STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366448	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on observation and staff interview, the facility failed to ensure a clean, safe, and homelike environment. This affected 25 residents (#2, #3, #4, #5, #6, #8, #9, #10, #11, #12, #15, #17, #18, #19, #20, #22, #23, #25, #27, #28, #29, #30, #31, #32 and #33) of 33 residents in the facility. Findings include: 1. Observation of the environment in the second floor secured Memory Care Unit, 08/26/24 between 8:07 A. M. and 9:38 A.M. included: a. Toilet paper holders were missing from rooms 202, 204, 205, 208 and 211. b. room [ROOM NUMBER]'s door frame into the bathroom needed painted bilaterally from the floor up three feet due to the paint being scratched off. c. room [ROOM NUMBER] was missing a cover on the air conditioner. d. room [ROOM NUMBER] had drywall damage in the bathroom, a one and half foot by one foot area, was loose with a hole. The drywall was falling apart. There was a mouse trap underneath the heating/air conditioning unit. e. room [ROOM NUMBER] left of the bathroom door the molding lining the floor was coming off the wall. f. room [ROOM NUMBER] the window side wall had paint off the wall and needed painted. Interview on 08/26/24 at 9:24 A.M. with Maintenance #51 revealed about a month ago someone thought they saw a mouse in room [ROOM NUMBER] so they put a trap in there and had the exterminator look. Maintenance further verified the paint and drywall that was in need of repair. Interview on 08/26/24 at 9:28 A.M. with Licensed Practical Nurse (LPN) #42 indicated she doesn't know where the toilet paper holders were. Interview on 08/26/24 at 9:29 A.M. with State tested Nurse Aide (STNA) #53 revealed she asked housekeeping the other day where the rollers from the toilet paper holders were. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366448	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation of the first floor on 08/26/24 between 10:18 A.M. and 12:04 P.M. included: a. The 100 hall was spotted with coffee spills, dirty with streaky marks on the linoleum, the floor was dull (no shine), the linoleum from the top of the 100 hall to the end of the 100 hall was heavily cracked up and breaking. Some areas had pieces missing. b. room [ROOM NUMBER] wallpaper was damaged by bed A. c. room [ROOM NUMBER]'s bathroom door frame and entry door doorframe both needed painted due to heavy scraping of paint off the frames. d. room [ROOM NUMBER] the door frame into the room was damaged and needed painted. The sink was clogged and had four to five inches of standing water. The threshold was damaged and raised going into the bathroom causing a tripping hazard. e. room [ROOM NUMBER]'s bathroom door frame and room door frame both were damaged and needed painted. f. room [ROOM NUMBER]'s door frame was in disrepair and needed painted. The threshold into and out of room [ROOM NUMBER] had four linoleum tiles, broken, and missing pieces. g. The A/B shower room had tile broken to the lower left of the door frame. The door need painted. h. The was a urine odor in the hall outside of room [ROOM NUMBER]. Interview on 08/26/24 at 12:04 P.M. with the Director of Nursing (DON) verified the soiled damaged floor linoleum, paint in disrepair, broken tiles, damaged thresholds and standing water and urine odor. Interview on 08/26/24 at 1:35 P.M. with Maintenance #51 revealed the staff has no mercy when it comes to calling him with issues. They call him in the middle of the night. Maintenance #51 said he counted the floor tile a couple years ago because he knew it needed replaced. He revealed he trips on the linoleum when he goes down the hallway. He revealed the sink in room [ROOM NUMBER] was not clogged from the drain. It is clogged from the shower room on the second floor. The drain is backing up from the shower room and vent is clogged from someone upstairs throwing Styrofoam in the plumbing. The purpose of the vent is to allow the water to go down and it was clogged. He did not know it was backed up today. This deficiency represents non-compliance investigated under Complaint Number OH00156671.

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on interview, record review, and review of the facility policy the facility failed to ensure a resident's physician was provided accurate information regarding a discharge Against Medical Advice (AMA), and failed to provide the resident or resident representative with required documentation upon transfer. This affected two residents (#34, and #36) of three residents reviewed for transfer. The facility census was 33. Findings include: 1. Review of Resident #36's closed medical record revealed an admitted [DATE] with diagnoses that included aftercare following joint replacement surgery, moderate protein calorie malnutrition, depression, gastroesophageal reflux disease, polyosteoarthritis, osteoarthritis, dizziness and giddiness, artificial left knee, dementia, hypertension, unsteady on feet, and muscle weakness. The resident was discharged to another nursing facility on 08/14/24. Review of the Minimum Data Set (MDS) annual assessment, dated 06/18/24, revealed the resident was moderately impaired for daily decision making. Review of the medical record revealed the resident did not have a Discharge Planning form. The resident was given a Release of Responsibility for Discharge Against Medical Advice (AMA) dated 08/14/24 and signed by the resident's power of attorney. A 08/14/24 Nursing Note included Resident #36's daughter and power of attorney (POA) was at the nurses station insisting that her mother is leaving and she is taking her to another facility. Staff tried to explain to her that we would need to contact physician for orders, daughter remained adamant that she is leaving, and we are leaving now; (the daughter) stated I can't ever get ahold of anyone at this place. Family has been packing residents' things and removing them to the car. Release of responsibility for discharge against medical advice signed by POA. Physician was called and made aware of situation, and that AMA paper was signed. Interview on 08/26/24 at 12:41 P.M. with Admissions Staff #120 of the receiving facility revealed she requested and received transfer paperwork for Resident #36 the week prior to her transfer to their facility. She did not have the Minimum Data Set (MDS) Assessment and the transfer level of care. Per Admissions Staff #120, facility Admission/Transfer Staff #77 informed her she did not know how to do a transfer level of care and they did not do them. She emailed her a contact and a number at the Area on Aging to Assist her but did not receive a response related to the MDS or receive the transfer level of care. The following week she dealt with the resident's daughter and told her to bring her mother over to the facility without the requested paperwork. Review of the medical record revealed no evidence of Social Service notes reflecting the resident/facility were working on a transfer. There was no evidence of paperwork being initiated for the pending transfer. There was no discharge plan of care. (continued on next page)

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F 0660

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Review of the facility discharge process (revised 02/08/22) included it is the policy of the facility to ensure that a discharge process is completed in accordance to state and federal requirements. When the facility anticipates discharge, a resident should have a discharge plan that includes, but it's not limited to the following: a post discharge plan care that is developed with the participation of the resident and with the resident's consent the resident representative, which will assist the resident to adjust to his or her new living environment.

Interview with Admission/Social Services Staff #77 on 08/26/24 at 1:57 P.M. included she received an email dated 08/06/24 when she was out of town related to Resident #36 and she called the Director of Nursing (DON) who had spoken to the daughter about transferring her mother. She gave Admissions Staff #120 her cell phone number. She forwarded the request for resident records to the Business Office Manager (BOM). She said she did not know how to do a level of care and the BOM was to do it. Admissions Staff #77 was at the facility on Friday she doesn't know why she would have not responded to Admissions request for an MDS. She had let her know she did not do transfer levels of care. She verified she did not document anything in the record about the pending discharge. She included the nurse probably had the resident sign out AMA because she did not know there was a transfer pending and it was after five and the office staff/management would have been gone. She verified she had not documented in the record or started discharge paperwork. She verified if there was documentation in the medical record the nurse may have read the paperwork had been sent to the transferring facility and an AMA could have been avoided.

Interview on 08/26/24 at 3:22 P.M. with BOM #86 revealed she was unable to complete the transfer level of care until the MDS was completed.

Interview 08/27/24 at 9:23 A.M. with The Director of Nursing (DON) revealed she provided the surveyor all the discharge information the facility had for Resident #36's discharge.

2. Review of Resident #34's closed medical record revealed an admitted [DATE] with diagnoses that included chronic systolic congestive heart failure, atherosclerotic heart disease, cerebral infarction, coronary angioplasty, diverticulosis, hyperlipidemia, iron deficiency anemia, myocardial infarction, seasonal allergies, transient ischemic attack, sick sinus syndrome, spinal stenosis, type 2 diabetes, cirrhosis of liver, fractured femur, and protein calorie malnutrition. The resident was discharged to another nursing facility on 07/12/24.

Review of the Minimum Data Set (MDS) quarterly assessment, dated 06/26/24, revealed the resident was moderately impaired for daily decision making.

A 07/12/24 Resident/Family Education Note included the transferring facility came to transport resident to their facility. Resident checked and changed prior to them coming. She went in a wheelchair that daughter states she will bring back to the facility. Report called to facility. All personal belongings taken with daughter.

A 07/12/24 Transfer/Discharge Report included vital signs dated 07/11/24, that the resident was going to another facility, was incontinent, needed fed, and was alert and oriented times one. There was no other information on the discharge summary.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/26/24 at 12:41 P.M. with Admissions Staff #120 of the receiving facility revealed she would have called the facility 07/08/24 or 07/09/24 and left a message on Admissions/Social Service Staff #77's voice mail. A fax that was sent from Admissions/Social Service Staff #77 on 07/10/24 was incomplete. She called and spoke to someone on floor who said she was agency and can get a message. She said no one is ever here from the office. She received an email of Resident #34's transfer paperwork. Admission Staff #120 said she needed the transfer level of care but never received it. She told Admissions/Social Services Staff #77 she did not know anything about it and Admissions Staff #120 suggested to contact the Administrator. On 07/12/24 Admissions/Social Services Staff #77 emailed back and she said they have never done a transfer level of care. The Administrator apparently said they never did a transfer level of care. Admissions Staff #120 emailed her back, gave a fax number and the Area on Aging to assist her with the transfer level of care. She provided a contact name and number for the regional council in [NAME] to assist her. Review of the medical record revealed there was not a discharge order. There were no social service notes related to an impending discharge. There was no discharge plan of care. Interview with Admission/Social Services Staff #77 on 08/26/24 at 1:57 P.M. included she did not include any social service notes related to the family wanting to transfer the resident to another facility. She included the transfer facility wanted a transfer level of care. She did not provide a transfer level of care, she did not know how to do one and the business office was to be completing them until she learned how to do them. Interview on 08/27/24 at 9:23 A.M. with the Director of Nursing revealed she provided to the surveyor all the discharge information the facility had for Resident #34's discharge. This deficiency represents non-compliance investigated under Complaint Number OH00156671.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on record review and interview, the facility failed to ensure a discharge summary which included a recapitulation (concise summary) of the resident's stay at the facility, was completed. This affected three residents (#34, #35 and #36) of three residents reviewed for discharge. The facility census was 33. Findings include: 1. Review of Resident #36's closed medical record revealed an admitted [DATE] with diagnoses that included aftercare following joint replacement surgery, moderate protein calorie malnutrition, depression, gastroesophageal reflux disease, polyosteoarthritis, osteoarthritis, dizziness and giddiness, artificial left knee, dementia, hypertension, unsteady on feet, and muscle weakness. The resident was discharged to another nursing facility on 08/14/24. Review of the Minimum Data Set (MDS) annual assessment, dated 06/18/24, revealed the resident was moderately impaired for daily decision making. Review of the medical record revealed the resident did not have a Discharge Planning form. The resident was given a Release of Responsibility for Discharge Against Medical Advice (AMA) dated 08/14/24 and signed by the residents power of attorney. Review of the closed medical record revealed no evidence of a discharge summary of recapitulation of the resident's stay at the facility. There was no discharge plan of care. Interview with Admission/Social Services Staff #77 on 08/26/24 at 1:57 P.M. verified she had not documented in the record or started discharge paperwork. Interview on 08/27/24 at 9:23 A.M. with the Director of Nursing (DON) revealed she provided all the discharge information the facility had for the discharge to the surveyor. She verified there was not an interdisciplinary or physician discharge recapitulation of the stay. 2. Review of Resident #34's closed medical record revealed an admitted [DATE] with diagnoses that included chronic systolic congestive heart failure, atherosclerotic heart disease, cerebral infarction, coronary angioplasty, diverticulosis, hyperlipidemia, iron deficiency anemia, myocardial infarction, seasonal allergies, transient ischemic attack, sick sinus syndrome, spinal stenosis, type 2 diabetes, cirrhosis of liver, fractured femur, and protein calorie malnutrition. The resident was discharged to another nursing facility on 07/12/24. Review of the Minimum Data Set (MDS) quarterly assessment, dated 06/26/24, revealed the resident was moderately impaired for daily decision making. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Transfer/Discharge Report dated 07/12/24 included vital signs dated 07/11/24, that the resident was going to another facility, was incontinent, needed fed, and was alert and oriented times one. There was no other information on the discharge summary. Review of the medical record revealed there was not a discharge order. There were no social service notes related to an impending discharge. There was no discharge plan of care. Interview on 08/27/24 at 9:23 A.M. with the DON revealed she provided all the discharge information the facility had for the discharge to the surveyor. She verified there was not an interdisciplinary or physician discharge recapitulation of the stay. 3. Review of Resident #35's closed medical record revealed an admitted [DATE] with diagnoses that included acute cholecystitis, chronic obstructive pulmonary disease, type 2 diabetes, unsteadiness on feet, muscle weakness, epigastric pain, hyperlipidemia, anxiety disorder, chronic kidney disease Stage 3, Atherosclerotic heart disease, dementia, gastroesophageal reflux disease, hydronephrosis, need for personal assistance and weakness. The resident was discharged to another nursing facility on 08/12/24. Review of the Minimum Data Set (MDS) admission assessment, dated 07/19/24, revealed the resident was moderately impaired for daily decision making. Review of a post fall evaluation note dated 08/11/24 at 10:37 P.M. revealed the resident was transferred to the emergency room post a fall. A 08/12/24 at 12:55 A.M. note indicated the emergency room did not have transportation to return Resident #35 to the facility. A 08/12/24 at 3:30 P.M. note indicated the Licensed Practical Nurse had been on the phone all day with a facility the family wants to transfer Resident #35 due to it being closer to family. The paperwork was sent to the facility and the family came and picked up the resident's belongings. The record revealed there was no physician discharge recapitulation of the stay. During interview on 08/27/24 at 9:23 A.M. with the DON revealed she provided all the discharge information the facility had for the resident's discharge to the surveyor. The DON verified there was not a physician discharge recapitulation of stay. This deficiency represents non-compliance investigated under Complaint Number OH00156671.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 26706 Based on record review and interview, the facility failed to ensure a resident with edema was provided ordered medication for the treatment of edema related to the medical condition of congestive heart failure, skin ointments were applied for open skin lesions, weights obtained for a resident with edema, and intake and output assessed. This affected two residents (#21, #32) of three residents reviewed for medications. The facility census was 33. Findings include: 1. Review of Resident #21's medical record revealed a 02/27/24 admission with diagnoses including dementia with behavioral disturbance, vitamin B deficiency, osteoarthritis, respiratory failure with hypoxia, chronic gout, localized edema, myocardial infarction, acute kidney failure Stage 3, hypertension, nutritional deficiency, hypo-osmolality and hyponatremia, acute and chronic combined systolic and diastolic congestive heart failure (CHF), Alzheimer's disease, muscle weakness, abnormalities of gait and mobility, and malignant neoplasm of unspecified part of bronchus or lung. A 05/28/24 Quarterly Minimum Data Set Assessment (MDS) included the resident was severely impaired for daily decision making, and required extensive assist of two for transfers. Physician orders included an order dated 06/25/24 for TED hose on in the morning off in the evening as resident allows/tolerates for edema, 07/11/24 order for Lasix (diuretic medication), Oral Tablet 20 milligrams (mg) (Furosemide) give one tablet by mouth one time a day related to acute and chronic combined systolic and diastolic congestive heart failure, and 08/20/24 Keflex 500 mg three times a day for 10 days due to cellulitis looking areas on his left lower leg, Neosporin and wrap as resident will allow, and a consult with, podiatry, if needed. There was not a physician order for monitoring of intake and outputs or weights. Review of the resident's August 2024 medication administration record (MAR) revealed Lasix 20 mg was not recorded as being administered on 08/25/24 for the 7:00 A.M. dose. Review of the resident's Treatment Administration Record (TAR) for August 2024 revealed the treatment record included Neosporin to left lower leg and wrap with Kerlix as resident allows/tolerates every day shift had a star in the box for 08/25/24. There was no staff initial indicating the resident's treatment was provided as ordered. Monthly weights were listed as a nursing order on the treatment sheet. Observation and interview on 08/27/24 at 11:25 A.M. with Resident #21 revealed the resident was sitting in his wheelchair in his room. Observation revealed the resident's left foot and calf were edematous with a scabbed lower leg. He pointed out the swelling in his foot and leg. There was no Kerlix dressing to his leg and no TED hose on. He said he did not want the TED hose on. Observation on 08/28/24 at 9:51 A.M. of the resident revealed he was in his room, in a wheelchair with a Kerlix dressing to his left calf. Interview on 08/28/24 at 1:15 P.M. with the Director of Nursing (DON) verified the Lasix was not administered as ordered 08/25/24 at 7:00 A.M. for a resident with bilateral foot and calf edema. Also verified there was a star not a staff initial for the Neosporin administration. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #32's medical record revealed a 05/25/19 admission with diagnoses including severe sepsis with septic shock, urinary tract infection, muscle weakness, depression, hypothyroidism, psychosis, hypomagnesemia, iron deficiency anemia, hypertension, vitamin B12 deficiency anemia, GERD, paroxysmal atrial fibrillation, vitamin D deficiency, kyphosis, scoliosis, insomnia, occlusion and stenosis of unspecified carotid artery, rheumatoid arthritis with rheumatoid factor, acute bronchitis, cardiomyopathy, protein calorie malnutrition, systolic congestive heart failure. Review of a 07/05/24 quarterly MDS revealed the resident was severely impaired for daily decision-making with no behaviors. The resident required set up or cleanup assistance for eating and dependent for other activities of daily living. She was 61 inches and weighed 150 pounds for the assessment. The resident had active diagnoses, including heart failure, and hypertension, and malnutrition risk. Physician orders included an order dated 07/22/24 for a daily weight, and intake and output if incontinence brief is not wet at least three times per shift, and notify the doctor/nurse practitioner. Review of the August 2024 TAR revealed there was no evidence of a daily weight on 08/24/24 and 08/25/24. There was no evidence of an intake/output recorded on 08/25/24. Interview on 08/28/24 at 7:35 P.M. with the DON verified the daily weights and intake output were not obtained as ordered for a resident with congestive heart failure. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00156671. This deficiency is evidence of continued non-compliance from the survey completed 07/29/24.

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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** 26706 Based on medical record review, interview, and policy review the facility failed to provide comprehensive pressure ulcer care timely and as ordered. This affected two residents (#14 and #26) of three residents reviewed for pressure ulcer care and services. The facility census was 33. Findings included: 1. Review of Resident #26's medical record revealed a 08/21/24 admission with diagnoses including metabolic encephalopathy, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia and hypercapnia, ulcerative colitis, severe protein calorie malnutrition, hypertension, hypothyroidism, depression, restless legs syndrome, polyneuropathy, scoliosis, gastroesophageal reflux disease, lupus erythematosus and spondylosis of lumbar region. Review of the 08/21/24 admission note included the resident had a Stage 1 pressure ulcer (defined as intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues) to coccyx (back of body above buttocks). The pressure ulcer measured length centimeters (cm): 0.5, width (cm): 0.5 x depth (cm): 0. Wound exudate: None. Peri wound: Normal. Pressure ulcer staging: Stage 1 Pressure ulcer / injury - non-blanchable erythema of intact skin. Painful: No. Skin tissue: Firm. Physician orders included an order dated 08/21/24 to cleanse Stage 1 pressure ulcer to coccyx with wound cleanser and pat dry, and cover with dry dressing daily every dayshift and as needed until healed and apply skin prep to bilateral heels everyday for prevention of break down. The resident did not have a comprehensive MDS assessment. Review of the resident's August 2024 Treatment Administration Record (TAR) revealed no evidence the 08/25/24 6:00 A.M. treatments to cleanse coccyx with wound cleanser and pat dry, and cover with dry dressing daily every dayshift and as needed until healed and apply skin prep to bilateral heels everyday for prevention of break down treatments was completed as ordered. Interview on 08/27/24 at 12:31 P.M. with Resident #26 revealed she gets the dressing changed on her bottom everyday or every other day. Interview on 08/27/24 at 12:46 P.M. with Registered Nurse (RN) #101 and review of the TAR verified Resident #26's treatment ordered to be completed on 08/25/24 was not completed. Review of the facility policy titled Pressure Injury Treatment (undated) revealed 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 an individualized treatment program that provides the appropriate treatment to facilitate healing and that assesses and addressed co-morbid conditions in a systematic manner. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #14's medical record revealed a 05/14/24 admission with diagnoses including fractured right femur, type 2 diabetes, vitamin D deficiency, dementia, unstageable pressure ulcer, protein calorie malnutrition, muscle weakness, difficulty walking, adult failure to thrive, hypertension, chronic embolism and thrombosis of deep veins of lower extremities, chronic kidney disease Stage 3, cellulitis, localized edema, non pressure chronic ulcer of foot and urinary tract infection. Review of the annual MDS dated [DATE] revealed the resident was moderately impaired of daily decision making, had lower extremity impairment on one side, uses a walker or wheelchair, needed substantial maximum assist for rolling side to side, moving, sit to stand and lying. Physician orders included an order dated 07/02/24 revealed for enhanced barrier precautions, order dated 08/01/24 to cleanse right heel with normal saline pat dry, and apply Santyl to wound bed only; then apply Dakins 1/4 Strength solution moist gauze to wound bed only. Keep off of good skin. Apply dry gauze. Apply ABD pad and secure. Change dressing daily and as needed one time a day. A wound assessment dated [DATE] revealed a right heel posterior unstageable pressure ulcer (defined as full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.) that measured 2.78 centimeters (cm) length x 2.59 cm width x 0.1 cm depth. Review of the August 2024 TAR revealed the pressure ulcer treatment to the right heel was not completed as ordered. Interview on 08/27/24 at 11:32 A.M. with Resident #14 revealed she gets her pressure ulcer dressing changed every day or every other day depending on the order. Interview on 08/27/24 at 5:54 P.M. with the Director of Nursing verified the pressure ulcer dressing change and treatment was not completed as ordered on 08/25/24. This deficiency represents non-compliance investigated under Complaint Number OH00156671. This deficiency is evidence of continued non-compliance from the survey completed 07/29/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366448	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Monroe County Operating Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 47045 Moore Ridge Road Woodsfield, OH 43793	

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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 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** 26706 Based on record review, observation, and interviews the facility failed to ensure residents received physician ordered nutritional supplements for identified nutritional needs. This affected two residents (#26 and #32) of four residents reviewed for nutritional care and services. The census was 33. Findings included: 1. Review of Resident #26's medical record revealed a 08/21/24 admission with diagnoses including metabolic encephalopathy, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia and hypercapnia, ulcerative colitis, severe protein calorie malnutrition, hypertension, hypothyroidism, depression, restless legs syndrome (RLS), polyneuropathy, scoliosis, gastroesophageal reflux disease, lupus erythematosus and spondylosis of lumbar region. The resident was not due for a comprehensive Minimum Data Set (MDS) assessment. Review of a Nutrition assessment dated [DATE] (1:59 P.M.) included the resident diagnoses included metabolic encephalopathy, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), colitis, severe protein-calorie malnutrition, RLS, polyneuropathy, and lupus. The resident receives therapeutic cardiac diet, thin liquids without supplements. The resident eats in own room. Meal intake 50% with no chewing/swallowing difficulties. Weight 71.6 pounds on 08/21/24. Goal weight 130 pounds. Body Mass Index (BMI)11.6 underweight. Resident has own teeth, ambulatory, independent with eating, requires no setup or physical help from staff. No pressure ulcers (this is an error as the resident had a Stage 1 pressure ulcer), and no pitting edema. Resident has active malnutrition diagnosis. Interventions: regular thin liquids diets, Healthshake twice a day. A mini nutrition score of five points: malnourished. Review of the Individual Nutrition Recommendations/Response dated 08/26/24 revealed malnutrition present. Recommendations regular, thin liquids diet, discontinue cardiac diet, Healthshakes twice a day and weekly weights. Interview and observation on 08/27/24 at 12:31 P.M. with Resident #26 revealed she ate pudding, hot chocolate, meat, part of noodles and part of corn. She indicated they have not given her a supplement and there was no supplement included for the resident's meal. She drinks Boost Plus Protein, a high calorie protein drink, three to four times a day at when she resided at home. Review of Physician orders dated 08/27/24 revealed there were no orders for a nutritional supplement, regular diet or weekly weights. Interview on 08/27/24 at 1:18 P.M. with the Director of Nursing (DON) revealed she had not called the doctor yet with the recommendations because she was busy yesterday and today. She said the recommendation came late last night and she did not get them until this morning. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/27/24 at 2:46 P.M. with Dietary Supervisor #79 revealed she received the the email at 3:22 P. M. from the Dietician with the recommendations and gave it to the DON when she was in the Business Office by 3:30 P.M. on 08/26/24. Review of a follow up on the Dietician recommendations revealed the Healthshakes and regular diet were ordered but there was no evidence of the weekly weight being ordered. Interview on 08/27/24 at 5:21 P.M. with the DON verified she did not see the order for the weekly weight. Review of the resident's Medication Administration Record (MAR) revealed the 08/27/24 6:00 P.M. healthshake was not provided as ordered. Interview on 08/28/24 at 9:27 A.M. with Registered Nurse (RN) #84 verified the resident had not been provided the supplement as ordered. 2. Review of Resident #32's medical record revealed a 05/25/19 admission with diagnoses including severe sepsis with septic shock, urinary tract infection, muscle weakness, depression, hypothyroidism, psychosis, hypomagnesemia, iron deficiency anemia, hypertension, vitamin B12 deficiency anemia, GERD, paroxysmal atrial fibrillation, vitamin D deficiency, kyphosis, scoliosis, insomnia, occlusion and stenosis of unspecified carotid artery, rheumatoid arthritis with rheumatoid factor, acute bronchitis, cardiomyopathy, protein calorie malnutrition, systolic congestive heart failure. Physician orders included an order dated 05/31/24 for Health Shake four ounces between breakfast and lunch. Review of a 07/05/24 quarterly MDS revealed the resident was severely impaired for daily decision-making with no behaviors. The resident required set up or cleanup assistance for eating and was dependent for other activities of daily living. She was 61 inches tall and weighed 150 pounds for the assessment. The resident had active diagnoses, including heart failure, and hypertension, and malnutrition risk. A Nutrition/Dietary Note dated 08/05/24 included continues regular, regular texture, thin liquid diet. NKFA. No supplements per order (actually was ordered). Oral intake ranges from 26-100 percent of meals. On 07/30/24: 149.8 pounds, BMI 28.3 healthy/normal category for advanced age. Recent significant weight loss; refer to nutrition notes. No new nutrition-related interventions at this time. Review of the TAR revealed there was no evidence of the health shake being provided 08/25/24. Interview on 08/28/24 at 7:35 P.M. with the DON verified the health shake was not provided as ordered. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00156671. This deficiency is evidence of continued non-compliance from the survey completed 07/29/24.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on observation, record review, policy review, and interview, the facility failed to ensure respiratory equipment was maintained in a sanitary manner. This affected one resident (#19) of four residents observed for medication administration. The census was 33. Findings include: Review of Resident #19's medical record revealed a a 07/29/20 admission with diagnoses including Alzheimer's disease, cataract, anxiety disorder, depressive disorder, hyperlipidemia, chronic obstructive pulmonary disease (COPD), hypothyroidism, gastroesophageal reflux disease, osteoarthritis, hypertension, vitamin D deficiency and insomnia. Physician orders included an order dated 12/28/22 for Albuterol nebulizer 0.63 milligrams (mg) and 3 milliliters (ml) inhale one vile via nebulizer every six hours as needed rinse mouth after each use. Physician orders included an undated treatment to change nebulizer set weekly and as needed for soiling on Sundays. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] included the resident was severely impaired for daily decision making, had COPD and shortness of breath. The resident had a 07/03/24 Impaired Pulmonary/respiratory Status plan of care related to Chronic Obstructive Pulmonary Disorder (COPD) and emphysema. Observation on 08/26/24 at 8:22 A.M. a nebulizer machine and mask were observed in the dining room on the heater. The mask was on top of the machine face down. The mask was not in a bag for sanitary storage. The mask was dated 08/18/24. Interview on 08/26/24 at 8:24 A.M. with State tested Nurse Aide (STNA) #53 revealed Resident #19 was the only resident on the hall that received nebulizer treatment. She indicated the resident doesn't come to the dining room for breakfast but does come for lunch and supper. She looked in the resident's room and said her nebulizer was not in her room. Review of the treatment sheet revealed the nebulizer set was not signed off as changed on 08/11/24 or 08/25/24. Review of the facility's Nebulizer Therapy policy (dated 04/23) included under Care of Equipment to clean after each use, and disassemble parts after every treatment. Rinse the nebulizer cup and mouthpiece with sterile or distilled water. Shake off excess water. Air dry on absorbent towel. Once completely dry, tore the nebulizer cup and mouthpiece in a Ziploc bag. Change nebulizer tubing every 72 hours or per policy. Review of the facility's Oxygen Administration policy (revised April 2023) included to keep delivery service devices covered in plastic when not in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/26/24 at 8:32 A.M. with Licensed Practical Nurse (LPN) #42 verified the nebulizer machine was on the heater in the dining room with the mask on top the machine not contained in a bag for storage. The mask was dated 08/18/24 and was not changed 08/25/24 as ordered. The treatment sheet was also not signed 08/11/24 as being changed. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00156671.

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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. 26706 Based on observation, record review, review of the daily census, review of staff postings and staff schedules and review of the facility assessment, the facility failed to ensure adequate staffing levels to meet resident needs. This had the potential to affect all 33 residents residing in the building. Findings included: Observation and interview on 08/26/24 at 8:07 A.M. revealed there was only one State tested Nursing Assistant (STNA) #53 on the Memory Lane secure unit to provide care for ten (10) residents. The STNA verified she was the only staff member on the unit due to the nurse administering medication on the connected assisted living (AL) (located on the first floor and the memory care unit is located on the second floor). STNA #53 revealed she usually worked 6:00 A.M. until 6:30 P.M. day shift on the secured unit and the nurse always went to the AL first around 6:30 A.M. to administer medications, leaving her alone on the unit to provide morning care (incontinence care and assist residents with activities of daily living), assist residents out of bed for breakfast, pass breakfast trays, and assist with resident meals. The nurse usually returns between 8:00 A.M. and 8:45 A.M. The STNA included the nurse must leave the secure unit several times throughout the day to go to the AL to work but she has a walkie talkie to call for help. Observation revealed on 08/26/24 from 8:07 A.M. to 8:30 A.M. STNA #53 passed the hall trays and the breakfast trays for the dining room. There were two residents (#17, and #25) sitting at the table in the dining room waiting for breakfast joined by a third resident later. At 8:09 A.M. Resident #24 was walking in the hall with a walker and was verbally prompted to go into the dining room for breakfast. At 8:11 A.M. Resident #8 was standing in her room eating breakfast from a tray that was on a counter in her room. At 8:13 A.M. Resident #11 was sitting on the side of her bed. Her room smelled like urine. At 8:14 A.M. Resident #23 was in her room sitting on the toilet. At 8:20 A.M., all of the trays were delivered except for two residents (#4 and #20) due to the residents were still sleeping. All three residents in the dining room were feeding themselves. Five residents had their breakfast trays in their rooms. Interview on 08/26/24 at 8:22 A.M. with STNA #53 revealed Resident #17 and #24 were identified to be a fall risk. They were two of the three residents eating in the dining room without staff. STNA #53 included Resident's #4 and #20 were in need of two assist. Observation and interview on 08/26/24 8:30 A.M. revealed Licensed Practical Nurse #42 returned to the floor. 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 08/26/24 at 9:58 A.M. with STNA #78 in revealed an aide is supposed to go from the first floor to the second floor when the second floor nurse is on AL. STNA #78 said they do not call down from the second floor to let them know the nurse went to AL so they work with one aide on the second floor when the nurse is on AL. It is their busy time on the first floor at 6:30 A.M. getting residents up so they will stay on the first floor and get residents ready for breakfast. Interview on 08/26/24 at 12:08 P.M. with the Director of Nursing revealed she is contracted as well as the Assistant Director of Nursing. She included two staff were to be on the secured unit at all times. They are trying to get a third aide on night shift so upstairs always has two staff when the nurse is on AL. Interview on 08/26/24 at 3:15 P.M. with the Administrator revealed it has been a challenge to get staff. The issue with one staff member in the secure unit had not been completely resolved. Review of the schedule and interview on 08/26/24 at 3:17 P.M. with Housekeeping/Scheduler #41 revealed there was only one nurse upstairs on 08/25/24 from 6:00 P.M. to 6:00 A.M The nurse functioned as the nurse and aide. When the nurse went to AL the aide from the first floor would of come up to the second floor leaving the first floor with one staff. Interview on 08/27/24 at 10:10 A.M. with STNA #53 revealed STNA #88 came to the second floor around 7:00 A.M. so the secured unit would not only have one staff. STNA #53 said she was the only staff on the floor for about 30 minutes after the nurse went to AL this morning and the aide came upstairs. Interview on 08/27/24 at 7:17 P.M. with the Administrator revealed STNA #115 should have floated upstairs when the nurse went to AL so only one staff would not be on the secured unit. When the aide goes to the second floor on the second shift that leaves just the one nurse on the first floor. On 08/26/24 STNA #115 should have floated upstairs on dayshift when the nurse was in AL. The Administrator further revealed there were two staff scheduled for night shift on 08/25/24. An agency aide had called off and no one called to inform her until 5:00 A.M. If she was called she would have come in to cover the shift. On 08/28/24 at 6:30 P.M. interview and observation with STNA #92 revealed the nurse was over on AL. She gets back about 8:00 P.M. leaving her on the secure unit herself from 6:30 P.M. until 8:00 P.M. There is only one STNA on the first floor from 6:00 P.M. till 6:30 A.M. If the aide comes up from the first floor then the first floor is left with just the nurse, one staff member. The nurse goes back to the AL for about a half hour in the morning. She said if she needs the nurse the nurse will come back up. The surveyor asked STNA #92 if she could leave and the STNA did not respond. When surveyor was leaving the second floor, STNA #53 told STNA #92 she was clocking out leaving the second floor with one staff member. Review of the facility assessment,(updated 07/2024), revealed the facility was licensed for 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. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0725 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 24 hours of RN service, 24 hours of LPN services, and 48 hours of state tested nursing assistant services for day shift and night shift included 24 hours for LPN, and 24 hours for STNA's. At our center, we take our resident population into account when determining staff and resource needs. This deficiency represents non-compliance investigated under Complaint Number OH00156671. This deficiency is evidence of non-compliance from the survey completed 07/29/24.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 26706 Based on observation, manufacturer guidelines, policy review, and interview, the facility failed to ensure a medication error rate of five percent or less when the facility had 26 opportunities for administration with two errors resulting in a 7.69 percent medication error rate. This affected one resident (#19) of four residents observed for medication administration. The facility census was 33. Findings include: Observation of medication administration on 08/26/24 at 8:38 A.M. with Licensed Practical Nurse (LPN) #42 revealed medications were administered to Resident #19. Oral medications were administered initially. At 9:13 A.M. the nurse returned to the resident to administer the first of two respiratory medications; Ventolin HFA Aerosol Solution micrograms (mcg) per activation (ACT) (Albuterol Sulfate HFA) two puffs inhale orally two times a day related to chronic obstructive pulmonary disease (COPD) was administered first. The nurse opened a new box of inhaler, shook it, held it to the resident mouth and activated the inhalation canister, asking the resident to breathe in. She waited approximately 15 seconds and repeated the steps for a second activation. At 9:36 A.M. LPN #42 administered the second inhaler Combivent Respimat Inhalation Aerosol Solution 20-100 MCG/ACT (Ipratropium-Albuterol) two puffs inhale orally two times a day for COPD. She shook the vial, held it to the resident's mouth and activated the inhalation canister, asking the resident to breathe in. She waited approximately 21 seconds and repeated the steps for a second activation. Review of the GlaxoSmithKline manufacturer guidelines for Ventolin included under instructions for use to hold your breath for about 10 seconds, or for as long as comfortable. Breathe out slowly as long as you can. If your healthcare provider has told you to use more sprays, wait 1 minute and shake the inhaler again. Repeat steps two through six. Review of the Teva Pharmaceuticals distributor guidelines for Combivent included if your doctor has told you to use more sprays, wait 1 minute and shake the inhaler again. Repeat steps two through six. Review of the facility's Administration of Metered-Dose Inhaler policy (dated 2022) included to wait at least a minute between puffs or per manufacturer's specifications. Interview on 08/26/24 at 9:38 A.M. with LPN #42 verified she did not wait one minute between puffs. She indicated she knew to wait 10 minutes between types of inhalers but did not know she was supposed to wait one minute between puffs. This deficiency represents non-compliance investigated under Complaint Number OH00156671.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26706 Based on record review and interview, the facility failed to ensure laboratory tests were obtained as ordered. This affected three residents (#3, #19, and #21) of four residents reviewed for laboratory testing. The facility census was 33. Findings include: 1. Review of Resident #19's medical record revealed a a 07/29/20 admission with diagnoses including Alzheimer's disease, cataract, anxiety disorder, depressive disorder, hyperlipidemia, chronic obstructive pulmonary disease (COPD), hypothyroidism, gastroesophageal reflux disease, osteoarthritis, hypertension, vitamin D deficiency and insomnia. Physician orders included a 01/28/24 order for a Basic Metabolic Panel (BMP), Complete Blood Count (CBC), Vitamin D, B12, and Folate levels every three months. A 04/01/24 physician order included a Hemoglobin A1C and Lipid Level every six months. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] included the resident was severely impaired for daily decision making, had COPD and shortness of breath. There was no evidence of a baseline Hemoglobin A1C and Lipid Level. The last Basic Metabolic Panel, Complete Blood Count, Vitamin D, B12, and Folate levels were drawn on 05/16/24. The lab tests were not drawn in August 2024. The lab test were not on the August or September 2024 calendar to be completed. Interview on 08/27/24 at 3:30 P.M. with the Director of Nursing (DON) verified the laboratory tests were not completed as ordered. 2. Review of Resident #21's medical record revealed a 02/27/24 admission with diagnoses including dementia with behavioral disturbance, vitamin B deficiency, osteoarthritis, respiratory failure with hypoxia, chronic gout, localized edema, myocardial infarction, acute kidney failure Stage 3, hypertension, nutritional deficiency, hypo-osmolality and hyponatremia, acute and chronic combined systolic and diastolic congestive heart failure, Alzheimer's disease, muscle weakness, abnormalities of gait and mobility, and malignant neoplasm of unspecified part of bronchus or lung. Physician orders included a 03/02/24 order for CBC, BMP, B12, Folate, Vitamin D levels every three months and Lipids and Uric Acid levels every six months. Review of the resident's medical record revealed no evidence laboratory testing was completed as ordered. Interview on 08/28/24 at 5:29 P.M. with the DON verified the CBC, BMP, B12, Folate, Vitamin D levels every three months and Lipids and Uric Acid levels every six months had not been obtained. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #3's medical record revealed a 03/17/23 admission with diagnoses including hemophilia, benign prostatic hyperplasia, affective mood disorder, protein calorie malnutrition, fractured femur, otitis media, muscle weakness, difficulty walking, type 2 diabetes, gastroesophageal reflux disease, anemia, abnormalities of gait and mobility, dysphagia, osteoarthritis of knee, hypertension, atherosclerosis, reflex neuropathic bladder, vitamin D deficiency, Vitamin D deficiency, hyperlipidemia, hyperkalemia, Barrett's esophagus, and protein calorie malnutrition. Physician orders included a 01/14/24 order for Thyroid Stimulating Hormone, Hemoglobin A1C and Lipids every six months. The order was renewed 06/04/24. Review of the quarterly MDS dated [DATE] revealed the resident was independent for daily decision making, extensive assist of one for bed mobility, dependent for transfers and toileting. The resident had bilateral upper extremity impairment. The resident had pressure ulcers. Review of the resident's medical record revealed no evidence of Lipid laboratory testing as ordered. Interview on 08/28/24 at 12:26 P.M. with the DON verified the facility had not drawn any laboratory test for Lipids since admission for Resident #3. This deficiency represents non-compliance investigated under Complaint Number OH00156671.