STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366488	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Lyndhurst	5442 Rae Road Lyndhurst, OH 44124

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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** 42733 Based on observation, resident record review, staff interviews, and facility policy review, the facility failed to ensure residents were treated with dignity and respect. This affected four residents (#50, #59, #70, and #71) of four residents reviewed for dignity and respect. The facility census was 100. Findings include: 1. Review of Resident #50's medical records revealed an admitted [DATE]. Diagnoses included paraplegia and bladder dysfunction. Review of the care plan revised 01/22/25 revealed Resident #50 had an indwelling urinary catheter. Interventions included ensure Resident #50 had a privacy bag on catheter. Observation on 01/21/25 at 3:02 P.M. revealed Resident #50 was in a wheelchair in the entrance foyer and Resident #50's urinary catheter drainage bag was not covered by a privacy bag. The Administrator confirmed the finding at the time of observation. 2. Review of Resident #70's medical records revealed an admitted [DATE]. Diagnoses included urinary retention and bladder dysfunction. Observation on 01/21/25 at 3:17 P.M. revealed Resident #70 was in bed with an indwelling catheter. Resident #70's catheter was not covered by a a privacy bag. Human Resources (HR) #871 confirmed the finding at the time of observation. 3. Review of Resident #59's medical records revealed an admitted [DATE]. Diagnoses included falls, muscle weakness, and dementia. Observation on 01/27/25 at 6:52 A.M. revealed Resident #59 was in a common dinning area and Resident #59's catheter had not been covered by a privacy bag. Licensed Practical Nurse (LPN) #834 confirmed the finding at the time of observation and stated she was unsure if the facility had privacy bags. 42730 (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of the medical record for Resident #71 revealed she was admitted to the facility on [DATE] with diagnoses that included polyosteoarthritis, dementia, and hypertensive heart disease with heart failure. Review of the care plan dated 02/27/24 revealed Resident #71 had a self-care deficit due to dementia and limited mobility with interventions that included eating supervised with assistance. Review of the physician orders dated 12/10/24 revealed Resident #71 had an order for a regular diet, pureed textured with thin liquid consistency. Review of the quarterly, Staff Assessment for Mental Status (SAMS) assessment dated [DATE] revealed Resident #71 had short and long-term memory loss and was severely impaired regarding tasks of daily life. Review of the SAMS assessment revealed Resident #71 was dependent on staff for Activities of Daily Living (ADLs). Review of the physician orders dated 01/17/25 revealed Resident #71 was to be encouraged to be in the main dining room for meals every shift for fall prevention. Review of the physician orders dated 01/22/25 revealed Resident #71 was now a feed assist for all meals. Review of the progress note dated 01/22/25 at 7:18 P.M. revealed Resident #71 was a feed assist as of 01/22/25 and for staff to assist with feeding of all meals, every shift, to start 01/23/25. Observation and interview on 01/23/25 at 8:25 A.M. of the dining room, located adjacent to the nursing station on the 200-hall unit, revealed Resident #71 and #98 seated together at a table. Resident #98 was observed eating her breakfast meal and Resident #71 was observed without a breakfast tray. Certified Nursing Assistant (CNA) #889 confirmed the findings at the time of the observation. Observation and interview on 01/23/25 at 8:38 A.M. revealed, approximately 13 minutes later, Resident #71 received her breakfast lunch tray. Dietary Manager (DM) #908, with the Director of Nursing (DON) present, confirmed and verified Resident #71 was seated at a table with Resident #98 and was without a breakfast meal tray until 8:38 A.M. Observation on 01/27/25 at 9:34 A.M. revealed Resident #71 laying in bed with her breakfast tray on her over-the-bed table and positioned over her body. Resident #71 was observed attempting to eat her breakfast meal with no staff present. Observation and interview on 01/27/25 at 9:37 A.M. revealed CNA #889 entered Resident #71's room with Resident #26's finished breakfast tray in her hand. CNA #889 revealed he was entering Resident #71's room to assist with her breakfast meal. CNA #889 approached Resident #71, while standing, begin to spoon feed the resident with his right hand, while he continued to hold Resident #26's completed tray still in hand. CNA #889 continued to feed Resident #71, while standing, 3 scoops of her breakfast meal before he exited the room. Resident #71 was then observed attempting to continue to eat her breakfast meal. Resident #71 spoon was upside down as she tried to feed herself. CNA #889 was then observed to re-enter the room and stated Resident #71 was capable of feeding herself. CNA #889 confirmed and verified the findings at the time of the observation. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility document titled Resident Rights revised October 2022, revealed the facility had a policy in place to ensure residents' personal dignity, well-being, and self-determination was maintained. Review of facility policy titled Foley Catheter Care revised 08/22 revealed privacy will be provided to drainage bags to ensure resident dignity. This deficiency represents an incidental finding identified while investigating Master Complaint Number OH00162102 and Complaint Numbers OH00161890, OH00161859, OH00161556, OH00161410, OH00161144, OH00161142, and OH00161136.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on review of camera footage, medical record review, interview, and review of facility policy, the facility failed to ensure call lights were within reach of residents. This affected one resident (#61) out of five observed for call lights. The facility census was 100. Findings include: Review of Resident #61's medical records revealed an admitted [DATE]. Diagnoses included falls, chronic heart failure and chronic obstructive pulmonary disease. Review of the care plan dated 05/08/24 revealed Resident #61's room had continuous video monitoring. Resident #61 had noted self-care deficits. Interventions included to encourage Resident #61 to use call bell for assistance. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #61 had intact cognition. Resident #61 was dependent with toileting and required maximum assistance with bathing and personal hygiene. Interview on 01/21/25 at 1:41 P.M. with Resident #61's wife revealed on 12/26/24 she had reviewed camera footage that had shown an unnamed aide that had taken Resident #61's call light and had placed it on the floor. Resident #61's wife stated she had shown the video to the Director of Nursing (DON) the following day. Review of camera footage (unable to obtain the date and time of footage) at time of interview provided by Resident #61's wife had shown an aide in Resident #61's room, she had turned the call light off and had then proceeded to take the call light from Resident #61's hand and the call light had then dropped to the floor. The video footage showed Resident #61 was sleeping at that time. Review of the video footage on 02/05/25 at 1:41 P.M. with the DON confirmed an aide (unable to provide a name) had turned Resident #61's call light off and the light had then fallen on the floor. At time of interview, Central Supply (CS) #814 had entered and stated the aide was Certified Nursing Assistant (CNA) #918 and she was no longer employed at the facility. Review of the policy Resident Call System revised 03/2023 revealed the staff will provide an environment to assist in meeting the needs of the resident and to provide an environment which supports and enhances each resident's quality of life, providing the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. The procedure stated when leaving the room, be sure the call light is placed within the resident's reach. This deficiency represents an incidental finding identified while investigating Master Complaint Number OH00162102 and Complaint Numbers OH00161890, OH00161859, OH00161556, OH00161410, OH00161144, OH00161142, and OH00161136.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep residents' personal and medical records private and confidential. 42733 Based on observation and interview the facility failed to ensure chart room that contained residents private information were secured. This had the potential to affect all residents residing in facility. The facility census was 100. Findings include: Tour on 01/21/25 at 10:42 A.M. with Director of Nursing (DON) revealed 3 out of 4 doors to the facility's chart rooms had tape over the locks and the rooms were not secured. Each room contained the resident's hard chart with access to various components of the medical record. The DON confirmed the tape on the door and stated chart rooms were to be locked at all times, and removed the tape during tour. Observation on 01/27/25 at 6:52 A.M. revealed a chart room located on the 300 hall that had a wheelchair leg placed in the doorway leaving the door propped open. Interview with Licensed Practical Nurse (LPN) #834 at the time of observation confirmed the door was propped open when she arrived to start her shift on 01/26/25 at 7:00 P.M. LPN #834 stated the doors to the chart rooms were to remain secured at all times. This deficiency represents non-compliance investigated under Complaint Numbers OH00161142 and OH00161136.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730 Based on observations, resident record review, resident interview, staff interview, and facility policy review, the facility failed to ensure the resident environment was maintained in a clean and sanitary manner, and failed to ensure water temperatures were at a comfortable level. This affected seven residents (#6, #29, #42, #49, #70, #82, and #83) of seven reviewed for physical environment. The facility census was 100. Findings include: 1. Review of the medical record for Resident #82 revealed he was admitted to the facility on [DATE] with diagnoses that included schizophrenia, syncope and collapse, and hypertensive heart disease. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE], revealed Resident #82 had a Brief Interview for Mental Status (BIMS) score of 7 that indicated he was alert with cognition impairment. Review of the MDS assessment revealed Resident #82 required assistance from staff for Activities of Daily Living (ADLs). Review of the care plan dated 01/17/24 revealed Resident #82 was at risk for ADL decline due to schizophrenia and impaired cognition and was at risk for bowel and bladder incontinence related to episodes of incontinence. Interventions included toileting assist of one and resident care per facility protocol. Observation and interview on 01/21/25 at 7:57 A.M. revealed Resident #82's bathroom had a soiled brief sitting atop of a soiled shirt and pair of pants in the middle of the floor. Observation of Resident #82's bathroom toilet revealed the inside of the toilet bowl was full to the rim with urine, feces, and toilet paper. Resident #82 revealed staff did not assist him to the bathroom or help clean him up. Observation and interview on 01/21/25 at 8:00 A.M. with Registered Nurse (RN) #844 revealed she was not aware which Certified Nursing Assistant (CNA) was assigned to Resident #82. RN #844 entered Resident #44 bathroom, confirmed and verified Resident #82's bathroom at the time of the interview. 2. Review of the medical record for Resident #42 revealed she was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, dementia, and chronic obstructive pulmonary disease. Review of the MDS assessment dated [DATE] revealed Resident #42 had an ADL self-care deficit with interventions that included assist with ADLs as needed. Observation and interview on 01/28/25 at 12:26 P.M. revealed Resident #42 standing in the hallway outside her room, pacing back and forth. Resident #42 revealed she was trying to locate staff to remove her old meal trays from her room. Observation of Resident #42's room revealed two old meal trays. Resident #42 revealed one tray was from her dinner meal on 01/27/25 and the second tray was from her breakfast tray on 01/28/25. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 01/28/25 at 12:36 P.M. during the lunch meal tray pass, revealed CNA #889 walking into Resident #42 room with her lunch meal tray in hand. CNA #889 was observed attempting to find a place to sit Resident #42's lunch tray down. CNA #889 stated to Resident #42 Oh, you still have two trays in here. I will get them when I come back later. CNA #889 stated another staff member must have forgotten to remove the resident's old trays prior to serving her new tray. CNA #889 confirmed and verified the findings at the time of the observation. 3. Review of the medical record for Resident #29 revealed he admitted to the facility on [DATE] with diagnoses that included Parkinson's disease, epilepsy, and transient cerebral ischemic attack. Review of the care plan dated 01/05/25 revealed Resident #29 had a self-care deficit with interventions that included staff assistance with ADLs. Observation and interview on 01/22/25 at 6:14 A.M. revealed a dirty dinner tray in Resident #29 room. Resident #29 dinner plate was observed to have dried crusted food and a drink cup with an unknown object floating in it. Resident #29 revealed staff always left his used dishes and trays in his room even though he requests them to be removed. Resident #29 stated the staff sit around all night on their do-nothing stools. 4. Review of the medical record for Resident #70 revealed she was admitted to the facility on [DATE] with diagnoses that included saddle embolus pulmonary artery, metabolic encephalopathy, and acute respiratory failure. Review of the care plan dated 07/12/24 revealed Resident #70 had a self-care deficit with interventions that included staff assistance with ADLs. Observation on 01/22/25 at 6:20 A.M. revealed a dried crusted dinner dishes in Resident #70 room. Resident #70 was non-interviewable at the time of the observation. Observation and interview on 01/22/25 at 6:20 A.M. with Business Office Manager (BOM) #822 revealed the evening shift staff were responsible for removing the dishes from residents rooms. BOM #822 confirmed and verified the findings at the time of the observation of Residents #29 and #70 room. Review of the facility document titled Activities of Daily Living (ADLs) dated March 2023, revealed the facility had a policy in place that residents would be given appropriate treatment and services to maintain or improve their ability to carry out ADLs including but not limited to, bathing and dining. Review of the facility provided document titled 7-Step Daily Washroom Cleaning undated, revealed the facility had a protocol in place that resident's commodes would be cleaned daily to include the tank, the seat, the bowl, and the base. 5. Review of the medical record for Resident #6 revealed she admitted to the facility on [DATE] with diagnoses that included sepsis, Alzheimer's disease, and muscle weakness. Review of the medical record for Resident #49 revealed he was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes, traumatic subarachnoid hemorrhage, and legal blindness. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record for Resident #83 revealed he was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, dementia, and epilepsy. Interview on 01/21/25 at 9:07 A.M. with Resident #54 revealed she had not received a bed bath or shower due to no hot water in her bathroom. Interview on 01/21/25 at 9:38 A.M. with Resident #3 revealed the water in her bathroom was ice cold. Interview on 01/21/25 at 1:41 P.M. with Resident #61 family member revealed Resident #61 was without hot water for 7 days. Resident #61 family member revealed residents went without being showered for at least a week and the water came back on, on 01/20/25. Interview on 01/21/25 at 1:34 P.M. with Resident #27 family member, revealed she contacted the Director of Nursing (DON) on 01/19/25 regarding the lack of hot water, and was told the water in the facility would be fixed within a few hours. Resident #27 family member revealed she was informed by other resident's families about the hot water issues. Resident #27 family member revealed she spoke with the Administrator on 01/20/25, who stated she was on bereavement, and informed her that the water issues would be fixed on 01/17/25. However, as of 01/21/25, the facility was still having issues with the lack of hot water. Interview on 01/21/25 at 3:03 P.M. with Resident #50 revealed he was without hot water for 3 days. Interview on 01/21/25 at 3:19 P.M. with LPN #852 revealed the facility was without hot water for a couple days, but she could not recall the day it started. LPN #852 revealed resident water temperatures fluctuated throughout the day. Tour of the facility on 01/21/25 at 3:12 P.M. with Maintenance Supervisor (MS) #853 revealed Resident #83 bathroom sink water had a temperature reading of 87.5 degrees Fahrenheit, Resident #6 bathroom sink water had a temperature reading of 96.6 degrees Fahrenheit, and Resident #49 bathroom sink water had a temperature reading of 91 degrees Fahrenheit. MS #853 revealed he was notified that the water temperatures were below regulation standards on 01/13/25 and placed a call to Standard Plumbing and Heating Company Mechanical Contractors and Engineers but no repairs had been made at this time. MS #853 revealed he attempted to adjust the water temperatures on his own, but he was still trying to adjust them. MS #853 confirmed and verified at the time of the observation the water temperatures were not meeting regulation standards and were supposed to be between 105 degrees and 120 degrees Fahrenheit. Observation and interview on 01/22/25 at 5:44 A.M. revealed Resident #26 bathroom sink water was on and running at a steady flow. Resident #26 revealed staff turned her water on to try to let it warm up because it was cold. Interview on 01/22/25 at 5:45 A.M. with CNA #894 revealed she turned on Resident #26 bathroom sink water to ensure it warmed up prior to attempting to wash her up bedside. CNA #894 revealed she always turned on the sink water to warm up before starting morning care due to fluctuating water temperatures. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/22/25 at 5:48 A.M with CNA #883 revealed resident rooms with running water was due to no hot water in the building and staff were attempting to let it warm up enough to provide morning care. Interview on 01/22/25 at 8:38 A.M. with CNA #861 revealed the Administrator and Director of Nursing (DON) were aware of the hot water issues. CNA #861 revealed she had refused to give residents showers in cold water and did not give showers for a week. CNA #861 revealed she had not completed shower sheets from 01/13/25 through 01/20/25 and the water still wasn't getting hot. Review of the water temperature logs dated 11/25/24 through 01/17/25 revealed no logs dated 01/13/25 through 01/23/25. Review of the quote regarding estimation for services regarding exhaust motors for two [NAME] Hot Water Tanks revealed Standard Plumbing and Heating Company Mechanical Contractors and Engineers were contacted on 01/21/25, approximately 8 days after acknowledgment of water temperatures issues. Interview on 01/22/25 at 2:30 P.M. with the Administrator revealed she was aware of the hot water issues regarding the building. The Administrator revealed she was made aware by MS #853 the hot water went out in the facility on 01/13/25 and at that time she was on leave. The Administrator revealed Standard Plumbing and Heating Company Mechanical Contractors and Engineers were contacted on 01/13/25 but was unable to provide documentation regarding services requested. The Administrator revealed she received a quote on 01/22/25, approximately 9 days later, regarding the hot water issues. The Administrator revealed the exhaust motors related to the hot water tanks went out and she was in the process of speaking to the regional director to get approval to determine which company to use to fix the issues. The Administrator revealed the water temps were retested and were fluctuating due to MS #853 temporarily adjusting the water temperatures manually. The Administrator revealed only a small section of the facility was affected by the hot water tanks. The Administrator confirmed and verified at the time of the interview the hot water tanks were not repaired. Review of the facility document titled Water Temperatures revised January 2023, revealed the facility had a policy in place that water temperatures would be monitored routinely to promote a comfortable and safe environment. Review of the policy revealed the facility would ensure appropriate water temperatures between the range of 105-120 degrees Fahrenheit. Review of the document revealed the facility did not implement the policy. This deficiency represents non-compliance investigated under Master Complaint Number OH00162102 and Complaint Numbers OH00161410, OH00161142, and OH00161136.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 42733 Based on interview, policy review, grievance log review, and personnel file review the facility failed to ensure resident concerns were addressed. This affected four residents (Resident #9, Resident #27, Resident #61, and Resident #73) and had the potential to affect all 100 residents residing in the facility. Findings include: Telephone interview on 01/21/25 at 11:26 A.M. with Resident #73's family revealed she had a camera placed in Resident #73's room due to care concerns. Resident #73's family stated she had observed Resident #73 had not received care for several hours and stated she had emailed the Administrator and had sent text messages to the Director of Nursing (DON) to express her concerns. Resident #73's family stated the issues had been addressed, however it had not lasted long and the same issues had continued to occur. Telephone interview on 01/21/25 at 12:50 P.M. with Resident #9' family revealed she had expressed concerns to the DON related to Resident #9's care as well as the cleanliness of her room and stated the DON had not addressed her concerns and the issues had still being going on. Interview on 01/21/25 at 1:41 P.M. with Resident #61's family revealed she had sent a text message to the DON regarding the lack of hot water the previous week, however Resident #61's family stated the DON had not responded to her text messages. Resident #61's family further stated she had sent text message to the DON regarding the lack of incontinence care, not assisting Resident #61 back into bed timely and a wound to Resident #61's penis. Resident #61's family stated her phone calls and text messages had not been answered. Interview on 01/22/25 at 1:34 P.M. with Resident #27's family revealed she had a camera placed in Resident #27's room and had observed Resident #27 not being changed for over 12 hours. Resident #27's family stated she had discussed her concerns with the DON and stated the issue had gotten better for a short time and then the issue had occurred again. Interview on 01/27/25 at 11:55 A.M. with Registered Nurse (RN) #874 revealed she had observed Certified Nursing Assistant (CNA) #823 and #905 (unable to recall exact dates, however stated it was during an evening shift) in a common area watching TV with blankets wrapped around them and were observed to have been using their phones. RN #874 stated she had written up statements regarding CNA #823 and #905 and had given them to the DON and stated she was unsure of the outcome. Interview on 01/27/25 at 12:59 P.M. with Resident #27's family revealed she had sent a text message to the DON on 01/26/25 1:16 P.M. that stated Resident #27 was out of incontinence briefs. Resident #27's family stated the DON had not responded to her text message. Review of personnel files on 01/29/25 at 10:53 A.M. for CNA #823 and #905 revealed no disciplinary actions in their files. Interview with HR #871 confirmed no disciplines in their files. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/04/25 at 2:53 P.M. with DON revealed she had responded to families regarding their concerns and stated she had not been given statements from RN #874 regarding CNA #823 and #905. Review of the facility grievances revealed the facility did not have any resident concerns logged since September 2024. Review of the facility Grievance Policy revealed the purpose was to ensure the facility makes prompt effort to resolve grievances a resident may have. The intent of the grievance process is to support each residents right to voice grievances and to assure that after receiving a concern/grievance, the facility actively seeks a resolution and keeps the resident appropriately apprised of it's progress toward resolution. Response to grievances include any employee of the facility who receives a concern shall immediately attempt to resolve the concern within their role and authority. If a concern cannot be immediately resolved the employee shall escalate the concern to their supervisor and the facility grievance official. Resolution to grievances include the facility will strive for a prompt resolution outcome of all grievances or concerns rendered. A reasonable time frame will be agreed upon with all parties involved. This deficiency represents non-compliance investigated under Complaint Numbers OH00161890, OH00161410, and OH00161142.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Lyndhurst	5442 Rae Road Lyndhurst, OH 44124

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on interview, record review, review of the Ohio Department of Health (ODH) Certification and Licensure System (CALS), and review of facility policy, the facility failed to timely report an injury of unknown origin to the State Agency as required. This affected one resident (#64) of three residents reviewed for self reported incidents. The facility census was 100. Findings include: Review of Resident #64's medical record revealed an admitted [DATE]. Diagnoses included muscle weakness, difficulty walking and dementia. Review of the care plan dated 01/09/25 revealed Resident #64 was at risk for falls. Interventions included maintain a safe and clutter free environment. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #64 had intact cognition and required moderate assistance with sit-to-stand transfers and bed-to-chair transfers. Review of a progress note dated 01/20/25 timed 10:16 P.M. with a created date of 01/22/25 at 11:26 A.M. authored by Registered Nurse (RN) #801 revealed the Nurse Practitioner (NP) had assessed Resident #64 and had informed him of a new order for an x-ray. The progress note stated RN #801 asked why the x-ray was being ordered and NP stated Resident #64 had stated he had fallen in December and his ankle was now bothering him. RN #801 had assessed Resident #64 and his ankle was swollen, painful to touch, and the resident reported pain during ambulation. Review of a progress note dated 01/22/25 timed 7:14 A.M. authored by RN #801 revealed Resident #64's x-ray examination report showed the resident had a fracture of the ankle. Review of a progress note dated 01/22/25 time 10:40 A.M. authored by Assistant Director of Nursing (ADON) #898 revealed orders were given to send Resident #64 to the hospital. Review of progress note dated 01/20/25 timed 10:16 P.M. with a created date of 01/24/25 timed 2:32 P.M. authored by the Director of Nursing (DON) revealed on 01/20/25 at 10:16 P.M. Nurse Practitioner had performed an evaluation of Resident #64 and he had reported complaints of left ankle pain related to a fall in December while living at a group home. Resident #64 had reported no pain unless ambulating and an order for an x-ray was placed. Assessment of Resident #64's ankle by NP revealed left ankle was swollen and pain during palpation. Resident #64 denied he had told anyone about the fall. Review of the ODH CALS website revealed on 01/22/25 at 11:37 A.M., the facility initiated a SRI for an injury of unknown origin related to Resident #64's ankle fracture. Interview on 02/03/25 at 1:37 P.M. with the DON revealed the SRI was initiated as soon as they had been made aware of the injury for Resident #64. Resident #64's progress notes dated 01/20/25 were reviewed with the DON and compared to the created date of the SRI. The DON shrugged her shoulders and was unable to provide further explanation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated policy titled Abuse Prohibition revealed injuries of unknown source must be reported immediately, but no later than two hours after the allegation is made, to the the Administrator and State Agency. This deficiency represents non-compliance investigated under Complaint Number OH00161859.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730 Based on resident record review, staff interview, and facility policy review, the facility failed to ensure resident care plans were up-to-date and reviewed on a quarterly basis as required. This affected four residents (#9, #26, #44, #54) of four residents reviewed for care planning. The facility census was 100. Findings include: 1. Review of the medical record for Resident #44 revealed she was admitted to the facility on [DATE] with diagnoses that included bilateral primary osteoarthritis of knee, hypertensive heart disease without heart failure, and major depressive disorder. Review of the quarterly, Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #44 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated she cognitively intact. Review of the MDS assessment revealed Resident #44 required assistance from staff for Activities of Daily Living (ADLs). Review of the physician orders dated 01/21/25 revealed Resident #44 had an order for droplet isolation for COVID-19 with all activities to take place in her room. Review of the progress note dated 01/20/25 at 2:54 P.M. revealed Resident #44 complained of cold-like symptoms, and was COVID-19 tested with positive results. Resident #44 placed on isolation precautions. Review of the care plan dated 03/06/24 revealed Resident #44 did not have a care plan in place for infection control, droplet precautions, or COVID-19. Review of the facility document provided by the DON titled Isolation Residents undated, revealed Resident #44 was positive for COVID-19 as of 01/20/25. Interview on 01/21/25 at 8:25 A.M. with the Director of Nursing (DON) revealed the facility had one positive case of COVID-19 and that was for Resident #44. The DON revealed Resident #44 tested positive for COVID-19 on 01/20/25. Follow-up interview and review of Resident #44's medical record on 01/22/25 at 1:23 P.M. with the DON confirmed Resident #44 did not have a care plan related to infection control, COVID-19, or isolation and/or droplet precautions in place. The DON instructed the state surveyor to click on multiple areas within the Electronic Medical Record (EMR) and was unable to produce results. The DON confirmed and verified the findings at the time of the interview. 45442 2. Review of the medical record for Resident #9 revealed a re-admitted [DATE]. Diagnoses included but were not limited to epilepsy, type II diabetes mellitus, and morbid obesity. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of 01/14/25 quarterly Minimum Data Set (MDS) 3.0 revealed a Brief Interview of Mental Status (BIMS) score of 12 which indicated mild cognitive impairment. Review of activities of daily living (ADLs) revealed Resident #9 was dependent upon staff for toileting, dressing, transfers and mobility. Review of the care plan review section in the electronic medical record for Resident #9 revealed the last fully completed care plan quarterly review was on 05/03/23. Interview on 02/03/25 at 2:30 P.M. with MDS Nurse #848 stated care plans are to be reviewed quarterly and confirmed Resident #9's care plan review page indicated Resident #9's care plan had not been fully reviewed since 05/03/23. 3. Review of the medical record for Resident #26 revealed an admitted [DATE]. Diagnoses included but were not limited to hemiplegia and hemiparesis, morbid obesity, unilateral osteoarthritis. Review of 01/11/25 annual Minimum Data Set (MDS) 3.0 for Resident #26 revealed a Brief Interview of Mental Status (BIMS) score of 13 which indicated the resident was cognitively intact. Review of activities of daily living (ADLs) revealed Resident #26 required supervision for meals. Review of Resident #26's care plan which was last updated on 11/01/24 revealed Resident #26 had a self-care deficit related to limited mobility and hemiplegia/hemiparesis related to stroke. Interventions dated 02/13/23 was for supervised eating assistance. Resident #26's care plan dated 07/16/24 for demonstrated extrapyramidal symptoms (EPS) (involuntary movements and tremors) revealed an intervention for a speech therapy referral for speech and eating difficulty dated 07/16/24. Resident #26 was noted to have potential for altered nutrition and hydration related to hemiplegia and morbid obesity. Intervention last revised on 01/26/24 was for nursing to assist with meals as needed. Interview on 02/03/25 at 2:30 P.M. with MDS Nurse #848 stated care plans are to be reviewed quarterly and confirmed Resident #54's care plan for feeding assistance had not been updated since 01/06/24. MDS Nurse #848 also confirmed on the care plan review page in the electronic medical record there were no completed quarterly care plan review dates listed. 4. Review of the medical record for Resident #54 revealed an admitted [DATE]. Diagnoses included but were not limited to acute and chronic respiratory failure, chronic obstructive pulmonary disease, type II diabetes mellitus, morbid obesity, mild protein-calorie malnutrition, and bipolar disorder. Review of 12/29/24 significant change Minimum Data Set (MDS) 3.0 for Resident #54 revealed a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. Resident #54 uses a wheelchair. Review of activities of daily living (ADLs) revealed Resident #54 requires set up for meals, supervision to wheel 50 feet and moderate assistance to wheel 150 feet. Review of Resident #54's care plan revealed it was initiated on 10/23/23 and latest revisions to any section were 05/29/24. Interview on 02/03/25 at 2:30 P.M. with MDS Nurse #848 stated care plans are to be reviewed quarterly and confirmed there was no indicated completed care plan review since 05/29/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy Care Plan - Advanced Care Plan Process revised December 2022 revealed the Interdisciplinary Team (IDT) will coordinate with the resident and/or their responsible party, an appropriate plan of care for the resident's needs or wishes specific to person-centered care based on the assessment and reassessment process within the required time frames. The IDT, in collaboration with the resident, will meet and review the care plan upon admission, quarterly, and annually. This deficiency represents non-compliance investigated under Complaint Number OH00161142 and OH00161136.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730 Based on observations, resident record review, staff interviews, and facility policy review, the facility failed to ensure residents were provided assistance with meals. This affected two residents (#26 and #71) of three residents reviewed for meal assistance. The facility census was 100. Findings include: 1. Review of the medical record for Resident #71 revealed she was admitted to the facility on [DATE] with diagnoses that included polyosteoarthritis, dementia, and hypertensive heart disease with heart failure. Review of the quarterly Staff Assessment for Mental Status (SAMS) assessment dated [DATE] revealed Resident #71 had short and long-term memory loss and was severely impaired regarding tasks of daily life. Review of the SAMS assessment revealed Resident #71 was dependent on staff for Activities of Daily Living (ADLs). Review of the physician orders dated 12/10/24 revealed Resident #71 had an order for a regular diet, pureed texture with thin consistency liquids. Review of the physician orders dated 01/17/25 revealed Resident #71 was to be encouraged to be in the main dining room for meals every shift for fall prevention. Review of the physician orders dated 01/22/25 revealed Resident #71 required feeding assistance for all meals. Review of the progress note dated 01/22/25 at 7:18 P.M. revealed Resident #71 was now a feed assist as of 01/22/25 and for staff to assist with feeding of all meals every shift to start 01/23/25. Review of the care plan dated 02/27/24 revealed Resident #71 had a self-care deficit due to dementia and limited mobility with interventions that included eating supervised with assistance. Observation on 01/27/25 at 9:34 A.M. revealed Resident #71 lying in bed with her breakfast tray on her over-the-bed table and positioned over her body. Resident #71 was observed attempting to eat her breakfast meal with no staff present. Observation and interview on 01/27/25 at 9:37 A.M. revealed Certified Nursing Assistant (CNA) #889 entered Resident #71's room with Resident #26's finished breakfast tray in her hand. CNA #889 revealed he was entering Resident #71's room to assist with her breakfast meal. CNA #889 approached Resident #71, while standing, begin to spoon feed the resident with his right hand, while he continued to hold Resident #26's completed tray still in hand. CNA #889 continued to feed Resident #71, while standing, 3 scoops of her breakfast meal before he exited the room. Resident #71 was then observed attempting to continue to eat her breakfast meal. Resident #71 spoon was upside down as she tried to feed herself. CNA #889 was then observed to re-enter the room and stated Resident #71 was capable of feeding herself. CNA #889 confirmed and verified the findings at the time of the observation. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/28/25 at 12:15 P.M. revealed CNA #885 transported Resident #71 to the main dining room which was located adjacent to the activities room. CNA #885 seated Resident #71 at a table. Observation and interview on 01/28/25 at 12:56 P.M. revealed Resident #71 was seated at the table in the main dining room with an unfinished meal still in front of her on the table. Resident #71 was observed lifting up her glass to drink a clear liquid with no staff seated near her. Observation revealed the Business Office Manager (BOM) #822 was standing approximately 5 feet in front of Resident #71 on the opposite side of the table. Interview with BOM #822 confirmed and verified no staff assisted Resident #71 with her lunch meal. Observation on 01/29/25 at 12:03 P.M. revealed Resident #71 seated at table in the main dining room. Resident #71 was observed seated with her lunch meal in front of her with no staff present to assist with her meal. Interview on 01/29/25 at 12:07 P.M. with the Director of Nursing (DON) revealed Resident #71 was on hospice services and could feed herself. The DON acknowledged Resident #71 was seated at the table staring at her plate of food. The DON revealed she would have hospice and speech therapy to evaluate her further to determine her dietary needs. Review of Resident #71's medical record with the DON, at the time of the observation on 01/29/25 at 12:07 P. M., confirmed approximately 7 days prior, Resident #71 had received a new order for feeding assistance. The DON confirmed and verified the findings at the time of the observations. Interview on 01/29/25 at 12:18 P.M. with Licensed Practical Nurse (LPN) #836 revealed Resident #71 was on hospice and received a new order to be assisted with all her meals. LPN #836 revealed Resident #71 physically needed help to eat her meals because she would get tired quickly. LPN #836 revealed when staff assists her with her meals, she eats all her food, but if not assisted, she would not be able to finish her meals. LPN #836 confirmed and verified Resident #71 required assistance with her meals as reconciled with her new orders to maintain her dietary and nutritional needs. 45442 2. Review of the medical record for Resident #26 revealed an admitted [DATE]. Diagnoses included but were not limited to hemiplegia and hemiparesis, morbid obesity, unilateral osteoarthritis. Review of 01/11/25 annual Minimum Data Set (MDS) 3.0 for Resident #26 revealed a Brief Interview of Mental Status (BIMS) score of 13 which indicated the resident was cognitively intact. Review of activities of daily living (ADLs) revealed Resident #26 required supervision for eating meals. Review of Resident #26's care plan revealed it was last reviewed on 07/16/24. Resident #26 was noted to demonstrate extrapyramidal symptoms (EPS) and subacute dyskinesia. Intervention dated 07/16/24 was a speech therapy referral for speech and eating difficulty. Review of physician order dated 07/12/24 revealed Resident #26 required supervision with each meal to for signs of choking with meals related to tardive dyskinesia (mild to severe involuntary movements which impair eating safety and ability) (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician order dated 07/17/24 revealed Resident #26 required feeding assistance and to aides were to assist with feeding of all meals related to drug induced subacute dyskinesia. Review of electronic medical record Activities of Daily Living (ADL) feeding task for Resident #26 dated 01/28/25 revealed over the past 30 days only two days (01/05/25 and 01/13/25) supervision was indicated as provided. Observation on 01/27/25 at 9:16 A.M. revealed CNA # 814 cutting up food for Resident #26 in her room. Interview with CNA #814 after leaving Resident #26's room confirmed she was unaware Resident #26 required assistance and supervision with meals, stating she was told she just required meal set up and was able to feed herself. Interview on 02/03/25 at 8:11 A.M. with Licensed Practical Nurse (LPN) #903 stated Resident #26 required set up for meals. LPN #903 confirmed she was unaware Resident #26 had orders for staff supervision and assistance with meals. Interview on 02/04/25 at 8:00 A.M. with CNA #835 confirmed was unaware of active order for supervision for meals for Resident #26 and thought she was just set up for meals. Interview on 02/04/25 at 11:05 A.M. with the Assistant Director of Nursing (ADON) there was an active order for supervision of meals for Resident #26 which should have been changed to meal set up but was not updated. Review of the policy Activities of Daily Living dated 03/2023 revealed the facility will provide care and services for activities of daily living, including eating meals and snacks. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out activities of daily living. This deficiency represents non-compliance investigated under Complaint Numbers OH00161859, OH00161142, and OH00161136.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, interview, medical record review, review of hospital records, and facility policy review, the facility failed to timely implement a physician-ordered treatment to a vascular wound upon admission. This affected one (Resident #77) of three residents reviewed for wound care management. Additionally, the facility failed to ensure resident call lights were answered and care provided in a timely manner. This affected four (Residents #17, #25, #26, and #44) of four residents reviewed for call lights. The facility census was 100. Findings include: 1. Review of Resident #77's medical records revealed an admitted [DATE]. Diagnoses included diabetes, muscle weakness, and difficulty walking. Review of Resident #77's pre-admission hospital records, dated 01/07/25 through 01/18/25 revealed the resident was hospitalized for care and treatment of a left foot arterial (vascular wound) ulcer to the top of the left foot and ankle. The records noted the resident had significant pain to the left lower extremity. The hospital initiated a betadine-soaked gauze dressing to the left lower extremity. Review of Resident #77's care plan dated 01/20/25 revealed the resident had an activity of daily living (ADL) deficit related to weakness. Interventions included observing skin for redness and open areas and reporting any changes to the nurse. Review of Resident #77's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Resident #77 required maximum assistance with toileting, and moderate assistance with bathing and personal hygiene. Review of Resident #77's medical record revealed no evidence that an admission nursing assessment had been completed, including a comprehensive skin assessment to identify any areas of skin impairment present upon admission. Review of Resident #77's physician's orders revealed an order dated 01/23/25 for a wound dressing to a vascular wound on the resident's left lower extremity. The order stated to cleanse the left foot, toe, and ankle with normal saline, apply betadine-soaked gauze, apply an absorbent dressing, and wrap with kerlix (gauze roll) and secure with tape daily. Observation on 01/21/25 at 8:02 A.M. revealed Resident #77 was yelling out in pain that was heard from the hallway outside of a closed door to Resident #77's room. Upon entering Resident #77's room, Registered Nurse (RN) #844, and Licensed Practical Nurses (LPN) #803 and LPN #852 were observed in Resident #77's room. Resident #77 was observed with a tattered gauze dressing to her left foot that was soiled with yellow drainage and was not intact. Interviews with RN #844 and LPN #852 revealed they were not aware of what type of wound the dressing was covering, and had not removed the dressing since the resident was admitted . RN #844 and LPN #852 stated Resident #77 had come from the hospital with that dressing. Resident #77 was observed to have been yelling out in pain and was not able to state what was under the dressing to her left foot. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 01/22/25 at 10:54 A.M. of Resident #77 with LPN #847 revealed the resident's left lower extremity dressing was the same tattered and soiled dressing, unchanged from the observation on 01/21/25. LPN #847 stated she was unaware of Resident #77 having a wound to the left foot, and confirmed the bandage appeared to be tattered and soiled. LPN #847 had proceeded to remove Resident #77's dressing and observation revealed a wound to the top of Resident #77's left foot that was approximately 2 inches long and 1 inch wide, with necrotic (black-colored areas indicating areas of dead tissue) areas, with the area surrounding the necrotic area appearing reddened. LPN #847 stated she would inform the wound nurse. During the observation, the DON entered Resident #77's room and DON stated she was unaware of the area. Observation on 01/22/25 at 11:04 A.M. revealed LPN #903 had entered Resident #77's room with the DON and the Administrator. LPN #903 stated she had been unaware of the wound to Resident #77's foot. LPN #903 stated she would gather supplies to cleanse the wound and had exited the room. At 11:04 A.M., LPN #903 returned to Resident #77's room and cleansed the area with normal saline, applied an absorbent dressing, and wrapped the resident's leg with a kerlix gauze roll. LPN #903 stated the edges of the wound appeared to be necrotic and confirmed the edges appeared reddened. LPN #903 stated the wound physician performed wound rounds on Thursdays and would be in the facility on 01/23/25 to see the resident's wound. Review of Resident #77's hard chart on 01/22/25 at 12:10 P.M. with the DON revealed the pre-admission hospital records noted the resident had been treated for a vascular wound and pain control prior to coming to the facility. Resident #77's hard chart was reviewed with the DON who confirmed the paperwork had included an ulcer to the left foot and pain control. The DON thanked the state surveyor for letting her know. Review of facility policy titled Pressure Ulcer Prevention and Risk Identification revised 01/23 revealed if a new skin area was identified the licensed nurse will initiate a skin grid flow record and update every seven days until area is resolved, the physician and responsible parties were to be notified and treatment will be initiated according to physician orders. 42730 2. Review of the medical record for Resident #17 revealed she was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, aphasia, and COVID-19. Review of the MDS annual assessment dated [DATE], revealed Resident #17 had a Staff Assessment for Mental Status (SAMS) that indicated she had a short and long-term memory problem and was severely impaired regarding task of daily life. Review of the MDS assessment revealed Resident #17 was impaired on one side, upper and lower extremities, and was dependent on staff for Activities of Daily Living (ADLs). Review of the care plan dated 07/05/23 revealed Resident #17 required staff assistance with ADLs with interventions that included one-person assist for transfers and resident care per facility protocol. Review of the physician orders dated 04/19/22 revealed Resident #17 had an order for a one-person assist for transfers. (continued on next page)

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	366488	A. Building B. Wing	02/11/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 01/21/25 at 7:49 A.M. revealed Resident #17 call light was activated. Interview on 01/21/25 at 7:50 A.M. with Resident #17 revealed she wanted to get out of bed. Observation and interview on 01/21/25 at 8:07 A.M. revealed Licensed Practical Nurse (LPN) #854 entered Resident #17 call light, turned it off, and exited the room as she told Resident #17 she would get someone to assist her. LPN #854 confirmed and verified she turned off Resident #17 call light and was going to get staff to assist her. Observation and interview on 01/21/25 at 8:30 A.M. revealed Resident #17 was still in bed. Resident #17 revealed she still wanted to get out of bed. Observation on 01/21/25 at 8:52 A.M. revealed Resident #17 was still in bed needing staff assistance. Observation and interview on 01/21/25 at 9:45 A.M. revealed Certified Nursing Assistant (CNA) #885 passing the morning breakfast trays. CNA #885 revealed if another staff member turned off a call light without telling her the care needs required, she would not know if residents needed assistance, and they would go without care. CNA #885 revealed Resident #17 still required assistance at the time of the interview. CNA #885 confirmed and verified Resident #17 call light was off but she still required help. CNA #885 revealed everyone on her assignment still needed care due to her arriving late for her shift. Observation, during tour with the Director of Nursing (DON), and interview on 01/21/25 at 10:37 A.M. revealed Resident #17 call light was on. Resident #17 revealed she needed to be toileted and staff still had not assisted her. DON confirmed and verified Resident #17 still needed assistance. 3. Review of the medical record for Resident #25 revealed she was admitted to the facility on [DATE] with diagnoses that included pressure ulcer of the sacral region, type 2 diabetes, and hypertension. Review of the MDS quarterly assessment dated [DATE], revealed Resident #25 had Brief Interview for Mental Status (BIMS) score of 14, that indicated she was alert and oriented to person, place, and time. Review of the MDS assessment revealed Resident #25 required assistance from staff for ADLs. Review of the care plan dated 07/04/23 revealed Resident #25 had a self-care deficit with interventions that included assist of one staff member and resident care per facility policy. Observation on 01/21/25 at 10:43 A.M. revealed Resident #25 call light activated. Admissions Director (AD) #825 was observed walking past Resident #25 call light without providing assistance. 4. Review of the medical record for Resident #44 revealed she was admitted to the facility on [DATE], with diagnoses that included bilateral primary osteoarthritis of knee, hypertensive heart disease without heart failure, and major depressive disorder. Review of the MDS quarterly assessment dated [DATE] revealed Resident #44 had a BIMS score of 13 that indicated she was alert and oriented to person, place, and time. Review of the MDS assessment revealed Resident #44 required assistance from staff for ADLs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan dated 03/07/25, for Resident #44 revealed she had a self-care deficit and was bed bound with interventions that included assistance of one staff. Observation on 01/21/25 at 10:06 A.M. revealed Resident #44 call light was activated. Observation on 01/21/25 at 10:12 A.M. revealed RN #880 walked past Resident #44 call light without providing assistance. Observation on 01/21/25 at 10:13 A.M. revealed CNA #889 approached Resident #44 room, grabbed a surgical mask from the personal protective equipment (PPE) bin outside of her room and continued to walk down the hall, without providing assistance. Observation on 01/21/25 at 10:14 A.M. revealed CNAs #826 and #885 walking past Resident #44 room without answering her call light. 5. Review of the medical record for Resident #26 revealed she was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction, morbid obesity, and depression. Review of the MDS annual assessment dated [DATE], revealed Resident #26 had a BIMS score of 13 that indicated she was alert and oriented. Review of the MDS assessment revealed Resident #26 was dependent on staff for ADLs. Review of the care plan dated 06/20/23 for Resident #26 revealed she had a self-care deficit related to limited mobility with interventions that included staff assistance and care per facility protocol. Observation and interview on 01/21/25 at 7:47 A.M. revealed Resident #26 call light was activated. Resident #26 revealed she required assistance from staff for incontinence care and hadn't been assisted since 11:00 P.M. the night before, 01/20/25. Resident #26 revealed she was on Lasix and required care more frequently. Observation and interview on 01/21/25 at 8:31 A.M. revealed Resident #26 call light was activated. Resident #26 revealed she activated her call light because she still needed assistance with incontinence care, due to staff turning off her call light, but not assisting. Observation on 01/21/25 at 8:50 A.M. revealed Resident #26 call light was activated again and she was heard from the hallway yelling out Hello. Observation on 01/21/25 at 8:53 A.M. revealed Registered Nurse (RN) #848 was observed entering Resident #26 room, turned off the call light, did not provide any care and exited the room. Resident #26 reactivated her call light after RN #848 exited her room. Observation and interview on 01/21/25 at 9:00 A.M. revealed RN #848 enter Resident #26 room, turned off her call light and did not provide care. RN #848 revealed Resident #26 required assistance with incontinence care and reported she had not been changed since 10:00 P.M. the night prior, 01/20/25. RN #848 revealed he informed Resident #26 he would get the CNA assigned to her. RN #848 confirmed and verified he turned off Resident #26 call light without providing assistance. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/21/25 at 11:09 A.M. with the DON revealed all staff were responsible to answer call lights to attempt to provide care to residents, however, if the staff assisting could not provide care, the call light were to remain on until a staff member that could provide care, did so. Review of the resident council meeting minutes dated 10/29/24 revealed residents voiced concerns regarding call light response. Review of the meeting minutes revealed the DON informed attendees that call lights were to be answered by all staff members and if assistance could not be provided, the call light should remain on until the appropriate staff could assist. Review of the resident council meeting minutes dated 12/27/24 revealed residents voiced concerns regarding call light responses. Review if the meeting minutes revealed the Administrator informed attendees that all staff were responsible for answering call lights and management and nursing management completed ambassador rounds. Review of the facility document titled Resident Call System revised March 2023, revealed the facility had a policy in place to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Review of policy revealed facility staff would respond to call lights in a timely manner and would not turn off the call light if needs were unable to be met. This deficiency represents non-compliance investigated under Master Complaint Number OH00162102 and Complaint Number OH00161556.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, interview, medical record review, and review of facility policy, the facility failed to ensure Resident #17's newly-identified pressure ulcer was timely assessed and had a treatment implemented. This affected one (Resident #17) of three residents reviewed for wounds. The facility census was 100. Findings include: Review of Resident #17's medical record revealed an admitted [DATE] with medical diagnoses including stroke with right-sided weakness, aphasia (difficulty speaking) and falls. Review of Resident #17's Minimum Data Set (MDS) assessment dated [DATE] revealed she was rarely or never understood. Resident #17's cognition was not assessed on the assessment. Resident #17 was noted to be occasionally incontinent of bowel and bladder. She required moderate assistance with toileting and maximum assistance with bathing and personal hygiene. Review of Resident #17's care plan dated as revised 01/18/25 revealed the resident was at risk for altered skin integrity due to incontinence of bowel and bladder. Listed interventions included immediately reporting any changes to the nurse of redness and skin breakdown, and applying treatments as ordered. Review of Resident #17's physician's orders revealed an order was placed on 01/23/25 for a wound treatment to the resident's right buttock. The treatment called for the wound to be cleansed with normal saline, a calcium alginate wound dressing applied, to be covered with a silicone dressing and changed daily and as needed. There was no listed treatment for a left buttock wound. Observation on 01/21/25 at 10:42 A.M. of toileting assistance revealed the Director of Nursing (DON) assisting Resident #17 with toileting. Resident #17 was observed to have a quarter-sized red, open area to her left buttock that was bleeding. A small amount of blood was additionally noted on Resident #17's incontinence brief. There was no area of skin impairment observed on Resident #17's right buttock. During the observation, Resident #17 stated the area to her left buttock hurts. An interview with the DON at the time of observation confirmed Resident #17's had an open area that she had been unaware of previously. Interview on 01/23/25 at 12:10 P.M. with Wound Nurse Practitioner (WNP) #925 revealed she just been informed moments earlier of Resident #17's open area to her left buttock and was going to see Resident #17 to assess the area. Interview on 01/23/25 at 12:11 P.M. with Licensed Practical Nurse (LPN) #903 revealed she had been notified by an unnamed nurse on 01/20/25 that Resident #17 had a wound on her buttock. LPN #903 confirmed she had not assessed the area and had been waiting for weekly wound rounds with WNP #925. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/23/25 at 12:16 P.M. of Resident #17 with WNP #925 and LPN #903 revealed the area to the Resident #17's left buttock was classified as a stage two pressure ulcer (partial thickness skin loss that exposes the deeper layer of skin). WNP #925 stated the area to the left buttock measured 0.6 centimeters (cm) in length by 0.5 cm in width by 0.1 cm in depth. There was no wound observed to Resident #17's right buttock. Review of the policy titled Pressure Ulcer Prevention and Risk Identification revised January 2023 revealed if a new skin area was identified the licensed nurse will initiate a skin grid flow record. The physician and responsible parties were to be notified and treatment will be initiated according to physician orders. This deficiency represents an incidental finding identified while investigating Master Complaint Number OH00162102 and Complaint Numbers OH00161890, OH00161859, OH00161556, OH00161410, OH00161144, OH00161142, and OH00161136.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442 Based on observation, interview and record review, the facility failed to ensure a hand splint was re-ordered and applied as requested. This affected one (Resident #26) of three residents reviewed for range of motion. The facility census was 100. Findings include: Review of the medical record for Resident #26 revealed an admitted [DATE]. Diagnoses included but were not limited to hemiplegia and hemiparesis, morbid obesity, and unilateral osteoarthritis. Resident #26 was recorded as being hospitalized from 07/08/24 to 07/10/24. Review of the physician order dated 08/15/23 revealed and order for Resident #26 to wear left hand resting splint daily for six hours as tolerated. The order was noted to be discontinued on 07/10/24. Review of Resident #26's Minimum Data Set (MDS) 3.0 annual assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident was cognitively intact. Review of activities of daily living (ADLs) revealed Resident #26 required supervision for meals and was dependent on staff for mobility and transfers. Observation on 01/21/25 at 9:48 A.M. on the wall in Resident #26's room revealed a sign dated 07/26/23 that stated a left-hand splint was to be applied daily. Interview at the time of observation with Resident #26 revealed she used to have a splint and had left the splint at the hospital several months ago. Resident #26 stated she had previously asked the therapist for a new one but had not been given one. Interview at the time of the observation with Certified Nursing Assistant (CNA) #883 confirmed she had not seen the splint for a long time. Review of Resident #26's Rehabilitation Screen Form dated 01/23/25 (initiated after surveyor brought concern to staff attention on 01/21/25) revealed a request for a left-hand splint. Observation on 01/28/25 at 11:45 A.M. of Resident #26 revealed call light was on. Interview at the time of the observation with Resident #26 revealed her left hand was bothering her and she said it was supposed to be on a pillow but staff did not assist her with the pillow. Resident #26 stated she had also previously told a nurse several months ago about wanting to get another splint, but was unsure which one she told. Interview on 01/28/25 at 1:52 P.M. with Therapy Director #912 confirmed Resident #26 previously had an order for a hand splint from 08/15/23 and had gone out to the hospital in July of 2024. Therapy Director #912 confirmed and the order was not re-ordered or re-activated when the resident returned from the hospital and should have been. Review of the invoice dated 01/31/25 (ten days after surveyor brought it to staff attention) revealed an order for Resident #26's left hand splint had been placed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00161144.

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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** 42013 Based on interview, record review, and review of facility policy, the facility failed to ensure Resident #97 and #110 had accurate and thorough fall investigations completed, and failed to ensure admission nursing care plans with individualized fall prevention interventions were implemented. This affected two (Residents #110 and #97) of three residents reviewed for falls. Additionally, the facility failed to ensure only clinical and trained staff members provided assistance with transfers. This affected one (Resident #115) of three residents observed for safe transfers. The facility census was 100. Findings include: 1. Review of the facility incident log from 11/22/24 through 01/22/25 did not revealed no indication Resident #110 had experienced a fall on 01/14/25. Review of an updated facility incident log from 11/22/24 through 01/22/25 revealed Resident #110 had a witnessed fall on 01/14/25 at 9:21 P.M. Review of Resident #110's medical record revealed an admitted [DATE] and diagnoses included pneumonia, unspecified organism, congestive heart failure, dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, muscle weakness, and repeated falls. Resident #110 was discharged from the facility on 01/16/25. Review of Resident #110's progress notes revealed a note dated 01/14/25 at 5:21 P.M. which stated Resident #110 had a fall five minutes after being admitted to the facility. Resident #110 was found lying on her back. Resident #110 stated she was trying to go through her belongings and lost her balance. Resident #110 complained of back pain. No skin issues were found. The noted stated Nurse Practitioner (unidentified) was in to assess Resident #110 right away. No new orders were given. Review of Resident #110's Fall Investigation Checklist included Resident #110 had a witnessed fall on 01/14/25 at 9:21 P.M. (the fall was documented in the progress notes on 01/14/25 at 5:21 P.M.). Resident #110 had a fall five minutes after her admission. The daughter was with Resident #110. Resident #110 said she lost her balance looking for something in her purse. The doctor was in to see her and we helped her up after assessing her. There were no fall risk assessments, pain assessments, 72-hour post-fall assessments, or an admission care plan documented in the Investigation Checklist. Review of Resident #110's medical record including progress notes dated between 01/14/25 through 01/16/25 did not reveal evidence Resident #110 had an evaluation due to a fall by her Nurse Practitioner. The facility was unable to provide documentation Resident #110 was evaluated by the unnamed Nurse Practitioner on 01/14/25 after a fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #110's medical record revealed no evidence a Nursing Admission Assessment was completed. There was no evidence that a Fall Risk Assessment was completed, and there was no evidence 72-hour post-fall documentation was completed following the fall on 01/14/25. There was no evidence Resident #110 had an admission care plan completed within 48 hours of her admission to the facility and there was no evidence a Pain Assessment had been completed. Review of Resident #110's physician orders dated 01/14/25 through 01/16/25 revealed the resident did not have an orders for Tylenol. Review of Resident #110's progress notes dated 01/14/25 through 01/16/25 revealed no evidence Resident #110 had denied need for pain management due to chronic back pain. A late entry progress note written on 01/29/25 stated Resident #110 denied need for pain management due to chronic back pain. Review of Resident #110's Medication Administration Record (MAR) dated 01/14/25 through 01/15/25 revealed Resident #110's pain was recorded at a zero on a zero-to-ten scale, with zero being no pain, and ten being the worst pain. Review of Resident #110's Discharge Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #110 was cognitively intact. Resident #110 required partial to moderate assistance with toileting hygiene, bathing, the ability to come to a standing position from sitting in a chair, wheelchair or on the side of the bed and the ability to transfer to and from a bed to a chair or wheelchair. Further review of the assessment revealed Resident #110 occasionally had pain or hurting in the last five days, occasionally pain interfered with Therapy activities, and occasionally day-to-day activities were limited because of pain. Resident #110's pain was rated as a five on a scale of zero to ten, zero being no pain and ten the worst pain you could imagine. Review of Resident #110's care plan dated 01/16/25 (two days after her fall) included Resident #110 was at risk for falls, was a safety risk, and an elopement risk. A listed goal included Resident #110 would remain free of injuries and falls. Interventions included encouraging use of call light, keeping call bell in reach, and instruct Resident #110 on safety measures. Review of Resident #110's Pain assessment dated [DATE] and signed and locked on 01/29/25 included Resident #110 had a diagnosis which gave reason to believe she would be in pain. Resident #110 had osteoarthritis (not included in medical diagnoses) and decreased mobility. Resident #110 verbalized she had pain described as aching. Pain was relieved by medication (there was no evidence of medication administered related to pain) and deep relaxation. The area for intensity of pain using a scale of zero-to-ten was not completed. The area for location and frequency of pain was not completed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #110's late entry progress note dated for 01/14/25 at 5:05 P.M. but recorded on 01/29/25 at 9:00 A.M. revealed Resident #110 was observed in a supine position to the right side of resident's bed, parallel to the bed. Resident #110 was admitted to the facility five minutes before the fall with daughter at bedside. Resident #110 stated I lost my balance trying to get something out of my bag. Neurological checks were initiated with no abnormalities observed. Resident #110 complained of generalized pain in her back. Skin dry and intact. The NP (Nurse Practitioner) was at the bedside post fall with a complete evaluation and no new orders. Neurological checks were discontinued due to denial of hitting head and no abnormalities during assessment. No injuries observed upon head-to-toe assessment. ROM (Range of Motion) at baseline per Resident #110's daughter. Resident #110 was oriented to the facility to acclimate to the new environment. Resident #110's bed was in the lowest position with call light in reach. Resident #110's daughter notified the nurse on duty that Resident #110 had a history of frequent falls. Resident #110 denied any need for pain management due to chronic back pain. IDT (interdisciplinary team) reviewed and initiated an admission care plan with updates as needed. Telephone interview on 01/27/25 at 12:36 P.M. of Licensed Practical Nurse (LPN) #836 revealed Resident #110 was admitted toward the end of her shift and she had a fall. LPN #836 stated Human Resource Manager (HRM) #871 saw Resident #110 on the floor, told an unidentified CNA, and the CNA told her and she immediately went in Resident #110's room to evaluate her. LPN #836 stated Resident #110 said she was reaching for something and fell , she was lying on her back when she entered the room and complained of back pain. LPN #836 stated an unidentified NP was at the facility and saw her at the time of the fall and was aware of Resident #110's complaints of pain. LPN #836 stated she gave Resident #110 Tylenol for complaints of pain. LPN #836 stated she called Resident #110's daughter, who was not present at the facility but on her way to the facility when she called. LPN #836 stated she told Unit Manager (UM) #874 she had not done Resident #110's incident report and thought UM #874 was going to complete it. Interview on 01/29/25 at 11:17 A.M. of Licensed Practical Nurse (LPN) #836 revealed Resident #110 had a fall on 01/14/25 and she did not remember if Resident #110 said she hit her head, but her back hurt. LPN #836 stated she worked on 01/14/25 until 3:00 P.M. and passed it to the next nurse about Resident #110's back pain. LPN #836 stated she was off shift and just finished up my charting and that was why it has a time of 5:00 P.M. LPN #836 stated she gave the keys to UM #874 and UM #874 stated she would handle the incident report, nursing assessment, and back pain. (continued on next page)

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	366488	A. Building B. Wing	02/11/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/29/25 at 12:33 P.M. of UM #874 revealed LPN #836 gave her report and the keys on 01/14/25 at 5:00 P.M. UM #874 stated LPN #836 worked until 5:00 P.M. UM #874 stated the NP (unidentified) was in the building, she did not see the NP, and by the time I got there everything was handled. UM #874 stated she saw Resident #110 with her daughter, Resident #110 was lying in bed, and she seemed fine. UM #874 stated LPN #836 should have done the assessments and notifications to the management team and to the physician because she was the nurse who had Resident #110 in her assignment when the fall occurred. UM #874 stated LPN #836 told her Resident #110 fell as soon as she was admitted to the facility and was seen by an unidentified NP and no new orders were given. UM #874 stated Resident #110's daughter had a conversation with the NP and the DON came over at that point. UM #874 indicated assessments for pain and fall risk should be completed and 72-hour fall assessments should be completed every shift for a duration of 72 hours. UM #874 revealed she was only filling in for a couple hours, she was not the Unit Manager for the unit Resident #110 resided on, confirmed the assessments were not completed and she did not know why the assessments were not completed and contained in the resident's medical record. UM #874 stated she asked LPN #836 if she needed help and she said she had it. Interview on 01/29/25 at 12:02 P.M. of Human Resources Manager (HRM) #871 revealed she was conducting an orientation class and was walking in the hall with her class, heard Resident #110 yelling, went in her room and found Resident #110 lying on the floor by her bed. HRM #871 stated she placed a pillow under Resident #110's head, did not notice bleeding or bruises, and she told an aide, and the aide told the nurse assigned to Resident #110. HRM #871 indicated she did not remember which aide she told or the nurse who came to the room. HRM #871 stated she asked Resident #110 what she was trying to do and she said, I do not know. Interview on 01/29/25 at 1:02 P.M. of the Director of Nursing (DON) and the Administrator revealed Resident #110 was admitted to the facility on [DATE] and tried to get something out of her purse, lost her balance and fell . The DON stated Resident #110 was lying supine by her bed and was fully evaluated. The DON stated she was not in the facility when Resident #110 fell and she was admitted at 5:00 P.M. The DON indicated Resident #110 had generalized complaints of pain after her fall, was here two days and had no complaints of pain. The DON stated Resident #110 's fall should have an IDT review in the progress notes and it was usually completed the next day. The DON confirmed Resident #110 did not have a fall risk assessment, a pain assessment, 72-hour post-fall assessments every shift, a baseline care plan and stated they were probably in the fall investigation. The DON confirmed Resident #110's fall was not documented on the incident log and provided an updated incident log with the fall documented on it. The DON confirmed the time of Resident #110's fall was documented on 01/14/25 at 9:21 P.M. and that was incorrect. Interview on 01/30/25 at 7:41 A.M. with CNA #819 revealed she worked on 01/14/25 and had Resident #110 in her assignment, but did not remember anything about her fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/30/25 at 9:57 A.M. of Family Member (FM) #926 revealed Resident #110 was on the phone talking to her sister when she fell . FM #926 stated she was not called by anyone from the facility, but Resident #110's sister told her she fell and FM #926 rushed to the facility. FM #926 stated Resident #110's back was hurting a lot, FM #926 talked to the doctor and the doctor said she was fine, but Resident #110 was later found to have a fracture of her lower back. FM #926 stated Resident #110 was transferred to another facility on 01/16/25, was still having severe pain and FM #926 transported her to the local Emergency Department. FM #926 stated an x-ray was taken and the x-ray showed a fracture of Resident #110's lower back. FM #926 stated on 01/14/25, the nurse gave Resident #110 Tylenol, but it did not work, and by the next day the pain was so bad Resident #110 could hardly be touched. The nurse said she would get something ordered for pain but only gave Tylenol. 2. Review of Resident #97's medical record revealed an initial admitted [DATE] and a re-entry date of 01/10/25. Resident #97's diagnoses included chronic obstructive pulmonary disease with acute exacerbation, acute and chronic respiratory failure, congestive heart failure, and weakness. Review of Resident #97's progress notes dated 11/21/24 included Resident #97 was discharged home. Review of Resident #97's Fall Risk Assessments dated 01/10/25 and 01/19/25 revealed Resident #97 was at risk for falls. Review of Resident #97's medical record including assessments dated 01/10/25 through 01/30/25 did not reveal evidence a Nursing Admission Care Plan was completed. Review of Resident #97's Admission Minimum Data Set assessment dated [DATE] revealed Resident #97 was cognitively intact. Resident #97 occasionally had pain or hurting in the last five days and occasionally pain interfered with Therapy activities and pain occasionally limited his day-to-day activities. Resident #97's worst pain was rated as a 7 on a scale of zero-to-ten. Resident #97 had shortness of breath with exertion, when sitting at rest and when lying flat. Resident #97 used a walker and a wheelchair. Resident #97 required partial to moderate assistance with toileting hygiene and bathing. Resident #97 required supervision or touching assistance with the ability to transfer to and from a bed to a chair or wheelchair and the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. Review of Resident #97's progress notes dated 01/19/25 at 3:48 P.M. included Resident #97 had a witnessed fall. Resident #97 had no complaints of pain or discomfort. The note referenced the NP and Unit Manager were notified A voicemail was left for the resident's family member. Resident #87's blood pressure was 139/70, pulse 65, oxygen saturation 97 percent and respirations 17 per minute. There was no description of events leading up to the fall or how the fall occurred. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #97's Fall Investigation Checklist dated 01/19/25 at 3:57 P.M. included Resident #97 had a witnessed fall. Resident #97 had no complaints of pain or discomfort. Notified NP (Nurse Practitioner) and Unit Manager (both were unidentified). Contacted family via voicemail. Resident #87's blood pressure was 139/70, pulse 65, oxygen saturation 97 percent and respirations 17 per minute. CNA #835 stated she was helping Resident #97 with his care; she turned around to get supplies and when she turned back Resident #97 had fallen backwards. CNA #835's statement did not include details of what she saw when Resident #97 fell backwards. The statement did not include if Resident #97 hit his head when he fell backwards. Resident #97's statement indicated he was trying to get the aides' attention so they could shave him and he fell backwards trying to sit in his chair. The statement did not include if Resident #97 was asked if he hit his head. Resident #97's Fall Investigation Checklist did not reveal evidence that an immediate fall intervention was implemented. The Fall Investigation Checklist did not include a statement from the nurse who evaluated Resident #97 after the fall. Review of Resident #97's medical record including assessments dated 01/19/25 through 01/30/25 did not reveal evidence a pain assessment was completed or 72-hour post-fall documentation was completed every shift. Review of Resident #97's care plan dated 01/24/25 (five days after a fall) included Resident #97 was high risk for falls related to deconditioning, gait and balance problems and incontinence. A listed goal included Resident #97 would not sustain serious injury through the review date. Interventions included to anticipate and meet Resident #97's needs; ensure Resident #97 was wearing appropriate footwear when ambulating or mobilizing in the wheelchair; follow facility fall protocol. Review of Resident #97's progress notes dated 01/19/25 through 01/30/25 revealed no additional documentation regarding his fall on 01/19/25. Observation on 01/21/25 at 1:50 P.M. of Resident #97 revealed he was lying in bed with the head of his bed elevated and was using oxygen via nasal cannula. Resident #97's brother was at the bedside. Resident #97's brother stated he was his Power of Attorney (POA) and he received a voicemail about Resident #97's fall and the call only said he had a fall and he was okay and nothing else. Resident #97 stated the aides rush his care, never check on him and did not do any follow up for his fall. Interview on 01/21/25 at 2:20 P.M. of Licensed Practical Nurse (LPN) #832 and Unit Manager (UM) #874 revealed Resident #97 had a witnessed fall but they did not give details of the fall. Interview on 01/30/25 at 3:52 P.M. of the DON confirmed Resident #97's Admission Care Plan was not completed. The DON confirmed Resident #97 did not have a Pain Assessment completed after his fall or 72-hour post-fall documentation every shift following the fall. The DON confirmed the Fall Investigation Checklist statement did not specify if Resident #97 hit his head when he fell and the progress notes did not have documentation of the details leading up to Resident #97's fall and no details and how the fall occurred. The DON confirmed there was no evidence that an immediate fall intervention was implemented to prevent additional falls. 42733 3. Review of Resident #115's closed medical records revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included right arm fracture, muscle weakness and difficulty walking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of MDS assessment dated [DATE] revealed Resident #115 had intact cognition. Resident #115's functional assessment was still in progress at time of review. Review of the care plan dated 01/22/25 revealed Resident #115 had functional incontinence and required staff assistance with toileting. Observation on 01/29/25 at 8:15 A.M. revealed Resident #115's call light was active. Observation further revealed Resident #115 was attempting to self-transfer from her bed into a wheelchair. Interview with Resident #115 at time of observation revealed no staff had come in to assist her out of bed when she requested. At 8:23 A.M., Admissions Director (AD) #825 entered Resident #115's room and had observed Resident #115 attempting to self-transfer. AD #825 assisted Resident #115 up out of bed and into a wheelchair and AD #825 had then exited the room. Interview on 01/29/25 at 11:23 A.M. with AD #825 revealed she was not a certified nursing assistant and stated she was only able to provide limited care that included answering call lights. AD #825 stated Resident #115 had requested assistance out of bed and into a wheelchair and AD #825 confirmed she had assisted Resident #115. AD #825 confirmed she was not trained to provide assistance with hands-on transfers and should have waited for a clinical staff member. Review of the facility policy titled Fall Management revised 12/2022 included the facility would identify each resident who was at risk for falls and would develop a Plan of Care and implement interventions to manage falls. The licensed nurse would perform a Fall Risk Assessment immediately if the resident was deemed to be at risk. If a fall occurred the licensed nurse would assess the resident for injury from the fall immediately and initiate an investigation of the reason for the fall and implement an immediate intervention to attempt to prevent future falls. The licensed nurse would update the Fall Risk and Pain Assessment at the time of the fall. A care plan would be implemented upon admission for residents who were identified as at risk for falls with interventions to attempt to prevent further incidents. This deficiency represents non-compliance investigated under Master Complaint Number OH00162102 and Complaint Numbers OH00161142 and OH00161136.

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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** 42733 Based on observation, interview, record review, and facility policy review, the facility failed to provided timely and appropriate incontinence care for dependent residents. This affected three residents (#26, #49 and #54) of three residents reviewed for incontinence care. The facility census was 100. Findings include: 1. Review of Resident #26's medical record revealed an admitted [DATE]. Diagnoses included stroke with left sided weakness, overactive bladder and muscle weakness. Review of Resident #26's care plan revised 11/01/24 revealed Resident #26 was incontinent of bowel and bladder. Interventions included check for incontinence every two hours. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 had intact cognition. Resident #26 required maximum assistance with toileting and bathing. Resident #26 was incontinent of bowel and bladder. Observation on 01/21/25 at 7:47 A.M. revealed Resident #26's call light was active. Interview with Resident #26 at time of observation revealed she needed incontinence care and Resident #26 stated she had not been changed since 10:00 P.M. the previous evening. At 8:31 A.M., Resident #26's call light remained active. Resident #26 stated staff had come in and she had told them she needed to be changed, however they had not provided her with incontinence care. At 9:00 A.M. observation revealed Registered Nurse (RN) #848 entered Resident #26's room and had turned off the call light, however had not provided Resident #26 with care. Interview with RN #848 at time of observation revealed Resident #26 had stated she needed incontinence care and RN #848 stated Resident #26 had informed him she had not received incontinence care since 10:00 P.M. the previous evening. Observation of incontinence care on 01/21/25 at 9:48 A.M. for Resident #26 with Certified Nursing Assistant (CNA) #824 and #885 revealed Resident #26 was saturated with urine that had soaked through her sheets and onto her mattress. Resident #26's sheets had areas of dried yellow stains and Resident #26 was wearing two incontinence briefs. Interviews with CNA #885 stated she had observed residents who had been heavily saturated when she arrived to start her shifts at 7:00 A.M. CNA #824 and #885 confirmed Resident #26 was heavily saturated and was wearing two incontinence briefs and stated residents should not be wearing more than one incontinence product. 2. Review of Resident #49's medical records revealed an admitted [DATE]. Diagnoses included muscle weakness, falls, and vision loss. Review of MDS assessment dated [DATE] revealed Resident #49 had intact cognition. Resident was dependent with toileting and bathing. Resident #49 was incontinent of bowel and bladder. Review of care plan dated 11/19/24 revealed Resident #49 was incontinent of bowel and bladder. Interventions included check and change on care rounds. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/22/25 at 5:45 A.M. for Resident #49 with CNA #883 revealed Resident #49 was heavily saturated with urine that had soaked through his sheets and onto his mattress and was wearing two incontinence briefs. CNA #883 stated she was unable to recall when she had last changed Resident #49 and Resident #49 stated he last been changed sometime before bed the previous evening. 3. Review of Resident #54's medical records revealed an admitted [DATE]. Diagnoses included respiratory failure, chronic obstructive pulmonary disease (COPD), and heart failure. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #54 had intact cognition. Resident #54 required moderate assistance with toileting and bathing. Resident #54 was incontinent of bowel and bladder. Review of care plan dated 10/23/23 revealed Resident #54 was incontinent of bowel and bladder. Interventions included changed brief every two hours and as needed. Observation on 01/27/25 at 8:25 A.M. revealed Resident #54's call light was active. Interview with Resident #54 at time of observation revealed she was soaked with urine and stated she had not been changed since 11:00 P.M. the previous evening. At 8:42 A.M. CNA #817 entered Resident #54's room and Resident #54 informed CNA #817 she needed to be changed and CNA #817 informed Resident #54 she would provide her with incontinence care after she had finished passing out the breakfast trays. Resident #54 informed CNA #817 she had not been changed since 11:00 P.M. the previous evening. Observation on 01/27/25 at 10:45 A.M. with CNA #817 for Resident #54 revealed Resident #54 was saturated with urine that had soaked through her sheets and onto her mattress. CNA #817 stated she had not provided Resident #54 with incontinence care since the start of her shift at 7:00 A.M. Review of the policy Activities of Daily Living revised March 2023 revealed the facility will provide care and services for activities of daily living, including elimination (toileting). A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal hygiene. This deficiency represents non-compliance investigated under Master Complaint Number OH00162102 and Complaint Numbers OH00161890, OH00161859, OH00161144, OH00161142, and OH00161136.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442 Based on record review, interview, facility policy review, the facility failed to adequately monitor resident nutritional status by not obtaining consistent weights per physician orders. This affected four residents (Resident #26, #54, #66, and #101) of eight residents reviewed for weights. This had the potential to affect all 100 residents residing in the facility. Findings include: 1. Review of the medical record for Resident #26 revealed an admitted [DATE]. Diagnoses included but were not limited to hemiplegia and hemiparesis, morbid obesity, unilateral osteoarthritis. Review of Resident #26's Minimum Data Set (MDS) 3.0 annual assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 13 which indicated the resident was cognitively intact. Review of activities of daily living (ADLs) revealed Resident #26 required supervision for meals. Review of physician orders for Resident #26 revealed no active order for weight monitoring. Review of the electronic medical record for Resident #26 revealed no recorded weights for August 2024 and October 2024. Review of Resident #26's nutrition care plan revealed potential for altered nutrition and hydration related to hemiplegia, and morbid obesity. Intervention dated 01/27/23 stated to monitor and record weights as ordered. Interview on 01/29/25 at 12:05 P.M. with Registered Dietitian #915 confirmed there was no active physician order for monthly weights for Resident #26 and no recorded weight for August 2024 and October 2024. 2. Review of the medical record for Resident #54 revealed an admitted [DATE]. Diagnoses included but were not limited to acute and chronic respiratory failure, chronic obstructive pulmonary disease, type II diabetes mellitus, morbid obesity, mild protein-calorie malnutrition, and bipolar disorder. Review of Resident #54's MDS 3.0 significant change in status assessment dated [DATE] revealed a BIMS score of 13 which indicated intact cognition. Review of activities of daily living (ADLs) revealed Resident #54 required set up assistance for meals. Review of Resident #54's physician orders revealed an order dated 02/01/24 for monthly weights to be obtained every day shift starting on the first and ending on the second of every month. Review of the weights recorded in the electronic medical for Resident #54 revealed no weights were recorded for January 2025 or February 2025 (through 02/05/25). Review of the nursing progress notes dated 01/01/25 for Resident #54 revealed no nursing progress notes indicating reason the resident's weights had not been obtained as ordered. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #54's Medication Administration Record (MAR) for February 2024 revealed on 02/01/25 and 02/02/25 to see nurses note related to why weight was not obtained. Review of nursing progress note dated 02/01/25 timed at 4:49 P.M. revealed monthly weight was unable to be obtained due to limited staffing. No progress note was found for 02/02/25 related to the reason the resident's weight had not been obtained. Interview on 02/04/25 at 11:05 A.M. with Assistant Director of Nursing (ADON) #898 confirmed weights were not completed as ordered for Resident #54 for January 2025 or February 2025. 3. Review of the medical record for Resident #66 revealed an admitted [DATE]. Diagnoses included but were not limited to alcohol abuse with intoxication, type II diabetes with hyperglycemia, and unspecified protein-calorie malnutrition. Review of Resident #66's MDS 3.0 admission assessment dated [DATE] revealed a BIMS score of 14 which indicated the resident was cognitively intact. Review of activities of daily living (ADLs) revealed Resident #66 required supervision for meals. Review of physician order for Resident #66 dated 01/10/25 revealed an order for a weight to be obtained on admission and weekly for three additional weeks. Review of Resident #66's recorded weights under the weight section in the electronic medical record revealed a weight of 123 pounds (#) upon admission and no additional weights recorded. Review of Resident #66's Medication Administration Record (MAR) for January 2025 revealed weight was recorded as refused on 01/17/25 and no response was recorded for 01/23/25. Review of Resident #66's nursing progress notes revealed no progress noted dated 01/17/25 indicating a weight refusal or indication of reattempts made to obtain Resident #66's weight. No progress note was found dated 01/23/25 indicating why weight for Resident #66 was not obtained. Interview on 01/29/25 at 12:05 P.M. with Registered Dietitian #915 confirmed weights upon admission are to be completed weekly for four weeks. RD #915 also confirmed no weight was recorded for 01/23/25 for Resident #66 and should have been per physician orders. 4. Review of the closed medical record for Resident #101 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included but were not limited to malignant neoplasm of brain, cerebral edema, altered mental status, and unilateral primary osteoarthritis. Review of Resident #101's MDS 3.0 assessment dated [DATE] revealed the resident had a BIMS score of 15 which indicated intact cognition. Review of activities of daily living (ADLs) revealed Resident #101 required set up for meals, used a walker, and required moderate assistance for walking 10 feet. Review of Resident #101's physician order dated 12/09/24 revealed weights were to be obtained on admission and weekly for three additional weeks. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #101's recorded weights under the weight section in the electronic medical record for revealed two weights were recorded: a weight recorded on 12/07/24 of 134# and a weight recorded on 12/24/24 of 136.1#. Review of Resident #101's MAR for December 2024 revealed the weight was checked off as being completed by the nurse on 12/09/24, 12/16/24, and 12/23/24, but no weight was recorded. Interview on 01/29/25 at 12:05 P.M. with Registered Dietitian #915 revealed weights are recorded under the weights tab in the electronic medical record. Upon admission, residents are to be weighed weekly for four weeks and then monthly unless otherwise indicated. RD #915 confirmed there were no recorded weekly weights for 12/14/24 as physician ordered. Interview on 02/024/25 at 11:05 A.M. with Assistant Director of Nursing (ADON) #898 confirmed weights were indicated as completed on 01/09/24, 01/16/24, and 01/23/24 on the MAR but was unable to provide evidence of weights obtained and stated if the weight was recorded it would have populated under the weight section and was unsure why weights were indicated as complete. Review of the policy Weight Policy and Procedure revised December 2022 revealed all new admissions will be weighed weekly for the first four weeks after admission. Weights will be recorded in the resident's medical record. If a resident refuses to be weighed, staff will educate on the risks, encourage the resident to reconsider and document in the medical record. This deficiency represents an incidental finding identified while investigating Master Complaint Number OH00162102 and Complaint Numbers OH00161890, OH00161859, OH00161556, OH00161410, OH00161144, OH00161142, and OH00161136.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366488	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Lyndhurst	5442 Rae Road Lyndhurst, OH 44124

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on observation, medical record review, hospital record review, facility policy review and staff and resident interview, the facility failed to develop and implement a comprehensive, individualized and effective pain management program for Resident #77 who was admitted with acute pain and difficulty with moving due to pain to the left foot and a vascular wound. Actual Harm occurred beginning on 01/18/25 when Resident #77 did not receive ordered pain medication, Tramadol (an opioid pain reliever). The resident was admitted to the facility (on 01/18/25) with a physician order for Tramadol 25 milligram (mg) every 12 hours as needed for pain for up to seven days; however, the medication was not administered until 01/21/25 (three days after admission). During this time, Resident #77 had complaints of severe and unrelieved pain. This affected one resident (#77) of three residents reviewed for pain management. The facility census was 100. Findings include: Review of Resident #77's medical record revealed an admitted [DATE] with medical diagnoses including type II diabetes mellitus, peripheral vascular disease, protein-calorie malnutrition, anxiety, and acute pain. Review of Resident #77's pre-admission hospital records dated 01/07/25 to 01/18/25 revealed the resident had been admitted to a local hospital on 01/07/25 for weakness, fatigue, and being unable to move around due to left foot pain. The hospital records noted Resident #77 had difficulty maintaining attention due to pain. Additionally, Resident #77 had a vascular wound ulcer to the top of her left foot with pain in the left foot and leg. Additional imaging was recommended at the hospital, but the record noted the imaging may not be able to be completed due to the resident's high pain ratings to the affected left leg. Review of Resident #77's hospital discharge paperwork dated 01/18/25 revealed Resident #77 had been treated at a local hospital for left arterial ulcer and left foot pain. Resident #77's medication list included Tylenol 500 mg every six hours as-needed for pain and Tramadol 25 mg every 12 hours as-needed for pain for up to seven days. Review of Resident #77's physician's orders revealed an order dated 01/18/25 for Tramadol 25 mg every 12 hours as needed for pain. The order was discontinued on 01/20/25, and a new order was placed for Tramadol 25 mg every 12 hours as needed for pain for a total duration of seven days, with a listed end date of 01/24/25. An order dated 01/23/25 for Oxycodone (narcotic opioid analgesic) 5 mg three times a day routinely for pain was discontinued on 01/24/25. On 01/24/24, Resident #77's order was changed to Oxycodone 5 mg every eight hours as needed for pain. On 01/24/25 Resident #77's Oxycodone order was increased in frequency to Oxycodone 5 mg every six hours as needed for pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #77's progress notes dated 01/19/25 at 9:25 A.M. authored by Licensed Practical Nurse (LPN) #852 revealed the resident had complaints of pain, and [as needed] Tylenol was administered. A progress note dated 01/19/25 at 5:17 P.M. authored by LPN #852 revealed Nurse Practitioner (NP) #913 had been notified that the pharmacy needed a hard copy of Resident #77's Tramadol prescription. A follow up note dated 01/19/25 at 5:56 P.M. authored by LPN #852 revealed NP #913 had responded ok when asked to send Resident #77's Tramadol prescription to the pharmacy. Review of Resident #77's care plan dated 01/20/25 revealed the resident was at risk for acute pain. Care planned interventions included administering analgesia per orders and one-half hour before treatment or care. Additional interventions included to monitor, record, and report any sight and symptoms of non-verbal pain which included moaning and yelling out. Review of Resident #77's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The assessment revealed Resident #77 required maximum assistance with toileting and moderate assistance with bathing and personal hygiene. Review of Resident #77's Medication Administration Record (MAR) for January 2025 revealed the resident's pain was not consistently assessed. On 01/20/25 and 01/25/24, Resident #77 reported a pain rating of seven out of 10 (with 10 being the most severe pain). Tylenol 500 mg was administered on 01/19/25 at 9:23 A.M. for pain level of six out of 10, 01/20/25 at 11:10 P.M. for a pain level of seven out of 10 and 01/23/25 at 6:06 A.M. for a pain level of five out of 10. Record review revealed Resident #77 received her first dose of Tramadol 25 mg on 01/21/25 at 12:50 P.M. with no associated pain rating recorded. Observation on 01/21/25 at 8:02 A.M. revealed Resident #77 yelled out in pain and was heard from the hallway outside of the resident's closed door. Upon entering Resident #77's room, Registered Nurse (RN) #844 and LPNs #803 and #852 were in Resident #77's room. An interview with LPN #852 at the time of observation revealed she had contacted NP #913 to obtain orders for Resident #77's pain medication and in the meantime had administered as-needed Tylenol while awaiting a return call from NP #913. LPN #852 stated she had contacted NP #913 to inform her of the need for the script for Tramadol to be sent to the pharmacy and stated NP #913 had told her she would send the script. LPN #852 stated she had not returned to work until 01/21/25 and verified, upon her return, Resident #77's needed prescription had not been obtained and Resident #77's Tramadol medication had been unavailable. RN #844 stated she was unaware Resident #77 had complaints of pain and Resident #77 stated to RN #844 I told you all night I was having pain. RN #844 did not respond to Resident #77 and had exited the room. LPN #803 and LPN #852 also proceeded to exit the room and Resident #77 continued to lay in bed and yell out in pain. There was no evidence the resident's pain was addressed at this time. Observation on 01/22/25 at 10:54 A.M. of Resident #77 with LPN #847 revealed Resident #77 had complaints of pain to a wound on her left foot. LPN #77 stated she was unaware of Resident #77 having pain and stated she would check if Resident #77 had been given pain medication earlier. At the time of observation, the Director of Nursing (DON) and Administrator entered Resident #77's room. The DON stated she was unaware of Resident #77's complaints of pain related to the wound on her left foot and stated she would have the wound nurse come in and assess the area. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Observation and interview on 01/22/25 at 11:04 A.M. revealed LPN #903 entered Resident #77's room with the DON and the Administrator. LPN #903 stated she had been unaware of Resident #77's left foot wound. LPN #903 proceeded to assess the area and Resident #77 yelled out in pain. Resident #77 was noted with facial grimacing. During the assessment and cleansing, when the area was manipulated, the resident attempted to withdraw her left leg from the painful stimuli. LPN #903 had continued to assess the area and neither LPN #903 nor the DON asked Resident #77 about her pain or offered her any pain medication. LPN #903 stated she would gather supplies to cleanse the wound and had exited the room. The DON remained at Resident #77's bedside and asked Resident #77 about the pain in her foot. The DON asked Resident #77 if the pain was present only when touched, and Resident #77 stated It hurts all the time. Interview on 01/22/25 at 12:10 P.M. with the DON confirmed Resident #77 was admitted to the facility with care needs which included ulcer care for the left foot wound and pain control. Observation on 01/23/25 at 6:32 A.M. revealed Resident #77 was heard yelling out in pain. Interview with Resident #77 at time of observation revealed she was having pain rated a 10 out of 10 in her foot and stated she wasn't sure if she had received pain medication. Review of facility policy titled Pain Management revised 02/2023 revealed the purpose of the policy was to ensure residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. The licensed nurse will perform a pain assessment upon admission, quarterly, with significant change, and with new onset of pain and incident. If the resident is assessed to be experiencing pain, the nurse will explore pharmacological and non-pharmacological interventions, as appropriate, per the resident's comprehensive assessment, plan of care, and standards of practice. This deficiency represents an incidental finding identified while investigating Master Complaint Number OH00162102 and Complaint Numbers OH00161890, OH00161859, OH00161556, OH00161410, OH00161144, OH00161142, and OH00161136.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730 Based on observations, resident interviews, staff interviews, review of time punch details, daily staffing sheets and schedules, review of the facility assessment, and facility policy review, the facility failed to ensure adequate staffing levels to meet the needs of the residents. This affected all residents residing in the facility. The facility census was 100. Finding include: 1. Review of the daily staffing sheet dated 01/21/25 revealed the facility had 7 Certified Nurses Assistants (CNAs) scheduled for the 1st shift. Review of the daily staffing sheet revealed each CNA had designated rooms to provide care for. Review of the daily staffing sheet revealed CNA #838 was assigned to fifteen residents (#7, #11, #13, #20, #24, #29, #32, #35, #36, #38, #50, #66, #70, #77, #98), CNA #824 was assigned sixteen residents (#15, #18, #26, #27, #28, #49, #61, #67, #71, #72, #80, #82, #89, #91, #94, #100), CNA #885 was fourteen residents (#1, #6, #9, #17, #25, #30, #42, #44, #45, #54, #62, #78, #83, #92), CNA #878 was assigned fourteen residents (#2, #21, #31, #37, #39, #40, #43, #58, #60, #63, #69, #75, #87, #99), CNA #835 was assigned sixteen residents (#3, #10, #16, #22, #33, #48, #52, #57, #59, #65, #73, #76, #79, #81, #84, #97), and CNAs #855 and #889 was assigned the premium side, twenty-one residents (#4, #5, #8, #12, #19, #23, #34, #46, #47, #51, #53, #55, #56, #64, #68, #74, #86, #88, #93, #95, #96). Observation on 01/21/25 during tour of the facility from 7:30 A.M. to 9:00 A.M. revealed no staff providing care for fourteen residents (#1, #6, #9, #17, #25, #30, #42, #44, #45, #54, #62, #78, #83, #92) assigned to CNA #885. Observation and interview on 01/21/25 at 7:47 A.M. revealed Resident #26 call light was activated. Resident #26 revealed she required assistance from staff for incontinence care and hadn't been assisted since 11:00 P.M. the night before, 01/20/25. Resident #26 revealed she was on Lasix and required care more frequently. Observation and interview on 01/21/25 at 7:49 A.M. revealed Resident #17 call light was activated, and she wanted to get out of bed and needed incontinence care. Interview on 01/21/25 at 7:51 A.M. with Resident #52 revealed there were not enough staff in the building to assist with the residents and call light response times were over 30 minutes. Interview on 01/21/25 at 8:10 A.M. with CNA #824 revealed the facility could use more staff. Observation and interview on 01/21/25 at 8:31 A.M. revealed Resident #26 call light was activated. Resident #26 revealed she activated her call light because she still needed assistance with incontinence care, due to staff turning off her call light, but not assisting. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 01/21/25 at 8:57 A.M. with CNAs #824 and #838 revealed they were unaware of what CNA was assigned to the rooms for residents #1, #6, #9, #17, #25, #30, #42, #44, #45, #54, #62, #78, #83, #92. Interview with CNAs #824 and #838 revealed CNA #885 was assigned to residents #1, #6, #9, #17, #25, #30, #42, #44, #45, #54, #62, #78, #83, #92 according to the daily staffing sheet, and had not arrived yet. Interview on 01/21/25 at 9:07 A.M. with Resident #54 revealed there were not enough staff and you could never find anyone. Resident #54 revealed no one answered her call light, she barely received care including showers and incontinence care. Observation and interview on 01/21/25 at 9:15 A.M. revealed CNA #885 had arrived for her shift. CNA #885 revealed she was assigned to work the 1st shift, which started at 7:00 A.M. CNA #885 confirmed and verified she had arrived approximately 2.5 hours late and residents assigned to her went without care. Interview on 01/21/25 at 9:30 A.M with Resident #25 revealed she had not got out of bed for two days, 01/17/25 and 01/28/25, due to no staff available. Interview on 01/21/25 at 9:41 A.M. with Licensed Practical Nurse (LPN) #832 revealed staffing could be better. Observation and interview on 01/21/25 at 9:45 A.M. revealed CNA #885 passing the morning breakfast trays. CNA #885 revealed if another staff member turned off a call light without telling her the care needs required, she would not know if residents needed assistance, and they would go without care. CNA #885 revealed Resident #17 still required assistance at the time of the interview. CNA #885 confirmed and verified Resident #17 call light was off, but she still required help. CNA #885 revealed everyone on her assignment still needed care due to her arriving late for her shift. Observation and interview on 01/21/25 at 9:49 A.M. revealed CNA #824 being called to assist on another unit. CNA #824 revealed she was going to help another unit, but did not know where the other assigned staff were. CNA #824 confirmed and verified some staff had not arrived for their shift. Observation, during tour with the Director of Nursing (DON), and interview on 01/21/25 at 10:37 A.M. revealed Resident #17 call light was on. Resident #17 revealed she needed to be toileted, and staff still had not assisted her. DON confirmed and verified Resident #17 still needed assistance. Interview on 01/21/25 at 11:26 A.M. with Resident #73 family member revealed Resident #73 had a camera in her room and staff were not checking on her for several hours. Resident #73 family member revealed she would call the nurse's station to get someone to check on Resident #73, but no one would answer the phone. Interview on 01/21/25 at 1:50 P.M. with Resident #97 Power of Attorney (POA) revealed facility staff never provide timely assistance. Resident #97 POA revealed staff would turn off call light but never return to provide care requested. Review of the punch detail report dated 01/21/25 revealed CNA #885 did not punch-in for her 1st shift assignment until 9:08 A.M. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the time punch dated 01/07/25 through 01/26/25 and 01/28/25, revealed CNA #885 was scheduled to work the 1st shift, 7:00 A.M.-7:00 P.M., however, she clocked-in 4 hours late (11:00 A.M.) on 01/08/25, approximately 3.5 hours late (10:22 A.M.) on 01/14/25, 2.5 hours late (9:30 A.M.) on 01/16/25, approximately 2.5 hours late (9:28 A.M.) on 01/18/25, and approximately 2 hours late (9:08 A.M.) on 01/21/25. Review of the time punch dated 01/28/25 revealed CNA #885 clocked-in approximately 2.5 hours late (9:23 A.M.) on 01/28/25. Review of the time punches for CNA #885 had a history of arriving late for her shift. Interview on 01/27/25 at 3:15 P.M. with CNA #838 revealed there were technically always only 5 CNAs to care for the residents on the A and B Units (Rooms 201-323) which housed 79 residents (#1, #2, #3, #6, #7, #9, #10, #11, #13, #15, #16, #17, #18, #20, #21, #22, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #35, #36, #37, #38, #39, #40, #42, #43, #44, #45, #48, #49, #50, #52, #54, #57, #58, #59, #60, #61, #62, #63, #65, #66, #67, #69, #70, #71, #72, #73, #75, #76, #77, #78, #79, #80, #81, #82, #83, #84, #87, #89, #91, #92, #94, #97, #98, #99, #100). CNA #838 revealed 21 residents (#4, #5, #8, #12, #19, #23, #34, #46, #47, #51, #53, #55, #56, #64, #68, #74, #86, #88, #93, #95, #96) residing on the Premium Suites Unit had their own (2 CNAs) dedicated staff that were not allowed to assist throughout the building. Interview on 01/29/25 at 2:01 P.M. with LPN #846 revealed staffing the facility was an issue and the facility failed to be fully staffed to meet the needs of the residents. LPN #846 revealed she was unable to complete her expected daily tasks, such as medication passes, due to staffing levels. 2. Review of the Facility assessment dated [DATE] revealed staffing was based on the resident population and acuity and direct care staff (nurses and aides) worked 12-hour shifts from 7:00 A.M.-7:00 P.M. and 7:00 P.M.-7:00 A.M. Review of the facility assessment revealed the facility required 7 full-time CNAs and 1 part-time CNA designated for the 1st shift and 7 CNAs for the 2nd shift to meet the needs of the residents in the facility for an average daily census of 90 residents. The current facility census was 100 residents. Review of the resident council meeting minutes dated 12/27/24 revealed residents voiced concerns regarding short staffed daily. The Administrator informed attendees that they were staffed to state guidelines. Review of staffing reports and time punch details for December 2024 and January 2025 were reviewed with Human Resources Director (HRD) #871 and Staff Scheduler (SS) #841 revealed the following concerns: Review of the time punch detail dated 12/24/24 revealed the facility had 2 CNAs working the 3rd shift. Review of the time punch detail dated 12/25/24 revealed the facility had 3 CNAs working the 1st shift and 5 CNAs working 3rd shift. Review of the time punch detail dated 12/31/24 revealed the facility had 6 CNAs working the 1st shift and 3 CNAs working the 3rd shift. Review of the time punch detail dated 01/28/25 revealed the facility had 6 CNAs working the 1st shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the time punch detail dated 01/31/25 revealed the facility had 5 CNAs working the 3rd shift. Interview on 01/28/25 at 8:39 A.M. with HRD #871 and SS #841 revealed they were responsible for staffing the facility. Interview revealed the facility did not utilize agency and staffing was based on census, acuity, and per patient day (PPD). HRD #871 revealed she scheduled between 7 and 8 aides per shift depending on the census with 2 aides on the premium unit and 5 to 6 aides on the other units. HRD #871 provided state survey staffing schedules and time-punches dated for the month of December 2024 through February 2025. HRD #871 confirmed and verified staffing schedules and time-punches were accurate at the time of review and reflected the facility was staffed under their planned ratios on the above dates and shifts. Reconciliation with the staff schedules, the daily staffing sheets, observed floor staff, and census and acuity levels, revealed the facility did not accurately staff the facility to meet the needs of the residents residing in the facility. Review of the facility document titled Resident Call System revised March 2023, revealed the facility had a policy in place to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Review of policy revealed facility staff would respond to call lights in a timely manner and would not turn off the call light if needs were unable to be met. Review of the document revealed the facility did not implement the policy. This deficiency represents non-compliance investigated under Master Complaint Number OH00162102 and Complaint Numbers OH00161890, and OH00161136.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42733 Based on record review, staff interview, and review of facility policy, the facility failed to ensure residents' were timely administered medications and were free from significant medication errors. This affected five (Residents #26, #27, #61, #77, and #115) of five resident records reviewed for medication administration. The facility census was 100. Findings include: 1. Review of Resident #26's medical record revealed an admitted [DATE]. Medical diagnoses included hemiplegia and hemiparesis, morbid obesity, and osteoarthritis. Review of Resident #26's Medication Administration Record (MAR) for January 2025 revealed the resident had orders for the following morning medications daily at 8:00 A.M.: a. Sennosides 8.6 milligram (mg) two tablets for bowel maintenance b. Gabapentin 300 mg one capsule for neuropathy c. Losartan potassium 25 mg one tablet for hypertension d. Levetiracetam 500 mg one tablet for convulsions e. Potassium chloride extended release (ER) 10 milliequivalents (mEq) one tablet f. Apixaban (blood thinner) 5 mg one tablet for atrial fibrillation g. Oxybutynin ER 5 mg one tablet for overactive bladder h. Docusate sodium 100 mg one tablet for bowel maintenance i. Fluocinonide external cream 0.05% topically to affected areas for psoriasis j. Furosemide (diuretic) 40 mg one tablet for edema k. Amlodipine besylate 2.5 mg one tablet for hypertensive heart disease without heart failure l. Austedo extended release (XR) 48 mg one tablet for subacute dyskinesia (involuntary movements) Review of Resident #26's time-stamped MAR for January 2025 revealed on 01/04/25, all 8:00 A.M. medications were recorded as administered between 11:36 A.M. and 11:37 A.M. (Three hours and 36 minutes after they were due). On 01/15/25, the 8:00 A.M. medications were recorded as administered at 11:11 A.M. (three hours and 11 minutes after they were due). On 01/16/25, the above 8:00 A.M. medications were recorded as administered at 11:49 A.M. (three hours and 45 minutes after they were due). On 01/21/25, all 8:00 A.M. medications were recorded as administered between 1:49 P.M. and 1:59 P.M. (five hours and 45 minutes after they were due). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #27's medical record revealed an admitted [DATE]. Medical diagnoses included coronary artery disease, gastroesophageal reflux disease (GERD), and hypertensive heart disease. Review of Resident #27's MAR for January 2025 revealed the resident had orders for the following medications daily at 8:00 A.M.: a. Apixaban 5 mg one tablet for history of deep vein thrombosis DVT) b. Amlodipine 5 mg one tablet for hypertension c. Atenolol 25 mg one tablet for hypertension d. Clopidogrel 75 mg one tablet for coronary artery disease (CAD) e. Furosemide 20 mg one tablet once daily for hypertension f. Isosorbide Mononitrate ER 120 mg one tablet for CAD/angina (chest pain) g. Pantoprazole 50 mg one tablet for GERD h. Sodium chloride 1 gram (gm) one tablet Review of Resident #27's time-stamped MAR for January 2025 revealed on 01/04/25, 8:00 A.M. medications were recorded as administered at 11:35 A.M. (three hours and 35 minutes after they were due). On 01/15/25, 8:00 A.M. medications were recorded as administered at 11:29 A.M. (three hours and 29 minutes after they were due). On 01/16/25, 8:00 A.M. medications were recorded as administered at 12:02 P.M. (four hours and two minutes after they were due). On 01/21/25, 8:00 A.M. medications were recorded as administered at 3:39 P.M. (seven hours and 39 minutes after they were due). 3. Review of Resident 61's medical record revealed an admitted [DATE]. Medical diagnoses included falls, chronic heart failure and chronic obstructive pulmonary disease (COPD). Review of Resident #27's MAR for January 2025 revealed the resident had orders for the following medications daily at 8:00 A.M.: a. Aspirin 81 mg one tablet for anticoagulant b. Isosorbide dinitrate 30 mg two tablets once daily for hypertension c. Phenytoin sodium extended one capsule for anti-seizure d. Torsemide (diuretic) 10 mg one tablet every other day for edema (only administered on even days) e. Zoloft 25 mg two tablets for anxiety (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #61's time-stamped MAR for January 2025 revealed on 01/03/25, 8:00 A.M. medications (with the exception of Torsemide) were recorded as administered at 10:42 A.M. (four hours and 42 minutes after they were due). On 01/04/25, 8:00 A.M. medications were recorded as administered at 11:27 A.M. (five hours and 27 minutes after they were due). On 01/06/25, 8:00 A.M. medications were recorded as administered at 11:46 A.M. (five hours and 46 minutes after they were due). On 01/12/25, 8:00 A.M. medications were recorded as administered at 4:00 P.M. (eight hours after they were due). On 01/13/25, 8:00 A.M. medications (with the exception of Torsemide) were recorded as administered at 11:19 A.M. (three hours after they were due). On 01/14/25, 8:00 A.M. medications were recorded as administered at 1:53 P.M. (five hours and 53 minutes after they were due). On 01/21/25, 8:00 A.M. medications (with the exception of Torsemide) were recorded as administered at 3:01 P.M. (seven hours and one minute after they were due). 4. Review of Resident #77's medical record revealed an admitted [DATE]. Medical diagnoses included type II diabetes mellitus, peripheral vascular disease, protein-calorie malnutrition, anxiety, and acute pain. Review of Resident #77's MAR for January 2025 revealed the resident had orders for the following medications daily at 8:00 P.M.: a. Atorvastatin Calcium 80 mg one tablet for statin (elevated cholesterol) b. Latanoprost Ophthalmic Solution 0.005% one drop in both eyes for eye pressure c. Heparin sodium 5000 units/milliliter (ml), one ml subcutaneously for prevention d. Isosorbide Mononitrate ER 30 mg one tablet for blood pressure e. Ranolazine ER 500 mg one tablet for angina f. Gabapentin 100 mg one capsule for nerve pain Review of Resident #77's time-stamped MAR for January 2025 revealed on 01/20/25, 8:00 P.M. medications were recorded as administered at 11:06 P.M. (three hours and six minutes after they were due). On 01/23/25, 8:00 P.M. medications were recorded as administered on 01/24/25 at 5:11 A.M. (nine hours and 11 minutes after they were due). On 01/24/25, 8:00 P.M. medications were recorded as administered on 01/26/25 at 2:19 A.M. (six hours and 19 minutes after they were due). On 01/26/25, 8:00 P.M. medications were recorded as administered on 01/27/25 at 2:30 A.M. (six hours and 30 minutes after they were due). 5. Review of Resident #115's medical record revealed an admitted [DATE]. Medical diagnoses included hypertension, COPD, osteoarthritis, and depression. Review of Resident #115's MAR for January 2025 revealed the resident had orders for the following medications daily at 8:00 A.M.: a. Bupropion HCl ER 150 mg one tablet for antidepressant b. Cetirizine 10 mg one half tablet for itching (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Lidocaine External Patch 4% topically applied to affected area for pain d. Loratadine 10 mg one tablet for antihistamine e. Vitamin D3 2000 unit one tablet for health maintenance f. Diclofenac sodium external gel 1% topical gel to affected area for analgesic Review of Resident #115's time-stamped MAR for January 2025 revealed on 01/26/25, 8:00 A.M. medications were recorded at 11:25 A.M. (three hours and 25 minutes after they were due). On 01/27/25, 8:00 A.M. medications were recorded as administered at 12:09 P.M. (four hours and nine minutes after they were due). Interview on 01/22/25 at 8:55 A.M. with LPN #847 revealed her medications had been late on occasion and at times medications were not available. Interview on 01/22/25 at 1:34 P.M. with a family member of Resident #27 revealed there had been days she had seen residents get their medications late. The family member reported on 01/21/25, a neighboring resident's morning and afternoon medications had been administered at the same time. The family member reported she had taken a picture of the two medications cups that were left in a nearby resident's room on 01/21/25 at 3:16 P.M. Interview on 02/04/25 at 3:30 P.M. with the Director of Nursing (DON) confirmed the above residents had medications recorded as administered late. The DON revealed she had been aware of resident complaints regarding late medications. The DON stated she had educated the nurse regarding timely medication pass, and stated she planned to further discuss the issue at an upcoming facility quality assurance meeting. Review of the policy Medication Administration - General Guidelines revised August 2014 revealed medications are administered as prescribed in accordance with good nursing principles and practices. The five rights - right resident, right drug, right dose, right route, and right time - are applied for each medication being administered. The Medication Administration Record (MAR) is always employed during medication administration. Medications are administered within 60 minutes of scheduled time unless otherwise specified by the provider. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. This deficiency represents non-compliance investigated under Complaint Numbers OH00161859, OH00161142, and OH00161136.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42733 Based on interview, review of photographs, and review of the facility policy, the facility failed to ensure medications were not left unattended in residents' room. This affected three residents (#27, #61 and #115) of five residents reviewed for . The facility census was 100. Findings include: 1. Interview on 01/22/25 at 1:34 P.M. with Resident #27's daughter revealed the resident's morning medications had been administered in the afternoon on 01/21/25. When she arrived at the facility on the afternoon of 01/21/25, she observed two cups of medications in Resident #27's room containing various pills. Resident #27's daughter stated she had taken a photo of the medication cups on 01/21/25 at 3:16 P.M. The photograph was provided at the time of interview and two cups of medications were observed in the photo. 2. Interview on 01/27/25 at 11:55 A.M. with Registered Nurse (RN) #874 revealed on 01/24/25 sometime before lunch (couldn't recall exact time), Resident #115's daughter had informed her that Resident #115 had unknown medications in her oatmeal. RN #874 stated she had went to Resident #115's room at that time and observed three unknown pills in Resident #115's oatmeal. RN #874 stated Resident #115's daughter had requested the oatmeal be saved in order to show the Director of Nursing (DON). RN #874 stated she had placed the oatmeal in Resident #115's drawer. RN #874 stated she had unsure how the medications had gotten in Resident #115's oatmeal and stated she had shown the medications in the oatmeal to the DON. RN #874 stated she had been aware of recent reports from various residents' family members of medications left unattended at the bedside. 3. Interview on 01/27/25 at 2:12 P.M. with Resident #61's wife had stated on 01/24/25 Resident #61's morning medications had been given after 2:00 P.M. and stated she had observed a cup of medications on his bedside table. Resident #61's wife stated she had taken a picture of the medications left in his room. The photograph was provided at the time of interview and showed a single pill in a medication cup. Review of facility policy titled Medication Administration revised 08/14 revealed residents are always observed after administration to ensure that the dose was completely ingested. This deficiency represents non-compliance investigated under Complaint Number OH00161136.

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of the facility policy, the facility failed to ensure Resident #64's diagnostic test for a suspected injury was ordered, reported, and treatment was initiated timely. This affected one resident (Resident #64) out of three residents reviewed for diagnostic testing. The facility census was 100. Findings include: Review of Resident #64's medical record revealed an admitted [DATE] and diagnoses included acute embolism and thrombosis of unspecified deep veins of the left lower extremity, encephalopathy and type two diabetes mellitus without complications. Review of Resident #64's care plan dated 01/09/25 included Resident #64 was a high risk for falls related to deconditioning, gait and balance problems and history of falls. Resident #64 would be free of falls through the review date. Interventions included to follow the facility fall protocol; anticipate and meet Resident #64's needs. Review of Resident #64's MDS admission assessment dated [DATE] revealed Resident #64 was cognitively intact. Resident #64 used a walker. Resident #64 required partial to moderate assistance for the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed, and for the ability to transfer to and from a bed to a chair or wheelchair. Review of Resident #64's physician orders dated 01/20/25 written by Nurse Practitioner (NP) #927 revealed x-ray of the left ankle, 2 view, status post fall, pain, edema. Review of Resident #64's electronic record physician orders dated 01/21/25 at 7:20 A.M. revealed left ankle, 2 views, one time only. The physician order was not placed in the electronic record until nine hours after it was ordered. Review of Resident #64's radiology results report dated 01/21/25 at 8:21 P.M. revealed the examination date was 01/21/25 at 00:00. Resident #64 had an acute distal fibular fracture with adjacent soft tissue swelling. The result was not reported to NP #927 until 01/22/25 at 7:14 A.M. which was eleven hours after the report date and time. Review of Resident #64's progress notes dated 01/22/25 at 7:14 A.M. revealed Resident #64's x-ray was done; result was positive and Resident #64 had a fracture of his ankle. Results were sent to NP #927 and the nurse was awaiting new orders. Review of Resident #64's progress notes dated 01/22/25 at 10:40 A.M. included NP #927 gave orders to send Resident #64 to the local hospital for a fracture of the left fibula. (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #64's progress notes dated 01/22/25 at 11:26 A.M. included on 01/20/25 at 10:16 P.M. NP #927 gave an order for an x-ray of Resident #64's left ankle after assessing and talking to him. Resident #64 stated he fell in December 2024 and did not report it, the left ankle was bothering him, it was swollen and painful to touch. Resident #64 stated his ankle only hurt when he walked or when it was pressed. Observation on 01/29/25 at 3:32 P.M. of Resident #64 revealed he was sitting in a wheelchair in his room. Resident #64's left lower leg had a splint applied. Resident #64 stated he broke his bone in his left ankle and was not sure how it happened. Resident #64 stated before he was admitted to the facility he was at a local discount store, it was slushy outside, he slipped, and his legs went in different directions. Resident #64 indicated this might have been when he fractured his ankle. Interview on 01/29/25 at 3:39 P.M. of RN #801 revealed on 01/20/25 he arrived for work at 7:00 P.M. and NP #927 was finishing her rounds and ordered a STAT (immediate) x-ray for Resident #64 and he placed the x-ray order in the system. RN #801 stated Resident #64 had a fall in December 2024 and his leg was swollen. RN #801 stated he did not know if Resident #64's leg was swollen before 01/20/25 because he had not had Resident #64 in his previous assignments, and this was the first day he met him. Interview on 01/29/24 at 4:06 P.M. of RN #890 revealed he worked night shift and usually had Resident #64 in his assignment and did not notice Resident #64's left ankle was swollen before 01/20/25. RN #890 stated Resident #64 never complained about pain or swelling in his left leg or ankle. Interview on 01/30/25 at 11:15 A.M. of NP #927 revealed she saw Resident #64 on 01/20/25 later in the afternoon and told the nurse he needed an x-ray of the left ankle. NP #927 stated she did not remember if the x-ray was ordered STAT, but it was not an emergency, and Resident #64 had not been complaining about his left ankle before 01/20/25. NP #927 indicated Resident #64 told her his ankle was swollen and kind of bothering him and he did not tell anyone before he told her. Interview on 02/03/25 at 12:20 P.M. of the Administrator confirmed the x-ray results were not reported to the physician for almost twelve hours after the results were reported to the facility and she would ask the Director of Nursing about it. Interview on 02/04/25 at 7:55 A.M. of the Director of Nursing (DON) revealed Resident #64's x-ray was reported to the facility via fax on 01/22/25 in the morning, and she would look into why it was not reported on 01/21/25 at 8:21 P.M. The DON confirmed the x-ray was ordered on 01/20/25 and she did not know why it was not placed in the system until 01/21/25 at 7:20 A.M. The DON did not provide additional information about why Resident #64's x-ray order was not placed in the system on 01/20/25 when it was ordered or why the results were not reported to the physician until 01/22/25. Review of the facility policy titled Resident Change in Condition dated 07/28/22 included ensuring staff provide timely and appropriate are and services when residents experience a change in condition that has or was likely to cause serious life-threatening harm or injuries and or adverse negative health outcomes. Change of condition might include a significant or acute change in the resident's physical, mental, or psychosocial status including abnormal lab values; there was a need to alter the resident's treatment significantly; deemed necessary or appropriate in the best interest of the resident. (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents an incidental finding identified while investigating Master Complaint Number OH00162102 and Complaint Numbers OH00161890, OH00161859, OH00161556, OH00161410, OH00161144, OH00161142, and OH00161136.

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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. 42730 Based on observation, resident interviews, staff interviews, facility policy review, and return demonstration of a test tray, the facility failed to serve hot, palatable meals. This affected all 100 residents as the facility did not identify any residents that were solely not receiving food by mouth (NPO). Findings include: Interview on 01/21/25 at 7:51 A.M. with Resident #52 revealed the food needed to be improved and was often cold. Interview on 01/21/25 at 9:07 A.M. with Resident #54 revealed she often did not want her breakfast because it was cold and always needed rewarmed. Interview on 01/21/25 at 9:38 A.M. with Resident #3 revealed the facility food was bad. Interview and observation at 9:44 A.M. revealed Resident #54 call light was activated. Resident #54 revealed her food was cold and needed warmed up. Resident #54 revealed she did not like eating cold food. Interview on 01/21/25 at 10:06 A.M. with Resident #62 revealed the facility food was a joke. Observation on 01/23/25 at 7:20 A.M. of the kitchen breakfast meal preparation with Dietary Manager (DM) #908 revealed the steam table consisted of scrambled eggs with a temperature reading of 155 degrees fahreneheit, oatmeal 206 degrees fahrenheit, grits 204 degrees fahreneheit, bagel 144 degrees fahrenheit, and sausage patties 202 degrees fahrenheit. Observation on 01/21/25 at 8:20 A.M. revealed the breakfast meal cart arrived to the 200-Hall Unit. A return demonstration of the test tray with DM #908 at 8:47 A.M., approximately 25 minutes later, revealed the scrambled eggs were 107.1 degrees fahreneheit, the bagel was 110.4 degrees fahreneheit, and the tray was absent of oatmeal, grits, and sausage patties. DM #908 confirmed and verified the eggs were not hot and the meal was absent of other items. This deficiency represents non-compliance investigated under Complaint Numbers OH00161142 and OH00161136.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730 Based on observation, resident record review, and staff interview, the facility failed to ensure resident meals were served in the proper, safe form. This affected one resident (#60) of one reviewed for therapeutic diets. The facility census was 100. Findings include: Review of the medical record for Resident #60 revealed she was admitted to the facility on [DATE] with diagnoses that included dementia, type 2 diabetes, and hypertension. Review of the quarterly Staff Assessment for Mental Status (SAMS) assessment dated [DATE], revealed Resident #60 had a short and long-term memory problem and was severely impaired regarding tasks of daily life with inattention that fluctuated. Resident #60 was dependent on staff for Activities of Daily Living (ADLs) Review of the care plan dated 08/17/23 revealed Resident #60 had potential for altered nutrition with interventions that included providing and serving prescribed diet as ordered by the physician. Review of the physician orders dated 05/23/24 revealed Resident #60 had an order in place for a low concentrated sweets diet, mechanical soft (minced and moist MM5) texture, and thin liquids consistency. Observation on 01/22/25 at 9:58 A.M. revealed Resident #60 sitting in the dining room with her breakfast meal tray. Observation of Resident #60 breakfast meal ticket revealed Resident #60 required a mechanical soft diet. Observation revealed Resident #60 had one whole crunchy hard hashbrown on her tray. Interview on 01/22/25 at 10:00 A.M. with Licensed Practical Nurse (LPN) #832 revealed Resident #60 required a mechanical soft diet as indicated on her meal ticket. LPN #832 revealed the hashbrown was too hard for Resident #60 to eat. LPN #832 confirmed and verified Resident #60 did not receive her appropriate therapeutic diet of mechanical soft for her breakfast meal. This deficiency represents an incidental finding identified while investigating Master Complaint Number OH00162102 and Complaint Numbers OH00161890, OH00161859, OH00161556, OH00161410, OH00161144, OH00161142, and OH00161136.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730 Based on observations, resident record review, staff interview, and facility policy review, the facility failed to ensure resident dietary preferences were maintained. This affected five residents (#25, #26, #28, #33, and #82) of five reviewed for dietary preferences. The facility census was 100. Findings include: 1. Review of the medical record for Resident #28 revealed she was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, cerebral infarction, and atrial fibrillation. Review of the quarterly, Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 12 that indicated she was alert and oriented to person, place, and time. Review of the MDS assessment revealed Resident #28 was dependent on staff for Activities of Daily Living (ADLs). Review of the care plan dated 07/03/23 revealed Resident #28 had potential for altered nutrition related to hemiplegia, dementia, and morbid obesity with interventions that included assessing food preferences, and to provide and serve prescribed diet as ordered by the physician. Review of the physician orders dated 10/12/23 revealed Resident #28 had an order for a No Added Salt (NAS), Low-Calorie Sweetener diet with regular texture, and thin liquids consistency. Observation and interview on 01/23/25 at 8:51 A.M. during the breakfast meal tray pass, revealed Certified Nurse Assistant (CNA) #889 picked up Resident #28 breakfast tray from the delivery car and stated She's not going to eat this. She only likes bacon for breakfast. CNA #889 revealed Resident #28 only liked to eat bacon for breakfast. CNA #889 revealed floor staff were aware of Resident #28 meal preferences. CNA #889 revealed Resident #28 breakfast meal ticket only consisted of preferences related to chicken tenders. Observation and interview on 01/23/25 at 8:55 A.M. revealed CNA #889 returning from Resident #28 room with her breakfast meal tray in hand. CNA #889 revealed Resident #28 declined her breakfast meal tray due to her preferences not being followed. CNA #889 revealed Resident #28 breakfast meal tray consisted of scrambled eggs and a bagel. CNA #889 revealed Resident #28 did not eat scrambled eggs, sausage, or bagels. CNA #889 confirmed and verified the findings at the time of the observation. Interview on 01/28/25 at 2:20 P.M. with the Director of Nursing (DON) revealed the facility currently did not have a kitchen manager and was in the process of interviewing and hiring someone. DON revealed there was no staff available at this time to individualize meal requests. Observation and interview on 01/29/25 at 8:40 A.M. revealed Central Supply Clerk (CSC) #814 entered and exited Resident #28 room with her breakfast meal tray in hand. CSC #814 revealed Resident #28 declined her breakfast meal tray due to her not liking to eat breakfast. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/29/25 at 8:42 A.M. with Resident #28 revealed she declined her breakfast meal tray because there was no bacon on it. Resident #28 revealed her breakfast meal consisted of waffles and sausage. Resident #28 revealed she did not eat sausage. Observation of Resident #28 breakfast meal ticket dated 01/29/25 revealed no breakfast meal preferences. 2. Review of the medical record for Resident #82 revealed he was admitted to the facility on [DATE] with diagnoses that included schizophrenia, syncope and collapse, and hypertensive heart disease. Review of the care plan dated 01/17/24 revealed Resident #82 had potential for altered nutrition with interventions that included to acknowledge changing food preferences. Observation and interview on 01/21/25 at 9:22 A.M. revealed Resident #82 breakfast tray consisted of an English muffin, scrambled eggs, and no bacon. Resident #82 revealed he preferred bacon. Interview on 01/28/25 at 2:20 P.M. with the DON revealed the facility currently did not have a kitchen manager and was in the process of interviewing and hiring someone. DON revealed there was no staff available at this time to individualize meal requests. 3. Review of the medical record for Resident #26 revealed she was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction, morbid obesity and depression. Review of the care plan dated 06/20/23 revealed Resident #26 had potential for altered nutrition with interventions that included acknowledging changing food preferences. Review of the menu dated 01/21/25 revealed the breakfast meal consisted of a cheesy Amish breakfast casserole, English muffin, hot cereal juice of choice, choice of hot coffee or tea, and milk of choice. Observation and interview on 01/21/25 at 9:10 A.M. revealed Resident #26 breakfast tray consisted of an English muffin, bacon, and no eggs. Resident #26 revealed she liked eggs and would have preferred them to be on her breakfast tray. Resident #26 revealed she was not sure why she did not have eggs for breakfast. Interview on 01/28/25 at 2:20 P.M. with the DON revealed the facility currently did not have a kitchen manager and was in the process of interviewing and hiring someone. DON revealed there was no staff available at this time to individualize meal requests. 4. Review of the medical record for Resident #25 revealed she was admitted to the facility on [DATE] with diagnoses that included pressure ulcer of sacral region, type 2 diabetes, and hypertension. Review of the care plan dated 07/04/23 revealed Resident #25 had potential for altered nutrition with interventions that included acknowledging changing food preferences. (continued on next page)

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	366488	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Lyndhurst	5442 Rae Road Lyndhurst, OH 44124

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 01/21/25 at 9:30 A.M. revealed Resident #25 breakfast tray consisted of an English muffin, eggs, and no bacon. Resident #25 revealed there were many times when she did not get breakfast meat with her breakfast meal. Interview on 01/28/25 at 2:20 P.M. with the DON revealed the facility currently did not have a kitchen manager and was in the process of interviewing and hiring someone. DON revealed there was no staff available at this time to individualize meal requests. 5. Review of the medical record for Resident #33 revealed she was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, dementia, and chronic kidney disease. Review of the care plan dated 02/13/24 revealed Resident #33 had a right to make lifestyle choices and had potential for altered nutrition with interventions that included acknowledging changing food preferences. Review of Resident #33 meal ticket for the lunch meal on 01/28/25 revealed she was to receive mashed potatoes with every meal, whole milk and a magic cup. Observation and interview on 01/28/25 at 1:25 P.M. revealed Resident #33 seated in the main dining room with a lunch meal tray that consisted of chicken tenders and French fries. Business Office Manager (BOM) #822, present during the observation, revealed Resident #33 had three cups of juice, no milk, and acknowledged no residents had received any magic cups. BOM #822 confirmed and verified Resident #33 meal ticket, and the lack of preferences followed. Interview on 01/23/25 at 7:20 A.M. with Dietary Manager (DM) #908 revealed all residents received meal tickets to ensure meals were accurate and preferences were honored. DM #908 revealed residents were not served breakfast meat daily, however, if they requested it or it was a preference, they would receive it with their breakfast meal. Review of the facility document titled Selective Menus (Always Available Menu and Room Service Menu) undated, revealed the facility had a policy in place that residents would be able to choose foods they wish to have. Review of the document revealed the facility did not implement the policy. This deficiency represents an incidental finding identified while investigating Master Complaint Number OH00162102 and Complaint Numbers OH00161890, OH00161859, OH00161556, OH00161410, OH00161144, OH00161142, and OH00161136.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 42730 Based on observation, resident interviews, staff interviews, and review of facility mealtimes, revealed the facility failed to ensure meals were served in a timely manner. This affected all 100 residents as the facility did not identify any residents that were solely not receiving food by mouth (NPO). The facility census was 100. Findings include: Interview on 01/21/25 at 7:51 A.M. with Resident #52 revealed the facility food could be improved. Resident #52 revealed the food was always served late and cold. Interview on 01/21/25 at 9:07 A.M. with Resident #54 revealed she had not received her breakfast yet. Resident #54 revealed the food was always cold and needed to be warmed up. Observation on 01/21/25 at 9:10 A.M. revealed the breakfast cart arrived to the 200-Hall unit. Observation and interview on 01/22/25 at 9:31 A.M. revealed Resident #77 did not have a breakfast tray. Certified Nurse Assistant (CNA) #862 confirmed and verified Resident #77 was still without a breakfast tray. Observation and interview on 01/22/25 at 9:34 A.M. revealed Resident #115 was seated in her wheelchair outside of her room visibly upset. Resident #115 revealed she was upset because her breakfast meal had not arrived. No meal cart or staff passing meal trays were observed at the time of the observation. Observation on 01/22/25 at 9:58 A.M. revealed residents on the 300-Hall unit were receiving their breakfast trays. Review of the meal service times revealed the facility served breakfast between 7:00 A.M. and 8:45 A.M. Observation and interview on 01/23/25 at 7:20 A.M. of the breakfast meal preparation with Dietary Manager (DM) #908 revealed the kitchen served the front hall rooms (201-230) first, then the middle hall rooms (231-256), followed by the back hall room (301-323). DM #908 revealed the kitchen staff delivered the meal carts to the units and the floor staff were responsible for delivering them to residents. Observation revealed the breakfast meals arrived to the first unit at 8:20 A.M., and the last tray for first unit was served at 8:46 A.M. Observation revealed the time in which the last tray was served on the first unit, was when the entire facility should have already been served according to the listed mealtimes. Observation revealed other units had not been served yet and the meals were late. DM #908 confirmed and verified the above findings at the time of the observations. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	This deficiency represents an incidental finding identified while investigating Master Complaint Number OH00162102 and Complaint Numbers OH00161890, OH00161859, OH00161556, OH00161410, OH00161144, OH00161142, and OH00161136.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730 Based on observation, resident record review, and staff interview, the facility failed to ensure residents were provided with the appropriate assistive devices for meals. This affected one resident (#60) of one reviewed for assistive devices. The facility census was 100. Findings include: Review of the medical record for Resident #60 revealed she was admitted to the facility on [DATE] with diagnoses that included dementia, type 2 diabetes, and hypertension. Review of the quarterly Staff Assessment for Mental Status (SAMS) assessment dated [DATE], revealed Resident #60 had a short and long-term memory problem and was severely impaired regarding tasks of daily life with inattention that fluctuated. Resident #60 was dependent on staff for Activities of Daily Living (ADLs) Review of the care plan dated 08/17/23 revealed Resident #60 had potential for altered nutrition with interventions that included utilizing a red divided plate as an assistive device for meals. Review of the physician orders dated 05/23/24 revealed Resident #60 had an order in place for a low concentrated sweets diet, mechanical soft (minced and moist MM5) texture, and thin liquids consistency. Review of the physician orders dated 01/19/25 revealed Resident #60 had an order in place for a red plate with a lid. Observation on 01/22/25 at 9:58 A.M. revealed Resident #60 sitting in the dining room with her breakfast meal tray. Observation of Resident #60 breakfast meal ticket revealed Resident #60 required a red plate. Observation revealed Resident #60 did not have a red plate, but a regular flat plate. Interview on 01/22/25 at 10:00 A.M. with Licensed Practical Nurse (LPN) #832 revealed Resident #60 required an divided plate. LPN #832 revealed all divided plates were red. LPN #832 confirmed and verified Resident #60 required a red divided plate and her meal was served without one. This deficiency represents an incidental finding identified while investigating Master Complaint Number OH00162102 and Complaint Numbers OH00161890, OH00161859, OH00161556, OH00161410, OH00161144, OH00161142, and OH00161136.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 42733 Based on observation and interview the facility failed to ensure adequate amounts of supplies were available to provide resident care. This had the potential to affect all residents residing in the facility. The facility census was 100. Findings include: Observation of clean linen closet on the 200 hall on 01/21/25 at 9:45 A.M. revealed no towels or washcloths and 1 package of disposable incontinence briefs. Observation was confirmed by Certified Nursing Assistant (CNA) #824 and CNA #824 stated she often had to go to other units to look for items and stated there had been times she had not had linens for a few hours after the start of her shift at 7:00 A.M. Interview on 01/22/25 at 8:38 A.M. with CNA #861 revealed there had been many times she did not have supplies to provide incontinence care. Interview on 01/27/25 at 12:59 P.M. with Resident #27's daughter revealed on 01/26/25 at 1:16 P.M. she had sent a text message to the Director of Nursing (DON) to inform her of the lack of incontinence briefs for Resident #27. Resident #27's daughter stated the DON had not responded to her text message and stated she had informed the Activities Director (AD) #813 about the lack of briefs and he was able to locate one package. Resident #27's daughter stated she had also shared some of the briefs with other residents due to she was worried they would not have any and might not be provided with incontinence care. Interview on 02/05/25 at 3:01 P.M. with Administrator and DON revealed the facility would not confirm or deny the lack of supplies. This deficiency represents non-compliance investigated under Complaint Number OH00161142.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42730 Based on record review and interview, the facility failed to ensure resident records were maintained in an accurate manner and contained the assessments and services provided. This affected seven residents (#6, #9, #49, #54, #77, #82, #83) of seven reviewed for accurate medical records. The facility census was 100. Findings include: 1. Review of the medical record for Resident #6 revealed she admitted to the facility on [DATE] with diagnoses that included sepsis, Alzheimer's disease, and muscle weakness. Review of the physician orders dated 12/18/24 revealed Resident #6 required two-person assist for transfers. Review of the care plan dated 12/19/24 revealed Resident #6 had a self-care deficit with interventions that included assistance of one for bathing. Review of the medical record for Resident #83 revealed he was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, dementia, and epilepsy. Review of the care plan dated 07/03/23 revealed Resident #83 had a self-care deficit with interventions that included bathing assistance as needed and resident care per facility protocol. Review of the medical record for Resident #49 revealed he was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes, traumatic subarachnoid hemorrhage, and legal blindness. Review of the physician orders dated 11/05/23 revealed Resident #49 had an order for transfer via hoyer lift. Review of the care plan dated 11/19/24 revealed Resident #49 had a self-care deficit with interventions that included bathing of one assist and resident care per facility protocol. Review of the medical record for Resident #82 revealed he was admitted to the facility on [DATE] with diagnoses that included schizophrenia, syncope and collapse, and hypertensive heart disease. Review of the care plan dated 01/17/24 revealed Resident #82 was at risk for Activities of Daily Living (ADLs) ADL decline with interventions included bathing assist of one and resident care per facility protocol. Review of the medical record for Resident #77 revealed she was admitted to the facility on [DATE] with diagnoses of cerebral infarction and type 2 diabetes. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #77 was alert and oriented to person, place, and time with cognition impairment and required staff assistance for showers. Review of the medical record for Resident #54 revealed she was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, chronic obstructive pulmonary disease, and diastolic heart failure. Review of the MDS assessment revealed Resident #54 had impairment on both sides of her lower extremities and required assistance from staff for ADLs. Review of the care plan dated 02/19/24 revealed Resident #54 had a self-care deficit with interventions that included extensive total assistance with all ADLs. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/21/25 at 9:07 A.M. with Resident #54 revealed she had not received any showers for a couple weeks. Interview on 01/21/25 at 1:50 P.M. with Resident #97 Power of Attorney (POA) revealed residents went without showers or bed baths. Resident #97 POA revealed Resident #97 went without a shower or bed bath due to staffing levels. Review of the shower sheet dated 01/20/25 for Resident #77 revealed she did not receive a shower due to the water being cold. Review of the shower sheets dated for the week of 01/12/25 through 01/18/25, for Residents #6, #49, #54, #77, #82, #83, identified to be affected by cold water temperatures, revealed documented showers. However, interviews with the Maintenance Director (MD) #853 on 01/21/25 at 3:12 P.M. and the Administrator on 01/22 25 at 2:30 P.M. revealed the unit in which residents #6, #49, #54, #77, #82, #83 resided on, did not have hot water at the time documented. The above findings were confirmed and verified by the Administrator on 02/05/25 at 3:04 P.M. 42733 2. Review of Resident #9's medical records revealed an admitted [DATE]. Diagnoses included obesity, muscle weakness and diabetes. Resident #9's Minimum Data Set (MDS) assessment revealed Resident #9 had intact cognition and required maximum assistance with bathing. Review of physician orders for January 2025 revealed Resident #9 was ordered Permethrin (cream used to treat scabies infection) 60 grams one time applied all over the body from the neck down and wash off skin within 8-14 hours. Orders were active from 01/20/25-01/27/25 and review of the Medication Administration Report (MAR) for January 2025 revealed Permethrin cream was administered on 01/22/25, 01/23/25, 01/25/25, 01/26/25 and 01/27/25. Physician orders for January-February 2025 had another order for Permethrin from 01/29/25-02/04/25. Review of MAR revealed cream was administered on 01/31/25, 02/01/25, 02/02/25 and 02/03/25. Interview on 02/04/25 at 10:06 A.M. with Licensed Practical Nurse (LPN) #928 revealed he had applied Resident #9's cream on 01/31/25 and 02/03/25. Telephone interview on 02/04/25 at 12:05 P.M. with pharmacy revealed one tube of Resident #9's Permethrin cream was sent on 01/10/25 and 01/12/25. Interview on 02/04/25 at 2:53 P.M. with Director of Nursing (DON) confirmed Resident #9's Permethrin cream was a one time dose and stated a second dose had been ordered on 01/12/25. DON stated the nursing staff should not have documented the extra doses as being administered. 3. Review of Resident #77's medical records revealed an admitted [DATE]. Diagnoses included falls, difficulty walking and muscle weakness. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #77's medical records revealed no admission assessment had been completed by nursing. Interview on 02/04/25 at 3:30 P.M. with DON revealed she had been aware assessments had not been completed upon admission and recorded in the resident's medical record as required. DON stated she had educated the staff on documenting admission assessments and stated the facility was going to discuss the issue during their quality assurance and performance improvement meeting. This deficiency represents non-compliance investigated under Complaint Number OH00161142.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 42013 Based on record review and interview, the facility failed to submit complete and accurate staffing information for the Payroll-Based Journal (PBJ) report to Centers for Medicare and Medicaid Services (CMS). This had the potential to affect all residents. Findings include: Review of the STNA assignments dated 01/07/25 through 02/05/25 revealed one nurse was assigned to the SNF (Skilled Nursing Facility) premium nursing unit and one to two Certified Nursing Assistant's (CNA)'s were assigned to the SNF premium nursing unit. The schedule did not specify which nurse and aide were assigned to care for residents in the attached Assisted Living (AL) area. Interview on 02/04/25 at 2:40 P.M. of the Administrator revealed the Skilled Nursing Facility (SNF) and the Assisted Living (AL) area did not have separate schedules for staff assignments. The Administrator stated the SNF and AL used the same schedule. The Administrator stated the nurse and aides assigned to the SNF premium nursing unit were the same nurse and aides who cared for residents in the AL area. The Administrator confirmed the schedule did not reflect that the nurse and aide assigned to the premium nursing unit were also assigned to care for the residents residing in the AL. The Administrator stated there was one resident (Resident #1) residing in the AL area. The Administrator stated she called the corporate office about not having a separate schedule for the SNF and AL and the auditor said the AL was not a separate building, it was part of someone's unit, Resident #1 needed minimal care, he did not have dressing changes, he was independent and the staff hours calculated for the Skilled Nursing Facility did not include hours needed to care for Resident #1 in the AL. This deficiency represents an incidental finding identified while investigating Master Complaint Number OH00162102 and Complaint Numbers OH00161890, OH00161859, OH00161556, OH00161410, OH00161144, OH00161142, and OH00161136.

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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** 42730 Based on observations, record review, staff interviews, and facility policy review, the facility failed to ensure facility staff followed infection control policies, protocols, and failed to ensure residents were care planned for infection control. This affected two residents (#9 and #44) of three reviewed for infection control. The facility census was 100. Findings include: 1. Review of the medical record for Resident #44 revealed she was admitted to the facility on [DATE] with diagnoses that included bilateral primary osteoarthritis of knee, hypertensive heart disease without heart failure, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #44 had a Brief Interview for Mental Status (BIMS) score of 13 that indicated she was alert and oriented to person, place, and time. Review of the MDS assessment revealed Resident #44 required assistance from staff for Activities of Daily Living (ADLs). Review of the progress note dated 01/20/25 at 2:54 P.M. revealed Resident #44 complained of cold-like symptoms, COVID-19 tested , and received positive results. Resident #44 placed on isolation precautions. Review of the physician orders dated 01/21/25 revealed Resident #44 had an order for droplet isolation for COVID-19 with all activities to take place in her room. Review of Resident #44's comprehensive care plan revealed no evidence of a care plan in place for infection control. Interview on 01/21/25 at 7:48 A.M. with Certified Nursing Assistants (CNAs) #835 and #878 revealed there was no COVID-19 positive residents in the facility. Interview revealed all residents diagnosed with COVID-19 were discharged from the building. Interview on 01/21/25 at 8:25 A.M. with the Director of Nursing (DON) revealed the facility had one positive case of COVID-19 and that was for Resident #44. The DON revealed Resident #44 tested positive for COVID-19 on 01/20/25. Observation and interview on 01/21/25 at 9:22 A.M. revealed a bin sitting outside of Resident #44 room with personal protective equipment (PPE) inside that included masks, gowns, and gloves. Resident #44 room door had a sign that read REPORT TO NURSES STATION BEFORE ENTERING and another sign above the PPE bin that read AIRBOURNE PRECAUTIONS. CNA #889 entered Resident #44 room to provide breakfast tray and entered without no PPE in place. Upon exiting Resident #44 room, CNA #889 revealed he did not pay attention to the sign on the door or the bin outside of Resident #44 room. CNA #889 revealed after he entered Resident #44 room, Resident #44 informed him that she did not feel well. CNA #889 confirmed and verified the above findings at the time of the observation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/21/25 at 9:23 A.M. with CNA #885 revealed she was not aware of Resident #44 isolation precautions, and she did not know what or why the precautions were in place. Interview on 01/21/25 at 11:09 A.M. with the DON confirmed and verified that she was aware of CNA #889 entering and exiting Resident #44 room without donning and doffing PPE. Follow-up interview on 01/22/25 at 1:23 P.M. with the DON, with the Administrator present, while reviewing Resident #44 electronic medical record, revealed no care plan in place for COVID-19, isolation precautions, and/or droplet precautions. The DON confirmed and verified Resident #44 care plan was not updated. Observation and interview on 01/28/25 at 12:44 P.M. revealed CNA #885 entered Resident #44 room without donning PPE. CNA #885, upon exiting Resident #44 room, without doffing PPE, revealed she entered and exited Resident #44 room without donning and doffing the required PPE. CNA #855 confirmed and verified Resident #44 was still on isolation precautions related to COVID-19. Interview on 01/28/25 at 12:46 P.M. with Licensed Practical Nurse (LPN) #852 confirmed and verified Resident #44 was currently on isolation precautions for COVID-19 and PPE was required when entering the room. Review of the facility document provided by the DON titled Isolation Residents undated, revealed Resident #44 was positive for COVID-19 as of 01/20/25. Review of the facility document titled COVID-19; SARS-CoV-2 revised August 2023, revealed the facility had a policy in place that staff who entered the room of a suspected or confirmed COVID-19 infection should don an N95 respirator, gown, gloves, and eye protection. Review of the document revealed the facility did not implement the policy. 42733 2. Review of Resident #9's medical records revealed an admitted [DATE]. Diagnoses included obesity, muscle weakness and diabetes. Review of MDS assessment dated [DATE] revealed Resident #9 had intact cognition. Resident #9 was dependent with toileting and required maximum assistance with bathing. Review of care plan dated 11/18/24, revised 01/08/25 revealed Resident #9 had scabies. Interventions included infestation may occur with direct skin to skin contact with an infected person, give prescribed lotions to treat scabies as ordered and a second treatment may be indicated in one week to ten days. Review of physician orders for January 2025 revealed Resident #9 was ordered Permethrin (cream used to treat scabies infection) 60 grams one time applied all over the body from the neck down and wash off skin within 8-14 hours. Orders were active from 01/20/25-01/27/25 and review of the Medication Administration Report (MAR) for January 2025 revealed Permethrin cream was administered on 01/22/25, 01/23/25, 01/25/25, 01/26/25 and 01/27/25. Physician orders for January-February 2025 had another order for Permethrin from 01/29/25-02/04/25. Review of MAR revealed cream was administered on 01/31/25, 02/01/25, 02/02/25 and 02/03/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366488	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Lyndhurst	5442 Rae Road Lyndhurst, OH 44124

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/23/25 at 6:40 A.M. revealed a sign posted outside of Resident #9's room that indicated contact precautions as well as an isolation bin that contained gowns, gloves and masks. Interview with CNA #829 and CNA #902 revealed Resident #9 was on contact precautions for scabies. CNA #829 and #902 stated Resident #9 has been on precautions for a long time and stated she they were unaware of when she had last received a shower, however their assignment sheet for 01/23/25 specifically stated for Resident #9 to receive a shower and stated it may have had something to do with a cream the nurses applied. Interview with Resident #9 at time of observation revealed she could not recall when she had last had cream applied and stated she had not received a shower for several months. Observation on 02/04/25 at 8:40 A.M. revealed contact precaution sign and isolation bin remained outside of Resident #9's room. Interview on 02/04/25 at 10:06 A.M. with Licensed Practical Nurse (LPN) #928 revealed he had applied two tubes of Resident #9's cream on 01/31/25 and also on 02/03/25. Observation on 02/04/25 at 10:39 A.M. revealed LPN #826 had entered Resident #9's room and had obtained a blood pressure reading and had not donned PPE prior to entering. After observation LPN #826 had exited Resident #9's room and had left the area. At 10:49 A.M. LPN #826 had returned with the Assistant Director of Nursing (ADON) and ADON had removed the contact precaution sign and isolation bin. ADON had not explained why she had removed the sign and isolation bin and had left the area. Telephone interview on 02/04/25 at 12:05 P.M. with pharmacy revealed one tube of Resident #9's Permethrin cream was sent on 01/10/25 and 01/12/25. Interview with LPN #826 at time of observation revealed she had asked the ADON if Resident #9 was still in active isolation and LPN #826 stated the ADON had told her no and then she had removed the isolation materials. Interview on 02/04/25 at 2:53 P.M. with Director of Nursing (DON) confirmed Resident #9's Permethrin cream was a one time dose and stated a second dose had been ordered on 01/12/25. DON stated Resident #9 should not have been on isolation after she had received her cream on 01/12/25 due to Resident #9 was not considered contagious after cream was applied and washed off. DON confirmed the physician orders were active for isolation from 01/21/25-01/31/25 and had not been able to provide a clear explanation or clarification of the orders. DON stated Resident #9 had an upcoming dermatologist appointment and would await the results of the appointment and stated until the appointment Resident #9 was no longer considered contagious and did not require isolation. Review of facility policy titled Scabies Identification. Treatment and Environmental Cleaning revised 08/2016, revealed an infected individual was to be placed on contact precautions for 24 hours after treatment. This deficiency represents non-compliance investigated under Complaint Number OH00161410.

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	366488	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Lyndhurst	5442 Rae Road Lyndhurst, OH 44124

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 42730 Based on observations, resident interviews, staff interviews, and facility policy review, the facility failed to ensure the resident environment was kept in a clean and sanitary manner. This had the potential to affect all 100 residents residing in the facility. Findings include: Observation on 01/21/25 at 7:52 A.M. revealed multiple old, dirty dinner trays sitting on the ledge of the common area on the 200-Hall Unit, adjacent to Resident #80 room. Observation on 01/21/25 at 7:53 A.M. revealed multiple open and used staff drinks situated at the nurses station located on the 200-Hall Unit. Observation and interview on 01/22/25 at 5:45 A.M. revealed dirty dinner dishes sitting on the ledge of the common area on the 200-Hall Unit, adjacent to Resident #62 room. Certified Nurse Assistant (CNA) #883 revealed she wasn't aware of who placed the dishes there. CNA #883 revealed staff should have taken them away after the dinner meal. CNA #883 confirmed and verified the dirty dinner trays and dishes located on the 200-Hall Unit at the time of the observations. Observation and interview on 01/22/25 at 6:20 A.M. revealed multiple drink cups at the nurse's station on the 200-Hall Unit. Business Office Manager (BOM) #822 revealed staff beverages and cups should not be kept at the nurses station. BOM #822 confirmed and verified the findings at the time of the observation. Observation and interview on 01/27/25 at 6:44 A.M. revealed dirty dinner dishes sitting on a ledge adjacent to Resident #94 room. Licensed Practical Nurse (LPN) #868 confirmed and verified the observation. Observation and interview on 01/30/25 at 10:52 A.M. revealed nine drinks were observed at the nurses station on the 300-Hall Unit. Observation revealed a sign located at the nurses station that read NO DRINKS AT THE NURSES STATION. Interview with LPN #826 revealed she was unaware that staff drinks were not allowed at the nurses station. However, LPN #826 acknowledged the sign posted and verified the findings at the time of the observation. This deficiency represents non-compliance investigated under Master Complaint Number OH00162102 and Complaint Numbers OH00161410, OH00161136, OH00161142.

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	366488	A. Building B. Wing	02/11/2025

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Avenue at Lyndhurst	5442 Rae Road Lyndhurst, OH 44124

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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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 45442 Based on employee file review and interview, the facility failed to ensure staff were trained as required. This had the potential to affect all 100 residents residing at the facility. Findings include: Review of the employee file for Certified Nursing Assistant (CNA) #823 on 01/29/25 at 10:30 A.M. with Human Resource Director #871 revealed an employee start date of 10/10/24. Review of the general orientation check list dated 10/10/24 for CNA #824 revealed it was incomplete with numerous sections not indicated as checked off as complete. The orientation checklist revealed various admissions/marketing, dietary, social services, administration, therapy, and nursing areas were not indicated as being checked off. Areas which were not checked off as complete included but were not limited to infection control, dementia and memory care training, wound care, incident/accident reporting, restorative nursing, transfer techniques, Hoyer procedures and enhanced barrier precautions. Review of the employee file for CNA #885 on 01/29/25 at 10:35 A.M. with Human Resource Director #871 revealed a start date of 07/03/24. Review of the general orientation checklist dated 07/03/24 for CNA #885 was incomplete with numerous sections not indicated as being checked off. The orientation checklist revealed various maintenance, housekeeping, admissions, activities, dietary, social services, administration, therapy, and nursing were not indicated as being checked off as completed. Some of the Identified areas that did not indicate completion included but was not limited to infection control, dementia training, wounds, incident/accident reporting, transfer techniques, Hoyer procedures and enhanced barrier precautions. Interview following the completion of employee files on 01/29/25 at 10:53 A.M. with Human Resource Director #871 confirmed orientation checklists for CNA #823 and #885 were partially filled out and not complete as required. Interview on 02/04/25 at 7:18 A.M. with LPN #832 stated did not feel proper orientation was given upon hire, was given an orientation packet to read and no staff went over the information, stated was supposed to have two-day orientation but only got one due to staffing shortage. This deficiency represents non-compliance investigated under Master Complaint Number OH00162102 and Complaint Numbers OH00161142 and OH00161142.