STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366475	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smiths Mill Health Campus	7320 Smiths Mill Road New Albany, OH 43054

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on record review, resident representative and staff interviews, and facility policy review, the facility failed to timely notify one resident's representative (Resident #34) and certified nurse practitioner (CNP) of changes in condition. The deficient practice affected one resident (Resident #34) of three reviewed for changes in condition. The facility census was 41. Findings Include: Review of the medical record for Resident #34 revealed an admitted on 06/13/24 and a discharge date on 09/27/24 with return to the facility expected. Medical diagnoses included abdominal aortic aneurysm without rupture, urinary tract infection (UTI), severe protein-calorie malnutrition, complication of surgical and medical care of abdominal wound, acute posthemorrhagic anemia, acute kidney failure, dysphagia, bacteremia, colostomy, peripheral vascular disease, and pressure ulcers of sacral region, buttock, and heel. Review of the resident profile for Resident #34 revealed the resident's girlfriend (Girlfriend #700) was listed as the resident's first Emergency Contact. Girlfriend #700 was also Resident #34's named Power of Attorney (POA). Review of the Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #34 had intact cognition and scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #34 required substantial assistance to total dependence from staff to complete Activities of Daily Living (ADLs). Review of CNP #603's progress note revealed Resident #34 was seen on 09/24/24 at 8:00 A.M. (47 minutes prior to vital signs being recorded) for a post-acute (PAC) visit to decrease recidivism to the hospital. Repeat Complete Blood Count (CBC) and Complete Metabolic Panel (CMP) laboratory tests were ordered. A chest x-ray (CXR) was ordered as well. An order for nebulizer treatments (breathing treatments) was given to the nurse with instructions to monitor the resident. Resident #34 was discussed with the facility's clinical team. There was no evidence Resident #34's representative was notified of changes in condition. Review of Resident #34's vital signs revealed on 09/24/24 at 8:47 A.M., the resident had a blood pressure (BP) of 98/70 and a pulse of 110 beats per minute (bpm). (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note prior to surveyor intervention revealed on 09/24/24 at 1:24 P.M. (approximately five hours after abnormal vital signs were recorded), Resident #34 was lethargic with a new onset cough, congestion, and low blood pressure. Certified Nurse Practitioner (CNP) #603 was notified and new verbal orders for a STAT (immediate) chest x-ray (CXR), Complete Metabolic Panel (CMP) blood laboratory test, and a urine culture were given. There was no evidence Resident #34's representative was notified of the resident's change in condition. Review of the chest x-ray (CXR) results reported on 09/24/24 at 1:55 P.M. revealed Resident #34 had hyperinflated lungs with chronic interstitial markings. Review of the lab results dated 09/24/24 revealed a blood draw was collected at 3:40 P.M. and results were reported at 8:06 P.M. The CBC results revealed a high white blood cell (WBC) count of 19.4 X 10E3/uL. The normal range was 3.4-10.8. The results also showed a critically low red blood cell (RBC) count of 2.44 X10E6/uL. The normal range was 4.14-5.80. Resident #34's blood urea nitrogen (BUN) was high at 49 mg/dL. The normal range was 8-27. The resident also had a high BUN/Creatinine Ratio at 58. The normal range was 10-24. There was no evidence CNP #603 was notified of the lab results upon receipt due to the critical value. Review of the progress note dated 09/25/24 at 6:57 A.M. (approximately 17 hours after CXR results were reported and 10 hours after the lab results were reported to the facility) revealed lab results were received and sent to CNP #603. CNP #603 ordered Rocephin (Ceftriaxone) (an antibiotic) 2 grams (g) intramuscular (IM) injection with instructions to dilute with Lidocaine daily for three days. CNP #603 also ordered CBC and Basic Metabolic Panel (BMP) laboratory blood tests to be drawn on 09/25/24 and 09/27/24. Family was notified. Review of Resident #34's vital signs revealed on 09/25/24 at 6:29 P.M., the resident's BP was 102/64 and pulse was 101 bpm. Review of the progress note dated 09/26/24 at 4:45 A.M. revealed Resident #34 refused blood draws for ordered laboratory tests during night shift. This was the second refusal in two days. There was no evidence CNP #603 or Resident #34's representative was notified of the lab refusals. Review of CNP #603's progress note revealed Resident #34 was seen on 09/26/24 at 8:00 A.M. revealed there were no vital signs recorded. The resident was alert to himself and situation only. Resident #34 refused blood draw last night but was in agreement to have the labs drawn today STAT. Resident #34 was administered another dose of IM Rocephin. The resident had a cough and diminished upper and lower lobes in his lungs. Ordered another STAT CXR. If the resident's WBC count had not trended down, would need to send the resident out to the hospital for further evaluation. Ordered repeat labs again on 09/27/24. Resident #34 was discussed with the facility clinical team. There was no evidence Resident #34's representative was notified of any changes in the resident's condition or treatment plan. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 09/26/24 at 8:40 A.M. revealed Resident #34 remained lethargic and dyspneic (short of breath) with a cough. The resident was hypotensive (low blood pressure) and tachycardic (fast heart rate). CNP #603 was on-site at the facility and assessed the resident. New orders were received to repeat a STAT CXR, STAT CBC and CMP, and administer another dose of IM Rocephin. There was no evidence Resident #34's representative was notified of the changes in condition. Review of Resident#34's vital signs revealed on 09/26/24 at 8:41 A.M., Resident #34's BP was 92/61 and pulse was 129 bpm. Review of the CXR results reported to the facility on [DATE] at 10:56 A.M. revealed the x-ray was ordered due to an altered mental status, cough, lethargy, and dyspnea (shortness of breath). The impression was hyperinflated lungs with no significant changes since the prior study. Review of the lab results dated 09/26/24 revealed the blood draw was collected at 9:45 A.M. and results were reported to the facility at 1:07 P.M. The CBC results revealed a high WBC count at 14.4 X10E3/uL. The normal range was 3.4-10.8. Resident #34 had a critically low RBC at 2.48 X 10E6/uL. The normal range was 4.14-5.80. The resident had a high BUN at 62 mg/dL. The normal range was 8-27. Resident #34 had a high BUN/Creatinine Ratio at 74. The normal range was 10-24. Review of the progress note dated 09/26/24 at 1:33 P.M. revealed Resident #34's CXR results were received. CNP #603 was notified of the results. Aspiration pneumonia was suspected. An order to continue IM Rocephin antibiotic treatment was received. There was no evidence Resident #34's representative was notified of the CXR results. Review of the progress note dated 09/26/24 at 1:54 P.M. revealed Resident #34's lab results were received and CNP #603 was notified of the results. An order to continue IM Rocephin daily through 09/28/24 was given. Resident #34 was noted to be dyspneic with an oxygen saturation of 92%. CNP #603 ordered oxygen as needed to keep saturation levels at or above 95%. There was no evidence Resident #34's representative was notified of the changes in condition. Review of Resident #34's vital signs revealed on 09/26/24 at 2:25 P.M., the resident's BP was 97/59 and pulse was 118 bpm. Review of the progress note on 09/27/24 at 10:33 P.M. revealed Resident #34 was found grey and going in and out of consciousness during night time medication administration. The resident was hypotensive (low BP) and tachycardic (fast heart rate). The nurse called 911 and the resident was sent to the hospital. Resident #34's BP was 96/50 and his pulse was 121 bpm. The resident's representative and CNP #603 were notified of the transfer. Interview on 10/02/24 at 2:36 P.M. with the Assistant Director of Nursing (ADON) #539 revealed she was on-site at the facility from 09/24/24 through 09/27/24. ADON #539 stated Resident #34 was cognitively intact normally and did not require a representative for decision making. ADON #539 confirmed Resident #34 had an altered mental status during the noted timeframe. ADON #539 confirmed there was no evidence of any communication with Resident #34's representative/POA related to changes in his condition or treatment plan. ADON #539 initially indicated Resident #34 had vital signs within normal ranges up until he was transferred to the hospital. However, after review of the resident's vital signs, ADON #539 confirmed Resident #34 did have abnormal vital signs prior to being transferred out of the facility. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews on 10/02/24 at 2:55 P.M. and 10/07/24 at 1:31 P.M with Girlfriend #700 via phone confirmed Resident #34 remained in the hospital and was receiving treatment with intravenous antibiotics for multiple different infections, including sepsis. Girlfriend #700 confirmed she was not notified of cxr results, lab results, new physician orders, or changes in Resident #34's condition. Girlfriend #700 confirmed she was the named Power of Attorney (POA) for Resident #34. Girlfriend #700 confirmed Resident #34 was not his normal self and was confused prior to being sent to the hospital. Interview on 10/03/24 at 8:10 A.M. with CNP #603 confirmed there was no evidence of communication with Resident #34's representative related to changes in his condition or treatment plan changes. CNP #603 confirmed she was not notified of Resident #34's abnormal vital signs in between her on-site visits and confirmed she was not called with lab or CXR results as noted above. Interview on 10/07/24 at 1:45 P.M. with Licensed Practical Nurse (LPN) #579 confirmed the CNP and resident representative should be notified immediately of any lab results that reveal a critical value. Review of the facility policy, Notification of Change in Condition, dated 05/10/16, revealed the policy stated, The facility must inform the resident, consult with the resident's physician and if known notify the resident's legal representative when: a significant change in the resident's physical, mental, or psychosocial status or a need to alter treatment significantly occurs. Sample reasons to notify the physician immediately included: A deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications or a need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment or to commence a new form of treatment) or a critical lab value which requires an immediate intervention. The resident representative/provider should be notified of change in condition or diagnostic testing results in a timely manner. Documentation of notification or notification attempts should be recorded in the resident electronic health record.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on record review, staff interview, and facility policy review, the facility failed to provide written notice of transfer to a hospital to one resident (Resident #34) and/or the resident's representative. The deficient practice affected one resident (Resident #34) of three reviewed for transfer and discharge. The facility census was 41. Findings Include: Review of the medical record for Resident #34 revealed an admitted on 06/13/24 and a discharge date on 09/27/24 with return to the facility expected. Medical diagnoses included abdominal aortic aneurysm without rupture, urinary tract infection (UTI), severe protein-calorie malnutrition, complication of surgical and medical care of abdominal wound, acute posthemorrhagic anemia, acute kidney failure, dysphagia, bacteremia, colostomy, peripheral vascular disease, and pressure ulcers of sacral region, buttock, and heel. Review of the Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #34 had intact cognition and scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #34 required substantial assistance to total dependence from staff to complete Activities of Daily Living (ADLs). Review of the progress note on 09/27/24 at 10:33 P.M. revealed Resident #34 was found grey and going in and out of consciousness during night time medication administration. The resident was hypotensive (low BP) and tachycardic (fast heart rate). The nurse called 911 and the resident was sent to the hospital. Resident #34's BP was 96/50 and his pulse was 121 bpm. The resident's representative and CNP #603 were notified of the transfer. There was not evidence of a written transfer notice in Resident #34's medical record. Interview on 10/07/24 at 12:09 P.M. with the Administrator confirmed no written transfer notice had been completed for Resident #34's transfer to the hospital on 09/27/24. Review of the facility policy, Guidelines for Transfer and Discharge (including AMA), dated 05/03/17, revealed the policy stated, Emergency Transfer procedures should include the following: Nursing should print and send the resident's CCD (Continuum of Care Document) which includes current diagnosis, most recent vital signs, allergies, attending physician, current medications, treatments, and Advance Directives.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on record review, staff interview, and facility policy review, the facility failed to provide a written notice of discharge to one resident (Resident #34) or the resident's representative prior to discharging the resident from the facility. The deficient practice affected one resident (Resident #34) of three reviewed for transfer and discharge. The facility census was 41. Findings Include: Review of the medical record for Resident #34 revealed an admitted on 06/13/24 and a discharge date on 09/27/24 with return to the facility expected. Medical diagnoses included abdominal aortic aneurysm without rupture, urinary tract infection (UTI), severe protein-calorie malnutrition, complication of surgical and medical care of abdominal wound, acute posthemorrhagic anemia, acute kidney failure, dysphagia, bacteremia, colostomy, peripheral vascular disease, and pressure ulcers of sacral region, buttock, and heel. Review of the Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #34 had intact cognition and scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #34 required substantial assistance to total dependence from staff to complete Activities of Daily Living (ADLs). Review of the progress note on 09/27/24 at 10:33 P.M. revealed Resident #34 was found grey and going in and out of consciousness during night time medication administration. The resident was hypotensive (low BP) and tachycardic (fast heart rate). The nurse called 911 and the resident was sent to the hospital. Resident #34's BP was 96/50 and his pulse was 121 bpm. The resident's representative and CNP #603 were notified of the transfer. There was no evidence of a written discharge notice in Resident #34's medical record. Interview on 10/07/24 at 12:09 P.M. with the Administrator confirmed no written discharge notice had been completed for Resident #34's discharge while resident remained hospitalized . Review of the facility policy, Guidelines for Transfer and Discharge (including AMA), dated 05/03/17, revealed the policy stated, Discharge Documentation: Nursing will complete the Discharge Summary at the time of discharge. A copy will be provided and printed, signed by the Resident or representative, and scanned into the medical record. A second copy will be go home with resident.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19571 Based on medical record review, staff interview, and review of the resident assessment instrument (RAI) guidelines, the facility failed to ensure that minimum data set assessment (MDS) were completed within required timeframe's. This affected eight (Resident #1, #4, #19, #20,#30, #31, #44 and #299. The census was 41. Findings included 1. Review of Resident #4's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included dementia, dysphasia, major depression, diabetes, incontinence, and atrial fibrillation. Review of the quarterly MDS dated [DATE] revealed her cognition is not intact. She had impairment to the upper and lower extremities on both sides, always incontinent of bowel and bladder, and no weight loss or wounds identified. Review of the MDS's revealed the following were completed late: Review of the quarterly MDS with the ARD (Assessment Reference Date) of 07/11/24 was not completed until 07/26/24 Review of the quarterly MDS with the ARD date of 06/28/24 was not completed until 07/18/24. Review of the quarterly MDS with the ARD date of 03/14/24 was not completed until 04/12/24. 2. Resident #20 was admitted to the facility on [DATE]. Diagnoses included acute cystitis, Chronic Kidney Disease Stage III, diabetes, anxiety, depression, high blood pressure, and obesity. Review of the admission MDS dated [DATE] revealed his cognition was intact. He is dependent on staff for foliating, requires substantial assistance for shower/bathing,and personal hygiene. He is always incontinent of his bowel. Review of the quarterly MDS with the ARD date 08/06/24 was not completed until 08/27/24. 3. Review of Resident #30's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included wedge compression fracture, UTI, spinal stenosis, low back pain, and atrial fib. Review of the admission MDS dated [DATE] revealed her cognition is intact, she is dependent on staff for foliating. She is always continent of urine and frequently incontinent of bowel. Review of the MDS's revealed the following: Review of the admission MDS with the ARD date 08/12/24 was not completed until 09/04/24. Review of the discharge MDS with the ARD dated 08/31/24 was not completed until 09/23/24. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Resident #44's medical record revealed she was admitted to the facility on [DATE] and discharged on [DATE]. Diagnoses included effusion to right and left knee, osteo arthritis , atrial fib, high blood pressure and pacemaker. Review of the 5-day MDS dated [DATE] revealed her cognition was intact, independent with oral hygiene, toileting, hygiene,supervision for showering. Review of the admission MDS with the ARD dated 08/12/24 not completed until 09/04/24 Review of the MDS with the ARD dated 08/31/24 (ARD) not completed until 09/23/24. Interview on 10/02/24 at 1:45 P.M. with MDS Coordinator #517 verified the MDS's were not completed on time. 50538 5. Review of medical records for Resident #31 revealed an admitted [DATE]. Diagnoses include a displaced trimalleolar fracture of left lower leg, non-ST elevation myocardial infarction, urinary tract infection, atherosclerotic heart disease of native coronary artery without angina pectoris, hypertensive chronic kidney disease unspecified sequelae of cerebral infarction, moderate protein-calorie malnutrition, iron deficiency anemia secondary to blood loss (chronic), unspecified dementia, and depression. Review of the MDS revealed an ARD of 06/20/24 for a quarterly assessment and a completion date of 07/22/24. An interview with MDS Coordinator # 517 on 10/02/24 at 1:57 P.M. confirmed the MDS completion date was 07/22/24 and the MDS completion date was outside of the guidelines of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual. Review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual revealed the MDS completion date for a quarterly assessment should be no later than the ARD plus 14 calendar days. 6. Review of medical records for Resident #299 revealed and admitted [DATE]. Diagnoses include hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, diabetes mellitus and hypertension. Review of the MDS revealed an ARD for Resident #299's admission assessment of 09/22/24. The admission assessment MDS was not completed at the time of the review on 10/02/24. An interview with MDS Regional support #600 on 10/02/24 at 2:00 P.M. confirmed the MDS admission assessment was not completed at the time of the interview and the MDS completion date was outside of the guidelines of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual. Review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual revealed the MDS completion date for an admission assessment should be no later than the 14 th calendar day of the resident's admission (admitted plus 13 calendar days. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	47987 7. Review of the medical record for Resident #19, revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included but were not limited to vascular dementia, pulmonary embolism without acute core pulmonale, and chronic kidney disease stage 3. Review of the most recent quarterly MDS 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 02 out of 15 which indicated severe cognitive impairment. The resident was assessed to require partial/moderate assistance with bed mobility, transfers and substantial/maximal assistance with toilet hygiene and shower/bathe self. Review of the MDS revealed a completion date of 09/19/24. Review of the quarterly MDS 3.0 assessment revealed ARD was 05/20/24 and revealed a completion date of 06/19/24. Interview on 10/01/24 at 1:49 P.M. MDS Coordinator-Registered Nurse #517 confirmed the quarterly MDS assessment for Resident #19 dated 05/20/24 and 08/20/24 were not completed timely per RAI Manual guidelines. Interview on 10/02/24 at 9:37 AM with the Regional Nurse #601 verified the facility follows the RAI manual guidelines for their MDS assessments. 41266 8. Review of the medical record for Resident #1 revealed an admitted on 04/08/21. Medical diagnoses included unspecified dementia with behavioral disturbances, unspecified sequelae of cerebral infarction (stroke), major depressive disorder, and anxiety disorder. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed the assessment was not signed until 09/19/24 (approximately one month after the assessment was due to be completed). Interview on 10/01/24 at 1:50 P.M. with MDS Coordinator #517 confirmed the MDS assessment for Resident #1 dated 08/16/24 was not completed timely per the Resident Assessment Instrument (RAI) guidelines. Interview on 10/08/24 at 10:58 A.M. with the Administrator via email revealed the facility did not have policy specific for MDS assessment completion. The Administrator confirmed the facility should follow the RAI manual.

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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** 47059 Based on record review and staff interview the facility failed to ensure minimum data set (MDS) assessments were completed accurately. This affected one resident (Resident #22) out of nine residents reviewed for MDS assessments. The facility census was 41. Findings included: Review of the medical record revealed Resident #22 was admitted on [DATE] with diagnoses that included dementia, atrial fibrillation, chronic kidney disease stage three, hypothyroidism, type two diabetes mellitus, major depressive disorder, anxiety disorder, dysphagia, dysphagia, and muscle weakness. Review of the quarterly minimum data set (MDS) 3.0 dated 08/24/24 revealed Resident #22 is severely cognitively impaired. Resident #22 received antidepressant, diuretic, and hypoglycemic medications with indications noted. Resident #22 is receiving hospice care. Review of orders revealed Resident #22 was taking warfarin 2.5 milligrams (mg) once a day and the order was written on 08/01/24. Review of the August medication administration record (MAR) for Resident #22 revealed warfarin 2.5 mg was given daily from 08/01/24 through 08/15/24. Warfarin was on hold 08/16/24 to 08/18/24 and then given daily 08/19/24 through 08/31/24. Interview on 10/03/24 at 3:45 P.M. with MDS Registered Nurse (RN) #517 and MDS Regional Support #600 confirmed Resident #22 was on warfarin during the look back period for the Quarterly MDS dated [DATE] and anticoagulant should have been checked in section N.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smiths Mill Health Campus	7320 Smiths Mill Road New Albany, OH 43054

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50538 Based on record review and interview, the facility failed to ensure Resident #299 received timely treatment for a urinary tract infection. This affected one resident (#299) of 21 residents reviewed for medication administration. The facility census was 41. Findings include: Review of medical records for Resident #299 revealed and admitted [DATE]. Diagnoses include hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, diabetes mellitus and hypertension. Review of Resident #299's progress noted revealed she complained of discomfort with urination on 09/21/24 and a urinalysis was ordered. Further review of the resident's medical record revealed the resident had a urine sample collected on 09/23/24 with a urinalysis and culture and sensitivity to be completed. The results of the urinalysis and culture and sensitivity were completed on 09/26/24. Review of the physician's orders revealed no order for an antibiotic to treat Resident #299's urinary tract infection until 10/02/24 at 4:20 P.M. An interview with Regional Support Nurse #601 on 10/02/24 at 4:28 PM confirmed the urine culture and sensitivity was completed on 09/26/24 but that treatment did not begin until 10/02/24. This deficiency represents non-compliance investigated under Complaint Number OH00157913.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on record reviews and interviews, the facility failed to ensure a resident with Post Traumatic Stress Disorder (PTSD) was appropriately assessed to identify the cause of the residents PTSD and minimize triggers and/or re-traumatization. This affected one resident (#147) identified by the facility as having PTSD/trauma. The facility census was 41. Findings include: Record review for Resident #147 revealed the resident was admitted to the facility on [DATE] and had diagnoses including PTSD, anxiety disorder, and depression. Review of the admission Minimum Data Set (MDS) assessment, dated 10/02/24, revealed an ongoing assessment that was not completed. Review of an assessment dated [DATE] for Resident #147 revealed a Brief Interview for Mental Status (BIMS) assessment score of 15 out of 15. Review of the active care plans for Resident #147 revealed no plan of care was in place addressing the cause of PTSD, triggers which may cause re-traumatization, or interventions to reduce the risk of re-traumatization and provide care for PTSD. Further record review for this resident revealed no assessment had been completed to identify the cause of PTSD for Resident #147 and to identify potential triggers which may cause re-traumatization. Interview on 10/03/24 at 9:03 A.M. with the Director of Social Work #615 verified an assessment of the cause of PTSD and possible triggers for Resident #147 had not been completed and additionally verified there had not been a plan of care implemented for Resident #147 to minimize the risk of re-traumatization.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19571 Based on medical record review, review of the medication administration record, staff interview, and facility policy review, the facility failed to ensure medications were available to be administered for one (Resident #20) resident and failed to ensure medication was administered timely as prescribed for four (Resident #12, #20,#30, and #22) residents. This affected four (Resident #12,#20,#30, and #22) residents out of 19 residents reviewed for medications. The facility census was 41. Findings include: 1. Resident #20 was admitted to the facility on [DATE]. Diagnoses included acute cystitis, Chronic Kidney Disease Stage III, diabetes, anxiety, depression, high blood pressure, and obesity. Review of the admission minimum data set (MDS) dated [DATE] revealed his cognition was intact. He is dependent on staff for toileting, requires substantial assistance for shower/bathing,and personal hygiene. He is always incontinent of his bowel. Review of the physicians orders revealed an order dated 07/30/24 for Soliqua 100/33 (insulin) insulin pen 29 units subcutaneous. Inject two hours prior to meal once a day between 5:00 A.M. and 7:00 A.M. Review of the medication administration record (MAR) for 08/24 revealed medication were documented as administered late on 08/10/24, 08/13/24, 08/18/24, 08/21/24, 08/24/24, 08/26/24, 08/29/24 and 08/31/24. Review of the MAR for 09/24 revealed medications were documented as administered late on 09/01/24, 09/05/24, 09/10/24, 09/11/24, 09/15/24, and 09/19/24. Review of the medication administration record revealed on 09/17/24 it was documented the medication was unavailable and pharmacy and the Certified Nurse Practioner (CNP) was notified. On 09/29/24 it was documented that pharmacy was notified to supply the medication and 09/30/24 it was documented the medication was out of stock per pharmacy and will restock and deliver that night. This was verified during interview with Regional Clinical Support #602 on 10/03/24 at 2:48 P.M. 2. Review of the medical record for Resident #12, revealed an admitted [DATE]. Diagnoses included but were not limited to acute kidney failure, hypertensive heart and chronic kidney disease with heart failure, paroxysmal atrial fibrillation and type 2 diabetes mellitus with diabetic chronic kidney disease. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 14 out of 15 suggested cognitive intactness. The resident was assessed to require partial/moderate assistance with bed mobility, chair/bed to chair transfer and substantial/maximal assistance with toilet hygiene, shower/bathe self and toilet transfers. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of active physician orders for Resident #12 revealed insulin lispro 100 unit/ml with a sliding scale as follows: if blood sugar is 70 to 150, give 0 units. if blood sugar is 151 to 200, give 2 units. if blood sugar is 201 to 250, give 4 units. If blood sugar is 251 to 300, give 6 units. If blood sugar is 301 to 350, give 8 units. If blood sugar is 351 to 400, give 10 units. If blood sugar is greater than 400, give 12 units. If blood sugar is greater than 400, call Medical Doctor. Review of the Medication Administration Record (MAR) for Resident #12 revealed on the following dates the insulin lispro to be late: 09/05/24, due to be administered between 6:30 A.M. to 9:00 A.M., blood sugar was 194 and 2 units were given at 10:20 A.M. and due to be administered 10:00 A.M. to 12:30 P.M., blood sugar was 182 and 2 units were given at 2:25 P.M.; On 09/19/24 due to be administered between 10:00 A.M. to 12:30 P.M., blood sugar was 207, 4 units were given at 12:43 P.M.; finally on 09/22/24 due to be administered between 6:30 A.M. to 9:00 A.M., blood sugar was 202, 4 units were given at 10:15 A.M. Interview on 10/02/24 at 10:06 A.M. with the Assistant Director of Nursing verified the late doses of insulin lispro for the dates and times of: 09/05/24 at 10:20 A.M. and 2:25 P.M., 09/19/24 at 12:43 P.M. and 09/22/24 at 10:15 A.M. 3. Review of the Resident #30's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included wedge compression fracture, urinary tract infection (UTI), spinal stenosis, low back pain, and atrial fibrillation. Review of the admission MDS dated [DATE] revealed her cognition is intact, she is dependent on staff for toileting. She is always continent of urine and frequently incontinent of bowel. Further review of the medication administration record (MAR) for 08/24 revealed medications were administered late on 08/15/24 and on 08/28/24 due to waiting on delivery from pharmacy. This was verified during interview with Regional Clinical Support #602 on 10/03/24 at 2:48 P.M. 4. Resident #22 was admitted on [DATE] with diagnoses that included dementia, atrial fibrillation, chronic kidney disease stage three, hypothyroidism, type two diabetes mellitus, major depressive disorder, anxiety disorder, dysphagia, dysphagia, and muscle weakness. Review of the quarterly minimum data set (MDS) 3.0 dated 08/24/24 revealed Resident #22 is severely cognitively impaired. Resident #22 received antidepressant, diuretic, and hypoglycemic medications with indications noted. Resident #22 is receiving hospice care. Review of September orders revealed Resident #22 is on [NAME] Solostar Insulin 14 units subcutaneous injection at bedtime and Novolog insulin on a sliding scale before meals and at bedtime. Review of the September MAR revealed Resident #22's Novolog Insulin was documented as late administration: administered late on 09/15/24 for the 3:30 P.M. - 6:30 P.M. time frame and 09/20/24 for the 7:00 A.M. to 11:30 A.M. time frame. Interview on 10/03/24 at 8:15; A.M. with RN #539 (assistant director of nursing) confirmed if the MAR documentation says Late Administration - administered Late the medication was given late, of it says Late Administration - charted Late the medication was given on time but charted late. The above insulin entries were administered late. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy Medication Administration last revision date 11/2018 revealed medications should be administered per physician's order. Medications are administered within 50 minutes of the scheduled time with the exception of before or after meal orders, which are based on meal times. This deficiency represents non-compliance investigated under Complaint Number OH00157913.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on record review, staff interviews, and facility policy review, the facility failed to ensure proper parameters were identified for anticoagulant, as needed (PRN) pain, and blood pressure medications. The deficient practice affected five residents (Residents #12, 28, 96, 98, and 146) of eight residents reviewed for unnecessary medications. The facility census was 41. Findings Include: 1. Review of the medical record for Resident #96 revealed an admitted on 09/14/24 and a discharge date on 10/01/24. Medical diagnoses included displaced intertrochanteric fracture of right femur, periprosthetic fracture around internal prosthetic right hip joint, paroxysmal atrial fibrillation, unspecified cirrhosis of liver, and anxiety disorder. Review of the census revealed Resident #96 was hospitalized from 09/20/24 to 09/25/24. There was not a comprehensive Minimum Data Set (MDS) 3.0 assessment completed for Resident #96. Review of the physician orders dated September 2024 revealed Resident #96 had an order for Tramadol 50 milligrams (mg) with instructions to give a 1/2 tablet (25 mg) every six hours as needed (PRN) dated 09/14/24. Resident #96 also had an order for Tylenol (Acetaminophen) 325 mg with instructions to give two tablets every six hours PRN for pain dated 09/17/24. There were not any parameters noted on either of the orders for PRN pain medication. Review of the Medication Administration Record (MAR) dated September 2024 revealed Resident #96 received PRN Tramadol on 09/16/24 for a pain level of five out of ten where ten is the most severe pain, 09/17/24 for a pain level of nine out of ten, 09/26/24 for a pain level of six out of ten, 09/27/24 for a pain level of ten out of ten where ten is the most severe pain level, twice on 09/28/24 for pain levels of five out of ten, 09/29/24 for a pain level of five out of ten, and 09/30/24 for a pain level of five out of ten. Resident #96 was administered PRN Tylenol on 09/19/24 for a pain level of five out of ten where ten is the most severe pain level and 09/20/24 for a pain level of five out of ten. Interview on 10/02/24 at 11:44 A.M. with Licensed Practical Nurse (LPN) #557 confirmed Resident #96 had orders for both Tramadol and Tylenol PRN for pain. LPN #557 confirmed neither order identified parameters for administration. LPN #557 confirmed Resident #96 was administered both Tramadol and Tylenol for the same pain levels. LPN #557 stated she typically asked the resident which pain medication he/she wanted to determine which medication was administered to the resident if there were orders for more than one PRN pain medication. 2. Review of the medical record for Resident #98 revealed an admitted on 09/13/24 and a discharge date on 10/02/24. Medical diagnoses included unspecified cirrhosis of the liver, celiac disease, chronic kidney disease, and charcot's joint for unspecified foot and ankle. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #98 had intact cognition and scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #98 received opioid medications and received scheduled and PRN pain medications. Resident #98 had occasional pain that interfered with activities. Review of the Medication Administration Record (MAR) dated September 2024 revealed Resident #98 had an order for Ibuprofen 200 milligrams (mg) every eight hours as needed (PRN) dated 09/13/24. The medication was not administered in the month of September. Resident #98 also had an order for Oxycodone 5 mg every six hours PRN dated 09/13/24. The medication was administered for pain on 09/14/24, 09/15/24, 09/16/24, and three times on 09/17/24. There was no pain level noted for the administration of these medications. Oxycodone was also administered one to three times daily from 09/18/24 through 09/30/24 for pain levels ranging from three to nine out of ten where ten was the most severe pain level. There were no parameters identified on either order. Interview on 10/02/24 at 11:44 A.M. with LPN #557 confirmed Resident #98 had orders for both Oxycodone and Ibuprofen for pain. LPN #557 confirmed neither order identified parameters for administration. LPN #557 confirmed Resident #98 had only been administered Oxycodone and was not administered any Ibuprofen. LPN #557 stated typically Ibuprofen would be administered for mild pain (pain levels of one to four to five) and Oxycodone would be administered for moderate to severe pain (pain levels of six to ten). LPN #557 stated she typically asked the resident which pain medication he/she wanted to determine which medication was administered to the resident if there were orders for more than one PRN pain medication and there were not any parameters identified. 47987 3. Review of the medical record for Resident #12, revealed an admitted [DATE]. Diagnoses included but were not limited to acute kidney failure, hypertensive heart and chronic kidney disease with heart failure, paroxysmal atrial fibrillation and type 2 diabetes mellitus with diabetic chronic kidney disease. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 14 out of 15 suggested cognitive intactness. The resident was assessed to require partial/moderate assistance with bed mobility, chair/bed to chair transfer and substantial/maximal assistance with toilet hygiene, shower/bathe self and toilet transfers. Review of the active care plan for Resident #12 revealed the resident will be free from complications related to heart failure with medications per orders to be administered. Review of the physician order start date 08/24/24 and end date of 09/09/24 for Resident #12 revealed metoprolol succinate 25 milligrams (mg) oral every day. Further review of the active physician order for this resident revealed a start date of metoprolol succinate 50 mg oral every day. Review of the Medication Administration Record (MAR) for Resident #12 revealed on 08/26/24, 08/30/24, and 09/06/24 metoprolol succinate 25 mg was not administered due to low blood pressures. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the MAR for Resident #12 revealed on 09/09/24, 09/11/24, 09/14/24, 09/19/24, 09/22/24, 09/23/24, 09/24/24, 09/25/24 and 09/27/24 metoprolol succinate 50 mg was not administered due to low blood pressures. Review of the progress notes for Resident #12 for 08/26/24 through 09/27/24 revealed no communication of facility staff with a physician or nurse practitioner to hold the metoprolol succinate 25 mg and 50 mg tablets. Interview on 10/02/24 at 11:45 A.M. with the Assistant Director of Nursing verified both the metoprolol succinate 25 mg and 50 mg physician orders did not have blood pressure perimeters for the nurses to hold the medication and were holding it without an order and without communication with a physician or nurse practitioner. She also verified the blood pressure perimeters are supposed to be part of the physician order with the medication for the nurses to follow at this facility. 4. Review of the medical record for Resident #146, revealed an admitted [DATE] . Diagnoses included but were not limited to COVID -19 virus, acute kidney failure, peripheral vascular disease, atherosclerotic heart disease of native coronary artery without angina pectoris, unspecified sequelae of cerebral infarction and systemic lupus erythematosus. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed an ongoing assessment that was not completed. Review of an assessment dated [DATE] for Resident #146 revealed a Brief Interview for Mental Status (BIMS) assessment score of 15 out of 15. Review of the active care plan for resident #146 revealed at risk for excessive bleeding and bruising related to medications and administer medications per current physician orders. Review of the active physician orders for Resident #146 revealed warfarin (blood thinner) 3 mg tablet, take mags once a day on Sunday, Tuesday, Thursday and Saturday and warfarin 4 mg tablet, take 8mgs once a day on Monday, Wednesday and Friday. Further review of the active physician orders for this resident revealed PT(prothrombin test time)/INR-Coag machine to check levels on Monday and Thursdays. Review of the PT/INR levels documented on the MAR for Resident #146 revealed on 09/26/24 a level of 3.7. Review of the MAR for Resident #146 revealed administration of warfarin 6 mgs on 09/24/24, 09/28/24 and 09/29/24. Resident #146 refused on 09/26/24 due to INR level. Further review of the MAR for this resident revealed warfarin 8mgs was administered on 09/25/24, 09/27/24 and 09/30/24. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/01/24 at 3:11 P.M. with the Regional Nurse #601 verified for Resident #146, the warfarin was being administered with no parameters set for the INR and the parameters are to be between 2 (blood is not thin enough)-3 (blood is too thin), anything over 3 is to be held due to bleeding precautions. Also verified on 09/28/24 Resident #146 refused the warfarin, was not held by the nurse. The order now contains the parameters for the nurses to follow. 47059 5. Review of the medical record for Resident #28 was admitted on [DATE] with diagnoses that included facial weakness, hemiplegia, and hemiparesis following a cerebral infarction, coronary artery disease, mild cognitive impairment, anxiety, and legal blindness. Review of the last quarterly minimum data set (MDS) 3.0 dated 06/29/24 reveled Resident #28 was cognitively intact, received antiplatelet, antianxiety, and antidepressant medications with indications present. Review of a significant change MDS 3.0 dated 07/30/24 revealed Resident #28 was moderately cognitively impaired and was now receiving hospice care. Review of current medication orders for Resident #28 revealed Resident #28 is to be given losartan 100 mg once a day. There are no parameters on when to hold the medication. Observation on 10/02/24 at 09:10 A.M. reveled LPN #579 was administering morning medications administrations to Resident #28. LPN #579 appropriately took blood pressure prior to medication administration and held blood pressure medications for BP 98/59. Interview on 10/02/24 at 9:20 A.M. with LPN #579 confirmed the losartan for high blood pressure was held. LPN #578 also confirmed there are no parameters in the orders indicating when the medication should be held. LPN #579 stated blood pressure medications should always be held if the blood pressure is less than 120 mmHg systolic or with a heart rate less than 60 beats per minute. These are parameters learned in school. For this resident LPN #579 notified Hospice (received orders to encourage fluids and call Hospice if symptomatic and they will send a nurse out) but usually the call is made to the nurse practitioner. Interview on 10/03/24 at 8:15; A.M. with RN #539 (assistant director of nursing) also confirmed blood pressure medications should have parameters of when to hold and verified Resident #28 did not have any parameters with his blood pressure orders. Review of the facility policy, Medication Administration: General Guidelines, revised 01/2018, revealed the policy stated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. The medication administration record (MAR) should contain supplemental information to help assure accurate dosing. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnoses or conditions, the facility personnel calls the provider pharmacy for clarification prior to the administration of the medication or if necessary contacts the prescriber for clarification.

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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** 41266 Based on record review, staff interviews, and facility policy review, the facility failed to ensure two residents (Residents #20 and #98) were free from significant medication errors. The deficient practice affected two residents (Residents #20 and #98) of two reviewed for medication errors. The facility census was 41. Findings Include: 1. Review of the medical record for Resident #98 revealed an admitted on 09/13/24 and a discharge date on 10/02/24. Medical diagnoses included unspecified cirrhosis of the liver, celiac disease, chronic kidney disease, and charcot's joint for unspecified foot and ankle. Review of the Admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #98 had intact cognition and scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #98 received daily insulin injections. Review of the Medication Administration Record (MAR) dated September 2024 revealed Resident #98 had an order for Humulin N insulin (a long acting insulin that starts to work within two to four hours and lasts for 12 to 18 hours) 25 units subcutaneously at bedtime dated 09/13/24. Resident #98 was administered the medication on 09/14/24 between 7:00 P.M. and 11:00 P.M. for a blood sugar of 233. Resident #98 also had an order for Humulin R (a short acting insulin that starts to work within 30 minutes and lasts for eight hours) 28 units before meals dated 09/13/24. Resident #98 was noted to have this insulin administered on 09/14/24 for a blood sugar of 338. This insulin was marked as administered by Licensed Practical Nurse (LPN) #551. Review of the progress note dated 09/14/24 at 8:01 P.M. by LPN #551 revealed during morning medication pass, Resident #98 was to receive 28 units of Humulin R before breakfast for a blood sugar of 353. LPN #551 administered 28 units of Humulin N, instead of Humulin R, due to the pharmacy sending one vial of Humulin N and one Humulin N Kwikpen. The pharmacy did not send any Humulin R insulin for Resident #98. Once the medication error was recognized, LPN #551 reported the error to her supervisor and the Certified Nurse Practitioner (CNP). LPN #551 was instructed to monitor Resident #98 and as long as there were not any side effects noted, the nurse could proceed with administering the correct insulin at lunchtime. Review of the Incident Report dated 09/14/24 at 1:04 P.M. revealed Resident #98 was administered Humulin N insulin instead of ordered Humulin R on 09/14/24 by LPN #551. Resident #98 remained in the facility for monitoring. Resident #98's medication list was reconciled to medications available, the physician's order was clarified, and LPN #551 was educated. Interview on 10/03/24 at 3:00 P.M. with LPN #551 confirmed she administered the incorrect insulin to Resident #98 on 09/14/24. LPN #551 acknowledged she should have ensured the label on the insulin matched the physician's order before administering the insulin to the resident. LPN #551 stated she marked Humulin R insulin as administered on 09/14/24 before she realized she had administered Humulin N instead. LPN #551 confirmed she did receive education related to ensuring the appropriate medications are administered per the physician orders. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	19571 2. Resident #20 was admitted to the facility on [DATE]. Diagnoses included acute cystitis, Chronic Kidney Disease Stage III, diabetes, anxiety, depression, high blood pressure, and obesity. Review of the admission MDS dated [DATE] revealed his cognition was intact. He is dependent on staff for toileting, requires substantial assistance for shower/bathing,and personal hygiene. He is always incontinent of his bowel. Review of the physicians orders revealed an order dated 07/30/24 for Soliqua 100/33 (insulin) insulin pen 29 units subcutaneous. Inject two hours prior to meal once a day between 5:00 A.M. and 7:00 A.M. Blood sugar's were to be obtained prior to administration of the insulin. Review of the medication administration record revealed on 09/17/24 it was documented the medication was unavailable and pharmacy and the Certified Nurse Practioner (CNP) was notified. On 09/29/24 it was documented that pharmacy was notified to supply the medication and 09/30/24 it was documented the medication was out of stock per pharmacy and will restock and deliver that night. No blood sugars were obtained on 09/29/24 or 09/30/24. This was verified during interview with Regional Clinical Support #602 on 10/03/24 at 2:48 P.M. Review of the facility policy, Guidelines for Medication Error Reporting, reviewed 12/31/23, revealed the policy stated, the purpose of the policy was to identify medications given in error and expedite corrective actions. Review of the facility policy, Medication Administration: General Guidelines, revised 01/2018, revealed the policy stated, medications should be administered according to the physician's order. This deficiency represents non-compliance investigated under Complaint Number OH00157913.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366475	A. Building B. Wing	10/09/2024

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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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50538 Based on staff and resident interview and review of facility arbitration agreement the facility failed to fully explain the arbitration agreement and the right to rescind the agreement within 30 days of signing. This affected two residents (#297 and #150) of three residents whose arbitration agreements were reviewed. The facility census was 41. Findings include: 1. Review of the medical record for Resident #297 revealed an admitted [DATE]. Diagnoses include fractures of the right fibula, muscular dystrophy, osteoarthritis, morbid obesity, depression and scoliosis. Review of the Minimum Data Set, dated dated dated [DATE] revealed the resident to be cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Review of the form titled Trilogy Voluntary Binding Arbitration Agreement dated 09/16/24 revealed Resident #297 signed the form as agreeing to the facility's binding arbitration agreement on 09/19/24. The agreement stated that the resident had 30 days to revoke the agreement after signing the agreement. An interview with Resident #297 on 10/02/24 at 8:22 A.M. revealed knowledge of what arbitration was but stated that she had been thinking that she wanted to change her mind. Resident #297 stated It's really been bothering me that I signed that. Resident #297 stated it was not explained to her that she had a period of time that she could revoke the agreement. 2. Review of the medical record for Resident #150 revealed an admitted [DATE]. Review of BIMS evaluation completed on 09/26/24 revealed Resident #150 to be cognitively intact with a BIMS score of 15 out of 15. Review of the form titled Trilogy Voluntary Binding Arbitration Agreement dated 09/26/24 revealed Resident #150 signed the form as agreeing to the facility's binding arbitration agreement on 09/26/24. The agreement stated that the resident had 30 days to revoke the agreement after signing the agreement. An interview with Resident #150 on 10/02/24 at 8:31 A.M. revealed the resident did not remember anything about the agreement. When asked if she was able to explain or understood what arbitration meant the resident stated, I'll need you to explain it. After surveyor intervention, Resident #150 stated, oh yeah that's okay. Resident #150 confirmed that she had not been told that she had 30 days after entering the agreement to revoke the agreement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366475	A. Building B. Wing	10/09/2024

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 10/01/24 at 1:26 P.M. with Director of Sales #500 confirmed the arbitration agreement is a voluntary agreement that is reviewed upon initial admission. Director of Sales #500 stated a resident can choose whether to enter into the agreement upon admission. She further stated residents can change their minds within 24-48 hours of admission and let her know or the residents would need to follow up with the Administrator, if beyond that amount of time. Director of Sales #500 stated the facility determines if a resident is cognitively able to understand the agreement based on the BIMS score. Director of Sales #500 stated if a resident has a low BIMS score, the facility will contact the resident representative or power of attorney to complete the arbitration agreement. Director of Sales #500 stated she does not request for the residents to demonstrate an understanding of the agreement prior to signing it. Review of the facility arbitration agreement Trilogy Voluntary Binding Arbitration Agreement revealed the resident has a period of 30 days to revoke the agreement after signing the agreement. A facility policy related to arbitration agreements was requested at the time of the survey, but the facility did not have a policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47059 Based on observation, staff interview, and record review, the facility failed to ensure Enhanced Barrier Precautions (EBP) were followed during gastric-tube medication administration. This affected one resident (Resident #11) out of one resident observed for medication administration via a gastric - tube. The facility census was 41. Findings include: Review of the medical record revealed Resident #11 was admitted on [DATE] with diagnoses that included Parkinson's disease without dyskinesia, Dementia, acute respiratory disease, complication of indwelling urethral catheter, cardiomegaly, Schizophrenia, anxiety disorder, and cognitive communication deficit. Review of the quarterly minimum data set (MDS) 3.0 dated 08/26/24 revealed Resident #11 has severe cognitive impairment, is on a mechanically altered diet with a gastric feeding tube and urinary catheter in place. Resident #11 is on anticoagulant, antipsychotic, and opioid medications with indications in place. Resident #11 is on hospice care with isolation precautions in place. Review of the care plan for Resident #11 dated 09/04/24 revealed focus and interventions for use of enhanced barrier precautions. Observation on 10/02/24 at 10:30 A.M. during medication administration Resident#11 is in enhanced barrier precautions with signage and isolation cart in room. Licensed Practical Nurse (LPN) #551 only wore gloves when administering medications via gastric tube. Interview on 10/02/24 at 10:43 A.M. with Registered Nurse (RN) #539 confirmed that LPN #551 has gloves on but should have worn a gown and gloves while administering mediations through the gastric tube. Review of the policy Enhanced Barrier Precautions (EBP) Standard Operating Procedure dated 04/01/24 reveled enhanced barrier precautions are used to decrease the risk of becoming colonized and developing infections with multidrug-resistant organisms. Enhanced barrier precautions should be used with all residents with chronic wounds and all residents with indwelling devices. This deficiency represents non-compliance investigated under Complaint Number OH00157913.