STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365600	a. building _____ b. wing _____	06/09/2025

name of provider or supplier	street address, city, state, zip code
LOST CREEK REHABILITATION AND NURSING CENTER	804 SOUTH MUMAUGH ROAD LIMA OH, 45804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000	INITIAL COMMENTS AMENDED 06/23/25 ANNUAL SURVEY COMPLAINT INVESTIGATION COMPLAINT NUMBER OH00165028 ADMINISTRATOR: Lynsey Stewart, #7935 CERTIFIED BED CAPACITY: 54 CENSUS IN HOUSE: 39 The following deficiencies are based on the annual survey completed 06/09/25. No deficiencies were cited in regards to the allegations contained in Complaint Number OH00165028 investigated concurrently.	F 0000		

laboratory director's or provider/supplier representative's signature | title | (x6) date

LYNSEY.STEWART | 06/24/2025

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F 0558	Continued From page 1	F 0558		
F 0558 SS=D	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This STANDARD is not met as evidenced by: Based on record review, observation, interview, and policy review, the facility failed to ensure call lights were in reach of residents. This affected two (#17 and #27) of 21 residents reviewed for call lights. The facility census was 39. Findings include: 1. Review of medical record for Resident #17 revealed an admission date of 03/20/23 with diagnoses including but not limited to urinary tract infection, anxiety, metabolic encephalopathy, dementia with agitation, major depressive disorder, and paranoid schizophrenia. Review of the Minimum Data Set (MDS) assessment dated 03/14/25 revealed a Brief Interview of Mental Status (BIMS) score of five which indicates severe cognitive impairment. Review of the care plan dated 04/21/25 revealed the resident was at risk for falls. Interventions included be sure the call light is within reach and encourage the	F 0558	F-0558D Lost creek Nursing and Rehabilitation Center wishes to have this plan of correction submitted as our written allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission to nor agreement with, either the existence of, or the scope and severity of, any of the cited deficiencies or conclusions set forth in the statements of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. Our alleged date of compliance is . F-0558 Reasonable Accommodations Needs/Preferences Resident #17 and #21's call lights were in reach on 6/11/25 at 1000 by the Director of Nursing. An initial audit was conducted on all residents on 6/11/25 at 1030 by the Director of Nursing and all had call lights within reach. All clinical staff were educated on the importance of all call lights being in reach for all residents on 6/11/25 by the Director of Nursing. The Director of Nursing or Designee will conduct an audit on 5 Residents 3X/week for 4 weeks to ensure all call lights are with in reach. Any unusual findings will be forwarded to the QAPI committee for prompt resolution. The Director of Nursing will monitor this area for compliance on an ongoing basis.	06/11/2025

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F 0558	Continued From page 2 resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Observation and interview on 06/05/25 at 8:41 A.M. revealed the resident lying in bed with the call light hooked to the privacy curtain out of reach. Interview at the time with Activity Director (AD #668) verified the resident uses the call light. AD #668 verified the call light was hooked to the privacy curtain and out of reach for the resident. 2. Review of medical record for Resident #27 revealed an admission date of 03/31/25 with diagnoses including but not limited to Parkinson's disease, muscle weakness, hypertension, difficulty walking, and thrombocytopenia. Review of the MDS assessment dated 04/10/25 revealed a BIMS score of 15 which indicated the resident was cognitively intact. Review of care plan dated 04/18/25 revealed the resident was at risk for falls. Interventions included be sure the call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Observation and interview on 06/05/25 at 8:28 A.M. revealed the resident sitting in his chair in his room stating he needed to use the bathroom. Call light was	F 0558		

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F 0558	Continued From page 3 observed to be lying on the bed out of reach of the resident. Interview at the time of the observation with AD #668 verified the call light was lying on the bed out of reach for the resident. Review of policy titled, "Answering the Call Light," revised October 2010 revealed be sure the call light is plugged in at all times. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.	F 0558		
F 0577 SS=C	483.10(g)(10)(11) Right to Survey Results/Advocate Agency Info §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to	F 0577	Tag: F 0577 Facility will ensure there is a visible posting on where to locate the survey results. Posting was placed on 6/10/25 in a prominent location adjacent to the business office. No other required postings were identified as missing. Licensed administrator was educated on requirements of F0577 by RDO on 6/05/25. Administrator or designee will audit one time a week x4 weeks to ensure signage is in place. Audit results will be reported to QAPI committee for review and recommendations.	06/10/2025

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F 0577	Continued From page 4 the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure there was a visible posting on where to locate the survey results. This had the potential to affect all residents. The facility census was 39. Findings include: Observation on 06/04/25 at 2:27 P.M. of the front lobby revealed three black letter holders hanging on the wall between the business office and the admissions office with a binder with a small label that stated survey results. Black binder was not easily identified as the survey results unless you were right up on it. No signage observed indicating where the binder is located. Interview on 06/05/25 at 8:09 A.M. with the Administrator verified there was no signage in the lobby or common area to indicate where the survey results were located.	F 0577		

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F 0578	Continued From page 5	F 0578		
F 0578 SS=D	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance	F 0578	F 0578 Lost Creek Nursing and Rehabilitation Center wishes to have this plan of correction submitted as our written allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission to nor agreement with, either the existence of, or the scope and severity of, any of the cited deficiencies or conclusions set forth in the statements of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. Our alleged date of compliance is 6/27/25. F 0578 Request/Refuse/Dscntnue Trmnt;Formite Adv Dir Resident #27 code status was checked on 6/10/25 at 0900 by the Director of Nursing, and code status matched in hard chart and PCC. An initial audit was conducted on all residents was done on 6/11/25 by the Director of Nursing and all resident code status hard chart and electronic chart matched. All clinical staff were educated on checking code status on admission and with any code status change to ensure accuracy from hard chart to electronic chart on 6/11/25 by the Director of Nursing. The Director of Nursing or Designee will conduct an audit on all Residents initially and 2x weekly for any changes. Director of Nursing will also audit new admits and any return from hospital day of return or following day for any changes. Any unusual findings will be forwarded to the QAPI committee for prompt resolution. The Director of Nursing will monitor this area for compliance on an ongoing basis.	06/27/2025

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F 0578	Continued From page 6 directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure the hard chart and the electronic medical record contained the correct advance directive information. This affected one (#27) of 21 residents reviewed for advanced directives. The facility census was 39. Findings include: Review of medical record for Resident #27 revealed an admission date of 03/31/25 with diagnoses including but not limited to Parkinson's disease, muscle weakness, hypertension, other specified forms of tremor, and thrombocytopenia. Review of the Minimum Data Set (MDS) assessment dated 04/10/25 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Review of current physician orders	F 0578		

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F 0578	Continued From page 7 revealed the resident was a full code. Review of hard chart for Resident #27 revealed the resident was a Do Not Resuscitate Comfort Care Arrest (DNR CCA). Review of care plan dated 04/18/25 revealed the residents advanced directive: DNR CCA with interventions including but not limited to acknowledge and maintain resident wishes regarding advanced directives and assess advanced directive upon admission, quarterly, annually, and with significant change to ensure resident wishes are maintained regarding advanced directive. Interview on 06/03/25 at 11:27 A.M. with the Director of Nursing (DON) verified the physician order was for a full code and the hard chart had a DNRCCA form signed by the physician. Review of policy titled "Advance Directives" updated 03/17/25 revealed upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.	F 0578		

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F 0628	Continued From page 8	F 0628		
F 0628 SS=D	483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) Discharge Process §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner	F 0628	Tag: F 0628 Facility has provided resident #28 and #42 with transfer notices. As well as updated transfer log and sent to ombudsman. Administrator reviewed all transfer / discharges from 5/1/25 through 5/30/25 for corresponding notice of transfer / discharge. Administrator or designee will review discharged patients for the last 30 days to ensure they received a transfer/discharge notice. If they did not receive a notice they will be issued one, this will occur on or before 6/25/25. Administrator provided education to social service designee on transfer / discharge notice requirements on 6/17/25. Administrator or designee will audit 3 discharge residents weekly x4 weeks to ensure proper notice of transfer / discharge notice. Results of audits will be reviewed by the QAPI committee for further recommendations.	06/25/2025

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F 0628	Continued From page 9 they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	F 0628		

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F 0628	Continued From page 10 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals	F 0628		

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F 0628	Continued From page 11 with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;	F 0628		

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F 0628	Continued From page 12 (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge	F 0628		

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F 0628	Continued From page 13 medications with the resident's post-discharge medications (both prescribed and over-the-counter). This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to provide a discharge notice and notice of transfer to residents, residents' representatives, and the Ombudsman. This affected two residents (#28 and #42) out of four residents reviewed for notices. The facility census was 39. Findings include: 1. Record review for Resident #28 revealed the resident was admitted to the facility on 11/14/24 and transferred to the hospital on 06/01/25. Diagnoses for Resident #28 include diabetes type two, paraplegia, chronic obstructive pulmonary disease, pain, and schizoid personality disorder. Review of Resident #28's Minimum Data Set (MDS) dated 3/13/25 revealed the resident had intact cognition. Review of Resident #28's progress note dated 06/01/25 at 2:10 A.M. the nurse documented Resident #28 had a change in condition with declining vital signs and was transferred to the hospital via emergency squad at 2:30 P.M. Per the note dated 06/01/25 at 3:11 P.M. the nurse documented Resident #28 had	F 0628		

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F 0628	Continued From page 14 been admitted to the hospital post fall. Further review of Resident #28's medical records revealed there was no evidence of any transfer summary dated from 06/01/25 to 06/05/25 sent to the hospital, resident, resident's representative, or the Ombudsman. Interview on 06/05/25 at 3:30 P.M. with Managed Care Provider (MCP) #903 verified there was no transfer notification to Resident #28, the resident's family representative, or the Ombudsman. 2. Record review for Resident #42 revealed the resident was admitted to the facility on 02/13/25 and discharged to the hospital on 03/14/25. Diagnoses for Resident #42 include complications post surgery to repair a femur fracture, depression, and myeloma. Review of Resident #42's MDS dated 2/26/25 revealed the resident had mildly impaired cognition. Review of Resident #42's progress notes dated 03/14/25 revealed Resident #42's sister notified the facility Resident #42 was transferred and admitted to the hospital from her outside physician appointment due to syncopal episode and possible urinary tract infection. Further review of Resident #42's medical records revealed no evidence of any notification of discharge or transfer to the	F 0628		

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F 0628	Continued From page 15 resident, resident's representative or the Ombudsman. Interview on 06/04/25 at 11:22 A.M. with Administrator verified there was no discharge or transfer summary documented for Resident #42. The Administrator verified Resident #42 was discharged from the facility as of 03/14/25.	F 0628		
F 0644 SS=D	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This STANDARD is not met as evidenced	F 0644	Tag: F 0644 The facility will ensure the PASARR is completed accurately. PASARR for resident #10 has been updated by social service designee to include all diagnosis and antipsychotic medications. Social services or designee will complete a whole house audit to determine if PASARR is accurate by 6/25/25. Administrator will provide social service designee with education regarding PASARR process on 6/17/25. Administrator or designee will audit 3 PASARRs weekly for x4 weeks. Audit results will be reviewed by the QAPI committee for further recommendations.	06/25/2025

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F 0644	Continued From page 16 by: Based on record review, interview, and policy review, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR) was completed accurately. This affected one (#10) of one resident reviewed for PASARR. The facility census was 39. Findings include: Review of medical record for Resident #10 revealed an admission date of 11/11/20 with diagnoses including but not limited to bipolar disorder current episode depressed mild or moderate severity, schizoaffective disorder bipolar type, visual hallucinations, altered mental status, auditory hallucinations, cognitive communication deficit, inadequate social skills, anxiety, and adult antisocial behavior. Review of the Minimum Data Set (MDS) assessment dated 05/18/25 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Review of current physician orders revealed depakote 500 milligrams (mg) at bedtime (bipolar), depakote 250 mg twice a day (bipolar), duloxetine 40 mg twice a day (depression), risperidal 0.5 mg at bedtime (hallucinations), seroquel 100 mg twice a day in the afternoon and bedtime (bipolar and schizoaffective disorder), and	F 0644		

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F 0644	Continued From page 17 seroquel 300 mg half a tablet in the morning. Review of Preadmission Screening and Resident Review (PASARR) dated 01/07/24 revealed the only diagnoses listed were mood disorders and panic or other severe anxiety disorders. No psychotropic medications were listed on the PASARR. Interview on 06/04/25 at 01:50 P.M. with Managed Care Coordinator (MCC #903) revealed they verified the PASARR did not include any psychotropic medications for Resident #10. MCC #903 verified there were no other diagnoses included besides mood disorder and panic or other severe anxiety disorders. Review of policy titled, "Resident Assessment - Coordination with PASARR Program," dated October 2024 revealed the facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs.	F 0644		

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F 0655	Continued From page 18	F 0655		
F 0655 SS=D	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that	F 0655	F-0655 Baseline Care Plan Resident #96 baseline care plan did not include instructions to provide effective and person-centered care on 6/10/25 by the Director of Nursing. An initial audit was conducted on all new residents on 6/10/25 by the Director of Nursing and all Base Line Care Plans were completed. All clinical staff were educated on 6/10/25 on baseline care plans needing to be completed on admission by the Director of Nursing. The Director of Nursing or Designee will conduct an audit on all new Residents for 4 weeks to ensure Baseline Care Plans reflect all minimum healthcare information needed to provide effective person-centered care. Any unusual findings will be forwarded to the QAPI committee for prompt resolution. The Director of Nursing will monitor this area for compliance on an ongoing basis.	06/10/2025

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F 0655	Continued From page 19 includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to implement a baseline care plan that included all care concerns from admission. This affected one (#96) of three residents reviewed for baseline care plan. The facility census was 39. Findings include: Review of medical record for Resident #96 revealed an admission date of 06/01/25 with diagnoses including but not limited to chronic obstructive pulmonary disease with exacerbation, chronic ischemic heart disease, bacteremia, heart failure, chronic kidney disease stage four, atrial fibrillation, and obstructive sleep apnea. Review of current physician orders revealed ampicillin sodium injection solution 2 grams (gm) intravenous (IV) every eight hours for implantable cardioverter-defibrillator (ICD) infection until 06/30/25, ceftriaxone 2000	F 0655		

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F 0655	Continued From page 20 milligrams (mg) IV twice daily for ICD infection, change life vest (wearable cardioverter defibrillator) battery every 24 hours during evening shift, check life vest back-up battery pack is getting charged every shift, check life vest placement every shift, and change peripherally inserted central catheter (PICC) dressing and caps weekly. Review of baseline care plan dated 06/01/25 revealed no care plan for the PICC line, life vest, infection, or receiving any antibiotics which were all present on admission. Interview on 06/04/25 at 01:25 P.M. with Director of Nursing (DON) verified the resident was on IV antibiotics, had an actual infection, and was wearing a life vest on admission and should be reflected in the baseline care plan. DON verified the above was not included on the baseline care plan.	F 0655		

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F 0657	Continued From page 21	F 0657		
F 0657 SS=E	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This STANDARD is not met as evidenced by:	F 0657	Tag: F 0657 Care conferences were held with residents / sponsors for the following residents #10, # 16, #35, #5 and #6 on or before 6/25/25. Social services or designee will review all current resident records by 6/25/25 to ensure that quarter care conferences have been completed timely. If care conference did not occur, one will be held by 6/25/25. The administrator provided education to social services designee on 6/17/25 regarding timely completion of quarterly care conferences, quarterly completion and requirement for IDT, resident and sponsor involvement. The administrator or designee will audit 3 resident charts for completion of timely care conferences weekly x4 weeks for timely completion and involvement of resident, sponsor and IDT. Results of audit will be reviewed by the QAPI committee for further recommendations.	06/25/2025

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F 0657	Continued From page 22 Based on record review, interview, and policy review, the facility failed to ensure quarterly care conferences were held including the families, residents, and interdisciplinary team and failed to ensure care conferences were held timely. This affected five (#10, #16, #33, #5, and #6) of 21 residents reviewed for care conferences. The facility census was 39. Findings include: 1. Review of medical record for Resident #10 revealed an admission date of 11/11/20 with diagnoses including but not limited to bipolar disorder current episode depressed, mild or moderate severity, schizoaffective disorder bipolar type, type two diabetes, visual hallucinations, altered mental status, auditory hallucinations, cognitive communication deficit, inadequate social skills, adult antisocial behavior, and anxiety. Review of the Minimum Data Set (MDS) dated 05/18/25 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Review of care conference documentation revealed a care conference was held on 01/31/24, 05/29/24, 09/12/24, 12/05/24, 02/05/25, and 05/21/25. Care conferences were held with dietary, social worker, and activities.	F 0657		

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F 0657	Continued From page 23 Interview on 06/02/25 at 04:24 P.M. with Resident #10 revealed they do not have care conference meetings with her or her family that she can remember. 2. Review of medical record for Resident #16 revealed an admission date of 02/05/19 with diagnoses including but not limited to chronic obstructive pulmonary disease, type two diabetes, asthma, cervicalgia, congestive heart failure, unspecified mood affective disorder, and hypertension. Review of MDS dated 03/29/25 revealed the resident was cognitively intact. Review of care conferences revealed conferences were held on 02/14/24, 06/26/24, 09/26/24, and 02/26/25 with only dietary, social services, and activities attending. Interview on 06/02/25 at 10:17 A.M. with Resident #16 revealed they do not hold care conferences any more. Resident #16 stated she has not had one in about a year. 3. Review of medical record for Resident #33 revealed an admission date of 02/26/25 with diagnoses including but not limited to hemiplegia and hemiparesis following cerebral infarction affecting non-dominant left side, chronic obstructive pulmonary disease, type two diabetes, atrial fibrillation, hypertension, bipolar disorder, and congestive heart	F 0657		

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F 0657	Continued From page 24 failure. Review of MDS dated 03/03/25 revealed a BIMS score of 13 which indicated the resident was cognitively intact. Review of medical record revealed no care conferences have been held. Interview on 06/02/25 at 3:12 P.M. with Resident #33 and spouse revealed they have never had a care conference since admission. Interview on 06/03/25 at 1:25 P.M. with the Administrator revealed Resident #33 has not had any care conferences scheduled. Interview on 06/05/25 at 1:37 P.M. with Managed Care Coordinator (MCC #903) verified the care conferences were not attended by the interdisciplinary team (IDT). MCC #903 verified Resident #10 and Resident #16 care conferences were not held every three months. MCC #903 verified the facility did not send out letters for care conferences with the date and time of the conference. MCC #903 stated they would just tell the resident when the care conferences were going to be held. 4. Record review for Resident #5 revealed the resident was admitted to the facility on 07/01/24. Diagnoses for Resident #5 include cerebral palsy, chronic obstructive pulmonary disease, dysphagia, and contractures.	F 0657		

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F 0657	Continued From page 25 Review of Resident #5's Minimum Data Set, (MDS) comprehensive assessment dated 03/28/25 revealed the resident had intact cognition. Review of Resident #5's contact census in the medical record revealed the resident was listed as his own person and can make his own medical decisions. Review of Resident #5's progress notes dated 05/28/25 revealed Social Worker (SS) #651 documented the resident's had a care conference meeting, see specifics in care conference assessment. Review of Resident #5's care conference assessment dated 05/28/25 revealed the meeting was documented in the form as being held on 05/28/25 at 11:00 A.M. Per the assessment, staff who attended included a Registered Nurse, activity staff, dietary staff, and the social worker. No family or resident was documented as having been invited or attending the meeting. No concerns from resident or family were documented in the assessment. Interview on 06/02/25 at 11:17 A.M. with Resident #5 revealed the resident stated he did not know if he had every attended a care conference meeting with the staff at the facility. Resident #5 denied being invited to a care conference per his knowledge.	F 0657		

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F 0657	Continued From page 26 Interview on 06/03/25 at 3:30 P.M. with Social Services (SS) #651 verified Resident #5 had not been in attendance for his 05/28/25. SS #651 verified there was no documentation his family or the resident had been invited and there was no documented input or concerns in the assessments from Resident #5. 5. Record review for Resident #6 revealed the resident was admitted to the facility on 01/23/24. Diagnoses for Resident #6 include cerebral infarction, hypertension, dysphagia, pain, and falls. Review of the progress notes dated 05/07/25 at 1:30 A.M. the social worker wrote Resident #6 had a care conference on 05/07/25. Review of the history of the note revealed the progress note was created and signed on 05/22/25 at 1:08 P.M. Review of the progress note dated 05/07/25 at 8:48 A.M. revealed the social worker contacted Resident #6's son, family representative, to invite him to attend the care conference and the son stated he will not be able to attend. Per the note the son voiced concerns and the concerns will be followed up. Interview on 05/02/25 at 3:14 P.M. with Resident #6's son stated he could not recall when the last time he attended a care conference with the staff at the facility. Per the son, he could not recall any invitations to any care conferences in	F 0657		

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F 0657	Continued From page 27 the year 2025. Interview on 06/03/25 at 3:30 P.M. with SS #651 verified there was missing documentation in Resident #6's most recent 05/07/25 care conference assessment. Per SS #651, the social worker held the care conference with dietary staff, the social worker, and activities. SS #651 verified there was no nurses or aides in the care conference. SS #651 verified Resident #6 did not attend the care conference. SS #651 stated she had contacted the resident's family representative the day prior to the care conference and the son reported he could not attend due to not having enough notice of time for the care conference. SS #651 verified when the care conferences are scheduled they are held with available staff and residents and their family representative sometimes are not able to attend and the social worker does not reschedule the meetings. SS #651 verified some care conferences do not include nurses and no aides come to the conferences. Review of policy titled, "Resident Participation - Assessment/Care Plans," revised December 2016 revealed the resident/representative's right to participate in the development and implementation of his or her plan of care includes the right to participate in the planning process, identify individuals to be included in the planning process, request meetings, request revisions, participate in	F 0657		

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F 0657	Continued From page 28 establishing his or her goals and expected outcomes of care, participate in the type, amount, frequency, and duration of care, receive the services and/or items included in the care plan, have access to and review the care plan, and be informed of, review and sign the care plan after any significant changes are made. The care planning process will facilitate the inclusion of the resident and/or representative, include an assessment of the resident's strengths and his or her needs, and incorporate the resident's personal and cultural preferences in establishing goals of care. A seven day advance notice of the care planning conference is provided to the resident and his or her representative. Such notice is made by mail and/or telephone. The social services director or designee is responsible for notifying the resident/representative and for maintaining records of such notices. Notices include: the date, time, and location of the conference, the name of each person contacted and the date he or she was contacted, the method of contact (mail, telephone, email), input from the resident or representative if they are not able to attend, refusal of participation, if applicable, and the date and signature of the individual making the contact.	F 0657		

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LOST CREEK REHABILITATION AND NURSING CENTER	804 SOUTH MUMAUGH ROAD LIMA OH, 45804

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F 0686	Continued From page 29	F 0686		
F 0686 SS=G	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This STANDARD is not met as evidenced by: Based on medical record review, observation, staff interviews, and review of the resource from the National Pressure Injury Advisory Panel titled "Best Practices for Prevention of Medical Device-Related Pressure Injuries in Long Term Care", the facility failed to monitor a resident's leg where a brace was applied. This resulted in actual harm when the resident developed a Deep Tissue Injury (DTI) later resulting in a stage four pressure ulcer (deep wound that may impact muscle, tendons, ligaments, and bone) that ultimately required two surgical debridements in an attempt to promote wound healing. This affected one (#9) of	F 0686	F 0686 Lost Creek Nursing and Rehabilitation Center wishes to have this plan of correction submitted as our written allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission to nor agreement with, either the existence of, or the scope and severity of, any of the cited deficiencies or conclusions set forth in the statements of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. Our alleged date of compliance is 6/27/25. F 0686 Treatment/Svcs to Prevent/Heal Pressure Ulcer Resident #9 skin check completed on 6/23/25 by the Director of Nursing, and no new skin areas of concern were noted. Wound is improving now stage IV with wound Dr. visits weekly. An initial audit was conducted on all residents with braces/splints on 6/23/25 by the Director of Nursing and Assistant Director of Nursing and no skin issues or areas of concern were noted. An audit was conducted to ensure daily skin checks were listed as a treatment on the TAR by Director of Nursing on 6/23/25. All clinical staff were educated on the importance of removing any and all braces and/or splints with daily skin checks and doing complete skin checks with hygiene and bathing on 6/23/25 by the Director of Nursing. Education also included daily documentation of braces and/or splints removal and skin checks daily in a progress note and/or TAR. The Director of Nursing will conduct an audit 3X/wk for 4 weeks to observe all residents with splints and/or braces to ensure daily skin checks are being completed. Director of Nursing will observe brace removal and review nursing	06/27/2025

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F 0686	Continued From page 30 three residents reviewed for pressure wounds. The facility census was 39. Findings include: Review of medical record for Resident #9 revealed an admission date of of 11/29/24 with diagnoses including but not limited to occlusion and stenosis of right carotid artery, muscle weakness, periodic breathing, fracture of lower end of right femur, cervical disc disorder with myelopathy, peripheral vascular disease, and major depressive disorder. Review of the Minimum Data Set (MDS) assessment dated 03/31/25 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Review of current physician orders revealed wound treatment to right upper lateral calf was to cleanse with soap and water, pat dry and apply calcium alginate to the wound bed, cover with abdominal (ABD) pad and wrap with kerlix, weight bearing as tolerated (WBAT) to right lower extremity while in knee brace with walker (03/19/25-04/16/25), liquid protein 30 milliliters (ml) daily for wound healing. Review of the care plan dated 03/26/25 revealed the resident is at risk for skin breakdown related to increased need for assistance with bed mobility and transfers, neuropathy, peripheral vascular disease, and right lateral calf pressure.	F 0686	documentation (progress notes and/or the TAR) is being completed daily. Any unusual findings will be forwarded to the QAPI committee for prompt resolution. The Director of Nursing will monitor this area for compliance on an ongoing basis.	

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F 0686	Continued From page 31 Interventions included apply lotion/moisture barrier cream as needed, can transition out of brace, WBAT to right lower extremity with walker, encourage to float heels as tolerated, observe skin for redness or open areas notify the nurse, skin assessment as needed, supplements per order, and turn and reposition every two hours as tolerated. Review of a general progress note dated 02/19/25 at 2:02 P.M. revealed the resident returned from an orthopedic appointment with order indicating okay to put right foot down for balance. Continue physical therapy (PT) and occupational therapy (OT). No Range of Motion (ROM) to right knee. Continue brace. Follow up in one month. Review of a general progress note dated 03/19/25 at 1:42 P.M. revealed the resident returned from an orthopedic appointment with new order to begin Weight Bearing as Tolerated (WBAT) to right lower extremity in the knee brace. Okay for ROM to right knee and continue PT/OT. Review of a general progress note dated 04/16/25 at 3:00 P.M. revealed the resident returned from an orthopedic appointment with new order to transition out of knee brace. WBAT to right lower extremity with walker. Continue with PT/OT. Review of a general progress note dated	F 0686		

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F 0686	Continued From page 32 04/17/25 at 11:58 A.M. revealed Certified Nursing Assistant (CNA) reported the resident had a skin tear on the outer right calf caused by the brace. Resident is to transition out of the brace and therapy is working with the resident towards that goal. Steristrips applied. Review of a general progress note dated 04/20/25 at 8:41 P.M. revealed this order was updated to cleanse and apply border foam to right outer calf. This nurse went to treat the area and found that the skin flap is slothing off and area had opened. Area measured 4.7 centimeters (cm) by 5.4 cm, area warm, seeping and plus two pitting edema compared to left leg at plus one pitting edema. Daughter present in room and explained they will await treatment plan and the resident could be seen by the in-house wound physician. Review of the wound physician note dated 04/21/25 revealed an unstageable wound to right upper lateral calf full thickness. Wound was a pressure wound. Wound measured 7.0 cm length by 5.9 cm width with a non measurable depth. Surface area 41.30 cm squared. Periwound surrounding deep tissue injury (purple/maroon). Moderate serous exudate. Thick adherent black necrotic tissue 60 percent (%), granulation tissue 40% with no pain or signs of infection. Treatment plan santyl apply once daily and as needed if saturated, soiled, or dislodged for 30 days and cover with gauze island with border dressing once	F 0686		

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F 0686	Continued From page 33 daily and as needed. Reason for no sharp debridement chronic stable wound with insignificant amount of necrotic tissue and no signs of infection. Monitor for now. Recommended lower extremity arterial Doppler. Review of wound physician note dated 04/28/25 revealed a stage four pressure wound to the right upper lateral calf full thickness. Per note patient had a fractured femur for which the resident was wearing a brace. The pad of the brace created a pressure wound on the calf. Wound measured 7.0 cm length by 6.0 cm width by depth is unmeasurable due to presence of non-viable tissue and necrosis. Surface area 42.00 cm squared. Periwound induration and maceration. Light serous exudate. 100% thick adherent black necrotic tissue. No pain or signs of infection observed. Debridement procedure completed to remove necrotic tissue and establish the margins of viable tissue, remove thick adherent eschar and devitalized tissue, and remove hematoma. Post-debridement assessment of this previously unstageable necrotic wound has revealed the underlying deep tissue at the muscle/fascia level, which had been obscured by necrosis prior to this point. This wound has now revealed itself to be a stage 4 pressure injury. This is not a wound deterioration. Lower extremity arterial Doppler left and right performed on 04/28/25 with mild to moderate peripheral vascular disease	F 0686		

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F 0686	Continued From page 34 without occlusion in the right lower leg. Review of the wound physician note dated 05/05/25 revealed a stage four pressure wound to the right upper lateral calf full thickness measuring 6.8 cm length by 5.8 cm width by 0.7 cm in depth with moderate serous exudate. 3% thick adherent devitalized necrotic tissue and 97% granulation tissue. Wound progress improved evidenced by decreased necrotic tissue and decreased surface area. No pain or signs of infection. Review of the wound physician note dated 05/12/25 revealed a stage four pressure wound to the right upper lateral calf full thickness measuring 7.0 cm length by 5.6 cm width by 0.4 cm depth with moderate serous exudate. 3% thick adherent devitalized necrotic tissue and 97% granulation tissue. Wound progress improved evidenced by decreased depth. No pain or signs of infection. Review of the wound physician note dated 05/19/25 revealed stage four pressure wound to the right upper lateral calf full thickness measuring 6.9 cm length by 5.0 cm width by 0.3 cm depth with moderate serous exudate. 3% thick adherent devitalized necrotic tissue and 97% granulation tissue. Wound progress improved evidenced by decreased depth. No pain or signs of infection. Review of the wound physician note dated 05/26/25 revealed stage four pressure	F 0686		

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F 0686	Continued From page 35 wound to the right upper lateral calf full thickness measuring 6.5 cm length by 4.5 cm width by 0.2 cm depth with light serous exudate. 3% thick adherent devitalized necrotic tissue and 97% granulation tissue. Wound progress improved evidenced by decreased depth. No pain or signs of infection. Review of the wound physician note dated 06/02/25 revealed stage four pressure wound to the right upper lateral calf full thickness measuring 5.8 cm length by 3.8 cm width by 0.1 cm depth with moderate serous exudate. 3% thick adherent devitalized necrotic tissue and 97% granulation tissue. Wound progress improved evidenced by decreased depth. No pain or signs of infection. Surgical excisional debridement completed. The wound was cleansed with normal saline and anesthesia was achieved using topical bensocaine. Curette was used to surgically excise devitalized tissue and necrotic tissue subcutaneous level tissues were removed to a depth of 0.1 cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 3% to 0%. Hemostasis was achieved and a clean dressing was applied. Interview on 06/04/25 at 8:39 A.M. with the Director of Nursing (DON) revealed the resident's brace came off every night at bedtime. The DON stated the nurses would look at the residents skin then. The DON stated that two days prior to the	F 0686		

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wound being discovered, she treated a skin tear. The DON stated she then treated another skin tear by cleaning the wound and applying Steristrips and kerlix. The DON stated that approximately two days later she was notified that the area was open and bleeding. The DON stated that when she cleaned the skin tear she thought the wound looked weird as the skin appeared to be darker. The DON stated the wound doctor saw the resident the next day and he removed what they thought was a big clot.

Further review of the medical record revealed no evidence the facility was removing the brace at night and checking the skin around the brace on a daily basis.

Interview on 06/04/25 at 3:18 P.M. with the DON and Assistant Director of Nursing (ADON #403) revealed they both verified the wound was caused by the brace. ADON #403 stated if you lined up the brace the wound was located where the dial of the brace was located. The DON verified they could have padded the area that the dial was on had they realized it would or was causing pressure. The DON verified the wound was staged by the wound physician. The DON verified the weekly wound documentation prior to the discovery of the deep tissue injury did not contain any lesions or open areas to the right lower extremity and on 04/20/25 there was documentation of a skin tear to the area. The DON verified there was no

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F 0686	Continued From page 37 supporting documentation regarding the removal of the brace for care or skin assessments under the brace. Review of the resource from the National Pressure Injury Advisory Panel titled "Best Practices for Prevention of Medical Device-Related Pressure Injuries in Long Term Care", dated February 2020, indicates, in part, the following: Inspect the skin under and around the device at least daily (if not medically contraindicated); Cushion and protect the skin with dressings in high risk areas; Be aware of edema under the device(s) and potential for skin breakdown; and Educate staff on correct use of devices and prevention of skin breakdown.	F 0686		
F 0847 SS=D	483.70(m)(1)(2)(i)(ii)(3)-(5) Entering into Binding Arbitration Agreements §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to	F 0847	Tag: F 0847 Administrator or designee will review and explain the arbitration agreement to residents and / or sponsors of #9, #25 and # 31 by 6/20/25. The administrator or designee will review arbitration agreement log with identified residents to ensure choice and understanding by 6/20/25. RDO provided education to administrator on arbitration requirements on 6/5/25. Three new admissions will be audited weekly x4 weeks to ensure understanding and choice in regards to signing arbitration agreements. Results of audit will be provided to QAPI committee for review and recommendations.	06/20/2025

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F 0847	Continued From page 38 sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the	F 0847		

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F 0847	Continued From page 39 State Long-Term Care Ombudsman, in accordance with §483.10(k). This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure a resident had the mental capacity to sign into an arbitration agreement and further failed to explain arbitration agreements in a language that the residents would understand. This affected three (#9, #25, and #31) of five residents reviewed for arbitration agreements. The facility census was 39. Findings include: 1. Review of medical record for Resident #9 revealed an admission date of 11/29/24 with diagnoses including but not limited to occlusion and stenosis of right carotid artery, muscle weakness, periodic breathing, fracture of lower end of right femur, cervical disc disorder with myelopathy, peripheral vascular disease, and major depressive disorder. Review of Minimum Data Set (MDS) dated 03/31/25 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Review of arbitration agreement revealed the agreement was signed on 02/03/25 by the resident. Interview on 06/05/25 at 10:09 A.M. with	F 0847		

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F 0847	Continued From page 40 Resident #9 revealed the resident did not know what an arbitration agreement was. Resident #9 stated he could not remember if the facility explained it to him. Resident #9 stated he did not know if he would sign one or not. 2. Review of medical record for Resident #25 revealed an admission date of 02/06/24 with diagnoses including but not limited to pneumonia, type two diabetes, unspecified asthma, paraplegia, heart failure, and atrial fibrillation. Review of MDS dated 03/31/25 revealed a BIMS score of 15 which indicated the resident was cognitively intact. Review of arbitration agreement revealed the resident signed the agreement on 02/19/25. Interview on 06/04/25 at 02:08 P.M. with Resident #25 revealed an arbitration agreement is that if they have a disagreement with the facility it goes to the judge and they argue the points and the decision of the judge is final. Resident #25 stated it takes place in a court. Resident #25 stated he is unsure if he signed one when he came to the facility. 3. Review of medical record for Resident #31 revealed an admission date of 09/20/23 with diagnoses including but not limited to ischemic heart disease and dementia without behavioral disturbances.	F 0847		

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F 0847	Continued From page 41 Review of MDS dated 04/16/25 revealed a BIMS score of 03 which indicated the resident had severe cognitive impairment. Review of arbitration agreement dated 02/19/25 revealed the agreement was signed by the resident. Interview on 06/04/25 at 01:43 P.M. with the Administrator revealed they are currently the one responsible for doing the arbitration agreements. Administrator stated she would explain to the resident that if they do not understand the arbitration agreement they do not have to sign it. Administrator stated she does not usually explain the agreement to them she would have them read it. Follow-up interview on 06/04/25 at 01:52 P.M. with the Administrator revealed that she would have the resident read the arbitration agreement and explain to the resident that it is their legal right to voluntarily obtain legal council prior to signing and they do not have to sign the agreement. Interview on 06/05/25 at 10:20 A.M. with Resident #31 revealed the resident did not know exactly what an arbitration agreement was. Resident #31 stated he did not remember signing one. Interview on 06/05/25 at 11:04 A.M. with the previous Admission Director (AD #905) revealed that she would explain the	F 0847		

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F 0847	Continued From page 42 arbitration agreement to the resident. AD #905 stated she would let the residents know it was voluntary and if they wanted to obtain legal council prior to signing it would be okay. AD #905 stated she would explain to the resident if they had an issue with the facility or their care they would go to an arbitrator instead of going to court. AD #905 stated she would let them know it would be faster and cheaper for both parties. AD #905 stated if the resident did not understand the agreement she would go to the next of kin or responsible party. Interview on 06/05/25 at 11:27 A.M. with Regional Director of Operations (RDO #902) verified that Resident #31 had a BIMS score of three and the power of attorney should have signed the second agreement as well.	F 0847		

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F 0880	Continued From page 43	F 0880		
F 0880 SS=D	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents	F 0880	F 0880 Lost Creek Nursing and Rehabilitation Center wishes to have this plan of correction submitted as our written allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission to nor agreement with, either the existence of, or the scope and severity of, any of the cited deficiencies or conclusions set forth in the statements of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. Our alleged date of compliance is 6/27/25. F 0880 Infection Prevention & Control Resident #23 & #9 dressing changes were monitored by the Director of Nursing on 6/12/25, and all infection control standards were followed An initial audit was conducted on all residents with wounds on 6/13/25 by the Director of Nursing and all infection control standards were met. All clinical staff were educated on infection prevention and control on 6/11/25 by the Director of Nursing. Including handwashing and EBP precautions The Director of Nursing or Designee will conduct an audit with staff 3x a week x 4 weeks to watch dressing changes . Any unusual findings will be forwarded to the QAPI committee for prompt resolution. The Director of Nursing will monitor this area for compliance on an ongoing basis.	06/27/2025

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F 0880	Continued From page 44 of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 0880		

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F 0880	Continued From page 45 This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to ensure proper handwashing, cleansing of re-usable equipment, and proper glove use was followed during resident care. This affected two residents (#23 and #9) out of five residents reviewed for infection control protocols. The facility census was 39. Findings include: 1. Record review for Resident #23 revealed the resident was admitted to the facility on 10/04/23. Diagnoses for Resident #23 include neoplasm of nervous system, anxiety, urinary tract infection, dysphagia, and weakness. Review of Resident #23's Minimum Data Set (MDS) dated 05/18/25 revealed the resident had impaired cognition and was receiving enteral nutrition via a feeding tube. Review of Resident #23's care plans dated 12/11/24 revealed a focus for Enhanced Barrier Precautions (EBP) protocols due to indwelling medical device. Intervention include signage placed on doorway and gloves and gown to be worn during direct care with resident. Observation on 06/05/24 at 9:00 A.M. with Licensed Practical Nurse (LPN) #511	F 0880		

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F 0880	Continued From page 46 revealed the nurse prepared the supplies for the feeding tube care. LPN #511 was observed placing on a gown and gloves prior to entering Resident #23's room. LPN #511 was not observed sanitizing her hands prior to applying the gloves. LPN #511 was observed discontinuing the feeding solution on the pump, removing the old tubing from the resident's feeding tube catheter. LPN #511 did not change her gloves during the care. LPN #511 was observed retrieving a syringe from the resident's bathroom, and filling a plastic cup with water to 150 milliliters. LPN #511 was observed checking the placement of the feeding tube with a stethoscope, checking the residual amount of tube feeding, and flushing the tube with 150 milliliters of water. LPN #511 was not observed washing her hands or changing her gloves during the care observed. LPN #511 was observed taking all supplies back into the bathroom and retrieving a new gauze pad. LPN #511 was observed opening the gauze pad and then stated she should change her gloves before applying the new bandage. LPN #511 was observed removing the current set of gloves and then put on a new set of gloves. LPN #511 did not use hand sanitizer or wash her hands in between the application of gloves. Interview on 06/05/25 at 9:25 A.M. with LPN #511 verified she only used one pair of gloves during most of the care provided until she applied the new bandage to the tube feeding site. LPN #511 stated it was	F 0880		

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F 0880	Continued From page 47 protocol to wash her hands and apply new gloves frequently during the care she provided. LPN #511 verified she did not sanitize or wash her hands during the care of Resident #23's feeding tube. 2. Review of medical record for Resident #9 revealed an admission date of of 11/29/24 with diagnoses including but not limited to occlusion and stenosis of right carotid artery, muscle weakness, periodic breathing, fracture of lower end of right femur, cervical disc disorder with myelopathy, peripheral vascular disease, and major depressive disorder. Review of MDS dated 03/31/25 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Review of current physician orders revealed wound treatment to right upper lateral calf was to cleanse with soap and water, pat dry and apply calcium alginate to the wound bed, cover with ABD pad and wrap with kerlix. Observation on 06/04/25 at 11:39 A.M. of Registered Nurse (RN #506) completing wound care for Resident #9 revealed the nurse placed a clean barrier on the over the bed table and placed one new wash basin with soap and water onto the barrier. RN #506 placed a second new wash basin with rinse water beside the other one on the clean barrier. RN #506 placed the dressing supplies (package of	F 0880		

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F 0880	Continued From page 48 kerlix, box of silver alginate, and ACE bandage) on the clean barrier. Nursing student precepting with the nurse was also in the room. RN #506 washed hands, donned gown and gloves and cleansed the wound to right calf with soap and water and rinsed the wound. Wound appeared to be beefy red in the bed of the wound. Wound edges were slightly macerated but intact. RN #506 removed her gloves, washed hands, and donned new gloves. RN #506 then patted the wound dry. RN #506 removed gloves, washed hands, and donned new gloves. RN #506 then touched the box of silver alginate dressings and pulled out one package of the silver alginate. RN #506 opened the package of silver alginate and placed the silver alginate into the wound bed. RN #506 then removed the dressing to cut the dressing to size with scissors that were removed from the student nurse preceptors pocket. The nurse was not observed cleansing the scissors prior to cutting the dressing. RN #506 then placed the dressing back in the wound bed and removed it for a second time to cut more off to fit it to the wound size. RN #506 then placed the dressing into the wound bed and placed an ABD pad over the silver alginate and wrapped the wound with kerlix. RN #506 then wrapped the leg with ACE bandage. RN #506 then cleaned up the area and removed gloves, washed hands and removed the trash from the room. Interview on 06/04/25 at 11:52 A.M. with	F 0880		

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F 0880	Continued From page 49 RN #506 revealed the nurse verified she placed the dressing in the wound bed and removed it to cut it to size so the dressing would not touch good skin twice. RN #506 verified the student pulled her scissors out of her pocket and did not sanitize them prior to cutting the dressing. RN #506 verified she touched the box of silver alginate and pulled out one package without changing gloves or washing hands prior to placing the dressing into the wound bed.	F 0880		
F 0947 SS=F	483.95(g)(1)-(4) Required In-Service Training for Nurse Aides §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive	F 0947	Tag: F 0947 All nurse aides (#510 and #519) identified during the survey who had not completed the required 12 hours of in-service training for calendar year 2025 were immediately scheduled for and have now completed the missing training, including dementia care and abuse prevention modules. A facility wide audit of all nurse aide training records for the past 12 months was conducted to identify any additional staff who were out of compliance with the annual in-service requirements. Any additional deficiencies found have been corrected as of 6/25/25. The administrator provided training to HR director on 6/16/25 regarding requirements of CNA's to complete 12 CEU's annually. HR or designee will audit monthly for the next 3 months. Results of the audit will be provided to the QAPI committee for review and recommendation.	06/25/2025

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F 0947	Continued From page 50 impairments, also address the care of the cognitively impaired. This STANDARD is not met as evidenced by: Based on employee file review and interview, the facility failed to ensure Certified Nursing Assistants (CNAs) received 12 hours of inservices annually. This affected two (CNA #510 and CNA #519) of three CNA employee files reviewed. This had the potential to affect all residents who reside in the facility. The facility census was 39. Findings include: Review of employee file for CNA #510 revealed a hire date of 01.09/23. Review of education file revealed the CNA #510 did not complete 12 hours of inservices annually. Review of employee file for CNA #519 revealed a hire date of 10/10/23. Review of education file revealed the CNA #519 did not complete 12 hours of inservices annually. Interview on 06/09/25 at 11:05 A.M. with Medical Records #655 verified the facility could not locate any documentation regarding the 12-hour inservices for CNA #510 and CNA #519 for 2024 and 2025.	F 0947		