resident #48's hard chart. VPCS #552 further stated staff were to use both the printed care plan in the hard chart and the care plan in the EMR until the transition was complete. Upon review of the printed care plan in Resident #48's hard chart, VPCS #552 confirmed one of the approaches listed under the trauma informed care plan was to identity triggers. VPCS #552 verified no triggers were identified for Resident #48. Review of the facility policy titled Trauma Informed Care, revised [DATE], revealed the purpose of trauma informed care was to guide staff in appropriate and compassionate care specific to individuals who have experienced trauma, and trauma-informed care would be culturally sensitive and person-centered. The organization would develop an organizational culture that supported trauma-informed care.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 46195 Based on observation, resident interviews, staff interviews, review of staff schedules and punch detail, review of Resident Council meeting minutes and review of the facility assessment, the facility failed to have sufficient staff to meet the acuity needs of each resident. This affected two (#57 and #29) of two residents reviewed for staffing with the potential to affect all 41 residents residing on the 100 and 200 halls. The facility census was 65. Findings include 1. Interview on 08/14/24 at 9:20 A.M. with Registered Nurse Supervisor (RNS) #405 and State tested Nursing Assistant (STNA) #424 revealed there was one aide for 19 residents on the 100 hall and one aide for 22 residents on the 200 hall. RNS #495 and STNA #424 stated a third, unidentified, aide was assigned to the 100/200 halls but had been sent out with a resident for an appointment. STNA #424 stated showers were not being completed as scheduled but did not provide any specific resident who had not received care. RNS #405 stated she had to deal with staffing for an hour before she could start her medication pass this morning. Observation on 08/14/24 at 4:48 P.M. of the call light screen at the 200 hall nurse's station, which displayed how long a call light had been on, revealed Resident #57's call light had been on for 54 minutes. Interview on 08/14/24 at 4:52 P.M. with STNA #440 confirmed Resident #57's call light had been on for a long time. STNA #440 stated the call light had not been answered because a number of residents, who required two-person assistance, required care and there were not enough staff to answer the call lights. Interview on 08/14/24 at 4:53 P.M. with Resident #57 confirmed he had been waiting a long time for his call light to be responded to and needed assistance to use the restroom. Interview on 08/15/24 at 1:32 P.M. with STNA #400 revealed, at times, there was only one aide on the 100 hall and one aide on the 200 hall. STNA #400 stated when each hall only had one aide, there was not enough staff to assist with the residents' care needs. 2. Observation on 08/19/24 at 7:39 A.M. of the call light system screen at the nurse's station revealed Resident #29's call light had been on for 51 minutes. Subsequent interview with Resident #29 revealed the call light had been on for a while and she needed incontinence care. Resident #29 stated it usually took a while for call lights to be answered, with typical wait times being 30 to 45 minutes. Review of Resident Council meeting minutes from 08/17/23 to 07/25/24 revealed on 10/26/23, 11/20/23, 02/29/24 and 05/30/24 residents voiced concerns regarding STNAs being short staffed and long wait times for care. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/21/24 at 1:06 P.M., and concurrent review of the daily assignment and punch detail for 08/14/24, with Human Resources (HR) #403 revealed STNA #449 had been assigned to the 100 and 200 halls but had been sent out to an appointment with a resident. HR #403 verified until 10:38 A.M., when STNA #553 clocked in, there were only two STNAs to provide care for 41 residents on the 100 and 200 halls. Review of the Facility Assessment, dated 08/08/24, revealed the facility would provide adequate staff as evidence by the residents' needs being met and resident council review. The goal of staffing would be to meet resident needs and have happy residents.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on medical record review and staff interview, the facility failed to ensure non-pharmacological interventions were attempted prior to the administration of as needed (PRN) anti-anxiety medication. The facility further failed to document the effectiveness of PRN medication use or the rationale for extended use past 14 days for the PRN anti-anxiety medication. This affected one resident (#44) of five residents reviewed for unnecessary medications. The facility census was 65. Findings include: Review of the medical record for Resident #44 revealed an admitted [DATE]. Diagnoses included acute and chronic respiratory failure with hypercapnia, chronic obstructive pulmonary disease (COPD), morbid (severe) obesity, major depressive disorder and anxiety disorder. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/02/24, revealed Resident #44 had intact cognition, had delusions, rejected care four to six days of the look back period and received antidepressants during the seven day look back period. Review of the physician orders revealed orders for Alprazolam (anti-anxiety) oral tablet 0.5 milligrams (mg), to give one tablet by mouth twice daily, as needed, for anxiety until 07/22/25. Review of the Medication Administration Record (MAR) for July 2024 revealed Resident #44 was administered PRN Alprazolam (anti-anxiety medication) on 07/05/24, 07/06/24, 07/17/24, 07/24/24 and 07/26/24. On 07/05/24 and 07/06/24, there was no documented evidence of the effectiveness of the Alprazolam administered. Further review revealed no evidence of non-pharmacological interventions attempted prior to the administration of the PRN Alprazolam, with 07/24/24 and 07/26/24 documented as not applicable. Further review of Resident #44's medical records, including physician progress notes and psychiatry notes, revealed no documentation regarding the extended use of extending the PRN Alprazolam greater than 14 days. Interviews on 08/20/24 at 3:25 P.M. and 4:21 P.M. with interim Director of Nursing (DON) verified there was no evidence of non-pharmacological interventions attempted or the effectiveness of Alprazolam administered on the dates identified in July 2024. Additionally, the DON confirmed there was no evidence in Resident #44's medical record documenting the rationale for extending the PRN Alprazolam greater than 14 days.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, staff interview, Power of Attorney (POA) interview and medical record review, the facility failed to ensure residents were free of significant medication errors. This affected two residents (#17 and #28) of five residents reviewed for medication errors. The facility census was 65. Findings include: 1. Review of Resident #28's medical record revealed an admitted [DATE]. Diagnoses included seizures and muscle weakness. Review of Minimum Data Set (MDS) assessment, dated 06/20/24, revealed Resident #28 had intact cognition. Review of Resident #28's care plan, dated 06/21/24, revealed the resident was at risk for seizures. Interventions included administer medications as ordered. Review of the physician orders revealed Resident #28 was ordered Depakote (anti-seizure medication) 250 milligrams (mg) once a day and Depakote 500 mg once a day for a total of 750 mg in the morning, once a day. Review of progress note, dated 08/13/24 timed 10:45 A.M. and authored by the Director of Nursing (DON), revealed the nurse reported that Resident #28 received 1250 mg of Depakote during morning medication pass. The physician was updated, orders were clarified and blood work was ordered. Observation on 08/13/24 at 7:14 A.M. of medication administration with Licensed Practical Nurse (LPN) #488 revealed LPN #488 removed two 500 mg tablets of Depakote from the medication card and one 250 mg Depakote tablet. Continued observation revealed LPN #488 administered three Depakote tablets, totaling 1250 mg, to Resident #28. Observation of the Depakote medication cards had instructions that stated to administer a total of 750 mg. Interview with LPN #488 on 08/13/24 at 8:29 A.M. confirmed she had administered a total of 1250 mg of Depakote to Resident #28 and stated she had she thought the orders read to administer two 500 mg tablets and one 250 mg tablet of the Depakote. Interview on 08/15/24 at 11:12 A.M. with the DON revealed she had been made aware Resident #28 received an extra 500 mg of Depakote on 08/13/24. The DON stated she had informed the physician and received orders to monitor Resident #28 and obtain blood work as well as inform Resident #28's neurologist. 2. Review of Resident #17's medical record revealed an admitted [DATE]. Diagnoses included stoke, muscle weakness and aphasia (difficulty speaking). Review of MDS assessment, dated 07/18/24, revealed no cognition score due to the resident rarely being understood. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician orders for July 2024 revealed Resident #17 was ordered Percocet (narcotic pain medication) 5-325 milligrams (mg) every six hours for pain. Review of a progress note, dated 08/12/24 at 6:10 P.M. and authored by agency LPN #600, revealed while performing morning medication pass at 8:10 A.M., she observed on the Medication Administration Record (MAR) Resident #17's ordered Percocet showed as needing to be administered. LPN #600 administered the Percocet, along with Resident #17's other ordered medications. Upon review of Resident #17's narcotic sheets, LPN #600 discovered Resident #17's Percocet had been signed out by the previous nurse as being administered, however it had not been signed off as administered on the MAR. LPN #600 notified the physician as well as the Assistant Director of Nursing (ADON) promptly. Review of a progress note, dated 08/13/24 at 7:00 A.M. and authored by Registered Nurse (RN) #601, revealed Resident #17's Power of Attorney (POA) had been updated on Resident #17's status and was monitored closely for the last 24 hours. A telephone interview on 08/14/24 at 1:01 P.M. with Resident #17's POA revealed she received a phone call on 08/13/24 to inform her Resident #17 had received a double dose of his Percocet. Interview on 08/15/24 at 11:12 A.M. with the DON revealed she had not been made aware Resident #17 had received a double dose of Percocet. Review of progress notes with DON at time of interview revealed RN #601 was a corporate nurse and had not informed her of the medication error.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 46195 Based on observation, staff interviews, review of the facility menu, review of the dietary spreadsheet and review of facility policy, the facility failed to ensure the spreadsheet was followed for residents on a mechanically altered diet. This affected eight (#5, #7, #13, #29, #32, #46, #59 and #76) of eight residents identified by the facility as being on a mechanically altered diet. The facility census was 65. Findings include: Review of the menu for dinner service on 08/13/24 revealed the meal consisted of baked fish, tartar sauce, boiled red potatoes with parsley, creamed spinach and strawberry trifle. Review of dietary spreadsheet for dinner service on 08/13/24 revealed mechanical soft diets were to receive two ounces of baked fish with one ounce of broth or sauce, one tablespoon of mayonnaise (instead of tartar sauce), boiled white potatoes (in place of boiled red potatoes with parsley), creamed spinach and strawberry trifle. Observations on 08/13/24 between 4:25 P.M. and 5:43 P.M. revealed all residents received the same food items of fish with no broth, red potatoes with parsley, creamed spinach with long pieces of red onion (onion was approximately two inches long), two packets of tartar sauce and strawberry trifle. There was no observation of any broth or sauce for the fish, boiled potatoes with no parsley, creamed spinach without long pieces of red onion or mayonnaise on the tray line. Interview on 08/13/24 at 5:08 P.M. with Assistant Dietary Manager ADM #419, who plated the food during tray line, confirmed all residents received the same meal, regardless of diet texture. ADM #419 confirmed the meal served to residents on a mechanically altered diet included fish with no sauce or broth, red potatoes with parsley, tartar sauce and creamed spinach with onion. ADM #419 confirmed the pieces of onion were long and stated the recipe called for frozen onion but the facility did not have any so she cut up fresh white and red onion. Observation of a test tray on 08/13/24 at 5:51 P.M. with Registered Dietitian (RD) #481 revealed the creamed spinach had one, approximately two-inch slice, of red onion. RD #481 confirmed the fresh onion pieces were not appropriate for a resident on a mechanically altered diet. Upon review of the dietary spreadsheet, RD #481 verified the menu had not been followed for mechanically altered diets. Review of the facility policy titled Mechanically Altered Diet Explanation, revised 05/06/19, revealed fish must be very tender and moist and vegetables should be soft, well cooked, and chopped.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on resident interview, observation, review of the dietary meal ticket, staff interview and medical record review, the facility failed to ensure resident food preferences were honored. This affected one resident (#74) of two residents reviewed for food preferences. The facility census was 65. Findings include: Review of the medical record for Resident #74 revealed an admitted [DATE]. Diagnoses included acute osteomyelitis (bone infection) of the right ankle and foot, methicillin susceptible staphylococcus aureus (MRSA) infection, non-pressure chronic ulcer of right lower leg with fat layer exposed, hypertension, hyperlipidemia and heart failure. Review of the admission Minimum Data Set (MDS) assessment, dated 07/30/24, revealed Resident #74 had intact cognition and was independent with eating. Interview on 08/12/24 at 2:20 P.M. with Resident #74 revealed during her first week of admission, she spoke with the dietitian, the former Director of Nursing (DON) and Dietary Manager (DM) #444 regarding her diabetic diet and food preferences. Resident #74 stated she asked for oatmeal, eggs with cheese, yogurt and coffee for breakfast. Resident #74 stated these items were on her meal ticket, under preferences. Resident #74 stated dietary sent her whatever they had on the menu and did not honor her preferences. Observation on 08/14/24 at 9:08 A.M. of Resident #74's breakfast tray revealed the meal consisted of toast, egg quesadilla, oatmeal, mandarin oranges and coffee. Continued observation of Resident #74's meal ticket revealed preferences included add banana or other fresh fruit, add yogurt and scrambled eggs with cheese daily. Concurrent interview with Resident #74 revealed she felt the kitchen staff were not reading the preferences section of her meal ticket. Interview on 08/14/24 at 9:14 A.M. with DM #444 revealed she was familiar with Resident #74 and had visited her daily regarding her meals. DM #444 confirmed Resident #74's preferences could be accommodated and verified the resident's preferences were not honored.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46195 Based on observation, staff interview and review of facility policy, the facility failed to ensure dietary staff performed hand hygiene prior to handling food and beverage items. This had the potential to affect all residents who received food from the kitchen. The facility identified two residents (#53 and #63) as receiving nothing from the kitchen. The facility census was 65. Findings include: Observation on 08/13/24 from 4:25 P.M. to 5:43 P.M. of the dinner tray line revealed at 5:11 P.M., Dietary Aide (DA) #439 took the 200-hall cart out of the kitchen. DA #439 did not perform hand hygiene upon return to the kitchen at 5:13 P.M. DA #439 proceeded to restock a snack cart. Continued observation revealed at 5:27 P.M., [NAME] #447 took the 300-hall cart out of the kitchen. [NAME] #447 returned to the kitchen at 5:29 P.M., did not wash her hands, and proceeded to place plated food and beverages onto trays and then placed the trays into a food cart. Interview on 08/13/24 at 5:39 P.M. with Dietary Manager #444 confirmed DA #439 and [NAME] #447 should have washed their hands upon entry to kitchen. Review of the facility policy titled Handwashing/Hand Hygiene, revised August 2019, revealed all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors, Situations where handwashing/hand hygiene procedures were to be followed included before handling food.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, staff interview, family interview, medical record review and review of facility policy, the facility failed to ensure appropriate personal protective equipment (PPE) was donned prior to providing care to a resident on Enhanced Barrier Precautions (EBP) and further failed to ensure contact precautions were implemented timely for a resident identified with a transmissable infection. This affected two resident (#4 and #74) of two residents reviewed for infection control. The facility census was 65. Findings include: 1. Review of Resident #74's medical records revealed an admitted [DATE]. Diagnoses included osteomyelitis (bone infection) of the right ankle and foot and Methicllin Susceptible Staphylococcus Aureus (MRSA). Review of the care plan dated 07/25/24 revealed Resident #74 required enhanced barrier precautions (EBP) related to risk for infections related to indwelling medical device and a wound. Interventions included to don appropriate personal protective equipment (PPE) prior to providing care activities, including wound care and device care. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #74 had intact cognition. Resident #74 required extensive assistance with transfers and toileting. Review of physician orders dated 08/08/24 revealed Resident #74 was on EBP every shift for wound and intravenous (IV) care. Observation on 08/19/24 at 9:49 A.M. revealed Resident #74 had a sign posted outside of her room that indicated EBP and included to wear gown and gloves prior to entering. Continued observation revealed Licensed Practical Nurse (LPN) #492 entered Resident #74's room at 10:01 A.M. and stated she was going to administer Resident #74's IV antibiotics. LPN #492 did not don PPE prior to entering Resident #74's room or administering IV medication. Concurrent interview with LPN #492 revealed she was unaware she was to don PPE prior to administering IV medications. Interview on 08/19/24 at 10:10 A.M. with LPN #458 confirmed Resident #74 was on EBP and PPE was to be worn prior to performing wound care or administering IV medications. Review of facility policy titled Enhanced Barrier Precautions, undated, revealed residents with indwelling medical devices required the use of gown and gloves during resident care activities. 39969 2. Review of the medical record for Resident #4 revealed an admitted [DATE]. Diagnoses included encephalopathy, Alzheimer's disease and benign prostatic hyperplasia with lower urinary tract symptoms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS assessment, dated 07/29/24, revealed Resident #4 had impaired cognition, had no behaviors and was dependent on staff for toileting hygiene. Review of the care plan dated 08/08/24 revealed Resident #4 had a focus area for urinary tract infections (UTI). Interventions included administer antibiotic therapy as prescribed and monitor laboratory results. Review of the physician orders for August 2024 revealed orders for Cephalexin (antibiotic) capsule 500 milligrams (mg). Give one capsule by mouth every six hours for infection for seven days with a start date of 08/08/24 and an end date of 08/15/24. Interview on 08/12/24 at 4:30 P.M. with Resident #4's wife revealed the resident was being treated for a UTI; however, the facility had difficulties with getting laboratory (lab) results back and started the resident on antibiotics before the results were received. Review of a progress note dated 08/16/24 revealed Resident #4's urinalysis (UA) came back positive, waiting on the culture from the lab. Review of the lab results, reported on 08/18/24, revealed Resident #4's urinalysis culture was positive for vancomycin-resistant enterococci (VRE). Further review revealed patients with a positive test result should be placed in isolation or cohorted with other VRE carriers according to the institution's infection control practices. Review of a late entry progress note, dated 08/19/24, revealed Assisted Director of Nursing (ADON) #900 notified the physician of abnormal lab results. Awaiting instruction. Review of a the progress note dated 08/20/24 revealed Resident #4 was placed on contact precautions due to VRE in urine. Review of a physician order dated 08/20/24 revealed orders for contact precautions due to VRE, every shift. Interview on 08/20/24 at 3:44 P.M. with ADON #900 revealed Resident #4's lab results were received on 08/18/24. ADON #900 stated lab results were typically received via fax and nurses notify the physician for new orders, if needed. ADON #900 stated she was unsure who received the lab results when they were sent to the facility, but she was not made aware of them until 08/19/24. ADON #900 stated she called the physician, but he did not get back to her until today. ADON #900 stated a corporate nurse instructed her today to place Resident #4 in contact precautions due to being VRE positive. Interview on 08/20/24 at 4:05 P.M. with the interim Director of Nursing (DON) revealed the expectation would have been for staff to place Resident #4 in contact precautions when the lab results were reported and the resident was positive for VRE. Review of the facility policy titled Isolation-Categories of Transmission-Based Precautions, revised October 2018, revealed transmission based precautions are initiated when a resident develops signs and symptoms of a transmissible infection, arrives for admission with symptoms of an infection, has a laboratory confirmed infection and is at risk for transmitting the infection to other residents.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on medical record review, staff interview and review of the facility policy, the facility failed to ensure influenza and pneumococcal vaccinations were offered to all residents. This affected one resident (#4) of five residents reviewed for immunizations. The facility census was 65. Findings include: Review of the medical record for Resident #4 revealed an admitted [DATE]. Diagnoses included encephalopathy, Alzheimer's disease and benign prostatic hyperplasia with lower urinary tract symptoms. Review of the quarterly MDS assessment, dated 07/29/24, revealed Resident #4 had impaired cognition, had no behaviors, and was dependent on staff for toileting hygiene. Further review of the medical record revealed no evidence Resident #4 was offered or received influenza or pneumococcal vaccinations. Interview on 08/20/24 at 3:42 P.M. with the interim Director of Nursing (DON) verified the facility had no evidence Resident #4 was offered or received influenza or pneumococcal vaccinations. Review of the facility policy titled Pneumococcal Vaccine, revised October 2019, revealed prior to, or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series and, when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Review of the facility policy titled Influenza, Prevention and Control of Seasonal, revised August 2020, revealed all residents and staff are offered the vaccine prior to the onset of the influenza season. All residents and staff are encouraged to receive the vaccine unless there is a medical contraindication.