STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366435	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand The	4500 John Shield Pkwy Dublin, OH 43017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on record review and staff interview, the facility failed to ensure Beneficiary notices were provided timely to resident and or resident representative. This affected one Resident (#139) of three reviewed for beneficiary notices. Facility census was 92. Findings include Review of the medical record for Resident #139 revealed an admitted [DATE] and discharge date of [DATE]. Diagnoses included congestive heart failure, non-traumatic subarachnoid hemorrhage, weakness, dysphasia, diabetes and acute respiratory failure. Review progress notes dated 02/19/24 revealed notice of medicare non-coverage (NOMNC) was given with last day of coverage on 02/21/24. Progress note dated 02/22/24 revealed resident would be staying at facility and SNF ABN was issued. Review of the NOMNC dated 02/19/24 revealed the last covered day was 02/21/24 and was signed on 02/19/24. Review of the SNF ABN was signed and dated 02/24/24. Review progress notes dated 03/25/24 revealed notice of medicare non-coverage (NOMNC) was given with last day of coverage on 03/28/24. Progress note dated 04/04/24 revealed resident would be transferring to an assisted living. Review found no mention a SNF ABN was issued. Review of the NOMNC dated 03/25/24 revealed the last covered day was 03/28/24 and was signed on 03/25/24. Review of the SNF ABN revealed a verbal notification was given by Social Services #11 on 03/28/24. Interview on 07/09/24 at 10:00 A.M. and again at 10:25 A.M. with Social Services #11 and Corporate Social Services #171 confirmed the SNF ABN for Resident #139 was not provided timely. The staff confirmed the SNF ABN was provided on 02/22/24 after the residents covered days were over and on 03/28/24 on the resident's last covered day. (continued on next page)

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled, Advanced Beneficiary Notice of Non-Coverage (ABN), undated, revealed the notice must be reviewed with the resident/representative and provided with far enough in advance that the beneficiary or representative had time to consider the options and make an informed choice. The form must be delivered and signed and a copy provided to the beneficiary. The policy revealed the ABN section G must be selected by the beneficiary and section I should include a cursive signature which must be completed by the beneficiary.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on observation, record review and staff interviews, facility failed to ensure flooring was maintained in good condition affecting all 25 residents residing on the 200 hall (#5, #7, #8, #9, #11, #13, #15, #16, #19, #21, #23, #30, #39, #43, #45, #48, #49, #50, #51, #52, #57, #64, #66, #78, and #82). The facility also failed to ensure a homelike environment for one Resident (#13) of 32 residents reviewed. Facility census was 92. Findings include 1. Observation on 07/08/24 from 9:30 A.M. to 4:00 P.M. revealed several torn and frayed sections of carpet, as well as loose and wavy carpet in the 200 hall. Observation and interview on 07/11/24 at 9:00 A.M. with Unit Manager #33 confirmed the 200 hall was getting all new flooring but she was unsure of the details or timeline. Unit Manager confirmed carpet was torn and frayed with loose wavy spots. She stated they try to trim the frayed pieces to prevent an increased tripping hazard. Review of Safety Committee Meeting Minutes dated 03/06/24 revealed carpet in memory care and various other areas including unit B (200 Hall). with recommendation/action of contacted flooring company and waiting on a quote. Review of the flooring quote dated 05/12/23 revealed a quote was obtained for carpet repair/replacement on Hall B (200 hall) between room [ROOM NUMBER] to 218. Interview on 07/11/24 at 9:20 A.M. with Maintenance Director #60 revealed facility had identified an issue with the flooring and was going to be replacing it. Provided meeting communication from 03/06/24 he was going to look for updated communication. Review of email communication dated 07/11/24 at 9:27 A.M. between Maintenance Director #60 and Carpet repair company revealed they would come to facility and measure the halls. Interview on 07/11/24 at 9:20 A.M. with Maintenance Director (MD) #60 confirmed the initial problem was identified 03/2024 and a quote was received 05/2024. He revealed they have not yet done any replacement or repairs on the 200 (B) hall and they were working in a staged approach by completing memory care, and front entrance first. MD #60 was unable to provide any documentation that the entirety of the 200 (B) hall or the large sections of the 200 hall were going to be repaired/replaced as the only quoted areas was from room [ROOM NUMBER] to 218. He confirmed facility did not have a previous plan for full replacement/repair of 200 (B) hall and revealed the flooring company would be coming out for a quote possibly today. 2. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record for Resident #13 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis, kidney disease cerebral infarct, and vascular dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 was cognitively impaired with a BIMS of 7 and required moderate assistance for upper body dressing and dependence with lower body dressing. Review of the medical record found no evidence for why clothing would be hung up in the shower and not the closet. Observation on 07/08/24 at 10:04 A.M. revealed residents closet was less than 10% occupied and majority of residents clothing was hanging in the residents shower. Observation on 07/09/24 at 11:40 A.M. and 07/10/24 at 3:20 P.M. revealed residents clothes remained hanging up on the shower bar. Observation and interview on 07/11/24 at 8:47 A.M. with Licensed Practical Nurse #124 confirmed resident's closet had very little in clothing and had plenty of room to hang additional items. LPN #124 confirmed she was unsure why Resident's clothing was being hung in the shower. Observation and interview on 07/11/24 at 9:00 A.M. with Unit Manager #33 confirmed resident's closet had very little in clothing and had plenty of room to hang additional items. Unit Manager #33 confirmed she was unsure why Resident's clothing was being hung in the shower and confirmed it was not homelike environment. Review of facility policy titled, Homelike Environment, dated 09/21/23 revealed residents shall be provided with a safe and clean homelike environment. Any unresolved environmental concerns shall be reported to the administrator. This deficiency represents non-compliance investigated under Complaint Number OH00154630.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review, facility investigative document review, staff interview, and facility policy review, the facility failed to report an allegation of abuse to the state agency in a timely manner. This affected one (Resident #138) of two residents reviewed for abuse. The census was 92. Findings Include: Resident #138 was admitted to the facility on [DATE]. Her diagnoses were pain in left leg, morbid obesity, difficulty walking, post traumatic stress disorder, agoraphobia, insomnia, anxiety disorder, depression, chronic pain syndrome, mood disorder, and edema. Review of her minimum data set (MDS) assessment, dated 06/05/24, revealed she was cognitively intact. Review of facility Self Reported incident (SRI) number 248352, dated 06/06/24, found that Resident #138 made an abuse allegation against a staff member on 06/05/24. It was documented that the facility receptionist reported the allegation to the administrator on 06/05/24, but the allegation was not reported to the state agency until 06/06/24. Interview with Administrator on 07/10/24 at 11:02 A.M. confirmed she did not report the allegation of abuse until 06/06/24. She confirmed she was informed of the abuse allegation on 06/05/24. Review of facility Abuse Policy, dated 05/24/23, revealed the facility will ensure that all allegations involving abuse, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property, and crimes are reported immediately to the administrator and report to the state survey agency immediately but not later than two hours after the allegation is made if the allegation involves abuse or results in serious bodily injury and to other officials.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008 Based on record review and staff interview, the facility failed to provide a written notice of transfer to an acute care facility to the family and/or long-term care Ombudsman. This affected two of three residents (Resident #87 and Resident #51) reviewed for discharge. The facility census was 92. Findings include: 1. Review of Resident # 87's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including cerebral infarction, muscle weakness, malignant neoplasm of endometrium, cerebral ischemia, and malignant neoplasm of uterus. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that Resident #87 had a Brief Interview of Mental Status (BIMS) of 12 indicating a moderate cognitive impairment, and the resident was identified to be her own responsible party. Resident # 87 was transferred to the hospital on 05/21/24 and had not returned to facility. Resident #87's had no documentation indicating the Ombudsman was notified of the discharge and the facility was not able to provided documentation that the Ombudsman was notified in writing regarding Resident #87's discharge to the hospital. Interview on 07/11/24 at 1:36 P.M. with the Administrator confirmed the facility had no evidence that written notification of Resident #87's discharge to the hospital was sent to the long-term care Ombudsman. 44070 2. Review of the medical record for Resident #51 revealed an admitted [DATE]. Diagnoses included heart failure, respiratory failure, hypoxia, fracture of lower leg, and diabetes. Review of the MDS assessment dated [DATE] revealed Resident #51 was cognitively intact with a BIMS of 15. Review of progress note dated 06/21/24 at 7:16 A.M. revealed resident was having change in condition and complained of feeling weak, vital signs obtained as followed blood pressure 124/87, heart rate 56, respiration 20, pulse oxygen 79-88%. The physician was notified for stat labs and chest x-ray. Progress notes dated 06/22/24 revealed resident had been transferred to the hospital. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Interview on 07/09/24 at 4:30 P.M. with the Administrator revealed facility had no evidence of the Ombudsman notifications being completed and the Administrator stated she did not know when the Ombudsman last received notice of resident discharges. The Administrator stated she started in her position in January of 2024. Interview on 07/10/24 at 3:30 P.M. with Director of Nursing and Administrator confirmed facility had no evidence of written notification being provided to residents representatives. Review of facility policy titled, transfers and discharge, dated 11/03/23, revealed facility shall provide to resident/representative and ombudsman a copy of the transfer/discharge notice.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008 Based on medical record review, staff interview and policy review, the facility failed to develop a comprehensive care plan to address a residents nutritional risk and significant weight loss. This affected one (#61) out of 22 residents reviewed for care plans. The facility census was 92. Findings include: Review of the medical record for Resident #61 revealed an admitted [DATE]. Diagnoses included myasthenia gravis, morbid obesity, severe protein calorie malnutrition, gastrostomy status, muscle weakness, chronic obstructive pulmonary disease, narcolepsy, dysphagia, acute respiratory failure, anxiety disorder. Review of the Nutrition assessment dated [DATE] revealed that Resident #61 had a past medical history of severe protein calorie malnutrition (PCM), and was at risk of malnutrition as evidenced by dysphagia and the need for alternative means of nutrition. Review of nutrition progress note from 05/08/24 revealed that Resident #61 had lost 76.8 pounds in three months, which was a 29.3% significant weight loss. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 05/22/24, revealed the resident had intact cognition with a Brief Interview of Mental Status (BIMS) score of 15 out of 15 (no impairment) and no documented behaviors. Review of the MDS dated [DATE] revealed that Resident #61 has lost over 10% of her body weight in six months. Review of medical record for Resident #61 revealed there was no care plan addressing her risk of alteration in her nutrition status or the resident's significant weight loss. Interview with Clinical Dietitian #122 on 07/09/24 at 4:53 P.M. revealed that if a resident had a weight loss, the weight loss would be identified as a concern on her nutrition care plan, and the goals and interventions would subsequently be updated. Clinical Dietitian #122 confirmed that Resident #61 did not have an active nutrition care plan since 03/13/24. Review of the policy tilted Care Plan Comprehensive and Revision revised on 08/25/23, revealed a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan is developed within seven days of the completion of the required MDS assessment (Admission, annual or significant change in status) and no more than 21 days after admission. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. When possible, interventions addressing the underlying source of the problem area, not just symptoms or triggers. Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on medical record review, review of a podiatry schedules, observations and staff, resident and resident representative interviews, the facility failed to provide a resident with timely podiatry services. This affected one (#67) of three residents reviewed for ancillary services. The facility census was 92. Findings include: Review of Resident #67's medical record revealed an admitted [DATE] with diagnoses of muscle weakness, Parkinson's disease, dementia, unsteadiness on feet, and acute kidney failure. Review of the care plan for Resident #67 dated 02/17/24 revealed the following actions: educate the resident to communicate their appointment needs with nursing and social services as required; and review resident preferences or identify responsible parties to arrange appointments. Review of Minimum Data Set (MDS) 3.0 assessment completed 07/07/24 revealed Resident #67 was cognitively intact and required a walker or wheelchair for mobility. Review of Resident #67's physician orders dated 08/17/23 revealed he may receive dental, vision, audiology, and podiatry through Ancillary Services Provider #09. Review of the request for services dated 04/29/24 completed by Director of Nursing revealed Resident #67 requested to see the podiatrist due to thickened, dystrophic, and/or painful nails with an increased risk of infection. Review of the podiatry group schedule dated 06/10/24 revealed Resident #67 was scheduled to be seen on 06/10/24; however, the podiatry group ran out of time. Resident #67 was rescheduled to be seen on 07/08/24, where again, the podiatry group ran out of time. Resident #67 was eventually seen on 07/10/24. Review of the podiatry group schedule revealed Resident #67 was scheduled to be seen on 07/08/24 but was unable to be seen until 07/10/24. Interview conducted on 07/08/24 at 11:30 A.M. with Resident #67 revealed concerns about not seeing the podiatrist on 07/08/24 during his scheduled visit. Resident #67 expressed frustration due to the failure to complete ancillary services as requested by him, his wife, and daughter. Observation of Resident #67's foot with a sock on revealed protruding toenails. Interview conducted on 07/10/24 at 9:55 A.M. with the DON confirmed Resident #67 was unable to be seen by the contracted podiatrist group for 10 weeks. DON confirmed Resident #67 did not receive timely ancillary services due to poor availability of the podiatry group. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview conducted on 07/11/24 at 10:32 A.M. with Resident #67's family members and Resident #67 voiced concerns regarding physician communication and timely response to requests to see ancillary services. Resident #67 confirmed a request for podiatry services was made at the end of April due to long toenails. Resident #67 confirmed he was not seen in a timely manner.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49039 Based on record review, review of video recording, staff and resident representative interviews, review of a user manual and policy review, the facility failed to ensure a resident was provided with an adequate amount of assistance while being transferred with a sit-to-stand lift. This affected one (#14) out of one residents reviewed for assistance with sit-to-stand lifts. The facility census was 92. Findings Include: Review of Resident #14's medical record revealed admission on 12/05/23 with diagnoses including chronic obstructive pulmonary disease, Parkinson's disease, hemiplegia, unsteadiness on feet, visual disturbances, and heart failure. Review of Resident #14's Minimum Data Set (MDS) 3.0 assessment completed on 04/04/24 indicated the resident required a wheelchair for mobility and maximum assistance for transfers. Review of Resident #14's physician orders dated 12/06/23 included an order to use a mechanical lift for transfers. Review of Resident #14's care plan dated 07/10/24 indicated the resident requires a mechanical lift with two-person assist. An interview on 07/10/24 at 3:32 P.M. with Resident #14's family revealed a concern regarding a transfer involving the sit-to-stand list, supported by a video from 07/09/24 at 7:30 P.M. showing an aide assisting Resident #14 back into bed alone. Observation of this video on 07/10/24 at 4:05 P.M. revealed State tested Nursing Assistant (STNA) #151 using a sit-to-stand lift to transfer Resident #14 from a wheelchair to bed. During the transfer, Resident #14 almost hit his head on the lateral bar when being placed back into bed. Review of the video confirmed STNA #151 conducted the transfer with Resident #14 alone. Interview on 07/10/24 at 4:25 P.M. with the Administrator confirmed viewing the video and acknowledged that STNA #151 should not have conducted the mechanical lift transfer without additional assistance. The Administrator committed to educating the staff member on proper lifting procedures. Interview on 07/11/24 at 8:43 A.M. with STNA #23 confirmed two staff members are required to conduct a safe transfer using the mechanical lift. STNA #23 also confirmed being the only aide on the unit during that shift. Interview on 07/11/24 at 3:52 P.M. with STNA #151 confirmed facility policy requires two staff members for transfers. STNA #151 explained that the nurse was unavailable due to medication administration and the other STNA in the hallway could not assist due to other duties. STNA #151 confirmed she transferred Resident #14 by herself. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Kwikpoint safety guide indicated that most lifts require two or more caregivers to safely operate and handle patients. Review of Hoyer Lift/Mechanical Lift policy revised 05/13/24 revealed two staff are required to operate the lift.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review, and resident and staff interviews, the facility failed to re-assess, monitor and notify the physician following a resident's significant weight loss. This affected one (#21) of three residents reviewed for nutrition. The census was 92. Findings include: Resident #21 was admitted to the facility on [DATE]. Diagnoses were chronic obstructive pulmonary disease, mental disorder, type II diabetes, repeated falls, hyperlipidemia, anxiety disorder, autistic disorder, pain, seborrheic dermatitis, depression, and vitamin D deficiency. Review of his minimum data set (MDS) assessment, dated 05/21/24, revealed Resident #21 was cognitively intact. Review of Resident #21 weights, dated 01/03/24 to 07/02/24 found that he lost a total of 22.6 pounds, which equated to 16.7% loss in six months. Also, within this given time period, significant weight loss moments included: from 03/06/24 to 04/15/24, he lost 11.4 pounds (8.4% in 30 days). Review of Resident #21 nutritional and nursing notes, dated 01/01/24 to 07/10/24, revealed no evidence that any points of significant weight loss were reported to the physician. Also, there was no documentation to support a root cause analysis was done to attempt to find a reason for Resident #21 losing weight. According to nutritional notes, dated 01/04/24 to 05/08/24, revealed a noted decline in Resident #21's weight, but his meal intakes were documented between 76-100%. There was no documentation to support medical exams, laboratory tests, or other medical and nutritional reviews were completed to attempt to find the reasoning for his significant weight loss. Interview with Resident #21 on 07/09/24 at 8:25 A.M. confirmed he has lost a significant amount of weight in the last six months and he didn't want to. Resident #21 stated he does not like the food in the facility, so he will buy his own food for the vast majority of his meals. Resident #21 stated he is not aware of any medical conditions as to why he would lose a significant amount of weight. Interview with Dietitian #122 on 07/10/24 at 2:30 P.M. stated she has only been at the facility for a little over a month and was getting to the point to do a deep research of all residents with significant weight loss, including Resident #21. Dietician #122 stated in the last 30 days, Resident #21 has eaten between 0-100%. Dietician #122 also stated Resident #21 buys his own food to eat for each meal. Dietician #122 stated Resident #21 also refuses all supplements and medications that could be ordered to stabilize his weight. Dietician #122 stated she was not sure if the physician was notified of his significant weight losses since she was not the dietitian in previous months. Interview with Corporate Dietitian #123 on 07/10/24 at 2:45 P.M. and 07/11/24 at 9:18 A.M. revealed they had questions about the accuracy of the weights the last few months. On 05/01/24, they put new procedures in place to make sure the weights were accurate. Corporate Dietician #123 confirmed there was no documentation to support Resident #21's weight loss; they are not sure why he is losing so much weight. They would have to speak with the nursing staff about medical reasons why he was losing weight. (continued on next page)

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	366435	A. Building B. Wing	07/11/2024

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Grand The	4500 John Shield Pkwy Dublin, OH 43017

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Director of Nursing (DON) on 07/11/24 at 9:18 A.M., 9:32 A.M., and 11:10 A.M. revealed she can not find a reason why Resident #21 has lost so much weight. The DON confirmed there is no documentation the physician was notified of the significant weight loss, but they have offered nutritional supplements, medications, and other interventions to stabilize his weight, and Resident #21 has declined them. The DON believed Resident #21 would benefit from being in an assisted living/more independent living location where he can dictate his eating patterns more. The DON confirmed Resident #21 is scheduled to be discharged to an assisted living in the next week. The DON confirmed Resident #21 has lost a significant amount of weight in the last six months, and there was no reasoning for it (based on documentation of meal intakes provided by direct care staff.)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008 Based on medical record review, observations, staff, resident and resident representative interviews and policy review, the facility failed to manage a resident's complaints of pain. This affected one (#73) of three residents reviewed for pain management. The facility census was 92. Findings include: Review of the medical record for Resident #73 revealed an initial admitted [DATE]. Diagnoses included dementia unspecified severity with agitation, need for assistance with personal care, moderate protein calorie malnutrition, metabolic encephalopathy, personal history of healed traumatic fracture, anxiety disorder, unspecified hearing loss bilateral, unspecified mood disorder. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 07/03/24, revealed Resident #73 had unclear speech, impaired cognition with no Brief Interview of Mental Status (BIMS) score due to the resident being rarely or never understood. Review of Resident #73's care plan dated 07/07/23 revealed the resident was at risk of impaired comfort related to surgical diagnoses and post-op care. Resident #73's goal was that episodes of pain would be relieved within one hour of intervention for 90 days. Resident #73's interventions listed were to administer pain medication as ordered and monitor for effectiveness; assess for verbal and non-verbal signs of pain and treat accordingly; encourage and assist to rest after pain medication given to help facilitate relief; encourage to report pain as soon as it starts; monitor/ record/ and report to nurse resident complains of pain or requests for pain treatment; and pain assessment on admission, quarterly, and as needed. Review of nursing progress note signed on 07/08/24 at 12:40 A.M. revealed that Resident #73 complained of left shoulder pain. The progress notes indicated that the Certified Nurse Practitioner (CNP) was called and that she gave an order for an x-ray. Review of physician orders revealed that Resident #73 was ordered to have his left shoulder x-rayed with two views due to pain on 07/08/24. Review of Resident #73's medical record revealed there was no documentation regarding any pharmological and/or non-pharmological interventions for pain on 07/08/24 and 07/09/24. Review of Resident #73's pain assessment signed on 07/09/24 at 7:52 P.M. revealed that when Resident #73 was asked, Have you had pain or hurting at any time in last 5 days?, the staff member indicated that Resident #73 was unable to answer. Review of orders for Resident #73 revealed a physician's order for Acetaminophen ER Oral Tablet Extended Release 650 MG, one tablet by mouth every six hours as needed for pain was ordered on 07/10/24 at 11:45 A.M. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #73 on 07/08/24 at 1:45 P.M. revealed the resident was making vocalizations and grimacing. Observations of Resident #73 on 07/08/24 from 1:45 P.M. to 2:16 P.M. revealed the Resident #73 was calling out and unable to vocalize his concerns in English. Observations revealed n caregivers addressed Resident #73's pain concerns during the observation. Interview with Resident #73 and Resident's son and Resident #73's Representative, who was interpreting for Resident #73, on 07/09/24 at 5:32 P.M. revealed Resident #73 had been experiencing pain on 07/08/24 and 07/09/24. Via Resident #73's son, who was interpreting, Resident #73 stated that he had pain in his left shoulder, his left elbow and his left upper thigh. Resident #73's Representative stated that he believed that his father was receiving Tylenol pain reliever and Resident #73's Representative would like for him to have a stronger pain medication. Interview with MDS Coordinator/Licensed Practical Nurse (LPN) #48 on 07/10/24 at 10:47 A.M. revealed Resident #73's family has not given the facility an update on how resident communicates his pain to the facility. Interview with Unit Manager #33 on 07/10/24 at 11:00 A.M. confirms Resident #73 had pain on 07/08/24 and 07/09/24 and confirmed Resident #73 had not received any pain medication during that time. Unit Manager #33 revealed that Resident #73's family members have not communicated a way that resident communicates his pain non-verbally. Review of a facility policy titled Pain Management, dated 02/14/23 revealed it is the facilities policy to recognize and manage resident's pain in order to assist residents to attain and/or maintain his or her highest practicable level of well-being and to prevent or manage pain, to the extent possible. The staff will recognize, evaluate and manage pain in patients and residents who are being treated for pain or have the potential to have pain symptoms. It is the facilities responsibility to assist with pain relief.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 47059 Based on staff interviews and review of daily staffing postings the facility failed to identify a licensed charge nurse in the facility for all tours of duty. Findings include: Review of the daily staffing postings for June 2024 and July 2024 revealed there is no designated charge nurse for the 7:00 A.M. - 7:00 P. M. shift on weekends (Saturday and Sunday) or any observed holidays (i.e. Memorial Day and the 4th of July). The sheets simply say see on call list at front desk. Interview on 07/11/24 at 7:20 A.M. with the Director of Nursing (DON) confirmed the nightshift supervisor is the charge nurse from 7:00 P.M. to 7:00 A.M. The DON confirmed the day shift charge nurse Monday through Friday is the unit manager. The DON stated on weekends and holidays the on-call manager is the day shift charge nurse and is available by phone. There is always a manager on duty scheduled and always a nurse on-call. The posting at the nurse's stations and front desk always lets them know who to call. Interview on 07/11/24 at 10:05 A.M. with state tested nursing assistant (STNA) #133 revealed if there was a concern that the nurse on the unit was not addressing resident concerns raised by STNA #133 she would simply call or text the unit manager. When asked if she knew who the charge nurse was or how to reach the charge nurse with concerns, STNA #133 indicated there is a list of who is on-call at the desk, but she would still simply text or call the unit manager with concerns. Interview on 07/11/24 at 10:30 A.M. with the DON revealed there is no job description for a charge nurse. The DON indicated all nurses are in charge of their units so any nurse can be considered a charge nurse.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47059 Based on review of staffing schedules and staff interview, the facility failed to ensure there was a registered nurse (RN) on duty for at least eight consecutive hours a day, seven days a week as required. This has the potential to affect all 92 residents residing in the facility. The facility census was 92. Findings include: Review of the staff schedules for 2024 to the current date revealed there was no RN scheduled in the facility on 01/14/24 (Sunday), 02/25/24 (Sunday), 03/23/24 (Saturday), 03/24/24 (Sunday). 03/29/24 (Friday and RN unit manager was on vacation), 06/29/24 (Saturday), and 06/30/24 (Sunday). Interview on 07/11/24 at 7:20 A.M. with the Director of Nursing (DON) confirmed the DON and unit managers were not aware that there was a regulation that states there needs to be a RN in the facility and available for resident care eight consecutive hours a day seven days a week. Interview on 07/11/24 at 10:00 A.M. with the DON confirmed the above dates did not have a RN on duty for at least eight consecutive hours.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47059 Based on observations, staff interviews, record review and policy review, the facility failed to ensure staff implemented the medication administration policy to administer medications for one resident at a time. This affected five residents (Residents #7, #19, #23, #39 and #51) who were incidentally observed outside of the six residents formally observed for medication administration. The facility census was 92. Findings include: 1. Observation on 07/09/24 at 12:32 P.M. of licensed practical nurse (LPN) #9 revealed the nurse brought three cups of pills stacked within each other and each labeled with a resident room number on the cup. Interview on 07/09/24 at 12:33 P.M. LPN #9 confirmed the nurse typically passed afternoon medication this way (stacking cups and bringing them all at once) due to most residents being out at the dining area for lunch. LPN #9 confirmed residents who received these cups of pills included Resident #19, #39, and #51. LPN #9 revealed she was not sure what medication was in each cup, but the medications were documented as given in the computer for Resident #19, #39 and #51. Review of the medical record for Resident #19 revealed Resident #19 was admitted on [DATE] with diagnoses of chronic kidney disease stage 4, heart failure, osteoporosis, vascular dementia, type 2 diabetes mellitus, and is on palliative care. Review of Minimum Data Set (MDS) 3.0 quarterly assessment completed 06/10/24 revealed Resident #19's cognitive function was not assessed. Further record review revealed Resident #19's lunch time medications on 07/09/20 were documented as given which included hydrocodone-acetaminophen 5-325 milligrams (mg). Review of the medical record for Resident #39 revealed Resident #39 was admitted on [DATE] with diagnoses of multiple sclerosis, cognitive communication deficit, displaced comminuted fracture of left fibula, three-part fracture of right humerus, diverticulosis, anxiety disorder, depression, and is on hospice care. Review of MDS 3.0 significant change assessment completed 07/01/24 revealed Resident #39's cognitive function was minimally impaired. Further record review revealed Resident #39's lunch time medication on 07/09/24 were documented as given which included Mometasone Furoate External Cream 0.1% and there was no oral medication documented. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record for Resident #51 revealed Resident #51 was admitted on [DATE] with diagnoses that included heart failure, respiratory failure with hypoxia, nondisplaced tri malleolar fracture of the left lower leg, type 2 diabetes mellitus, seborrheic keratosis, chronic pain syndrome, anxiety disorder, and major depressive disorder. Review of MDS 3.0 quarterly assessment completed 06/30/24 revealed Resident #51 was cognitively intact. Further record review revealed Resident #51's lunch time medications on 07/09/24 were documented given which included ferrous sulfate 325 mg, gabapentin 600 mg, potassium chloride 20 milliequivalent's (mEq), and tizanidine 4 mg. 2. Observation and interview on 07/11/24 at 8:47 A.M. with LPN #124 revealed two separate medication cups were made out and filled with morning medications. LPN #124 then walked to Resident #7's room with both cups of pills. Then LPN #124 walked to Resident #23's room and returned to the medication cart with one cup of pills in hand. LPN #124 confirmed she had two cups of pills made out at the same time with no labeling. LPN #124 revealed she was making up the medication cups while waiting for residents to come out for breakfast and stated she can make up different types of medication cups if residents have pills and liquids but confirmed neither Resident #7 nor #23 were given any liquid medications. Interview on 07/11/24 at 7:20 A.M. with the Director of Nursing (DON) confirmed that medications should be dispensed, given, and documented one resident at a time. Review of the medical record for Resident #7 revealed the resident was admitted on [DATE] with diagnoses of muscle wasting, disorders of bone density, dementia, and hypertension. Review of MDS 3.0 quarterly assessment completed 05/15/24 revealed Resident #7 was cognitively impaired with significant memory issues. Further review of Resident #7's medical record revealed morning medications on 07/11/24 were documented as given at 9:00 A.M. which included allopurinol 300 mg, cholecalciferol 1000 units, Nifedipine ER 90 mg, PreserVision 1 capsule, Apixaban 2.5 mg, and acetaminophen 650 mg. Review of medical Record for Resident #23 revealed Resident #23 was admitted on [DATE] with diagnoses that included heart failure, pulmonary embolism, edema, thrombosis of deep vein, chronic pain syndrome, and long-term use of anticoagulants. Review of MDS 3.0 quarterly assessment completed 06/30/24 revealed cognition was not assessed. Further review of Resident #23's medical record revealed morning medications on 07/11/24 were documented as given at 9:00 A.M. which included calcium-vitamin D 600-400 mg-unit, FerrouSul 325 mg, and Lasix 40 mg. Review of the policy titled Medication Administration dated 08/07/2023 revealed the outline of a procedure to verify, dispense, administer, and document medication administration for one resident at a time.

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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** 47059 Based on observation, staff interview, and review of the policy for medication storage, the facility failed to ensure medications were secure from the time they were dispensed until the medications were administered. This affected one (#67) of one residents observed during the annual survey with medications left unattended at the bedside. The facility census was 92. Findings include: Review of the medical record for Resident #67 revealed he was admitted on [DATE] with diagnoses of Parkinson's disease, muscle weakness, cognitive communication deficit, dementia, depression, and anxiety. Review of Minimum Data Set (MDS) 3.0 quarterly assessment completed 06/07/24 revealed Resident #67 was cognitively intact. Review of baseline admission evaluation completed 07/12/23 revealed Resident #67 was unable to self-administer medication. Review of Resident #67's physician's order for citalopram hydrobromide oral tablet 10 milligrams (mg) (citalopram hydrobromide) give 0.5 tablet by mouth one time a day for depression, scheduled for 9:00 A.M. Orders found Carbidopa-Levodopa Oral Tablet 25-100 mg give one tablet three times a day for Parkinson. Resident #67 did not have orders for self-administration of medications. Observation on 07/10/24 at 9:38 A.M. of Resident #67 room revealed two medications were left at bedside, those medications were identified as carbidopa-levodopa and citalopram hydrobromide. Interview on 07/10/24 at 9:38 A.M. with Licensed Practical Nurse (LPN) #111 in Resident #67's room confirmed medications were left unattended with the spouse in the room. LPN #111 confirmed this was not a part of standard nursing practice. Interview on 07/11/24 at 7:20 A.M. with the Director of Nursing (DON) confirmed that medications should not be left in the resident's room to take later unless the resident has been assessed to self-medicate. Review of the policy titled Medication and Treatment Storage dated 08/07/2023 revealed all medications are to be kept secured in a locked compartment unless under direct supervision of the nurse administering the medications.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47059 Based on medical record review, review of a hospice communication book/binder and staff interviews, the facility failed to ensure timely communication was occurring between hospice staff and facility staff. This affected one (#35) out of one residents reviewed for hospice care. The facility census was 92. Findings include: Review of medical records for Resident #35 revealed the resident was admitted on [DATE]. Diagnoses include malignant neoplasm of the colon, malignant neoplasm of liver and intrahepatic bile duct, colostomy, basal cell carcinoma of skin, anxiety disorder, chronic kidney disease, atherosclerotic heart disease, chronic pain syndrome, osteoarthritis, hypotension, and history of transient ischemic attack (TIA) and cerebral infarction. Review of Minimum Data Set (MDS) 3.0 Quarterly assessment completed 06/20/24 revealed Resident #35 was cognitively intact. Resident #35 has a limited range of motion on one side of the body for both upper and lower extremities, has a colostomy present, and is on hospice care. Review of Resident #35's medical record revealed the resident was admitted to hospice services on 06/06/24. The record review revealed there was no documentation regarding communication of hospice services for Resident #35 since admission to hospice. Review of the hospice communication book/binder for Resident #35 revealed the only documentation in the book/binder was the admission to hospice plan documentation and plan of care dated 06/06/24. Interview on 07/10/24 at 4:33 PM with Registered Nurse (RN) #131 confirmed there is a notebook at the desk with hospice documentation and communication. RN #131 confirmed the documentation in the notebook reflected the admission to hospice visit and hospice plan of care dated 06/06/24. RN #131 stated the hospice RN was here to see Resident #35 today but agreed there was no documentation in the notebook to reflect any hospice visits. Interview on 07/10/24 at 4:45 P.M. with the Director of Nursing (DON) confirmed there are no hospice notes in the notebook or Resident #35's chart since the admission to Hospice. The DON stated the hospice staff verbally communicate with the nurse on the unit, the unit manager, and the DON on a regular basis as well. DON stated she has requested the notes be faxed to the facility today.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on record review, staff interviews, and facility policy review, the facility failed to implement their antibiotic stewardship program to ensure infections and antibiotics were ordered appropriately. This affected one (#42) of two residents reviewed to proper antibiotic usage. The facility census was 92. Findings include: Review of the medical record for Resident #42 revealed an admitted [DATE] with diagnosis of chronic obstructive pulmonary disease, type two diabetes mellitus, hypertension, muscle weakness, anxiety and diverticulitis. Review of Minimum Data Set (MDS) 3.0 assessment completed 03/07/24 revealed she required maximum assistance with toileting and was frequently incontinent. Review of Resident #42's care plan dated 03/01/24 outlined monitoring and documenting signs and symptoms of urinary tract infection (UTI), including pain, blood-tinged urine, cloudiness, decreased output, urine color changes, increased temperature, and altered mental status. Review of progress note dated 04/19/24 revealed Resident #42 was observed talking to persons that were not in the resident's room and talking about objects that were not there . new orders for UA received. Review of change in condition evaluation completed 04/19/24 revealed Resident #42 exhibited a change in mental status, a temperature of 97 degrees Fahrenheit and was ordered to obtain a urinalysis. Review of physician progress note dated 04/22/24 revealed Resident #42 had increased confusion, culture was pending and started on Bactrim. Review of Resident #42's physician orders dated 04/22/24 revealed she was receiving Bactrim DS (antibiotic) 800-160 milligrams tablet two times a day for UTI with an end date of 04/29/24. Review of the Medication Administration Record revealed this antibiotic course was completed. Review of Resident #42's vitals from 04/19/24 to 04/29/24 revealed she had pain on 04/24/24 at 7/10, on 04/24/24 at 3/10 and on 04/28/24 at 4/10. Review of temperature record from 04/19/24 to 04/29/24 revealed no concerns for increased temperature. Review of lab results report reported 04/24/24 revealed Resident #42 yeast presence in urine with no microorganisms detected. Review of infection control logs from 04/01/24 to 04/30/24 confirmed Resident #42 was treated for a UTI with Bactrim, despite no microorganism presence in the urine culture. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Society for Healthcare Epidemiology of America ([NAME]) infection criteria for surveillance of infections dated 04/29/24 for Resident #42 revealed the resident did not meet the criteria for a UTI requiring antibiotics. The criteria for a resident both #1 and #2 must be present. Resident #42 only met #1 where it was indicated she had acute dysuria or acute pain. No additional concerns regarding UTI were found. Interview on 07/11/24 at 12:52 P.M. with Director of Nursing (DON) confirmed Resident #42 did not meet [NAME] criteria for antibiotic initiation. DON also confirmed that Resident #42 did not exhibit additional symptoms such as fever or blood in urine. DON confirmed Resident #42's urinalysis on 04/24/24 showed no organisms, indicating the antibiotic was unnecessary. However, Resident #42 remained on the antibiotic due to transitioning to hospice care. Review of Antibiotic Stewardship policy dated 12/26/23 revealed it's the center's policy to maintain an antibiotic stewardship program with the mission of promoting the appropriate use of antibiotics to treat infections. Actions included utilizing the [NAME] criteria when considering the initiation of antibiotics.