STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366487	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tallmadge Health & Rehab Center	619 Northwest Avenue Tallmadge, OH 44278

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015 Based on observation, interview, medical record review, observation of resident council, review of resident rights, and review of the formal complaint from residents at the facility, the facility failed to ensure residents were treated with dignity and respect. This affected four residents (#3, #69, #285, #28) of four residents reviewed for dignity. The facility census was 85. Findings include: Review of the formal complaint filed by several residents on 11/24/24 revealed the residents felt like staff members were immature, untrained, lacked common sense, and were not compassionate, yet were hired to care for the elderly. The resident questioned why can't staff be friendly or smile, and noted small talk would be nice. The residents further noted they wanted staff to quit being uncaring and unfriendly, and wanted staff to stop talking down to residents and family members. The written complaint revealed some residents in wheelchairs feel belittled by staff. The complaint went on to say the facility staff, especially nursing and Certified Nursing Assistants (CNA), were very intimidating. The complaint also noted staff wear ear buds, and they feel like this could be considered a privacy violation. Observation of a resident council meeting on 03/20/25 at 1:26 P.M. with 15 residents present revealed resident concerns included staff were still wearing ear buds while working, staff would enter their rooms and would say what do you want. The residents noted there was a lack of respect towards residents, and nurses sat at the desk and would not answer the call lights. 1. Review of the medical record for Resident #3 revealed an admitted [DATE]. Diagnoses included type one diabetes mellitus with diabetic polyneuropathy, obesity, Aspergers syndrome, and post-traumatic stress disorder, and needs assistance with personal care. Continued review revealed she was cognitively intact. Interview on 03/18/25 at 9:52 A.M. Resident #3 reported CNA #557 does not assist with undoing brief and pulling brief up/down, does not assist with ambulation to the bathroom and stands off to the side telling her she should be able to do more for herself. The resident stated CNA #557 made negative comments to her about not doing more for herself. Resident #3 stated she felt like CNA #557 neglected to provide care, and felt the negative comments were hurtful. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/24/25 at 4:46 P.M. with the Administrator revealed CNA#557 was suspended on 03/18/25. The Administrator reported CNA #557 does not normally take care of Resident #3, but did care for her one day last week. She continued the CNA wanted her to walk to the bathroom, and would sometimes take the wheelchair out of the bathroom as she wanted the resident to walk back out. The CNA reported she knew the resident walks back, but sometimes she did not want to. The Administrator revealed CNA #557 would receive a teachable moment related to if resident doesn't want to walk, she has the right to use her wheelchair. 2. Review of the medical record for Resident #69 revealed admitted [DATE]. Diagnoses included acute and chronic respiratory failure with hypercapnia, congenital central alveolar hypoventilation syndrome, and tracheotomy status. The record indicated the resident was cognitively intact. Review of Resident #69's care plan dated 10/28/24 revealed the resident had self-care deficits and was limited in ability to transfer self-related to acute on chronic respiratory failure with hypercapnia, ventilator associated pneumonia, congenital central alveolar hypoventilation, bilateral knee pain, tracheostomy, dependence of respirator, chronic respiratory failure with hypercapnia and hypoxia, oxygen tubing and anemia. Interventions include providing assistance of one staff for transfers and ambulation with platform walker and wheelchair follow and praise resident for efforts. Interview on 03/18/25 at 9:04 A.M. with Resident #69 revealed the resident reported CNA #574 did not speak kindly to her and was rude while she provided care. Interview on 03/25/25 at 11:25 A.M. with CNA #574 revealed the she was a fast-paced worker, and when they are pulled into a split assignment, it was hard to get everything done. She stated she does have to tell residents that she will come back at a later time. CNA #574 stated residents say they feel like a burden or feel like she is rushing them because they are short-staffed. CNA #574 went on to say Resident #69 had been sick recently and needed more assistance. She stated that now that she is better, CNA #574 was trying to get Resident #69 to be more independent, but she was used to the extra assistance. Interview on 03/24/25 at 4:02 P.M. with the Administrator revealed after speaking with Resident #69, the resident wanted CNA #574 to spend more time during care with her. She stated she spoke with CNA #574 and provided her a teachable moment about slowing down, not appearing rushed, and to spend extra time with residents who desire it. 3. Review of the medical record for Resident #285 revealed an admitted [DATE]. Diagnoses included nondisplaced trimalleolar fracture of right lower leg, subsequent encounter for closed fracture with routine healing, Type two diabetes mellitus with hyperglycemia, chronic obstructive pulmonary disease, unspecified, and major depressive disorder, recurrent, unspecified. Her record indicated she was cognitively intact. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/17/25 at 9:33 A.M. with Resident #285 revealed the resident was tearful when she reported on her first night in the facility, a (unnamed) CNA on second shift belittled her. She feels as if it was mental abuse. Resident #285 stated she reported the incident to someone but did not know it was. The resident went on to say when she came to the facility, she was sick with bad diarrhea and the (unnamed) CNA got upset with her. She stated the (unnamed) CNA told her to stop going to the bathroom because she was going to be at lunch. She rolled her eyes and threw something against the wall. The resident reported this scared her. The resident stated she never wanted that (unnamed) CNA to come into her room again. Resident #285 stated she was afraid of her coming in again. Interview on 03/24/25 at 4:23 P.M. with the Administrator revealed she determined that CNA #546 was the CNA that was assigned to the resident and met the description given to her. The CNA was placed on administrative leave on 03/17/25 while they investigated the complaint. She stated after speaking with CNA #546, it was revealed that CNA #546 did tell the residents that if she went to the bathroom again, she wouldn't be able to change her until after she was back from lunch. The CNA denied throwing anything. The Administrator revealed CNA #546 would be provided a teachable moment related to not offering medical options to residents. Telephone interview on 03/25/25 at 2:46 P.M. with CNA #546 reported that when she worked a split assignment between two halls it was hard to get all the work done. She reported that the nurses usually do not answer call lights at night. She went on to say residents felt rushed because the hall is full. She stated when Resident #285 was newly admitted , she hit her call light five times between 7:00 P.M. and 8:00 P.M. The resident kept saying she needed changed, and she told Resident #285 I'm changing people it'll be a minute. CNA #546 stated later that night, she was about to go on her lunch break, when Resident #285 called again. CNA #546 told her that she wouldn't be back in for approximately 30 minutes, and she would come in after her lunch. 4. Observation on 03/17/25 at 7:25 A.M. revealed CNA #556 delivered a meal tray to a resident with ear buds in her ears. Observation on 03/17/25 at 10:00 A.M. revealed Registered Nurse (RN) #641 had an ear bud in their ear. Observation on 03/17/25 at 2:10 P.M. revealed LPN #546 had an ear bud present in her ear. Interview on 03/17/25 at 1:51 P.M. with Resident #28 reported that sometimes staff come in with their ear pods on while they are talking on the phone. Resident #28 stated she was not okay with that. Resident #28 stated staff wearing ear buds were rude and believed it was a privacy issue. Interview on 03/24/25 at 5:07 P.M. with the Administrator revealed staff are not allowed to wear ear buds while at work. The Administrator stated she would pull staff aside and tell them to remove the ear buds when she sees them doing this. Review of the Ohio Revised Code, Resident Right effective October 03, 2023 revealed the rights of residents of a home shall include, but are not limited to, the following: the right to be free from physical, verbal, mental, and emotional abuse and to be treated at all times with courtesy, respect, and full recognition of dignity and individuality; The right to have all reasonable requests and inquiries responded to promptly. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This deficiency represents non-compliance investigated under Complaint Number OH00162488.

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 42733 Based on interview, record review, and review of email correspondence, the facility failed to ensure resident concerns were addressed in manner that provided a resolution to their concerns. This affected two residents (#10 and #21) of four residents reviewed for concerns. The facility census was 85. Findings include: Interview on 03/20/25 at 9:23 A.M. with Resident #21 revealed he was the president of resident council and stated he had many residents who had expressed concerns related to their care. Resident #21 stated he had shared those concerns with the Administrator and the Director of Nursing (DON), however, their concerns had not been addressed and they had not seen any changes. Resident #21 stated he had sent his letter of concerns to the corporate office, and stated he had not received or seen any resolution or effort to address the residents' numerous concerns. Resident #21 further stated when he had brought issues to the Administrator, she would then go to the staff members he had complained about and then those staff members would ignore him and not assist him with care. An observation on 03/20/25 at 1:26 P.M. of the resident council meeting revealed several residents, including Residents #10 and #21, were present for the meeting. Residents had expressed various concerns that included laundry, maintenance, nursing, and administration and stated their concerns have been ongoing with no resolution. Interview on 03/24/25 at 11:09 A.M. with Administrator revealed she had spoken with Resident#10 and Resident #21 regarding their concerns and stated she had been aware of a letter that was sent to the corporate office. Administrator stated she had addressed their concerns, however they had continued to make complaints. Interview on 03/26/25 at 2:07 P.M. with Licensed Practical Nurse (LPN) #514 revealed she had spoken with Resident #10 on occasions regarding her concerns. LPN #514 stated she had advised Resident #10 to discuss her concerns further with the Administrator and the DON. LPN #514 stated she was unaware of the outcome of the residents concerns. Review of submitted letter to the corporate office authored by Residents #10 and #21, and signed by numerous other residents, revealed several concerns that included staff treatment, housekeeping, poor food quality, and nursing concerns. Review of email received by the corporate office dated 11/25/24 and timed 10:37 A.M. revealed the corporation had confirmed they had received resident concerns that stated management at the facility isn't taking the issues seriously. This deficiency represents non-compliance investigated under Complaint Number OH00162488.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015 Based on interviews, medical record review, personnel file review, and policy review, the facility failed to implement their abuse policy by failing to immediately remove a staff member accused of emotional abuse during the investigation. This affected one resident (#3) of four residents reviewed for abuse and neglect. A second example of no actual harm with the potential for minimal harm occurred when the facility failed to ensure reference checks were completed on new employees upon hire. This had the potential to affect all residents residing in the facility. The facility census was 85. Findings include: 1. Review of the medical record for Resident #3 revealed an admitted [DATE]. Diagnoses included type one diabetes mellitus with diabetic polyneuropathy, obesity, Aspergers syndrome, and post-traumatic stress disorder, and needs assistance with personal care. Continued review revealed she was cognitively intact. Review of Resident #3's nursing progress note dated 02/23/25 at 8:30 P.M. revealed Licensed Practical Nurse (LPN) #543 stated Resident #3's brother came to the nurse and stated Certified Nursing Assistant (CNA) #584 was mean to Resident #3. The nurse and the resident's brother went to Resident #3's room, and found the resident crying due to fear that CNA #584 would be mean to her again. Resident #3 stated CNA #584 had been mean to her a few times when she wanted to go to the bathroom. The note indicated LPN #543 had explained to Resident #3 and her brother that the nurse would switch CNA #584's assignment with another CNA, so Resident #3 would feel safe and not worry about care that night. The resident and her brother agreed and stated they wanted to speak with management about the situation. The note indicated the Director of Nursing (DON) was notified and explained what happened, and the note indicated the DON stated she would speak with Resident #3 the next day. Interview on 03/19/25 at 10:45 A.M. with Resident #3 revealed the last five or so times, that CNA #584 cared for her, she was not nice to her. Resident #3 reported when she put on her call light, CNA# 584 would come in and say she was short-staffed and had 16 other residents to take care of. CNA #584 would tell Resident #3 she didn't have time to run down to her room and take her to the bathroom. CNA #584 would continuously tell her to squeeze it all out because she could not keep running down to take her to the bathroom. Resident #3 stated at times she would urinate herself because she was fearful of how CNA #584 would treat her. Resident #3 stated one day she finally had enough and called her brother hysterically because she knew she would be working with CNA #584 that night. Resident #3 stated her brother had to come in and settle her down. She stated the Administrator was aware and ensured her that CNA #584 would not be working with her anymore. When asked how CNA #584 made her feel, Resident #3 reported that she thought CNA #584 was mentally abusive to her. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone interview on 03/25/25 at 6:10 P.M. with Family Member #630 reported he had heard CNA #584 say inappropriate things to Resident #3, including telling her that she [CNA #584] did not have time to keep coming to Resident #3's room and taking her to the bathroom as the facility was short staffed. Family Member #630 reported he heard CNA #584 state to Resident #3 to push all her urine out now because she was too busy to keep coming to the resident's room. Family Member #630 would then see CNA #584 seated at the nurse's station on her phone. He reported Resident #3 had called him crying over the treatment she received from CNA #584. His sister was afraid to voice concerns due to staff retaliation, and instead, let it all build up and she would eventually break down. He requested CNA #584 to not work with her anymore. He reported the Administrator told him if his sister kept complaining, then no one would be left to take care of her. Family Member #630 reported he thought that was a rude comment. Review of the Disciplinary Action Form initially dated 02/24/25 revealed CNA #584 was disciplined on 03/06/25 due to a resident and her brother stating CNA #584 used poor customer service skills when caring for the resident, the CNA was said to have stated on several evenings she was busy, she was short staffed, and told the resident to urinate completely because she could not toilet the resident over and over during the shift. Counseling included not rushing residents or telling them you were busy or understaffed. Review of schedules showed the shifts were not understaffed. Residents do not want to feel like they are a burden to staff. Review of the staffing schedules revealed on Sunday 02/23/25 CNA #584 was scheduled to work on the 100 and 200 halls from 7:00 P.M. to 7:00 A.M (Resident #3 resided on the 100 hall) Review of staff time punches for this day revealed she clocked in at 7:00 P.M. and out at 7:30 A.M. on 02/24/25. Interview on 03/24/25 at 4:46 P.M. the facility Administrator verified that the facility did not follow their abuse policy. She revealed that had it been reported in the way that was relayed in the nurses note, or reported that the resident felt she was emotionally abused, CNA #584 would have been removed and not allowed to remain working in the facility while an investigation was conducted. Review of the facility policy, Ohio Resident Abuse Policy dated 07/11/24 revealed the facility will not tolerate abuse, neglect, mistreatment, exploration of residents, and misappropriation of resident property by anyone. Facility staff must immediately report all such allegations to the administrator/abuse coordinator. The facility administrator/abuse coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with procedures in this policy. If a staff member is accused or suspected of abuse, neglect, mistreatment, or exploration, the facility immediately remove the staff member from the resident care area and requests a written statement from accused staff member. The accused staff members will remain under direct supervision until the statement is complete and or law enforcement arrives if applicable. The accused staff member will then be removed from the facility and the schedule pending the outcome of the investigation. 2. Review of the personal files for facility staff revealed eight sampled staff members did not receive references checks before being employed by the facility and having resident contact. These included: 1. Certified Nursing Assistant (CNA) #584 hired on 02/16/22. 2. CNA #546 hired on 03/25/24. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. CNA #574 hired on 04/15/24. 4. CNA #557 hired on 06/28/23. 5. Admissions Coordinator #524 hired on 09/03/24. 6. Registered Nurse #512 hired on 06/26/24. 7. Laundry aide #612 hired on 03/21/24. 8. Respiratory Director #513 hired on 09/12/24. Interview on 03/26/25 at 10:33 A.M. with Human Resource Coordinator #517 confirmed the facility did not obtain reference checks prior to employing the above staff members. Review of the facility policy, Ohio Resident Abuse Policy dated 07/11/24 revealed as part of the facility screening procedure included that the facility will generally attempt to obtain references from two prior employers for each applicant. This deficiency represents non-compliance investigated under Complaint Number OH00162488.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015 Based on interview and record review the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) for Resident #56 was accurately completed upon the resident's admission to the facility. This affected one resident (#56) of one resident reviewed for PASARR. The facility census was 85. Findings include: Review of the medical record for Resident #56 revealed an admitted [DATE]. Diagnoses included traumatic subdural hemorrhage without loss of consciousness, Post Traumatic Stress Disorder (PTSD), anxiety, and dementia. The record indicated the residents had moderate cognitive impairment. Review of Resident #56's PASARR dated 12/13/24, the day after admission to the facility, revealed the PASARR was completed due to no previous PASARR records. The PASARR did not include the residents' diagnoses of PTSD, anxiety, or dementia. Interview on 03/19/25 at 1:25 P.M. Social Service Designee #579 verified when Resident #56 was admitted to the facility she did not have a PASARR. She stated she completed the PASARR but not include the resident diagnoses of PTSD, anxiety, or dementia.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015 Based on record review, observation, interview, and facility policy review, the facility failed to ensure Resident #23's Thrombo-Embolic Deterrent (TED) hose (compression stockings) were in place as ordered and failed to ensure monitoring was completed for Resident #63's biliary drain. This affected two residents (#23 and #63) out of six residents reviewed for skin conditions. The facility census was 85. Findings include: 1. Review of the medical record for Resident #63 revealed an admitted [DATE]. Diagnoses included metabolic encephalopathy, acute kidney failure with tubular necrosis, dependence on renal dialysis, and hypertensive heart and chronic kidney disease without heart failure. The resident was admitted with a right biliary drain (a medical device used to drain bile from the liver or gallbladder. It consists of a thin, flexible tube that is inserted into the bile duct to collect and remove bile). Review of Resident #63's care plan dated 02/05/25 revealed she did not have a care plan addressing her biliary drain. Review of Resident #63's progress notes revealed she was admitted to the hospital from 02/21/25 to 03/01/25 with influenza type A. Review of Resident #63's January 2025 physician orders revealed orders to document biliary drain output twice a day, and to monitor the residents biliary drain site for signs and symptoms of infection. The orders were received on 01/11/25 and were discontinued by 02/24/25. Continued review of the March 2025 physician orders revealed the resident did not have any orders related to monitoring the biliary drain site or recording its output. Review of Resident #63's Medication Administration Record, skin assessments, and progress notes revealed no evidence that the facility was monitoring the resident biliary drain site or output after 02/21/25. Review of Resident #63's nursing progress note dated 03/21/25 at 7:54 P.M. revealed the resident's family reported that the resident was having pain at the site of her drain. Upon assessment, the area around resident's drain was slightly swollen, tender to touch with slight redness around the area. Vitals were obtained and the resident was noted with a temperature of 100.2 degrees Fahrenheit (F). The family was at bedside and wanted the resident to be sent to the emergency room . A call was placed to the Nurse Practitioner who recommended the resident be sent out. Emergency medical services came to transport resident to the hospital. The family was at bedside and aware. Review of Resident #63's hospital paperwork dated 03/21/25 revealed she was admitted with clostridium difficile (c-diff) and cholecystitis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Phone interview on 03/20/25 at 1:55 P.M. with Family Member #632 revealed Resident #63 had a biliary drain since November 2024. Yesterday, (03/19/25) the family member noticed it appeared that the tubing did not appear to be clean, the drainage appeared chunky, did not appear to have been flushed, and the amount in the bag did not appear to be different from several days prior. She asked the CNA if she had dumped it, and the CNA stated there had not been a reason since the amount had not changed. Family Member #632 stated the resident had gotten sick yesterday, and last night she complained of pain in that area, and she reported her pain was a seven (indicating seven on a scale of zero to 10, zero indicating no pain and 10 the worst pain). The family member spoke with the nurse last night, the nurse assessed the resident and stated her abdomen was in pain. She stated the resident went out to the hospital in February 2025 for Influenza A and since coming back, it was discovered upon discussion with the nurse last night that there were no orders for cleaning, draining, or documenting the amount of drainage for the biliary drain following the residents readmission from hospital. The nurse contacted the Nurse Practitioner, and orders were received and an order for an ultrasound was ordered. Interview on 03/24/25 at 5:19 P.M. the Director of Nursing revealed Resident #63 went to the hospital in February 2025 and when she came back to the facility, the hospital paperwork did not provide orders for her biliary drain. She stated because of this, the nurse did not initiate the residents' previous drain orders. She confirmed the facility did not have any documented evidence where the residents drain was monitored since her admission back to the facility on [DATE]. She stated that her expectation would be for the nurses to monitor the drain twice daily and monitor the resident's output twice a day. 45442 2. Review of the medical record for Resident #23 revealed an admitted [DATE]. Diagnoses included but were not limited to chronic obstructive pulmonary disease, epileptic seizures, congestive heart failure, peripheral vascular disease, and abnormalities of gait and mobility. Review of the 01/17/25 quarterly Minimum Data Set (MDS) 3.0 for Resident #23 revealed he was cognitively intact and required moderate assistance for dressing, toileting and transfers. Review of the 11/01/24 physician order for Resident #23 revealed an order to put on Thrombo-Embolic Deterrent (TED) hose (compression stockings) every morning and they were to be taken off at night. Review of the physician order dated 01/22/24 for Resident #23 revealed an order for weekly skin checks and as needed. Review of the care plan last reviewed on 01/29/25 for Resident #23 revealed an alteration in cardiovascular status related to congestive heart failure, cardiomyopathy, presence of a pacemaker, hypertension, and hyperlipidemia. Interventions listed were TED hose on in the morning and off at night. Review of the March 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) for Resident #23 revealed each day in March 2025 indicated the residents TED hose were on as ordered, including on 03/18/25. Review of the nursing progress notes from 12/01/24 to 03/18/25 did not reveal any TED hose refusals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the weekly skin assessments from December 2024 to March 2025 for Resident #23 revealed skin assessments were completed on 12/08/24, 12/15/24, 01/26/25, 02/09/25, 02/23/25, and 03/23/25. Interview on 03/17/25 at 1:06 P.M. with Resident #23 revealed both feet were swollen and he did not feel the staff monitored his edema. Observation on 03/18/25 at 2:31 P.M. of Resident #23 revealed his TED hose were not on. Interview at the time of the observation with Resident #23 revealed staff did not offer to put TED hose on the resident this morning and had not offered to put them on in a long time. Interview on 03/18/25 at 2:46 P.M. with Licensed Practical Nurse (LPN) #586 confirmed Resident #23 did not have his TED hose on and stated it was an accident that the 03/18/25 MAR/TAR indicated them as being on and that it shouldn't have been checked off as completed. Interview on 03/24/25 at 2:47 P.M. with LPN #586 also confirmed weekly skin checks for Resident #23 were not completed weekly as physician ordered. Review of the 02/08/21 revised facility policy titled Application of Anti-Emboli Stockings/TED Hose revealed anti-embolic stocking will be applied according to providers orders. The policy revealed if possible, anti-emboli stoking should be applied in the morning, prior to the resident getting out of bed, and to remove and reapply stockings according to providers orders (usually left off at night).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015 Based on observation, interview, record review, and policy review, the facility failed to ensure Resident #7 was safely transferred using a mechanical lift. This affected one resident (#7) of three residents reviewed for accidents. The facility census was 85. Findings include: Review of the medical record for Resident #7 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), Alzheimer's disease, unspecified, and type two diabetes mellitus with hyperglycemia. The resident was noted to have a severe cognitive impairment. Review of Resident #7's March 2025 physician orders revealed an order dated 05/15/24 for Hoyer (mechanical) lift (a mobile, wheeled device used to safely lift and transfer individuals with limited mobility) with assist of two staff for all transfers. Review of Resident #7's comprehensive care plan date 02/27/25 revealed the resident had self care deficits related to COPD, Alzheimer's, dementia, diabetics, atherosclerotic heart disease, and cognitive communication deficit. One intervention stated the resident was dependent on two staff with the use of a mechanical lift for all transfers. Observation of video recordings submitted anonymously to the Ohio Department of Health via email revealed a video clip dated 01/27/25 starting at 4:39 P.M. lasting one minute and 50 seconds showing Certified Nursing Assistant (CNA) #633 using a mechanical lift to transfer Resident #7 from her wheelchair into the bed independently. There was not a second staff member present in the video. Interview on 03/25/25 at 2:14 P.M. the Administrator confirmed the facility staff member was observed on video unsafely transferring Resident #7 independently. Review of the facility policy titled Mechanical Lift Policy dated 01/07/22 revealed two staff persons were required for total body lifts.

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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** 42015 Based on interview, medical record review, and policy review, the facility failed to establish a baseline weight for Resident #73. This affected one resident (#73) of four residents reviewed for nutrition. The facility census was 85. Findings include: Review of the medical record for Resident #73 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, unspecified fracture of third thoracic vertebra, subsequent encounter for fracture with routine healing, and dysphagia following cerebral infarction. Review of Resident #73's physician orders revealed an order dated 11/30/24 to 01/03/25 to obtain weight upon admission, then weekly for four weeks. Additional orders dated 03/03/25 called for Resident #73 to receive a magic cup (fortified ice-cream type supplement) four ounces (oz) daily with lunch and dinner, and for a regular diet, pureed texture, with a 1500 milliliter (ml) daily fluid restriction. Review of Resident #73's Admission nutrition assessment dated [DATE] revealed the resident was on a pureed diet with a 1500 ml daily fluid restriction. His weight was listed as 164 pounds (lbs), a BMI of 23.5, and his ideal body weight was noted to be 164 lbs. The assessment stated to monitor weekly weights, intakes, skin, and labs. Review of Resident #73's care plan revised 03/03/25 revealed the resident had increased nutrition/hydration risk related to hemiplegia, fracture right clavicle, fracture of vertebra, hypertension, alcohol abuse, aphasia, dysarthria, dysphagia, and significant weight loss of one month. A listed goal stated the resident will be free of significant weight changes every month. Interventions included provide diet per order,monitor weight per protocol, monitor need for increased nutritional intervention related to diagnosis, medications and listed problems, monitor dietary intake Review of Resident #73's weights revealed the following weights: - 12/16/24 a weight of 163.4 lbs - 01/06/25 a weight of 163.4 lbs - 01/30/25 a weight of 145.5 lbs - 02/06/25 a weight of 145.5 lbs - 03/03/25 a weight of 144.8 lbs The recorded weights indicated Resident #73 had a 10.95 percent weight loss from December 2024 to January 2025. (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 03/18/25 at 9:55 A.M. with Resident #73 revealed the resident reported he had lost a lot of weight recently and was unsure why. Interview on 03/19/25 at 9:45 A.M. with Dietitian #610 revealed all residents are ordered weekly weights upon admission to establish a baseline weight. Dietician #610 stated weights were not always consistently obtained due to staffing, but the issue was improving. Interview on 03/27/25 at 10:38 A.M. with Regional Registered Dietitian #627 verified the facility failed to establish a baseline weight for Resident #73 by obtaining an initial weight and weekly weights following. She stated it is her expectation that a baseline weight should be obtained within 48 hours of admission. She reported without the facility obtaining a baseline weight she is unable to determine if the resident had a true weight loss. Review of the policy Resident Weight Policy last revised on 12/12/23 revealed weights will be obtained routinely in order to monitor nutritional health over time. Each residents weight will be determined upon admission/readmission to the facility, weekly for the first four weeks after admission/readmission and monthly or more often if risk is identified or as ordered. Nursing is responsible for obtaining weights. Review of the facility policy, Resident Change in Condition Policy last revised 06/27/24 revealed the physician, provider and resident/family/responsible party will be notified when there has been a significant weight loss of five percent in 30 days, or 10 percent in 180 days.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on medical record review, observation, and interview, the facility failed to ensure Resident #287's midline intravenous access site dressing changes were completed per physician order. This affected one resident (#287) out of one residents reviewed for intravenous therapy. The facility identified four residents receiving intravenous therapy. The facility census was 85. Findings include: Review of Resident #287's medical record revealed an admitted [DATE]. Diagnoses included osteomyelitis (bone infection), respiratory failure and quadriplegia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #287 had intact cognition. Resident #287 was dependent for toileting, bathing and personal hygiene. Review of physician orders for March 2025 revealed orders dated 03/07/25 to observe Resident #287's midline intravenous access site every shift and change the transparent dressing and securement device every seven days and also as needed (PRN). Review of Resident #287's care plan revealed no documented evidence of a care plan related to the residents midline. Review of Medication Administration Record (MAR) and Treatment Administration Record (TAR) for March 2025 revealed documentation that Resident #287's midline dressing change had been completed on 03/09/25, 03/10/25, 03/11/25, 03/12/25, 03/13/25, 03/14/25, 03/15/25, 03/17/25, 03/23/25, 03/24/25, 03/25/25 and 03/26/25. Observation on 03/26/25 at 10:39 A.M. with Licensed Practical Nurse (LPN) #587 revealed Resident #287's midline dressing to her left upper arm had a date of 03/05/25 and there was dried blood around the insertion site. LPN #587 confirmed the date of 03/05/25 and stated midline dressings were to be changed every seven days and also PRN. Interview on 03/26/25 at 3:08 P.M. with Director of Nursing (DON) confirmed Resident #287's MAR and TAR for March 2025 had included inaccurate documentation of Resident #287's midline dressing being changed and stated nurses should not document treatments they had not completed. The DON further revealed the facility had not updated the residents care plan since the midline was placed.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on interview and record review the facility failed to ensure dialysis communication forms had been completed before and after dialysis treatments. This affected one resident (#10) of two residents reviewed for dialysis communication. The facility census was 85. Findings include: Review of Resident #10's medical records revealed an admitted [DATE]. Diagnoses included end stage renal disease (ESRD) and dialysis dependent. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had intact cognition. Review of Resident #10's care plan dated 01/30/25 had ESRD and required dialysis Monday through Friday. Review of Resident #10's physician orders for March 2025 revealed to obtain Resident #10's weight post-dialysis and notify the physician of weight or losses of three pounds. Review of Resident #10's dialysis communication forms for February 2025 and March 2025 revealed dialysis communication forms were only completed for 02/04/25, 02/07/25, 02/10/25, 02/13/25, 02/20/25, 02/21/25, 02/24/24, 02/25/25, 02/27/25, 03/03/25, 03/04/25, 03/06/25, 03/11/25, 03/14/24, 03/17/25 and 03/21/25. Review of progress note dated 03/05/25 timed 2:24 P.M. authored by Licensed Practical Nurse (LPN) #587 revealed Resident #10 had refused dialysis. Progress note did not include notification to the physician of refusal. Interview on 03/25/25 at 12:23 P.M. with Director of Nursing (DON) confirmed missing dialysis communication forms and stated dialysis communication forms were to be filled out before and after dialysis treatments. The DON stated if a resident refused dialysis treatments, a progress note was to be written.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on interviews, observation, record review, facility policy review, review of pharmacy destruction logs, review of facility policy, and review of Ohio Revised Code, the facility failed to ensure medications were returned to the pharmacy timely following discharge and narcotics were destroyed in a timely manner. In addition, the facility failed to ensure Resident #21 received routine medications per physician orders. This affected Resident #21 and had the potential to affect all residents residing in the facility. The facility census was 85. Findings include: 1. Review of Resident #800's closed medical records revealed an admitted [DATE] and a deceased date of [DATE]. Review of Resident #801's closed medical records revealed an admitted [DATE] and a deceased date of [DATE]. Review of Resident #802's closed medical records revealed an admitted [DATE] and deceased date of [DATE]. Review of Resident #803's closed medical records revealed an admitted [DATE] and a discharge date of [DATE]. Review of Resident #804's closed medical records revealed an admitted [DATE] and a deceased date of [DATE]. Resident #804 was ordered oxycodone (narcotic pain medication) 5 milligrams (mg). Review of Resident #805's closed medical records revealed an admitted [DATE] and a discharge date of [DATE]. Resident #805 was ordered oxycodone 5 mg. Review of Resident #806's closed medical records revealed an admitted [DATE] and a discharge date of [DATE]. Resident #806 was ordered lorazepam (controlled substance to treat anxiety) 0.5 mg. Review of Resident #807's closed medical records revealed an admitted [DATE] and deceased date of [DATE]. Resident #807 was ordered oxycodone 5 mg, morphine (narcotic pain medication) 20 mg and lorazepam 0.5 mg. Observation and interview on [DATE] at 8:33 A.M. with the Director of Nursing (DON) of the facility medication rooms revealed no excess medications present. The DON stated unused medications were sent back to the pharmacy twice weekly. The DON denied she had any narcotics in the facility that were not being used and stated that narcotics had been destroyed. The DON stated there were some medications in the nursing office that were in the process of being sent back to the pharmacy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the nursing office on [DATE] at 9:12 A.M. with the Assistant Director of Nursing (ADON) revealed four boxes of several cards of unused medications. ADON stated she was assisting with getting the medications sent back to the pharmacy. Observation revealed several medication cards in the bins for Residents #800, #801, #802 and #803, and ADON stated those residents no longer resided in the facility. Interview on [DATE] at 1:30 P.M. with Regional Registered Nurse (RRN) #628 revealed the DON had stated she had unused narcotics in the facility that should have been destroyed. RRN #628 stated she had wasted the unused narcotics with the DON on [DATE] after she had been informed the narcotics had not been destroyed previously. RRN #628 stated unused narcotics should be destroyed as soon as possible after a resident is discharged or the medication is not longer being used. Review of controlled substance inventory form revealed Resident #804, #805, #806 and #807's controlled substance medications were destroyed on [DATE]. Review of facility policy titled Discontinued Medication Procedure revised [DATE] revealed items eligible for return were to be returned to the pharmacy within 48 hours or as soon as practicably possible. Review of facility policy titled Disposal/Destruction of Expired or Discontinued Medication revised [DATE] revealed facility should dispose of discontinued medication after a residents discharge or death in a timely fashion, no longer than 90 days after the medication was discontinued. Review of Ohio Revised Code 4729:5 effective date [DATE]: (6) Controlled substances shall be destroyed pursuant to this paragraph no later than ten days from the date the patient's controlled substance medication is removed from the medication cart or storage area. 2. Review of Resident #21's medical record revealed an admitted [DATE] with the diagnosis including diabetes. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 had intact cognition. Review of the physician orders for [DATE] revealed Resident #21 was ordered Ozempic (diabetic/weight loss injection) 2 milligrams (mg), once daily on Mondays. Review of Resident #21's Medication Administration Record (MAR) for [DATE] revealed a dose of Ozempic was given on [DATE] and [DATE]. Review of the pharmacy delivery slip dated [DATE] revealed Resident #21 had an Ozempic injection pen which contained 8 milligrams/3 milliliters of medication (4 doses of the ordered medication). Review of the progress note dated [DATE] timed 5:16 P.M. revealed they were awaiting a pharmacy delivery for Resident #21's Ozempic and to place the medication on hold until medication was delivered which was scheduled for [DATE]. Review of the progress note dated [DATE] time 3:59 P.M. revealed the facility had agreed to pay for Resident #21's Ozempic. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 9:23 A.M. with Resident #21 revealed he had not received his ordered Ozempic once a week as he was supposed to. Resident #21 stated the medication was supposed to be administered on Saturdays, however he had not received it and stated he had been told he would need to change the day it was administered because the medication was unavailable and stated he had been told the medication could not be reordered until [DATE]. Resident #21 stated he believed someone had taken the medication for their own personal use for weight loss because the facility was having a weight loss contest. Interview on [DATE] at 12:33 P.M. with the Director of Nursing (DON) confirmed the pharmacy delivery slip dated [DATE] revealed Resident #21 had an Ozempic pen that contained 8 mg/3 mL. The DON further confirmed Resident #21's physician orders were for 2 mg once daily on Mondays and that the injection pen contained a total of 4 doses. She stated she was unsure why the medication was not available to be given on [DATE] and further confirmed the dose documented on [DATE] was prior to the medication being delivered on [DATE]. This deficiency represents non-compliance investigated under Complaint Numbers OH00162488 and OH00162160.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on record review and staff interview, the facility failed to ensure pharmacy recommendations were timely reviewed and addressed by the provider. This affected two residents (#30 and #67) of five residents reviewed for unnecessary medications. The facility census was 85. Findings include: Review of Resident #67's medical records revealed an admitted [DATE]. Diagnoses included diabetes and congestive heart failure. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #67 had impaired cognition. Review of physician orders for March 2025 revealed Resident #67 was ordered metformin (oral diabetic medication) 500 milligrams (mg) once daily. Review of pharmacy recommendation dated 01/23/25 revealed a recommendation to monitor blood work to assess for kidney function on the next convenient lab day, and every six months thereafter. Review of Resident #67's medical records revealed lab work was not completed until 03/11/25. Interview on 03/26/25 at 3:08 P.M. with the Director of Nursing (DON) confirmed Resident #67's pharmacy recommendation was dated 01/23/25 and confirmed Resident #67's lab work was not completed until 03/11/25. 42015 2. Review of the medical record for Resident #30 revealed an admitted [DATE]. Diagnoses included end stage renal disease, generalized anxiety disorder, and major depressive disorder. Review of Resident #30's quarterly Minimum Data Set, dated dated dated [DATE] revealed the resident was cognitively intact and had no symptoms of depression. Review of Resident #30's physician ordered revealed an active order dated 12/18/23 for sertraline 50 mg by mouth one time a day for depression and an active order for mirtazapine 7.5 mg by mouth every night at bedtime for depression. Review of Resident #30's pharmacy recommendation dated 09/25/24 revealed the resident received two antidepressants for depression: mirtazapine 7.5 mg at bedtime and sertraline 50 mg in the morning. The recommendation stated to please reduce one of these medications, if possible, with the end goal of discontinuation. Continued reviewed revealed the physician did not address the recommendation. Interview on 03/27/25 at 2:47 P.M. with the Administrator confirmed there was no evidence where the physician addressed the pharmacy recommendation.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on medical record review and staff interview, the facility failed to ensure appropriate follow up with a specialty physician related to an antibiotic medication. This affected one resident (#296) out of two residents reviewed for death. The facility census was 85. Findings include: Review of Resident #296's closed medical records revealed an admitted [DATE] and a discharge date of [DATE], with the diagnosis of bladder cancer. Review of the care plan dated 01/31/25 revealed Resident #296 had a diagnoses of cancer and was receiving chemotherapy. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #296 had impaired cognition. It also noted that Resident #296 was independent with self care and had received antibiotics in the previous seven days. Review of Resident #296's physician orders for February 2025 revealed to follow up with infectious disease regarding antibiotic orders and to fax laboratory results every week, Cefazolin (intravenous antibiotic) 2 grams every eight hours from (02/03/25 to 02/19/25), Cefazolin 1 gram twice a day was ordered from 02/20/25 to 02/20/25 and Cefazolin 2 grams was ordered three times a day from 02/20/25 to 02/28/25. Review of Medication Administration Record (MAR) for February 2025 revealed the resident received Cefazolin 2 grams three times per day (12:00 A.M., 8:00 A.M., and 4:00 P.M.) from 02/04/25 until 02/19/25, besides during the 8:00 A.M. shift on 02/06/25, 02/13/25, 02/15/25, 02/17/25, and 02/18/25 when the medications were not signed off as received. On 02/19/25 at 4:00 P.M. and 02/20/25 at 12:00 A.M., the medication was documented as being on hold. On 02/20/25 at 8:00 A.M. Cefazolin 1 gm was documented as given. On 02/20/25 at 4:00 P.M., the Cefazolin 2 gm three times per day resumed until 02/24/25 when the resident received the last dose at 12:00 A.M. Review of Resident #296's laboratory (lab) results dated 02/14/25 revealed the residents kidney labs were high. The Blood Urea Nitrogen (BUN) level was 74 milligrams per deciliter (mg/dL)(normal ranges from 7 to 25 mg/dL), the Creatinine level was 2.4 mg/dL (normal ranges from 0.6 to 1.2 mg/dL), and the GFR was 32 milliliters (ml) per minute (normal range was to be greater than 60 mL/min). The lab results indicated the kidney function was worsening from the previous labs received on 02/11/25. The lab results from 02/11/25 revealed BUN level was 67 mg/dL, the Creatinine level was 2.1 mg/dL, and the GFR was 37 ml per minute. Review of Resident #296's progress note dated 02/19/25 timed 1:15 P.M. authored by LPN #518 revealed she had received a call from the pharmacy regarding Resident #296's lab work related to his kidney function. The pharmacy had advised to change Resident #296's antibiotic dosages due to decreased kidney function. The progress note stated the nurse practitioner had been called and she advised staff to follow the pharmacy recommendations. The progress note also stated the orders had not been changed and the information had been relayed to the oncoming nurse. (continued on next page)

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	366487	A. Building B. Wing	04/01/2025

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Tallmadge Health & Rehab Center	619 Northwest Avenue Tallmadge, OH 44278

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #296's progress note dated 02/19/25 timed 11:00 P.M. authored by LPN #535 revealed she had been informed that Resident #296's antibiotic had been placed on hold due to abnormal kidney function. LPN #535 had contacted the pharmacy who had recommended a lower dose of antibiotic which was 1 gram every 12 hours, instead of 2 grams every eight hours. The progress note stated the nurse practitioner had been notified and stated Resident #296's laboratory results were supposed to have been faxed to infectious disease because they were to handle Resident #296's antibiotics. The progress note stated the nurse practitioner informed them to go ahead with the pharmacy recommendations until infectious disease had placed orders. Review of progress note dated 02/20/25 timed 11:19 A.M. authored by LPN #514 revealed she had spoken with the nurse practitioner to clarify Resident #296's antibiotic orders and Resident #296 was to continue with 2 grams Cefazolin until they received clarification from infectious disease. There were no further notes indicating if the infectious disease physician was contacted or notified. Interview on 03/27/25 at 12:16 P.M. with LPN #518 revealed she recalled the pharmacy calling and had made recommendations to decrease Resident #296's antibiotics due to his decrease kidney function. LPN #518 stated she had informed the DON and stated the DON was supposed to have contacted infectious disease and stated she had passed the information on to the oncoming nurse. Interview on 03/27/25 at 3:14 P.M. with Administrator revealed she was unable to locate orders from infectious disease regarding Resident #296's antibiotic orders. Telephone interview on 03/27/25 at 3:21 P.M. with Nurse Practitioner (NP) #629 revealed she could not recall if she had given orders for Resident #296's antibiotics, however she had advised the nurses to contact infectious disease for orders. This deficiency represents non-compliance investigated under Complaint Number OH00162160.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 45442 Based on observation, interview, tasting of meal test tray, and facility policy review, the facility failed to ensure meals provided were palatable and served at an appetizing temperature. This affected seven residents (Resident #10, #21, #26, #28, #30, #41, and #69) and had the potential to affect all 82 residents receiving meals from the facility. The facility identified three residents (#25, #65, and #281) who received nothing by mouth and did not receive food from the facility kitchen. The facility census was 85. Findings include: Interview on 03/17/25 at 10:44 A.M. with Resident #21 revealed the food is frequently cold and the coffee is cold. Interview on 03/17/25 at 1:16 P.M. with Resident #10 revealed the food tasted horrible and stated other residents have said they can't eat it as the food made them nauseous. Interview on 03/17/25 at 1:37 P.M. with Resident #28 revealed the facility frequently served cold food, especially on the weekends, and the food tasted terrible. Resident #28 stated staff do not use the plate warmer, instead they place food on the plate and cover it. Resident #28 stated she had brought her concerns to management about the food and meals being repetitive during past care conferences, but no changes had been made. Interview on 03/17/25 at 2:03 P.M. with Resident #30 revealed meals are frequently cold. Interview on 03/17/25 at 3:09 P.M. with Resident #26 revealed the breakfast tray is usually cold. Interview on 03/18/25 at 9:27 A.M. with Resident #69 revealed she did not eat breakfast as it was cold and really did not taste good. Resident #69 stated the food frequently tasted bad and the resident is not really interested in eating the facility's food. Interview on 03/19/25 at 9:36 A.M. with a family member of Resident #41 revealed sometimes her food is not served hot and does not look appealing. Observation on 03/18/25 at 7:42 A.M. with [NAME] #542 revealed the following food temperatures prior to the start of tray line: oatmeal 190 degrees Fahrenheit (F), pureed eggs 158 degrees F, pureed oatmeal 166 degrees F, egg spinach frittata 190 degrees F, egg and cheese omelet 152 degrees F and bacon 140 degrees F. Continued observation revealed the tray line started at 7:50 A.M. No sanitation concerns were observed. Observation of the egg spinach frittata revealed it was not firm and did not hold shape upon being plated. Tray line ended at 8:27 A.M. A test tray went with the 300 resident hall cart. The last tray was passed on the 300 hall at 8:42 A.M. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of test tray with Food Service Manager #542 on 03/18/25 at 8:42 A.M. revealed the following temperatures: coffee 154 degrees F, milk 40 degrees F, oatmeal 114 degrees F, egg spinach frittata 115 degrees F, pureed eggs 111 degrees F, pureed oatmeal 106 degrees F, egg and cheese omelet 105 degrees F. Appearance of the test trays food items revealed the egg spinach frittata appeared mushy and had moisture around it. Upon tasting the egg spinach frittata, pureed oatmeal, and egg and cheese omelet, the items were not warm enough for preference. Interview with Food Service Manager #542 at the time of the tasting confirmed the items were not as warm as she would have preferred, and the spinach frittata was not as firm as it could have been. Review of the facility food committee meeting minutes dated 01/23/25 revealed a concern related to cold coffee. Review of the 12/31/24 revised facility policy called; Dining Experience at Mealtimes Policy revealed the facility will provide attractive, nourishing, and palatable meals that minimize negative health outcomes. Foods will be served at a palatable temperature.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442 Based on observation, interview and facility policy review, the facility failed to ensure resident refrigerators were maintained in a safe and sanitary condition, free from expired food. This affected one (Resident #10) of three resident refrigerators observed. The facility identified 29 residents with refrigerators in their rooms. The facility census was 85. Findings include: Review of the facility resident council meeting minutes dated [DATE] revealed a concern related to resident refrigerator having items that are not being labeled or dated and should only be kept for three days and then discarded. Observation and interview on [DATE] at 12:36 P.M. with the Administrator of Resident #10's room refrigerator revealed the following concerns: - A 16-ounce (oz.) bottle of Italian dressing with an expiration date of [DATE]. - A 16-oz. bottle of honey mustard dressing with an expiration date of [DATE]. - A 16-oz. bottle of ranch dressing with an expiration date of [DATE]. - A 32-oz. bottle of strawberry jam with an expiration date of [DATE]. -A 16-oz. opened bag of mild cheddar shredded cheese that appeared moldy and had some liquid in it with an expiration date of [DATE]. - An open and undated saran-wrapped chunk of Swiss cheese that had visible mold. At the time of the observation, the Administrator confirmed the findings. The Administrator stated facility management and nursing staff are to be checking the resident room refrigerators to ensure they are cleaned and expired items are discarded. Interview on [DATE] at 12:36 P.M. with the Administrator confirmed facility leadership talked with residents at the [DATE] resident council meeting about staff-identified concerns with residents having food in their room refrigerators. The Administrator stated staff would be monitoring resident refrigerators to ensure items were labeled, dated, and discarded timely for resident safety. Administrator confirmed more monitoring was needed. Review of the facility policy called; Food Brought in from outside the facility dated [DATE] revealed resident room refrigerator foods must be labeled and dated to ensure proper rotation by expiration dates. Designated employees will check food labels and date marking daily. Resident refrigerators and freezers will be kept clean and in working order.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, interview and record review, the facility failed to ensure accurate documentation was recorded regarding Resident #287's midline intravenous (IV) dressing changes. This affected one resident (#287) of four residents reviewed for documentation. The facility census was 85. Findings include: Review of Resident #287's medical records revealed an admitted [DATE]. Diagnoses included osteomyelitis (bone infection), respiratory failure, and quadriplegia. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #287 had intact cognition. Resident #287 was dependent for toileting, bathing and personal hygiene. Review of physician orders for March 2025 revealed to observe Resident #287's IV site every shift and to change the mideline IV site dressing and securement device every seven days and as needed (PRN). Review of Medication Administration Record (MAR) for March 2025 revealed documentation Resident #287's IV dressing change had been completed on 03/09/25, 03/10/25, 03/11/25, 03/12/25, 03/13/25, 03/14/25, 03/15/25, 03/17/25, 03/23/25, 03/24/25, 03/25/25 and 03/26/25. Observation on 03/26/25 at 10:39 A.M. with Licensed Practical Nurse (LPN) #587 revealed Resident #287's IV dressing to her left upper arm was dated 03/05/25. There was dried blood around the insertion site. LPN #587 confirmed the date of 03/05/25 and stated IV dressing were to be changed every seven days and also PRN. Interview on 03/26/25 at 3:08 P.M. with Director of Nursing (DON) confirmed Resident #287's MAR for March 2025 had included documentation of Resident #287's IV dressing being changed and stated nurses should not document treatments they had not 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** 42733 Based on observation, interview, medical record review, and review of facility policy, the facility failed to ensure effective infection control measures were maintained during wound dressing changes. This affected one resident (#287) of six residents reviewed for skin conditions. The facility census was 85. Findings include: Review of Resident #287's medical records revealed an admitted [DATE]. Diagnoses included osteomyelitis (bone infection), respiratory failure and quadriplegia. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #287 had intact cognition. Resident #287 was dependent for toileting, bathing and personal hygiene. Review of physician orders for March 2025 revealed Resident #287 had an order to cleanse the right and left ischium (hip) and sacrum (tailbone) wounds with Dakins (antiseptic solution) and apply calcium alginate (wound dressing) and cover with a foam dressing daily and as needed and cleanse right calf with wound cleaner, apply xeroform (wound dressing) and cover with an absorbent dressing three times a week and as needed. Observation of wound care on 03/26/25 at 10:39 A.M. with Licensed Practical Nurse (LPN) #587 revealed she had entered Resident #287's room with the required wound supplies. LPN #587 had proceeded to place foam dressings and calcium alginate directly onto Resident #587's soiled bed linens. LPN #587 proceeded to cleanse Resident #287's buttocks and sacrum. LPN #587 retrieved a pair of scissors from her pocket, cut Resident #287's foam dressings and calcium alginate, and then replaced the scissors back into her pocket. LPN #587 had not disinfected scissors prior to cutting Resident #287 foam dressings or calcium alginate. LPN #587 had then proceeded to cleanse Resident #287's right leg and had obtained the same scissors she had used previously to cut open Resident #287's xeroform packaging and then placed the xeroform dressing onto Resident #287's soiled bed linens. LPN #587 had not changed her gloves or performed hand hygiene after cleansing Resident #287's leg wound or prior to applying a clean dressing. LPN #587 had then placed Resident #287's right leg onto the soiled bed linens. Interview with LPN #587 on 03/26/25 at the conclusion of the observation confirmed the above observations. Review of the Clean Dressing Change Policy dated 03/10/24 revealed when sterile technique is not ordered or indicated, wounds will be dressed using clean technique which avoids direct contamination of material and supplies.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015 Based on medical record review and interview, the facility failed to ensure Resident #56 received appropriate treatment following an Urinary Tract Infection (UTI). This affected one resident (#56) of two residents reviewed for treatment of UTIs. The facility census was 85. Findings include: Review of the medical record for Resident #56 revealed an admitted [DATE]. Diagnoses included traumatic subdural hemorrhage without loss of consciousness, type two diabetes mellitus without complications, urinary tract infection, and chronic kidney disease, stage three unspecified. The record indicated the resident had moderately impaired cognition. Review of Resident #56's January 2025 progress notes revealed the resident was hospitalized from 01/21/25 to 01/28/25. Review of Resident #56's hospital After Visit Summary (AVS) dated 01/28/25 revealed the resident was ordered Macrobid (an antibiotic) 100 milligram (mg) capsule with instructions to take one capsule by mouth two times a day with meals for one day for treatment of a UTI. Review of Resident #56's physician orders revealed an order dated 01/29/25 for Macrobid 100 mg to be given twice daily and to be repeated every day. On 02/19/25 the order was updated to add it was to be used as prophylactic. Review of Resident #56's Medication Administration Record (MAR) revealed the resident received Macrobid 100 mg from 01/30/25 through 03/19/25. Review of progress notes from 01/21/25 to 03/18/25 revealed no evidence as to why the antibiotic was being given prophylactic. Interview on 03/20/25 at 10:39 A.M. with the Director of Nursing (DON) revealed Resident #56 returned from the hospital on 01/28/25. The resident came back with orders for Macrobid 100 mg to be given twice a day for one day. When it was ordered, the facility did not put an end date on the medication. During reviews of the medication, because there was not an end date, the infection preventionist assumed it was ordered prophylactic and updated the order to say so. The DON reported she contacted the doctor who signed off on it and she could not remember ordering it. The DON confirmed Resident #56 received the antibiotic incorrectly. Telephone interview on 03/28/25 at 8:38 A.M. with Physician #269 revealed she was not aware the hospital had ordered the antibiotic to be given for one day only. She stated she would have only ordered it prophylactic if nursing would have reported that is what the hospital recommended.