STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366448	A. Building B. Wing	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe County Operating Inc	47045 Moore Ridge Road Woodsfield, OH 43793

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 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** 32801 Based on medical record review and staff interview, the facility failed to ensure resident assessments were completed accurately on admission. This affected one (Resident #14) of three residents reviewed for accuracy of assessments. The facility census was 37. Findings include: Record review revealed Resident #14 was admitted to the facility on [DATE] with diagnoses including femur fracture, left wrist fracture, cirrhosis, esophageal varices, pancytopenia, and hypertension. Review of Resident #14's hospital discharge summary dated 05/07/24 revealed no evidence the resident had pressure ulcers. Review of Resident #14's admission history of physical dated 05/07/24 revealed no evidence the resident had pressure ulcers. Review of Resident #14's nursing admission assessment dated [DATE] revealed the resident had a surgical incision (right wrist and right hip), scattered bruising throughout the body. The note indicated the resident had no other skin issues noted. Review of Resident #14's five-day admission Minimum Date Set (MDS) 3.0 dated 05/11/24 revealed the resident had one Stage II pressure ulcer that was present upon admission/entry or reentry. Interview on 07/10/24 at 3:00 P.M., with Registered Nurse (RN) #180 confirmed the five day admission MDS was inaccurately due to the resident did not have a pressure ulcer upon admission. The RN reported the MDS nurse was contracted and obtained information from the resident's medical record and staff interviews. The MDS nurse does not make on-site observations. This deficiency represents non-compliance investigated under Master Complaint Number OH00155046 and Complaint Number OH00154208.

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 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 32801 Based on closed and open medical record review, hospital record review, review of patient handout information from Medscape.com, emergency medical services (EMS) records, policy review and interviews the facility failed to provide comprehensive, resident centered care to adequately manage and prevent worsening of cardiac conditions for Resident #50. This resulted in Immediate Jeopardy and serious life-threatening harm/death for Resident #50, who was admitted to the facility on [DATE] with a history of chronic heart failure, cardiomyopathy, ventricular tachycardia (with an implanted defibrillator), atrial fibrillation, hypertension, and hypokalemia (low blood potassium level) when the resident did not receive the correct physician ordered dose of diuretics or antiarrhythmic medications for his cardiac conditions upon admission to the facility. The resident also did not receive comprehensive, individualized care for his extensive cardiac history including monitoring for fluid volume overload (intake and output), monitoring of weights and use of anti-embolism stockings, related to congestive heart failure. Despite the resident's known history of hypokalemia, no potassium supplement was ordered on admission to the facility. Potassium supplements were ordered once the facility identified the resident had a critical (low) potassium level; however, the resident experienced vomiting after meals. The physician and/or certified nurse practitioner (CNP) were not notified of the resident's declining condition. On [DATE] the resident was found unresponsive. Cardiopulmonary resuscitation was initiated, however unsuccessful, and the resident passed away. Per the coroner's report the resident's cause of death was cardiopulmonary failure due to coronary artery disease and cardiomyopathy in addition to the significant condition of hypertension. In addition, a concern that did not rise to Immediate Jeopardy occurred when facility failed to ensure Resident #14 was provided a comprehensive, resident centered status-post surgery treatment plan upon admission to the facility and failed to provide wound care as ordered. This affected two residents (#14 and #50) of three residents reviewed for appropriate care and services. The facility census was 37. On [DATE] at 4:48 P.M. the Business Office Manager, Social Service Designee #145, Regional Director of Operation #700, [NAME] President of Clinical Operation #701, and Registered Nurse (RN)/Regional Director of Clinical Operations #180 were notified Immediate Jeopardy began on [DATE] when the facility failed to ensure Resident #50's admission physician orders were clarified regarding discrepancies with the resident's diuretic medication, Torsemide and the resident's prescribed anti-arrhythmic medications, Amiodarone and Mexiletine, resulting in the medications not being administered and/or not being administered as ordered. Additionally, the resident did not receive comprehensive, individualized care for monitoring of known extensive cardiac history including obtaining resident weights and intake and output daily. The resident's family requested lab work due to diuretic use and a known history of hypokalemia which revealed a critically low potassium level of 2.9 (normal range 3XXX,d+[DATE].1 millimole per liter (mmol/L). Oral potassium supplementation was ordered, however the resident experienced vomiting after meals which had the potential to affect the effectiveness of the potassium medication. The facility failed to notify the resident's physician of medication discrepancies/errors, and the resident's decline in condition resulting in the resident's death after unsuccessful CPR. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 6:47 A.M. Resident #50 expired in the facility. On [DATE] at 6:21 P.M. RDCO/Registered Nurse (RN) #180 completed an audit of all 34 current resident's progress notes to ensure notification of a decline in resident condition was reported to the physician in the past 72 hours. Daily audits would begin on [DATE] and would be completed for the next three months by the Director of Nursing (DON) and/or designee for any change in condition and physician notification. On [DATE] at 6:45 P.M. RN #180 reviewed/audited the medical records for two additional residents (#55 and #56), who had expired since [DATE] to review the residents' care. Residents (#55 and #56) were receiving Hospice services and death were expected. Daily audits would begin on [DATE] and would be completed by the DON and/or designee for three months for any resident who experiences an unexpected death. On [DATE] RDCO/RN #180 reviewed the medical records for all new resident admissions since [DATE] who were still residing in the facility (Resident #6, #20, #54) to ensure orders were transcribed correctly from hospital discharge to facility admission. Daily audits would begin on [DATE] and would be completed by the DON and/or designee for new admission/readmissions daily for three months. RDCO #180 and/or designee would review Point Click Care (PCC) for any new or re-admissions for any medication error reports documented into the risk management in PCC by the DON/Assistant Director of Nursing (ADON) to ensure that an investigation of the error has been completed as needed. On [DATE] at 9:56 P.M. the Administrator notified Medical Director #501 of the Immediate Jeopardy situation. On [DATE] at 10:05 P.M RN #180 audited all current residents (#10, #30, #35 and #36) with a diagnosis of congestive heart failure (CHF) and discussed with Physician #501. The need for intake and output (I&O), weight orders, and anti-embolism stocking orders were discussed. Physician recommendations were ordered. Daily audits would begin on [DATE] and would continue for the next three months and would be completed by the DON and/or designee. Audits would include any new diagnoses of CHF for current residents or new admission with a diagnosis of CHF and would be discussed with the medical provider regarding the need for intake and output monitoring, weight orders, anti-embolism stockings and any other care needed related to the CHF diagnosis. Beginning [DATE] 10:03 P.M. and concluding on [DATE] at 11:29 A.M. education was provided in person or via phone to eleven licensed nurses (Licensed Practical Nurse #103, #127, #129, #140, #149, #168 and RN #113, #124, #206, #703 and Agency RN #709) by RN #180, Assistant Director of Nursing (ADON)#704, and the Administrator. The education included the new process of two nurses verifying new resident admission orders to ensure the orders were transcribed correctly from the hospital discharge to admission to the facility; newly diagnosed or new admissions with CHF would be discussed with the medical provider regarding care of the resident with CHF, and reviewed the change of condition policy, and notification of the physician/CNP of medication omission/discrepancies/errors and notification of decline in resident condition. RN #180 and #704 followed-up with the nurses after the education to ensure there were no unanswered questions related to the education. On [DATE] starting at 6:31 A.M. 14 of the facility 16 STNAs were educated in person and by via phone by ADON #704 and the Administrator on ted hose, change of condition, and I&0. Two STNAs (#711 and #712) would be educated prior to working their next scheduled shift. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ADON #704 was educated on [DATE] at 5:30 P.M., by RDCO #180 that residents who had an unexpected death would have a chart audit completed to ensure no corrective action/education was needed and reviewing CNP/physician progress notes to ensure orders are implemented or if there are any questions to contact the provider. A new Medication Error policy and procedure created by VP of Clinical Services was reviewed by RDCO #180 and Medical Director #501 at 2:36 P.M. and would be implemented effective [DATE]. ADON #704 was educated on the new Medication Error Policy on [DATE] at 2:45 P.M. by RDCO #180. Any medication error needed to be investigated and any interventions implemented as indicated and if any med error occurs it was added to risk management. The DON/designee would review progress notes daily regarding resident and/or resident representative concerns and would address any concerns following the grievance process. The audits would begin on [DATE] and continue for three months. The contracted staffing agency was sent education by the Administrator on [DATE]. Education would be added to the site for our building for the staff to review prior to picking up a shift and there was a Nursing/Agency communication book at the nurse's station for them to review prior to the shift starting. The DON/designee would ensure Agency staff have reviewed education by contacting them once they have arrived at the facility and getting a verbal acknowledgement that they have reviewed. Starting [DATE] all new staff would be verbally educated and on the above education of what to do if a medication error occurs, what to do a patient has CHF, what to do if a family has concerns, what to do if there was a change in condition with a patient and the process of new admission orders by the DON/designee during new hire orientation. On [DATE] at 10:15 A.M. the previously identified 11 nurses were educated by Interim ADON #704 and RDCO#180 on Medication Error policy in person and via phone. Audit findings will be reviewed weekly by the QAPI Committee with further recommendations as needed for eight weeks. Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings included: 1. Closed record review revealed Resident #50 was admitted to the facility on [DATE] with diagnoses including chronic systolic heart failure, cardiomyopathy, hypertension, ventricular tachycardia with an implanted cardiac defibrillator (a small battery-operated device implanted in the chest that detects dangerous, irregular heart rhythms), atrial fibrillation and hyperlipidemia (elevated cholesterol levels). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #50's hospital discharge summary note dated [DATE] revealed the resident's chief complaint was vomiting and diarrhea. He was admitted in March of 2024 with heart failure, had weight gain in a few weeks post discharge and his Torsemide (diuretic medication) was increased to twice daily. The resident had heart failure with a reduced ejection fraction that was maintained on Torsemide and Metolazone (diuretics). The resident's blood pressure was ,d+[DATE] millimeters of mercury (mmHg) and ,d+[DATE] mmHg the day of discharge ([DATE]). He had no edema in the lower extremities and his potassium was 4.4 mmol/L (normal limits). The resident had a history of hypokalemia (low potassium). The resident's condition on discharge was noted to be improved. Further review of Resident #50's discharge summary revealed Torsemide 20 milligram (mg) twice daily was resumed, and patient tolerated well, the heart failure team was consulted for management of diuretics. The plan was to monitor closely as an outpatient and gradually resume his heart failure medication depending on his blood pressure and improvement of his diarrhea. The Torsemide was held today ([DATE]) since he was nothing by mouth (NPO). The resident had non-sustained ventricular tachycardia (abnormal beating of the ventricles that did not continue) with numerous episodes. Mexiletine dose increased to every eight hours post discharge, his potassium (laboratory) goal was greater than four (4.0) and Magnesium goal greater than two (2). Record review revealed the resident's hospital discharge medication list dated [DATE] did not include orders to continue the Torsemide twice daily as indicated in the hospital discharge summary note. However, the hospital discharge medication orders included to administer Amiodarone 300 milligrams (mg) daily and Mexiletine 150 mg every eight hours (antiarrhythmic medications). Review of Resident #50's facility general progress notes, authored by Registered Nurse (RN) #703, revealed on [DATE] male resident admitted to the skilled nursing home at 1:45 P.M. after a short acute care hospital stay. The resident was alert and oriented times three. The resident was a full code (advance directives) and he had a brief medical history including but not limited to paroxysmal atrial fibrillation, coronary artery disease, decreased ejection fraction of 20% (the heart was not pumping blood as strong as it normally would) and generalized weakness. Non-pitting edema noted to upper and lower extremities. The resident's lung fields were diminished at this time with a moist non-productive cough noted. The physician was made aware of the new admission, no orders were given other than to continue current regimen at this time until the resident could be seen by a provider. The resident weighed 123 pounds per mechanical lift. Record review revealed no evidence the resident's Torsemide was discussed or clarified with the physician at this time. Review of a skilled note, authored by RN #167 and dated [DATE] at 12:47 P.M., revealed the resident's blood pressure was ,d+[DATE] and pulse was 72 and regular. The resident had plus two pedal (feet) edema (an indentation in the skin that stays present for approximately two seconds and indicates there is fluid accumulation). No signs of shortness of breath or difficulty breathing. Lung sounds were clear. Review of general progress note authored by RN #167 dated [DATE] at 4:12 P.M. revealed the resident's power of attorney (POA) was in to visit and was concerned with resident's increased edema to his bilateral lower extremities. The note indicated the POA requested resident's the diuretic be restarted. Staff spoke to the doctor and a new order was received to give Torsemide 20 mg now and to re-start 20 mg daily. The note also indicated, will have the Certified Nurse Practitioner (CNP) come in and see resident for admission history and physical. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a dietary note, authored by Dietary Manager #706 and an addendum note added by Dietary Supervisor #705 dated [DATE], revealed the resident was on a cardiac diet and it was clarified with the facility for a no-added salt (diet). The resident's meal intakes were ,d+[DATE]%. The resident's body mass index was 19.9 (low/underweight) and his current body weight was 123 pounds on [DATE]. The note indicated the resident was at risk for weight fluctuations due to fluid shifts per hospital notes. Review of Resident #50's nutrition/hydration plan of care initiated on [DATE] revealed no evidence the resident was at risk related to CHF. Interventions included to monitor meal intakes, labs, tolerance to diet, weights per the facility policy, and to provide diet and snacks per order/preference. There was no evidence to monitor intake and output (I&O) for the resident. Review of the progress note dated [DATE] and authored by CNP #500 revealed the resident was a pleasant male with a past medical history consisting of, but not limited to, paroxysmal atrial fibrillation, chronic kidney disease, recurrent bowel obstructions, coronary artery disease, heart failure with reduced ejection fraction maintained on Torsemide and Metolazone (this medication was not ordered on admission to the nursing facility) cardiomyopathy, hypertension, and dyslipidemia. The resident had been admitted in [DATE] to the hospital for heart failure exacerbation and acute kidney injury. He had weight gain a few weeks ago post discharge so his Torsemide was increased to twice daily. The resident's heart rate was irregular, and lungs sounds were diminished. No edema noted. The plan was to monitor input and output, edema, and blood pressure. The note indicated continue Torsemide twice daily, potassium supplement (the medical record did not contain an order for potassium), and knee-high ted hose (anti-embolism/compression stockings). Review of an email confirmation, dated [DATE], revealed CNP #500 faxed Resident #50's progress note to the facility Medical Records Clerk #106 on [DATE]. Review of Resident/Family Education note authored by Agency Licensed Practical Nurse (LPN) #707 dated [DATE] revealed the Nurse Practitioner (NP) #500 saw the resident and new orders were received to apply ted hose (anti-embolism/compression stockings) daily for edema. Review of Resident #50's admission laboratory results, dated [DATE], revealed the resident's potassium level was 3.7 mmol/L (below the goal of 4.0). Record review revealed no evidence the facility developed and implemented a comprehensive and individualized plan of care for CHF/Cardiac. However, on [DATE] there was a plan of care initiated for risk of altered fluid balance and the only intervention was to evaluate skin turgor. Further review of Resident #50's plan of care revealed on [DATE] a risk for ineffective peripheral tissue perfusion was initiated. The intervention included to evaluate capillary refill and evaluate skin color, temperature, and characteristics. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #50's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a poor appetite or overate ,d+[DATE] days. The assessment revealed the resident exhibited no behaviors including rejection of care. He was independent with prior function of everyday activities. The resident required setup or clean up assistance with eating and was dependent on staff for toileting. He had an ostomy (urostomy) and frequently incontinent with bowel. The assessment revealed the resident had CAD, heart failure, hypertension, hyperlipidemia, and malnutrition. Hyponatremia, hyperkalemia, vomiting, and shortness of breath were marked no. Weight loss/gain was marked no or unknown and the assessment noted the resident was on a therapeutic diet. The resident was on diuretics. The resident, family, significant other, legal guardian, or other legal authorized representative had not participated in the assessment or goal setting. The resident's overall goal was to be discharged to the community per family. Review of Resident/Family Education note, authored by LPN #140 and dated [DATE] at 8:00 A.M., revealed the family was in to visit and requested a lab draw to check the resident's potassium level due to the resident having a history of hypokalemia and he was on Torsemide. The physician agreed. The lab test was obtained, and the family took the specimen to the lab to drop it off. The note indicated, will await results. Review of Resident/Family Education note authored by LPN #140 and dated [DATE] at 11:17 A.M., revealed the lab called back with a critical potassium level of 2.9 (hypokalemic). The provider (Physician #501) was notified, and new orders were received for Potassium Chloride 20 milliequivalent (mEq) by mouth three times a day and recheck levels on Tuesday ([DATE]). The family was visiting and aware of the new order. Review of Resident/Family Education note, authored by LPN #140 and dated [DATE] at 6:03 P.M., revealed the resident had a small emesis this evening. It was green in color. There was no documented evidence CNP #500, or Physician #501 were notified of the resident's emesis. Review of the resident's paper and electronic medical record revealed no evidence the resident's oral intake or urinary output (I & O) were being monitored as stated in CNP #500's progress note dated [DATE]. Review of Resident #50's medication administration record (MAR) and treatment administration record (TAR), dated [DATE], revealed no evidence the potassium supplement (20 mEq) was administered until ordered on [DATE] even though the potassium supplement was first noted in CNP #500's progress note dated [DATE]. There was no further notation of the potassium supplement until [DATE] when the resident's family requested a potassium level be completed and the results were critically low, and potassium replacement was ordered in oral form. Review of Resident #50's medication administration records dated ,d+[DATE] revealed on [DATE] the resident only received 200 mg of Amiodarone (order from hospital was 300 mg daily) and he didn't receive any Amiodarone on [DATE]. The order was discontinued and re-written for 300 mg on [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Mexiletine order was entered as twice daily from [DATE] to [DATE]. The resident received one dose on [DATE], one dose on the 20th due to the morning dose was not administered and two doses on the [DATE]. The order was for three times daily not twice daily from the hospital. The order was discontinued and re-written three times daily on [DATE]. Further review of Resident #50's MAR revealed no evidence the ted hose daily for CHF were applied per orders. In addition, review of the MAR revealed there was an order dated [DATE] to monitor for side effects of coronary artery disease (CAD) every shift such as chest pain with activity, heartburn, nausea, vomiting, shortness of breath, excessive sweating, dependent edema, alternation in color/warmth of extremities. The MAR revealed staff were to mark 0 if no signs or symptoms of side effects and + if signs and symptoms are present. If present, staff were to document and notify the physician. Review of the MAR revealed staff were handwriting initials on the MAR for monitoring instead of 0 or +. Further review of Resident #50's [DATE] TAR revealed the resident was to be weighed every Friday for monitoring until [DATE] then monthly. There was no evidence the resident was weighed on Friday [DATE] per order. Review of a skilled note dated [DATE] at 4:04 A.M. revealed the resident was assessed by RN #167. (Note- It was determined this date and time was inaccurate per interview with Registered Nurse (RN) #167 on [DATE] at 10:30 A.M. The RN reported the assessment was completed on [DATE] around 11:00 P.M. not on [DATE] at 4:04 A.M.). The residents blood pressure was ,d+[DATE], pulse 74 and regular, respiration was 18, oxygen saturation was 95% on room air, and documented he was alert to time, person, and place. The resident had ted hose ordered. Left and right pedal pulses were plus two and normal. No signs of difficulty breathing or shortness of breath. Denied indigestion, nausea, vomiting, diarrhea, constipation, or bowel incontinence. Skin warm and dry, color within normal limits, and turgor was normal. No changes in the pressure ulcer on the coccyx, right knee, or right ankle. The resident had impairment of range of motion of both upper and lower extremities. His gait was unsteady, and he had poor balance. No safety concerns noted. Review of Resident/Family Education note, authored by RN #206 and dated [DATE] at 5:00 A.M., revealed per State tested Nursing Assistant (STNA) #110, she had provided incontinence care to the resident around 3:00 A.M. The note indicated the resident was pleasant and carried on a conversation with the STNA throughout the care. When the nurse entered the resident's room to administer medication as ordered, the resident was non-responsive, and no vitals were found. The resident's code status was checked, and he was a full code. Cardiopulmonary resuscitation (CPR) was initiated and 911 was called. Paramedics arrived. assessed the resident and stopped CPR. The resident's time of death was noted to be 5:46 A.M. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of emergency medical services (EMS) report dated [DATE] revealed at 5:03 A.M. a call was received from nursing home that Resident #50 had coded, and CPR was in progress. At 5:11 A.M. the squad arrived on the scene and went to Resident #50's room and CPR was being done by nursing home staff. The resident was in bed, but with a backboard under him. The EMS report indicated nursing home staff continued high quality CPR using bag valve mask (BVM) for ventilation. The EMS hooked the resident up to a four-lead showing asystole. The RN reported the resident was last seen at 3:00 A.M. and was fine. The nurse came in around 5:00 A.M. to administer medication and found the resident in this condition. Unknown down time. Due to the residents' condition and unknown down time, it was decided the resuscitation efforts would be futile. CPR was discontinued at this time. The cardiac arrest etiology was presumed cardiac. Coroner #710 arrived on scene, report given, and care transferred. Review of Resident #50's death certificate dated [DATE] revealed immediate cause of death was cardiopulmonary failure due to CAD and cardiomyopathy. Another significant condition was hypertension per Local Coroner #708. Record review revealed the facility did not complete an investigation into the resident's unexpected death and there was no documented evidence of any medication error reports being filed for the medication errors involving Resident #50. Review of the facility incident log for [DATE] revealed no documentation of the medication errors related to potassium, Amiodarone or Mexiletine for Resident #50. Review of Resident #50's medical record revealed no evidence the physician was notified of the medication errors related to the potassium, Amiodarone or Mexiletine. Interview on [DATE] at 4:28 P.M., with Family Member (FM)/Power of Attorney (POA) #502 revealed she was an RN and had voiced concerns on [DATE] to the facility regarding Resident #50's edema and difficulty breathing and requested the facility call the physician regarding restarting the resident's diuretics. The POA stated the diuretics had been stopped in the hospital due to the resident vomiting and having diarrhea. She stated she also asked daily for staff to call the provider back to get orders for a potassium supplement due to the resident having a history of hypokalemia while on diuretics. The POA voiced concerns the nurses would not address her requests related to starting a potassium supplement until [DATE] when a nurse finally agreed to call the provider to obtain orders. FM #502 stated she also requested a potassium level be obtained as well since the resident had been on a diuretic for five days. FM #502 reported a potassium level was done on [DATE] (which was within normal level but lower than the resident's goal determined by his recent hospitalization) however the resident had only received one dose of the diuretic when that lab test was obtained. An additional lab test was obtained on [DATE], and the resident had a critical (low) potassium level. FM #502 reported the resident had vomiting, which she determined the nurses were not documenting all the vomiting episodes and she didn't believe the resident could keep the oral potassium down. During the interview, POA #502 shared the resident had passed away the following morning on [DATE] and stated family believed his death was a result of poor care by facility staff. (continued on next page)

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	366448	A. Building B. Wing	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe County Operating Inc	47045 Moore Ridge Road Woodsfield, OH 43793

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 8:17 A.M., with CNP #500 revealed he had seen the resident on [DATE] for Physician #501 to review admission orders. The CNP reported he had ordered labs on [DATE], however the labs were routine admission lab orders. The CNP reported he had ordered a potassium supplement; however, he did not document or recall if he ordered 10 or 20 mEq of potassium. He stated when he visits the facility, he gives the nurses verbal orders, and the nurses enter the orders in the computer. He had also ordered ted hose to be applied. The CNP reported, in his professional opinion, if a resident had a potassium level of 2.9 (critical) he would have ordered potassium to be administered intravenously and hospitalization for monitoring but ultimately it would be up to the physician to treat. The CNP stated he was not aware or notified the resident had vomiting. The CNP reported he does his own visit dictation from his visits and emails the dictation note to Medical Records Clerk #106 usually the same day or the next day. Interview on [DATE] at 10:30 A.M., with RN #167 confirmed the skilled note dated [DATE] at 4:04 A.M. was not documented with the actual time and date the assessment was completed. The RN reported she had completed the skilled assessment on [DATE] around 11:00 P.M. The RN confirmed the resident was only weighed on admission and stated the resident should have been weighed on [DATE], however there was no documented evidence the weight was obtained. The RN reported staff had documented a weight on [DATE] after the resident had expired in error as well. The RN confirmed the provider was not notified the resident was vomiting due to the family voicing it was normal for the resident to vomit after eating. RN #167 reviewed the resident's May and [DATE] MAR/TAR with the surveyor and confirmed staff were not documenting vomiting or edema on the MAR/TAR as indicated per orders. The RN reported the nurse who received orders on [DATE] from the CNP was an agency nurse and there was no order for a potassium supplement documented in the medical record. The RN confirmed the CNP, and/or physician do not write orders when they see residents and only provide verbal orders for staff to enter. RN #167 confirmed all MAR/TARs were documented on paper and not electronically. Interview on [DATE] at 11:12 A.M., with Physician #501 revealed a resident with a diagnosis of CHF should be weighed daily or at least every other day. The physician confirmed he did not physically see Resident #50 during his brief stay. The physician reported he decided to administer oral potassium because he was unaware the resident had vomiting and thought he could tolerate the oral potassium. The physician reported if he had known the resident was vomiting, he would have sent him to the emergency room for potassium intravenously (IV) and fluids IV. He stated he really can't speak on the matter, it was very unfortunate, and he understood the family concerns however he couldn't really say if the resident's death occurred due to cardiac issues as that was hard to judge. Interview on [DATE] at 1:36 P.M., with RN #180 confirmed there was no documented evidence the facility was monitoring the resident's I&O during his stay. The RN confirmed staff were not documenting on the MAR/TAR the resident was having edema or vomiting as indicated with 0 or + and that signing their initials did not provide information regarding the monitoring. Interview on [DATE] at 9:50 A.M., with Registered Nurse (RN) #180 confirmed the admission orders for the Amiodarone and Mexiletine were not transcribed accurately on admission. RN #180 reported she could not find any evidence a medication error report was completed, or the physician was notified. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An additional telephone interview on [DATE] at 8:00 A.M. with FM/POA #502 revealed she was not notified Resident #50's antiarrhythmic medication was not administered as ordered. The POA reported she had issues with Agency LPN #707 not addressing her concerns regarding the potassium supplement timely. The POA stated the LPN kept telling her the resident did not need potassium due to his potassium levels being normal. The POA reported she did request staff to adjust medication times around the resident's meals because he was having vomiting episodes, and she was afraid his medications were not absorbing/effective. The POA reported she would clean the vomit off the resident, however, would leave the bucket so the staff could assess the amount and color. The resident was scared to eat because he was afraid he would vomit. He would only eat 25% of his meals, if he ate anything at all. She stated she tried to bring him ice cream so he would at least get something on his stomach. The DON informed the POA the resident could not see a gastroenterologist while he was skilled (through Medicare) to try to determine what was causing the vomiting. The POA voiced concerns staff were not applying his ted hose or monitoring his intake and o [TRUNCATED]

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, observation, interview, and policy review the facility failed to provide comprehensive pressure ulcer care timely and as ordered. This affected one (Resident #14) of three reviewed for care and services. The facility census was 37. Findings included: Record review revealed Resident #14 was admitted to the facility on [DATE] with diagnoses including femur fracture, left wrist fracture, cirrhosis, esophageal varices, pancytopenia, and hypertension. Review of Resident #14's hospital discharge summary, dated 05/07/24, revealed no evidence the resident had pressure ulcers. Review of Resident #14's admission history of physical, dated 05/07/24, revealed no evidence the resident had pressure ulcers. Review of Resident #14's nursing admission assessment dated [DATE] revealed the resident had surgical incisions (right wrist and right hip) and scattered bruising throughout the body. The note indicated the resident had no other skin issues noted. Review of Resident #14's skilled note, dated 05/10/24, revealed the resident had a pressure area on the buttocks that was generalized with no odors, tunneling, or undermining. There was no comprehensive assessment of the wound including measurements or staging. There was no evidence a treatment was initiated nor was the physician notified. Review of Resident #14's skin integrity care plan, dated 05/10/24, and as evidenced by surgical repair of left wrist and open area to the left inner upper thigh, revealed to encourage good nutrition and hydration, monitor and document location, size and treatment of injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration etc. to the physician, and treatment administered as ordered. Review of Resident #14's five-day admission Minimum Date Set (MDS) 3.0, dated 05/11/24, revealed the resident had one Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister) pressure ulcer that was present upon admission/entry or re-entry to the facility. The resident was identified at risk for pressure ulcer development. Review of Resident #14's skin note, dated 05/14/24, revealed the resident had a pressure area on the buttocks that was generalized with no odors, tunneling, or undermining. There was no comprehensive assessment of the wound including measurements or staging. There was no evidence a treatment was initiated nor was the physician notified. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #14's Braden scale for predicting pressure risk evaluation, dated 05/14/24, revealed the resident's sensory perception was very limited, the skin was very moist, the resident was chairfast with limited body movement but occasionally able to make slight changes in body or extremity position but unable to make frequent or significant changes independently. Problems with friction and shearing. The score was 12.0, indicating the resident was at risk for pressure ulcer development. Review of Resident #14's skin assessment dated , 05/16/24, revealed the resident had an open area on the upper right buttocks measuring four centimeters (cm) by three cm. Area cleansed, patted dry, and comfort foam applied. The physician was notified however, there was no depth or staging of the area. Review of Resident #14's orders and medication administration records/treatment administration records (MAR/TAR) dated 05/24 revealed to cleanse the area to the right buttocks with wound cleaner, pat dry, apply demasyn hydrogel (wound dressing that donates moisture to dry or minimally exudating wounds for an optimal moist environment), and cover with a foam dressing every other day until resolved. There was no evidence the dressing was administered on 05/20/24, 05/22/24, 05/24/24, 05/26/24, or 05/28/24 per physician orders. The treatment order was discontinued on 05/29/24. Review of Resident #14's wound note, dated 05/22/24, revealed the resident has two new skin alterations on the right buttocks (stage 2 pressure) measuring 1.5 cm by 1.8 cm by 0.1 cm with 10% slough (a by-product of the inflammatory phase of wound healing, manifesting as pale yellow, viscous fibrinous tissue that can be loosely or firmly attached, covering the wound bed) and 90% epithelial (tissue). Cleanse the area with wound cleanser, pat dry, apply a collagen dressing to the wound bed, cover with a border gauze and change daily and as needed. Spoke to nursing staff and will add house protein supplement, multivitamin, Vitamin C and low air loss mattress. Review of Resident orders and MAR/TAR dated 05/24 revealed no evidence of the order, documented on the wound note, dated 05/22/24 (Cleanse the area with wound cleanser, pat dry, apply collagen dressing to wound bed, cover with border gauze and change daily as needed. Spoke to nursing staff and will add house protein supplement, multivitamin, Vitamin C and low air loss mattress.) was implemented. Review of Resident #14's wound note, dated 05/29/24, revealed the Wound Nurse Practitioner spoke to nursing staff and will add house protein supplement, multivitamin, Vitamin C and low air loss mattress. The pressure area on the right buttocks has resolved. Review of Resident #14's wound note, dated 06/05/24, revealed the Wound Nurse Practitioner (WNP) spoke to nursing staff and will add house protein supplement, multivitamin, Vitamin C and low air loss mattress. Review of Resident #14's wound note, dated 06/12/24, revealed the Wound Nurse Practitioner spoke to nursing staff and will add house protein supplement, multivitamin, Vitamin C and low air loss mattress. Review of Resident #14's dietary note, dated 06/17/24, revealed recommendations for Multi-Vitamin and ProStat 30 milliliters (ml) (liquid protein supplement) daily to assist with wound healing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident was not seen by the WNP on 06/19/24 or 06/26/24. Review of Resident #14's orders and medication and treatment administration records dated 05/07/24 to 07/08/24 revealed no evidence a house supplement, Vitamin C, or low air loss mattress were ordered, however new orders were received from the dietitian's recommendation on 06/18/24 for a Multi-Vitamin and ProStat. The multivitamin was not ordered prior to the dietician recommendation. Observation on 07/02/24 at 8:15 A.M. and 07/03/24 at 7:34 A.M., revealed no evidence Resident #14 had a low air loss mattress on their bed. Interview on 07/10/24 at 3:00 P.M., with Registered Nurse (RN) #180 confirmed the five-day admission MDS was inaccurate due to the resident did not have a pressure ulcer upon admission. RN #180 confirmed on 05/10/24 and 05/14/24 staff had documented the resident had a pressure ulcer on her buttocks; however, there was no comprehensive assessment completed, treatment orders were not implemented, and there was no evidence the physician was notified of the pressure ulcer development. RN #180 confirmed the Wound Nurse Practitioner (WNP) ordered to cleanse the area with wound cleanser, pat dry, apply collagen dressing to the wound bed, cover with border gauze and change daily and as needed, a house supplement, multivitamin, Vitamin C, and low air loss mattress on 05/22/24 but the orders were not implemented. However, the multi-vitamin was implemented on 06/18/24 after recommended by the dietitian. The RN also confirmed there was no documented evidence the dressing was changed on 05/20/24, 05/22/24, 05/24/24, 05/26/24, or 05/28/24 per orders. Review of the facility policy titled Pressure Injury Treatment undated revealed a residents with pressure injuries will be treated with consistent treatment protocols to aid in the healing process. In addition, residents with pressure injuries will have ab individualized treatment program that provides the appropriate treatment to facilitate healing and that assesses and addresses comorbid conditions in a systematic manner. This deficiency represents non-compliance investigated under Master Complaint Number OH00155046.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on closed record review and interviews the facility failed to ensure a resident was provided a comprehensive, resident centered plan for urostomy care This affected one (Resident #50) of one residents residing in the facility with a urostomy. The facility census was 37. Findings included: Closed record review revealed Resident #50 was admitted to the facility on [DATE] with diagnoses including chronic systolic heart failure, cardiomyopathy, hypertension, ventricular tachycardia, urinary tract infections, atrial fibrillation, acute kidney failure, retention of urine, and mixed hyperlipidemia. The residence expired on [DATE]. Review of Resident #50's hospital discharge summary, dated [DATE], revealed the resident had acute cystitis secondary to Escherichia. Coli (bacteria found in feces) due to cystostomy catheter (surgical connection between the urinary bladder and the skin used to drain urine) malfunctioning urostomy (surgical procedure that creates a stoma (artificial opening) for the urinary system). It was suspected the patient was not using sterile technique. Urology was consulted and coude catheter (type of catheter with a curved tip to help urine drain) placed. Advised to continue #14 French catheter to gravity drainage (do NOT clamp as that would encourage drainage from fistula (abnormal connection joining two hollow spaces) (instead of the bladder) for several days until the fistula dries up and then can resume regular clean intermittent catheterization (CIC) (inserting a tube through the urinary opening to empty the bladder) per routine. Review of Resident #50's admission assessment, dated [DATE], revealed the resident had a urostomy intact and the stoma was within normal limits, the urine was amber in color and there were no urinary complaints. Review of Resident #50's provider note, dated [DATE], revealed the resident had acute cystitis, secondary to E. Coli due to cystostomy catheter. Staff need to use sterile technique when handling the catheter or changing the catheter. Follow up with specialists. Monitor the output, color, and consistency. Review of Resident #50's five-day Minimum Data Set 3.0 dated [DATE] revealed the resident had a catheter, urinary ostomy, or no urine output for the entire seven days. Review of Resident #50's paper and electronic medical record (EMR), dated [DATE] to [DATE], revealed no evidence the facility was monitoring urinary output, color, or consistency. Review of Resident #50's orders, dated [DATE] to [DATE], revealed on [DATE] a new order was received to irrigate the urostomy catheter with ,d+[DATE] milliliters of sterile normal saline as needed for occlusion. Further review revealed no evidence for orders related to care of the urostomy drainage system, stoma care, monitoring urinary output, color, or consistency. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #50's Medication and Treatment Administration Record, dated ,d+[DATE], revealed no evidence the urostomy catheter irrigation was administered. Review of Resident #50's risk for toileting self-care deficit plan of care, dated [DATE], revealed to consult ostomy/wound nurse for stoma care, educate resident/representative on proper stoma care, evaluate resident's ability for toileting self-care, and provide assistance based on resident's ability to perform self-care of stoma. Further review revealed no evidence of an individualized plan of care for the urostomy drainage system, collection system, and care including irrigation/flushes. Interview on [DATE] at 4:52 P.M., with Register Nurse (RN) #180 confirmed Resident #50 didn't have orders for his urostomy care (drainage system, stoma care, monitoring intakes and outputs, etc.) except four days after admission, staff wrote orders to flush (the urostomy) as needed. RN #180 reported she had interviewed RN #167 today to determine what type of drainage system the resident was using, and the RN thought he had a tube that drained into a catheter bag. The RN shared the granddaughter had visited frequently and the RN thought she provided urostomy care and bathed him however, the facility did not document care or have documentation the family provided care. Interview on [DATE] at 5:20 P.M., with the Administrator and RN #180 confirmed the facility did not have a policy and procedure for urostomy care. Interview on [DATE] at 5:21 P.M., with Resident #50's granddaughter, who is a nurse, revealed when the resident was at home he only did urostomy care if he had to, however when he came from the hospital, they had put in a coude catheter because he had a bad infection and the stoma was swollen and the doctor wanted it secured to his abdomen. The granddaughter reported she had to shower the resident after he had been there a few days and he didn't receive a shower. He had asked staff to shower him in the evening., and the facility wanted to give him one in the morning., so he declined the shower. The facility finally moved his shower day time shower to a night time shower, but he wasn't feeling great so after he was there a few days, she told him he was getting a shower and staff helped her transfer him. Unfortunately, when the water hit the securement of the catheter it became loose, and the catheter came out so she just put a foley catheter in since she knew the facility staff wouldn't have time to replace it due to being that they are short staffed, and he was panicked they wouldn't get it back in. She used a foley to replace the coude because she thought it would stay better and it did. She told the facility nurse what she was doing. He must have his ostomy flushed at least every four hours and the content had to be pulled back out or it would clog. The thick mucus was normal for him, he would ask the staff to flush it a few times a shift to make sure it continued to drain. Some nurses would refuse to flush it but if they didn't have orders on admission, then that would be why the nurses refused to flush it. She was not sure what French catheter she used when she re-inserted a catheter. The facility didn't have the size he usually used so she thought she went up a size. She had to flush it three times a day and it would drain about 500 cc after she flushed it with 50 cc of NS then she pulled the 50 cc back out. It was always thick and gross but that was his normal state, especially since he wasn't taking much fluids in orally. This deficiency represents non-compliance investigated under Master Complaint Number OH00155046.

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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** 32801 Based on closed record review and interviews the facility failed to ensure residents received physician ordered nutritional supplements for identified nutritional needs. This affected one (Resident #50) of three residents reviewed for care and services. The census was 37. Findings included: Closed record review revealed Resident #50 was admitted to the facility on [DATE] with diagnoses including chronic systolic heart failure, cardiomyopathy, hypertension, ventricular tachycardia, urinary tract infections, Escherichia coli (E. coli), atrial fibrillation, acute kidney failure, retention of urine, and mixed hyperlipidemia. Review of Resident #50's hospital discharge summary, dated 05/19/24, revealed the resident had moderate malnutrition and anasarca (general swelling throughout the body). Ensure (a nutritional supplement) three times a day was ordered for hypoalbuminmenia (when your body doesn't produce enough of the protein, albumin) and anasarca secondary to poor intakes from ileus and would need increased nutrient needs as evidenced by body max index of 18.8 which was low for the resident's body weight and height. He had visible severe muscle wasting to his temples, clavicle and hands. Review of Resident #50's provider note, dated 05/21/24, revealed the resident appeared ill, thin, frail, and had muscle wasting and decreased muscle tone. Review of Resident #50's orders dated 05/19/24 to 05/27/24 revealed no evidence the ensure or any type of nutritional supplement was ordered. Review of Resident #50's Medication and Treatment Administration Record, dated 05/2024, revealed no evidence a nutritional supplement was administered. The medical record contained no documentation as to why the Ensure would not be appropriate or not ordered for the resident. Interview on 07/10/24 at 11:36 A.M.,with Registered Nurse (RN) #180 confirmed the discharge summary indicated the resident was ordered Ensure three times daily, however no Ensure or any other type of nutritional supplement was ordered on admission. This deficiency represents non-compliance investigated under Master Complaint Number OH00155046.

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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. 32801 Based on record review, observation, review of the daily census and staff postings, review of staff time punches/timecards, review of the facility assessment, review of resident notes, and interviews the facility failed to ensure adequate staffing levels to meet resident needs. This had the potential to affect all 37 residing in the building. Findings included: 1. Observation and interview on 07/10/24 at 7:24 A.M. revealed there was only one State tested Nursing Assistant (STNA) #173 on the secure unit to provide care for 10 residents. The STNA confirmed she was the only staff member on the unit due to the nurse administering medication on the connected assisted living (located on the first floor and the memory care unit is located on the second floor). The STNA confirmed she usually worked day shift on the secured unit and the nurse always went to the AL first to administer medications, leaving her alone on the unit to provide morning care (showers/incontinence care/dress residents), assist residents out of bed for breakfast, pass breakfast trays, and assist with resident meals. The STNA confirmed the nurse must leave the secure unit several times throughout the day to go to the AL to work. Additional observations revealed from 8:08 A.M. to 8:20 A.M. there were five residents on the secure unit (Resident #12, #24, #28, #29, #30) that were left unattended in the dining room as they ate breakfast. Resident #5 was observed in her room with the lower portion of her body hanging off the edge of the bed. There was only one staff member (STNA #173) on the unit. At 8:09 A.M., as STNA #173 started down the hallway to pass the hall trays, she noticed Resident #5 was hanging out of bed and reported she needed to call for help I can't do this. The STNA confirmed she couldn't pass breakfast trays, supervise residents in the dining room, supervise residents in their rooms, and answer call lights by herself. The STNA called for help and the nurse arrived at the unit a minute later. The STNA assisted Resident #5, as the LPN #129 continued delivering breakfast trays, still leaving five residents in the dining room unattended. At 8:17 A.M., all of the trays were delivered except for two due to the residents were still sleeping. At 8:18 A.M. STNA #173 asked the LPN to help her with Resident #5. Resident #24 had not eaten anything from her breakfast tray and there was no staff from 8:00 A.M. to 8:20 A.M. encouraging her to eat. LPN #129 confirmed the resident had not eaten anything from her breakfast tray and reported it was difficult to supervise all the residents on the secure unit when there was only one staff member in the mornings. The LPN confirmed after she receives report in the morning, she goes straight to the AL to administer medication, leaving the STNA to monitor and assist the residents on the memory care unit, alone. Review of Resident #24's functional assessment, dated 05/16/24, revealed the resident required supervision or touch assistance with eating. (continued on next page)

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Monroe County Operating Inc	47045 Moore Ridge Road Woodsfield, OH 43793

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Interviews on 07/02/24 from 7:05 A.M. to 8:01 A.M. with anonymous staff members #200 and #201 confirmed there was a staffing shortage on both shifts, however especially on night shift. On night shift there will be times there is only one STNA for the entire building (two stories) from 10:30 P.M. until 4:00 A.M. The day shift aide will stay over four hours and the day shift aide for the next day will come in early to cover parts of the shift; however, it still leaves an aide by themselves from 10:30 P.M. to 4:00 A.M. The facility had two STNAs resign, making staffing more challenging. The Director of Nursing (DON) doesn't help much but can be found in her office or on smoke breaks. The DON will not come in when she is on call even though there are call offs that need to be replaced/shifts covered. Staff reported the facility had an Assistant Director of Nursing (ADON)/Registered Nurse (RN) #167 but they didn't know what her duties were except follow the DON around. The staff members reported there was a night last week when there were no aides in the building. 3. Interview on 07/02/24 at 7:33 A.M., with the Business Office Manager (BOM) #170, confirmed the facility was utilizing staffing agency for direct care staffing (RN, Licensed Practical Nurses (LPN), and State tested Nursing Assistant (STNA) needs currently. The facility has had staff quit due to not being able to accommodate their schedules. 4. Interviews with Anonymous staff members #202 and #203 on 07/02/24, confirmed staffing shortages were an issue and there were residents that had skin breakdown as a result of incontinence care not being performed timely especially on the first floor. They were told staffing was determined by the census and not the care needs of the residents. Sometimes there may only be one aide in the entire building, sometimes showers would not get done as result of a staffing shortage. On day shift, the staff were expected to start getting residents up (for the day) at 7:00 A.M. for breakfast, pass water and ice, provide showers/incontinence care, and pass trays with only one aide. The nurse assigned upstairs was also the Assisting Living (AL) nurse and the nurse goes to the AL first thing in the morning to administer medication, leaving one STNA on the secure unit (second floor) alone. The DON comes and goes when she wants. The DON and ADON take a lot of smokes breaks. The DON thinks the nurse helps with transfers when the facility is short staffed, however most of the nurses don't help and staff are performing transfers that require two assist, by themselves. There have not been any major injuries as a result of transferring residents with less assistance than required, that they are aware of, but there have been an increase in falls due to a lack of supervision and short staffing. Staff reported there was an aide that stayed over last night until 10:30 P.M. and STNA #169 came in early to work from 4:00 A.M. to 8:00 A.M. to help because they were short staffed and only had one STNA last night. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9. An interview with an anonymous licensed staff #206, during the onsite survey, revealed staffing was a concern especially on night shift. One night the facility wanted her to be the only nurse in the building to provide care to all the nursing home and AL residents. Frequently they only have one STNA on night shift and there were times she couldn't help the STNAs because she had her own assignments to complete. Lastly, the staff member shared the residents don't always get their scheduled showers due to a lack of staff. 10. Interview on 07/08/24 at 1:17 P.M., with Resident #31 revealed there were concerns with staffing. He has had to sit in a dirty depends for hours. He would ring his call light and after waiting for hours, they would answer the call light and say they would be right back, but they never returned so he would ring again and wait. The resident stated sometimes it took one to one and a half hours for staff to answer his call light. One time, he waited four hours to be changed. The resident reported he understood there were other residents that needed help but occasionally, he does as well. 11. Interview on 07/09/24 at 8:48 A.M. and 9:03 A.M. with two anonymous family members (#606 and #607) confirmed there were staffing concerns. Both families reported they were in the building and witnessed call lights not being answered timely or not being able to find staff. One family member reported their loved one did not receive a shower and was not provided incontinence care timely. Both families also reported there have been urine odors in the building on several occasions, noted while they were visiting. 12. Interview on 07/10/24 at 5:10 P.M., with family member #502 confirmed the facility was short staffed. Family Member #502 reported they have provided direct care and treatment to their loved one due to the staffing shortage. 13. Review of the daily staff posting dated 06/01/24 to 06/30/24 revealed there were two separate staff postings. One was posted for downstairs and one for the secure unit (upstairs). a. On 06/02/24 on night shift there was one STNA and one LPN for 12 hours each to care for 24 residents downstairs and one LPN for 12 hours and one STNA from 6:00 P.M. to 10:00 P.M. (four hours) to care for 10 residents on the secure unit. After 10:00 P.M., the facility had one STNA and two nurses in the facility. b. On 06/15/24 on night shift, there was one LPN and one STNA on night shift for 12 hours each to care for 29 residents downstairs and one LPN for 12 hours and one STNA for four hours to care for 10 residents on the secure unit. c. On 06/16/24 on night shift there was one RN and one STNA for 12 hours to care for 29 residents downstairs and one LPN for 12 hours and one STNA from 6:30 P.M. to 10:00 P.M. (four hours) to care for 10 residents on the secure unit. d. On 06/24/24 on night shift there was one LPN and one STNA to care for 28 residents downstairs and one LPN for 12 hours and one LPN working as the STNA for eight hours to provide care for 10 residents on the secure unit. e. On 06/28/24 on night shift there was one RN for 12 hours and no STNA to care for 28 residents downstairs and one LPN and one STNA 12 hours each to care for 10 residents on the secured unit. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	f. On 06/29/24 on night shift there was one LPN and one RN for 12 hours to provide care for 28 residents downstairs and one LPN and no STNA to provide care for 10 residents on the secure unit. The daily postings did not account for time for when the nurse on the secure unit had to leave the unit to provide care to the AL unit. 14. Interview on 07/03/24 at 7:34 A.M. with Resident #14 revealed the facility was short staffed. The resident reported she had to wait four and a half hours for someone to answer her call light resulting in her being incontinent. The resident showed the surveyor the chair she was sitting in when she was incontinent due to it leaving a brown stain on the chair. The resident reported also when she first arrived at the facility, she could not ambulate due to a hip fracture. Staff would also put her in a chair and push her into a common area or outside for hours without any way to call for help or assistance and staff were not available. Review of Resident #14's handwritten notes (the resident kept care notes in a personal notebook), dated 06/19/24, revealed she had waited hours for help and was left alone for four and a half hours. Observation on 07/10/24 at 10:00 A.M. of Resident #14's chair, with the Administrator, revealed there was a brown stain on the chair. The resident reported again it was a result of being incontinent and staff not answering her call light timely. Maintenance Director #171 walked into the resident's room during observation and confirmed the stain was not on the chair when the resident had moved into the room, however he thought it was chocolate. 15. Review of the facility assessment, dated 04/02/24, revealed the facility was licensed for 42 beds (actually 41 beds). The center had three areas which included A Hall with the capacity to care for 18 residents and specialized in short-term care as well as long term care; B hall with the capacity of 13 residents, and the Memory care unit with the capacity to care for 11 residents and specialized in the care of residents with dementia. At the center, we consider other pertinent facts and descriptions of our resident population that we take into account when determining staffing and resource needs. We utilize the information collected in the resident profile to identify the care and services needed to care for our residents. We evaluate the type of staff members, other health care professionals, and medical practitioners that are needed to provide support and care for our residents. Listed below is a list of staff we have identified that are needed to care for our resident population: infection control and prevention, nursing services (RN and Minimum Data Set nurse), therapy services. Further review of the facility assessment revealed based on our resident population and their needs for care and support, we have made a good faith effort and approach to ensure that we have sufficient staff to meet the needs of the residents at any given time. At our enter we make a god faith effort to evaluate the overall number of facility staff needed to ensure a sufficient number of qualified staff are available to meet each resident's needs. Total direct care hours include 12 hours of RN service, 24 hours of LPN services, and 24 hours of state tested nursing assistant services for day shift and night shift included eight hours for RN, 12 hours for LPN, and 24 hours for STNAs. This deficiency represents non-compliance investigated under Master Complaint Number OH00155046 and Complaint Number OH00154208.

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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. 32801 Based on review of the staffing schedules, timecard review, review of the daily census and staff postings, review of the facility assessment, and interviews the facility failed to ensure there was eight consecutive hours of Registered Nurse (RN) coverage seven days a week. This had the potential to affect all 37 residents residing in the facility. Findings included: Review of the staffing schedule dated 06/01/24 to 06/30/24 revealed on (Sunday) 06/09/24, (Saturday) 06/22/24, and (Sunday) 06/30/24 there was no RN scheduled to work. Review of the staffing time sheets, dated 06/09/24, 06/22/24, and 06/30/24, revealed there was no evidence an RN worked on 06/09/24 or 06/22/24. On 06/30/24, RN #113 clocked in at 6:52 A.M., however, there was no time entered for the end of the RN's shift that date. Review of the daily postings dated 06/09/24, 06/22/24, and 06/30/34 revealed no evidence an RN worked on those dates. Interview on 07/02/24 at 9:21 A.M., the Staffing Scheduler #102, confirmed there may be some days in June there was no RN coverage due to the facility on ly having one RN, at that time, and she would trade her days with a Licensed Practical Nurse (LPN). Interview on 07/02/24 at 1:43 P.M., Business Office Manager (BOM)/Human Resources (HR) #170 confirmed there was no RN coverage for 06/09/24 or 06/22/24 and on 06/30/24, there was only five hours of RN coverage provided on that day. The BOM reported the facility only had one RN besides the Director of Nursing (DON) and Assistant Director of Nursing (ADON) (which were available Monday through Friday). Review of the facility assessment, dated 04/02/24, revealed the facility was licensed for 42 beds (actually 41 beds). The center had three areas which included A Hall with the capacity to care for 18 residents and specialized in short-term care as well as long term care; B hall with the capacity of 13 residents, and the Memory care unit with the capacity to care for 11 residents and specialized in the care of residents with dementia. At the center, we consider other pertinent facts and descriptions of our resident population that we take into account when determining staffing and resource needs. We utilize the information collected in the resident profile to identify the care and services needed to care for our residents. We evaluate the type of staff members, other health care professionals, and medical practitioners that are needed to provide support and care for our residents. Listed below is a list of staff we have identified that are needed to care for our resident population: infection control and prevention, nursing services (RN and Minimum Data Set nurse), therapy services. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Further review of the facility assessment revealed based on our resident population and their needs for care and support, we have made a good faith effort and approach to ensure that we have sufficient staff to meet the needs of the residents at any given time. At our enter we make a god faith effort to evaluate the overall number of facility staff needed to ensure a sufficient number of qualified staff are available to meet each resident's needs. Total direct care hours include 12 hours of RN service, 24 hours of LPN services, and 24 hours of state tested nursing assistant services for day shift and night shift included eight hours for RN, 12 hours for LPN, and 24 hours STNA. This deficiency represents non-compliance investigated under Master Complaint Number OH00155046 and Complaint Number OH00154208.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on closed and open medical record review, review of the facility investigation, interview, and policy review the facility failed to ensure medications were administered per physician orders resulting in significant medication errors. This affected two (Resident #6 and #25) of 11 residents reviewed for medications. The facility census was 37. Findings included: 1. Record review revealed Resident #6 was admitted to the facility on [DATE] with diagnoses including dementia, transient ischemic attack (TIA), Vitamin D deficiency, acute cystitis, anemia, anxiety, epilepsy, chronic pain, glaucoma, peripheral vascular disease, gastroenteritis, osteoporosis, overactive bladder, falls, long term use of anticoagulants, and history of venous thrombosis and embolism. Review of Resident #6's progress notes, dated 05/28/24, revealed the nurse was walking down the hall with medication and forgot which room Resident #28 was in and the STNA (unidentified) said the resident was in the room (specific location was provided in the progress note). The physician was notified that Resident #6 received Resident #28's medication in error. The physician reported all medication were okay other than dicyclomine (used to treat irritable bowel syndrome). The medical doctor (MD) wanted the resident monitored for shortness of breath, hypertension, nausea/vomiting, and low blood glucose (level). The resident was alerted of the medication error. Review of Resident #6's medication error investigation report, dated 05/28/24, revealed the nurse was walking down the hall with medication and forgot which room Resident #28 was in and the STNA stated the resident was in the room (location provided on the medication error report. The physician was notified that Resident #6 received Resident #28's medication in error. The physician reported all medication were okay other than dicyclomine (used to treat irritable bowel syndrome). The MD wanted the resident monitored for shortness of breath, hypertension, nausea/vomiting, and low blood glucose (level). The resident was alerted of the medication error. Further review of the investigation report revealed no evidence of what medications were given in error. Interview on 07/09/24 at 9:03 A.M., with Family Member #505 revealed the first night his mom was admitted to the facility, her medication was not available and the facility refused to let him bring medication in to administer (from home). After returning home he had received a call the nurse gave his mom (Resident #6) the wrong medication, and the doctor was wanting them to monitor his mom because one of the medications given (a stomach medication) could cause a possible interaction. Interview on 07/10/24 at 3:00 P.M., with Registered Nurse (RN) #180 revealed she would have to pull Resident #28's medication records to determine which medication may have been given in error because the medications were not identified. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #28's May 2024 medication administration record, provided by RN #180, revealed the RN highlighted the medication that may have been given in error by an agency nurse. The medication included: Two acetaminophen 325 mg, dicyclomine 10 mg for irritable bowel syndrome, Aricept 10 mg for cognition, Glucosamine 500 mg three tablets as a supplement, Melatonin 3 mg for insomnia, and Crestor 5 mg for hyperlipidemia. 2. Record review revealed Resident #25 was admitted on [DATE] and readmitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia, anxiety, hypothyroidism, hyperlipidemia, gastro-esophageal reflux disease (GERD), rheumatoid arthritis, urge incontinence, history of transient ischemic attack (TIA), Vitamin D deficiency, protein-calorie malnutrition, fracture of left wrist, insomnia, and psychotic disorder. The resident resided on the secure unit. Review of Resident #25's medication administration record (MAR), dated 07/24, revealed on 07/08/24 the resident did not receive her once-a-day house supplement, offered a snack, or was monitored for pain or side effects of psychoactive medications, hypothyroidism, coronary heart disease, or anticoagulants per orders. The resident also didn't receive the following medication as well: Vitamin D 2000 unit once daily, aspirin 81 mg daily (TIA), diltiazem 240 mg daily for hypertension, divalproex 240 mg for dementia, ezetimibe 10 mg once daily for hypertension, oxybutynin 5 mg for urge incontinence, and MiraLAX one scoop daily. Interview on 07/10/24 at 9:08 A.M., with Licensed Practical Nurse (LPN) #129 confirmed there was no documented evidence the resident received her medication on 07/08/24. The LPN reported she had helped that morning on the floor because she thought she had picked up an extra shift and the facility had already booked an agency nurse to work. She had stayed to help the agency nurse get caught up with medications, however she never administered Resident #25's medications because she was asleep. Review of the facilities policy titled Medication Administration-General Guideline dated 07/01/21 revealed medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. The facility has sufficient staff and a medication distribution system to ensure safe administration of medication without unnecessary interruptions. Ensure you have the right resident, right drug, right dose, right time, right route for each medication being administered. Triple check the five rights. Medications are administered in accordance with written orders of the prescriber. Residents are identified before the medication is administered using two methods of identification. A scheduled or routine dose administration times is established by the facility and utilized on the administration record. Medication supplied for one resident are never administered to another resident. Monitoring of side effects or medication-related problems occurs continually. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication was given, This deficiency represents non-compliance investigated under Master Complaint Number OH00155046.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on observation, personnel file review, job description review, facility assessment review, time sheet review, daily census and staff posting review, schedule review, medical record review, infection log review, policy review and interview the facility failed to maintain an effective governing body, legally responsible to establish and implement policies regarding the management and operation of the facility including but not limited to staffing needs, complete and accurate medical records, staff education and certification renewal to ensure the total care needs of all residents, residing in the facility, are met as planned. This had the potential to affect all 37 residents residing in the facility. Findings include: 1. Review of State tested Nursing Assistant (STNA) #108's personnel file revealed the STNA's certification to work in a long term care facility was verified with the nurse aide registry (keeps track of those individuals who have met written and skills test criteria to be certified for employment in long-term care settings, usually nursing homes. Once certified, nurse aides must meet certain requirements to maintain their certification and continue to be listed on the Nurse Aide Registry as able to work in Ohio) on [DATE] and was to expire on [DATE]. The STNA signed her job description for an STNA position on [DATE], which included she would possess current state certification as a nursing assistant. Review of STNA #108's timecard, dated [DATE] to [DATE], revealed the staff position was listed as an STNA. The STNA worked [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Review of the Nurse Aide Registry verification information, dated [DATE], revealed STNA #108's certification expired on [DATE]. Review of STNA #108's disciplinary form, dated [DATE], revealed the STNA was suspended on [DATE] pending a license issue. Interview on [DATE] at 10:30 A.M., with the Business Office Manager (BOM)/Human Resource (HR), confirmed the facility was unaware STNA #108's certification had expired until an updated verification was completed on [DATE]. The STNA was suspended on [DATE] because of the finding. The facility determined the STNA's hours were not updated in the Enhanced Information Dissemination and Collection system (EIDC) (an electronic reporting system) by the Administrator. The Administrator was the only staff member that has access to the EIDC system at this time and she only works 20 hours per week, at the facility, , d+[DATE] hours per week at another skilled facility and she has another full-time job as well. The BOM reported she was also the HR person and only worked ,d+[DATE] hours per week at the facility due to having a full-time job elsewhere. 2. Review of STNA #108, #110, #138, #144, #153, #154, #162, #169, and #173 personnel files revealed no evidence of the 12-hours yearly in-services for ,d+[DATE]. (continued on next page)

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Monroe County Operating Inc	47045 Moore Ridge Road Woodsfield, OH 43793

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility assessment, dated [DATE], revealed nurse aides were required to have 12 hours per year of in-service training to ensure continuing competence to provide the necessary level and types of support and care needed for the facility's population. Interview on [DATE] at 12:04 P.M., with the Business Office Manager (BOM) /Human Resource (HR) #170 confirmed the facility employed 16 STNAs and nine of the 16 had worked greater than a year at the facility. BOM/HR #170 confirmed there was no documented evidence that the identified nine STNAs had received 12 hours of in-service training in 2023 or 2024. BOM/HR #170 reported the facility had not started in-service training for the STNAs for the [AGE] year even though it was already [DATE]. 3. Interview on [DATE] at 12:04 P.M., with BOM/HR #170 confirmed, as of today, the facility Administration consisted of the Administrator who worked an average of 20 hours per week (including time as the Administrator of the AL) as she has two other jobs, herself (BOM/HR) who works ,d+[DATE] hours per week because she has a full time job, the social service designee/admission director who works 40 hours a week. The facility just hired the medical records staff member full time as of yesterday ([DATE]) however she was only 16 hours a week prior, the Director of Nursing (DON) resigned yesterday ([DATE]), the Assistant Director of Nursing (ADON) resigned last week (who was also the Infection Preventionist (it was determined the ADON was the IP nurse but had not met the federal requirement to be the facility IP Nurse prior to the survey) and the unit manger resigned two weeks ago. The facility had hired an Interim DON and have posted the DON and ADON positions but would not be replacing the unit nurse position. 4. During the onsite survey, it was identified the facility did not maintain adequate staffing levels to meet the needs of the residents. On [DATE] at 7:24 A.M. observations were made on the secured unit. STNA #173 was observed to provide care to 10 residents including showers/incontinence care/dressing) and assist residents out of bed for the breakfast meal, pass breakfast trays and assist the residents with the meal. Licensed Practical Nurse (LPN) #129 was off the secured unit and was said to be administering medications to residents on the secure Assisted Living (AL). From 8:08 A.M. to 8:20 A.M. STNA #173 continued to provide care to residents with five residents (Resident #12, #24, #28, #29, #30) who were left unattended in the dining room, on the secured unit, as they ate breakfast. Resident #5 was observed in her room with the lower portion of her body hanging off the edge of the bed. At 8:09 A.M. the STNA saw Resident #5 partially hanging out of bed and she called for assistance from the LPN. The LPN arrived and continued to deliver meal trays while the 10 residents remained in the dining room, unattended/unsupervised. Resident #24 was not observed to eat from her breakfast tray and was not encouraged to eat from 8:00 A.M. to 8:20 A.M. LPN #129 confirmed the resident had not eaten anything from her breakfast tray and reported it was difficult to supervise all the residents on the secure unit when there was only one staff member in the mornings. The LPN confirmed after she receives report in the morning, she goes straight to the AL to administer medication, leaving the STNA to monitor and assist the residents on the memory care unit, alone. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interviews with anonymous staff and family members, during the onsite survey, revealed both shifts had a staffing shortage but especially night shift. The DON would not assist in covering shifts, residents had skin breakdown and incontinence due to staffing levels, showers were not provided as planned and call lights rang for longer than they should. Further interviews revealed residents were not receiving the amount of transfer assistance required for transfers (using one assist instead of two), families were unable to find staff during visits and family members would provide resident care due to staffing needs. On [DATE] at 7:34 A.M. interview with Resident #14 revealed the facility was short staffed. The resident reported she had to wait four and a half hours for someone to answer her call light resulting in her being incontinent. The resident showed the surveyor the chair she was sitting in when she was incontinent due to leaving a brown stain on the chair. The resident reported also when she first arrived at the facility, she could not ambulate due to a hip fracture. Staff would also put her in a chair and push her into a common area or outside for hours without any way to call for help or assistance and staff were not available. Review of Resident #14's handwritten notes (the resident kept care notes in a personal notebook), dated [DATE], revealed she had waited hours for help and was left alone for four and a half hours. Observation on [DATE] at 10:00 A.M. of Resident #14's chair, with the Administrator, revealed there was a brown stain on the chair. The resident reported again it was a result of being incontinent and staff not answering her call light timely. Maintenance Director #171 walked into the resident's room during observation and confirmed the stain was not on the chair when the resident had moved into the room, however he thought it was chocolate. 5. Review of the staffing schedule dated [DATE] to [DATE] revealed on (Sunday) [DATE], (Saturday) [DATE], and (Sunday) [DATE] there was no RN scheduled to work. Review of the staffing time sheets, dated [DATE], [DATE], and [DATE], revealed there was no evidence an RN worked on [DATE] or [DATE]. On [DATE], RN #113 clocked in at 6:52 A.M., however, there was no time entered for the end of the RN's shift that date. Review of the daily postings dated [DATE], [DATE], and [DATE] revealed no evidence an RN worked on those dates. Interview on [DATE] at 9:21 A.M., the Staffing Scheduler #102, confirmed there may be some days in June there was no RN coverage due to the facility on ly having one RN, at that time, and she would trade her days with a Licensed Practical Nurse (LPN). Interview on [DATE] at 1:43 P.M., with Business Office Manager (BOM)/Human Resources (HR) #170 confirmed there was no RN coverage for [DATE] or [DATE] and on [DATE], there was only five hours of RN coverage provided on that day. The BOM reported the facility only had one RN besides the Director of Nursing (DON) and Assistant Director of Nursing (ADON) (which were available Monday through Friday). (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility assessment, dated [DATE], revealed the facility was licensed for 42 beds (actually 41 beds). The center had three areas which included A Hall with the capacity to care for 18 residents and specialized in short-term care as well as long term care; B hall with the capacity of 13 residents, and the Memory care unit with the capacity to care for 11 residents and specialized in the care of residents with dementia. At the center, we consider other pertinent facts and descriptions of our resident population that we take into account when determining staffing and resource needs. We utilize the information collected in the resident profile to identify the care and services needed to care for our residents. We evaluate the type of staff members, other health care professionals, and medical practitioners that are needed to provide support and care for our residents. Listed below is a list of staff we have identified that are needed to care for our resident population: infection control and prevention, nursing services (RN and Minimum Data Set nurse), therapy services. Further review of the facility assessment revealed based on our resident population and their needs for care and support, we have made a good faith effort and approach to ensure that we have sufficient staff to meet the needs of the residents at any given time. At our enter we make a god faith effort to evaluate the overall number of facility staff needed to ensure a sufficient number of qualified staff are available to meet each resident's needs. Total direct care hours include 12 hours of RN service, 24 hours of LPN services, and 24 hours of state tested nursing assistant services for day shift and night shift included eight hours for RN, 12 hours for LPN, and 24 hours for STNAs. 6. During the onsite survey, it was identified Resident #9, and #24 did not have physician progress notes filed within their medical record (electronic and/or paper) for 2024. This finding was verified with RN #180 and the Administrator on [DATE] at 9:50 A.M. stating Medical Records #106 only worked 16 hours per week. Interview on [DATE] at 6:00 P.M., with Medical Records (MR) #106, confirmed she only worked 16 hours per week and sometimes resident information wasn't placed timely on the charts. During the interview, a cart was observed in the medical records office that contained files with the name of each unit and was filled with resident medical records. Interview and observation on [DATE] at 9:50 A.M., with RN #180 and the Administrator, verified there was a cart for medical records that had a folder with the name of each hall. The folder was filled with papers that needed to be filed in several resident records. The papers were dated back to [DATE] to present. Both confirmed the facility only had MR #106 16 hours per week. 7. During the onsite complaint survey, it was discovered the facility identified Infection Preventionist, RN #167 did not receive the certificate of completion for the Centers for Disease Control (CDC) Nursing Home Preventionist Training Course until [DATE]. Interview on [DATE] at 8:50 A.M., with the Director of Nursing (DON) revealed she was hired about seven months ago and the IP nurse had been RN #167 since she (the DON) started. Interview on [DATE] at 1:16 P.M. and [DATE] at 11:46 A.M. with RN #167 revealed she had been the IP nurse for about one year now, however she just started the IP training a little over a week ago ([DATE]). She thought she had completed the course, however when she logged into the system today ([DATE]) she had to complete the evaluation before it would allow her to print the certificate of completion. The RN confirmed she had no oversight from the Corporate RN (RN#180) in the past year. RN #167 confirmed she had not signed, nor did she have a copy of a job description for the IP. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on [DATE] at 11:29 A.M., with the Administrator confirmed the facility didn't have a job description for the IP nurse. 8. Review of the infection control log dated ,d+[DATE] to ,d+[DATE] revealed no evidence infections were being trended. Further review revealed all the infections listed on the log were treated with antibiotics. There was no documented evidence of infections not treated with antibiotics. Further review revealed no evidence staff illnesses were being tracked/monitored. Review of the facility policies revealed no evidence an infection control policy and procedure was readily available for staff reference. Interview with Infection Preventionist (IP)/Registered Nurse (RN) #167 on [DATE] at 8:33 A.M., revealed she had not trended infections for the last six months or so and she doesn't always include the organism on the tracking log. The IP nurse reported she was told by someone (would not provide name) that it was not necessary to trend infections, so she stopped. The IP nurse also confirmed she only tracked infections that were treated with antibiotics. If a resident had an infection and it didn't require antibiotic treatment, she doesn't document the infection on the log. The IP reported she doesn't track staff illness/infections except for COVID-19. The IP nurse confirmed she didn't have an infection control policy or procedure to reference The IP nurse reported she had been in the IP role for about one year. Interview on [DATE] at 2:25 P.M., with the Administrator verified she called the facility's regional office and obtained a policy and procedure for the infection preventionist and control program as the policy was not readily available to staff at the facility. Review of the facility assessment dated [DATE] revealed the facility utilized the information collected in the resident profile to identify the care and services needed to care for our residents. The facility then would evaluate the type of staff members, other health care professionals, and medical practitioners that are needed to provide support and care for our residents. Listed below is a list of staff we have identified that are needed to care for our resident population: infection control and preventionist. The facility would take a good faith effort to provide the staff training/education and competencies that are necessary to provide the level and types of support and care needed for our resident population. The nursing centers monitor staff certification requirements as applicable. The infection control must include as part of its IP program mandatory training that includes written standards, policies, and procedures for the program.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, review of e-mail correspondence, observation, and interview the facility failed to ensure medical records were accurate and complete. This affected four (Resident #9, #14, #24, and #50) of four records reviewed but had the potential to affect all 37 residents residing in the building. Findings included: 1. Record review revealed Resident #9 was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia, delusional disorders, anxiety, major depression, Vitamin B 12 and D deficiency, suicidal ideations, insomnia, and protein-calorie malnutrition. Review of Resident #9's physician progress notes for 2024 revealed no evidence the physician progress notes were filed in the resident's paper medical record or scanned into the electronic medical record (EMR) Interview on [DATE] at 9:50 A.M., with Registered Nurse (RN) #180 and the Administrator, confirmed the physician had visited the resident on [DATE], [DATE], [DATE], and [DATE] however, the progress notes had not been filed in the resident's medical record, at this time, due to the medical records staff member only working 16 hours a week. 2. Record review revealed Resident #24 was admitted to the facility on [DATE] with diagnoses including Alzheimer's, anxiety, depression, hyperlipidemia, hypothyroidism, chronic obstructive pulmonary disease, gastro-esophageal reflux, osteoarthritis, insomnia, and Vitamin D deficiency. Review of Resident #24's physician progress notes for 2024 revealed no evidence the physician progress notes were filed in the resident's paper medical record or scanned into the electronic medical record (EMR). Interview on [DATE] at 9:50 A.M., with RN #180 and the Administrator confirmed the physician had visited the resident on [DATE], [DATE], [DATE], [DATE], and [DATE] however, the notes have not been filed in the resident medical record at this time due the medical records staff member only worked 16 hours a week. 3. Interview on [DATE] at 6:00 P.M., with Medical Records (MR) #106, confirmed she only worked 16 hours per week and sometimes resident information wasn't placed timely on the charts. During the interview, a cart was observed in the medical records office that contained files with the name of each unit and was filled with resident medical records. Interview and observation on [DATE] at 9:50 A.M., with RN #180 and the Administrator, verified there was a cart for medical records that had a folder with the name of each hall. The folder was filled with papers that needed to be filed in several resident records. The papers were dated back to [DATE] to present. Both confirmed the facility only had MR #106 16 hours per week. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. Record review revealed Resident #14 was admitted to the facility on [DATE] with diagnoses including femur fracture, left wrist fracture, cirrhosis, esophageal varices, pancytopenia, and hypertension. Review of Resident #14's orders, dated [DATE], revealed to obtain a complete blood count, basic metabolic profile, Vitamin D and B 12, and folate (labwork). Review of Resident #14's medical record revealed no evidence the laboratory testing was obtained. Interview on [DATE] at 3:00 P.M. and 4:52 P.M., with RN #180 revealed the facility could not locate the lab testing that was ordered on [DATE] however, she would call the lab to obtain the results. Review of an email sent on [DATE] at 7:13 A.M., from the Administrator, revealed the lab results dated [DATE] were printed on [DATE]. 5. Closed medical record review revealed Resident #50 was admitted to the facility on [DATE] with diagnoses including chronic systolic heart failure, cardiomyopathy, hypertension, ventricular tachycardia, urinary tract infections, Escherichia coli (E. coli), atrial fibrillation, acute kidney failure, retention of urine, cervicalgia, and mixed hyperlipidemia. The residence expired on [DATE]. Review of a skilled note dated [DATE] at 4:04 A.M. revealed the resident was assessed by RN #167. Interview with Registered Nurse (RN) #167 on [DATE] at 10:30 A.M. revealed the assessment was completed on [DATE] around 11:00 P.M. not on [DATE] at 4:04 A.M., as documented in the medical record. This deficiency represents non-compliance investigated under Master Complaint Number OH00155046.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 32801 Based on infection control log review, interviews and policy review the facility failed to maintain a comprehensive infection control program responsible for tracking and trending infections. This had the potential to affect all 37 residents residing in the facility. Findings included: 1. Review of the infection control log dated 04/24 to 06/24 revealed no evidence infections were being trended. Further review revealed all the infections listed on the log were treated with antibiotics. There was no documented evidence of infections not treated with antibiotics. 2. Further review revealed no evidence staff illnesses were being tracked/monitored. 3. Review of the facility policies revealed no evidence an infection control policy and procedure was readily available for staff reference. Interview with Infection Preventionist (IP)/Registered Nurse (RN) #167 on 07/03/24 at 8:33 A.M., revealed she had not trended infections for the last six months or so and she doesn't always include the organism on the tracking log. The IP nurse reported she was told by someone (would not provide name) that it was not necessary to trend infections, so she stopped. The IP nurse also confirmed she only tracked infections that were treated with antibiotics. If a resident had an infection and it didn't require antibiotic treatment, she doesn't document the infection on the log. The IP reported she doesn't track staff illness/infections except for COVID-19. The IP nurse confirmed she didn't have an infection control policy or procedure to reference The IP nurse reported she had been in the IP role for about one year. Interview on 07/03/24 at 2:25 P.M., with the Administrator verified she called the facility's regional office and obtained a policy and procedure for the infection preventionist and control program as the policy was not readily available to staff at the facility. Review of the Infection Prevention and Control Program Policy, revised 08/23, revealed this facility has developed and maintains an Infection Control Program that will provide a safe sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The program will develop prevention, surveillance and control measures to protect residents and personnel from acquired infections; perform surveillance activities to monitor and investigate causes of infection and manner of spread in order to prevent infection in the facility; analyze clusters of infection, changes in prevalent organisms and any increase in the rate of infection; monitor community-acquired infections in residents newly admitted to the facility and develop control measures to protect other residents; identify circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. This deficiency represents non-compliance investigated under Master Complaint Complaint Number OH00155046.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 32801 Based on review of the infection control logs, interview, and policy review the facility failed to ensure infections met criteria for treatment with antibiotics. This affected seven residents (Resident #8, #15, #21, #22, #36, #52 and #53) of 37 residents residing in the facility. Findings included: 1. Review of April 2024 infection control log revealed: Resident #53 was treated with Cipro 250 milligrams (mg) twice daily for 10 days for a urinary tract infection (UTI). There was no documented evidence the resident meet McGeer Criteria (provide standardized guidance for infection surveillance activities and research studies in nursing homes and similar facilities). for treatment of the UTI. The physician was not notified regarding the antibiotic use. 2. Review of May 2024 infection control log revealed: a. Resident #8 had an oral infection and was treated with an erythromycin dose pack. There was no documented evidence the resident met McGeer Criteria for treatment or the physician was updated regarding treatment. b. Resident #21 was treated with Bactrim DS twice a day for eight days for a urinary infection (proteus species). There was no documented evidence the resident met McGeer Criteria for treatment or the physician was updated regarding treatment. c. Resident #22 was treated with Bactrim DS twice daily for seven days for a urinary infection. There was no documented evidence the resident met McGeer Criteria for treatment or the physician was updated regarding treatment 3. Review of June 2024 infection control log revealed: a. Resident #52 was ordered Keflex 500 milligrams (mg) every eight hours post-operatively as a preventive measure. There was no documented evidence the resident met McGeer criteria for treatment or the physician was updated regarding treatment. b. Resident #15 returned from the hospital with a urine bacterial infection and treated with Cefdinir 300 mg for three doses. There was no evidence supporting the resident met McGeer criteria, such as culture and sensitivity results or documented evidence the McGeer criteria form was completed to ensure the antibiotic was appropriate. c. Resident #36 returned from the hospital with sepsis (urine) and was treated with Cephalexin 500 mg three times a day for seven days. There was no evidence the resident met McGeer criteria, such as culture and sensitivity results or documented evidence the McGeer criteria form was completed to ensure the antibiotic was appropriate. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Infection Preventionist (IP)/Registered Nurse (RN) #167 on 07/03/24 at 8:33 A.M., verified she doesn't verify residents who return from the hospital on antibiotic therapy meet criteria for treatment. The IP/RN #167 also reported she doesn't have documentation that the providers were notified when residents don't meet criteria for antibiotic treatment. Further interview verified there was no documented evidence Resident #53 met criteria for antibiotic treatment in April 2024 and she had no documented evidence Residents #8, #21, or #22 met criteria for antibiotic treatment in May. In June she had no documented evidence Residents #15, #36 and #52 met criteria for antibiotic treatment when they returned from the hospital with new orders for antibiotics. The IP nurse also confirmed she didn't have evidence the residents' providers were notified they didn't meet criteria for treatment. Review of the facilities policy and procedure titled Antibiotic Stewardship dated 08/2023 revealed the program was to monitor the use of antibiotics. When a culture and sensitivity is ordered lab results and the current clinical situation would be communicated to the prescriber as soon as available if antibiotic therapy should be started, continued, modified, or discontinued. This deficiency represents non-compliance investigated under Master Complaint Number OH00155046.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on review of the certificate of training, review of the facility assessment, and interview the facility failed to ensure the Infection Preventionist (IP) had specialized training in infection prevention and control from 09/23 through 07/02/24. This had the potential to affect all 37 residents residing in the facility. Findings include: Review of the Centers for Disease Control and Prevention (CDC) Nursing Home Infection Preventionist Training Course certificate revealed Register Nurse (RN) #167 completed the course on 07/02/24. Interview on 07/02/24 at 8:50 A.M., with the Director of Nursing (DON) revealed she was hired about seven months ago and the IP nurse had been RN #167 since she (the DON) started. Interview on 07/02/24 at 1:16 P.M. and 07/03/24 at 11:46 A.M. with RN #167 revealed she had been the IP nurse for about one year now, however she just started the IP training a little over a week ago (06/23/24). She thought she had completed the course, however when she logged into the system today (07/02/24) she had to complete the evaluation before it would allow her to print the certificate of completion. The RN confirmed she had no oversight from the Corporate RN (RN#180) in the past year. RN #167 confirmed she had not signed, nor did she have a copy of a job description for the IP. Interview on 07/03/24 at 11:29 A.M., with the Administrator confirmed the facility didn't have a job description for the IP nurse. Review of the facility assessment dated [DATE] revealed the facility utilized the information collected in the resident profile to identify the care and services needed to care for our residents. The facility then would evaluate the type of staff members, other health care professionals, and medical practitioners that are needed to provide support and care for our residents. Listed below is a list of staff we have identified that are needed to care for our resident population: infection control and preventionist. The facility would take a good faith effort to provide the staff training/education and competencies that are necessary to provide the level and types of support and care needed for our resident population. The nursing centers monitor staff certification requirements as applicable. The infection control must include as part of its IP program mandatory training that includes written standards, policies, and procedures for the program. This deficiency represents non-compliance investigated under Complaint Number OH00154208.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366448	A. Building B. Wing	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe County Operating Inc	47045 Moore Ridge Road Woodsfield, OH 43793

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on personnel file review, review of the facility assessment, and interview the facility failed to ensure State tested Nursing Assistants (STNA) received the required 12 hours of in-service training per year. This had the potential to affect all 37 residents residing in the building. Findings included: 1. Review of STNA #154's personnel file revealed STNA #154 was hired on [DATE]. There was no documented evidence the STNA had in-service hours for 2023 or 2024. 2. Review of STNA #138's personnel file revealed STNA #138 was hired on [DATE]. There was no documented evidence the STNA had in-service hours for 2023 or 2024. 3. Review of STNA #110's personnel file revealed STNA #110 was hired on [DATE]. There was no documented evidence the STNA had in-service hours for 2023 or 2024. 4. Review of STNA #153's personnel file revealed STNA #153 was hired on [DATE]. There was no documented evidence the STNA had in-service hours for 2023 or 2024. 5. Review of STNA #162's personnel file revealed STNA #162 was hired on [DATE]. There was no documented evidence the STNA had in-service hours for 2023 or 2024. 6. Review of STNA #169's personnel file revealed STNA #169 was hired on [DATE]. There was no documented evidence the STNA had in-service hours for 2023 or 2024. 7. Review of STNA #173's personnel file revealed STNA #173 was hired on [DATE]. There was no documented evidence the STNA had in-service hours for 2023 or 2024. 8. Review of STNA #144's personnel file revealed STNA #144 was hired on [DATE]. There was no documented evidence the STNA had in-service hours for 2023 or 2024. 9. Review of STNA #108's personnel file revealed STNA #108 was hired on [DATE]. There was no documented evidence the STNA had in-service hours for 2023 or 2024. Further review revealed STNA #108's STNA certification had expired on [DATE]. Review of the facility assessment dated [DATE] revealed nurse aides were required to have 12 hours per year of in-service training to ensure continuing competence to provide the necessary level and types of support and care needed for the facility's population. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366448	A. Building B. Wing	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on [DATE] at 12:04 P.M., with the Business Office Manager (BOM) /Human Resource (HR) #170 confirmed the facility emplyed 16 STNAs and nine of the 16 have worked greater than a year at the facility. The BOM/HR #170 confirmed there was no documented evidence that the identified nine STNAs had received 12 hours of in-service training in 2023 or 2024. The BOM/HR #170 reported the facility had not started in-service training for the STNAs for the [AGE] year even though it was already [DATE]. This deficiency represent non-compliance investigated under Complaint Number OH00154208.