STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365394	A. Building B. Wing	09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare at Adams Lane	1856 Adams Lane Zanesville, OH 43701

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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 - Few	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** 43064 Based on observation, medical record review and interview the facility failed to ensure Resident #89 was provided a dignified dining experience during the lunch meal on 09/20/21. This affected one resident (#89) of two residents reviewed for dignity. Findings include: Review of the medical record for Resident #89 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, anxiety disorder, depression, repeated falls, cognitive communication disorder and dementia with behavioral disturbance. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 09/07/21 revealed the resident was rarely or never understood and required extensive assistance from one staff for eating. Review of the care plan, dated 09/10/21 revealed Resident #89 was at risk for malnutrition and dehydration related to diagnoses, need for mechanically altered diet, being overweight, using psychoactive medication, and being totally dependent (from staff) at meals. Interventions included providing assistance with meals as needed, honoring food preferences, providing diet as ordered, monitoring for any decrease in appetite and weighing according to facility policy. On 09/20/21 at 11:35 A.M. State tested Nursing Assistant (STNA) #335 was observed beginning to feed Resident #89. Immediately upon sitting down STNA #335 mixed the resident's meat and mashed potatoes. She was observed feeding Resident #89 bites of mixed meat and mashed potatoes at 11:38 A.M., 11:40 A.M. , 11:42 A.M., and 11:44 A.M. She fed her a spoonful of mixed meat, mashed potatoes, and green beans at 11:43 A.M., and a bite of mixed green beans and mashed potatoes at 11:45 A.M. During the lunch meal starting at 11:42 A.M. STNA #335 was observed using the spoon to wipe food off Resident #89's lips and chin and putting the spoon back in her mouth three bites in a row. On 09/20/21 at 12:19 P.M. interview with STNA #335 confirmed the above observations. She reported Resident #89 liked her food mixed and that using the spoon in that manner was habit for her. Review of the policy titled Feeding a Resident, dated October 2018 revealed residents should be fed in a dignified manner that promotes independence, self-esteem and a sense of well-being.

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

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 42015 Based on record review, facility policy and procedure review and interview the facility failed to ensure all staff were checked against the Nurse Aide Registry to ensure no staff member had a finding entered into the State Nurse Aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property. This had the potential to affect all 95 residents residing in the facility. Findings include: Review of the facility personnel files on 09/22/21 revealed no evidence any of the facility contracted rehabilitation staff were checked against the Nurse Aide Registry to ensure no staff member had a finding entered into the State Nurse Aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property. This included Rehab Director #390, Physical Therapist #391, Physical Therapy Assistant (PTA) #392, PTA #393, PTA#394, Certified Occupational Therapy Assistant (COTA) #395, COTA #396, Occupational Therapist #397 and Speech-Language Pathologist #398. On 09/22/21 at 1:30 P.M. interview with the Administrator confirmed the facility was not checking contracted staff against the Nurse Aide Registry. On 09/22/21 at 2:36 P.M. interview with Human Resource Manger #363 revealed the facility does not check any of their contracted employees, which included the above therapy staff against the Nurse Aide Registry prior to working in the facility. For purposes of the guidance related to this Centers for Medicare and Medicaid (CMS) requirement staff includes employees, the medical director, consultants, contractors and volunteers. In addition to the facility not checking these contracted staff against the Nurse Aide Registry prior to working in the facility, there was no evidence the employees had been checked by the contracted company who they were hired by. Review of the facility policy titled Abuse, Neglect, Exploitation, and Misappropriation, dated 09/2020 revealed all employees were to be checked against the Nurse Aide Registry.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on closed record review and interview the facility failed to complete a discharge summary including a recapitulation of the resident's stay for Resident #95. This affected one resident (#95) of two residents reviewed for discharge. Findings include: Review of the closed medical record for Resident #95 revealed an admitted [DATE] and discharge date of [DATE]. The resident had diagnoses including malignant neoplasm of the brain, severe protein calorie malnutrition, failure to thrive and seizure disorder. Record review revealed the resident was cognitively impaired and required limited to extensive assistance from one staff for activities of daily living. Review of the progress note, dated 07/01/21 at 2:41 P.M. revealed Resident #95 went for a follow up visit with the surgeon who indicated the resident could be discharged home from the facility on this date. The facility physician gave the verbal order for the resident to discharge home with family. Record review revealed the facility failed to complete a discharge summary that included a recapitulation of the resident's stay. On 09/22/21 at 1:50 P.M. interview with the Social Service Designee confirmed there was not a recapitulation of stay completed for Resident #95 following the resident's discharge from the facility.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on observation, record review, facility policy and procedure review and interview the facility failed to ensure residents, who required staff assistance for personal care/showers and/or meals received adequate and timely assistance to maintain proper hygiene and oral intake. This affected two residents (#11 and #22) of four residents reviewed for shower/bathing and two residents (#89 and #92) of seven residents observed for dining. Findings include: 1. Record review revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including need for assistance with personal care, epilepsy, pain in right wrist and hand, unsteadiness on feet, abnormal posture, muscle weakness, chronic pain and neurofibromatosis. Review of Resident #11's Minimal Data Set (MDS) 3.0 assessment, dated 07/02/21 revealed Resident #11 required physical help from one staff for bathing. A current plan of care revealed the resident was at risk for decline in activities of daily living (ADL) function related to impaired mobility, mild intellectual and developmental disabilities. Interventions indicated the resident preferred to shower in the evening and preferred female staff to provide personal care. A plan of care related to fall risk revealed staff were to use lower seating shower chair for showers. On 09/20/21 at 2:51 P.M. interview with Resident #11 revealed concerns related to showers. The resident revealed she was unable to shower by herself and required staff to assist her with showers. The resident revealed she was supposed to be offered a shower every night, however she had not been receiving or being offered showers and staff were refusing to help her. Review of Resident #11's electronic medical records/staff TASK documentation revealed the resident was to receive a shower on night shift. Review of the electronic shower records from 08/24/21 to 09/22/21 revealed no evidence the resident was provided or refused a shower on 08/30/21, 08/31/21, 09/01/21, 09/03/21, 09/09/21, 09/11/21, 09/16/21 or 09/19/21. On 09/23/21 at 10:40 A.M. interview with the Director of Nursing (DON) verified the resident was to receive a shower every night on night shift. Initially, the DON indicated she believed staff had just forgotten to document the showers in the electronic medical record and indicated there could be paper shower sheets completed. However, the DON was only able to find one paper shower sheet, dated 09/06/21 that indicated the resident received a shower. The DON verified there was no documented evidence the resident received a shower on 08/30/21, 08/31/21, 09/01/21, 09/03/21, 09/09/21, 09/11/21, 09/16/21 or 09/19/21 as planned and per the resident's preference. 03137 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #22's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, type two diabetes with neuropathy, chronic kidney disease, severe protein calorie malnutrition, history of COVID-19, anxiety disorder, traumatic amputation at knee left lower leg, dementia without behavioral disturbance, peripheral vascular disease and hypothyroidism. Review of Resident #22's annual Minimum Data Set (MDS) 3.0 assessment, dated 07/20/21 revealed the resident's speech was clear, she made herself understood, she understands others and her cognition was intact. The assessment revealed the resident had no behaviors and did not reject care. Resident #22 required extensive assistance of one staff for bed mobility, was totally dependent on two staff to transfers, required extensive assistance of one staff for personal hygiene. The resident had had limited range of motion of both lower extremities and used a wheelchair. The MDS assessment revealed it was somewhat important for the resident to choose between a tub bath, bed bath and shower. Review of Resident # 22's plan of care revealed she preferred showers in the morning, but on 03/07/19 Resident #22 changed her mind and now preferred showers in the evening. Review of Resident #22's shower documentation revealed between 09/01/2021 and 09/21/2021 staff documented two showers were provided. On 09/17/2021 Resident #22 refused a shower due to not feeling well, she was diagnosed and treated for pneumonia. On 09/20/21 at 11:18 A.M. interview with Resident #22 revealed concerns she did not receive showers twice a week as she wanted. During the interview the resident revealed she was not sure when she had last received a shower. Resident #22 revealed she preferred a morning shower, but since she was not getting one in the morning regularly she changed her preference to evenings. On 09/22/21 at 8:16 A.M. interview with State tested Nursing Assistant (STNA) #353 revealed Resident #22 preferred a shower twice a week. On 09/22/21 at 2:54 P.M. interview with the DON revealed Resident #22 had not received any showers from 09/01/2021 to 09/20/2021 and that staff were completing bed baths instead. The DON revealed there was no reason why Resident #22 received bed baths and not showers as per the resident's plan and preference. 43064 3. Review of the medical record for Resident #92 revealed an admitted [DATE] with diagnoses including encephalopathy, unspecified severe protein-calorie malnutrition, anxiety disorder, dementia without behavioral disturbance, hypothyroidism and major depressive disorder. Review of the plan of care, dated 09/06/21 revealed Resident #92 was at risk for malnutrition and dehydration related to need for supplementation, psychoactive medications, requiring assistance at meals, history of severely poor intakes, and diagnoses including anxiety, depression and dementia. Interventions included using adaptive equipment as ordered, providing medications as ordered, offering meal alternates when the resident refused, providing the diet as ordered, and providing assistance with meals and snacks as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was rarely or never understood and required extensive assistance from one person for eating. On 09/20/21 from 11:03 A.M. to 12:15 P.M. observation of the lunch meal revealed the first lunch cart arrived to the unit at 11:03 A.M. and the second arrived at 11:05 A.M. Resident #92 was observed sitting on the couch in the living room from 11:03 A.M. until 11:35 A.M. when staff brought her to the dining room. Resident #92's meal was set up and the staff walked away from her. The resident had meatloaf, mashed potatoes, french fries and green beans. Resident #92 was not observed touching her tray until 11:50 A.M. when she put her fingers in the mashed potatoes and licked it off. She was again observed doing this at 11:58 A.M. and 12:00 P.M. At 12:11 P.M. State tested Nursing Assistant (STNA) #335 approached the resident and put her sandwich in her hand to prompt her to eat. She additionally fed her a bite of food and walked away at 12:14 P.M. At 12:15 P.M. an STNA sat down finished assisting the resident with her meal. On 09/20/21 at 12:19 P.M. interview with STNA #335 revealed she believed Resident #92 was able to feed herself. The STNA confirmed the resident had stuck her fingers in the mashed potatoes but stated Resident #92 was able to feed herself finger foods. STNA #335 revealed they usually gave the resident time to feed herself and then provided assistance. The STNA confirmed it had been over an hour since the meal had arrived to the unit when staff began to assist the resident and the resident had not consumed much of the meal independently in that time period. Review of the policy titled Feeding a Resident, dated October 2018 revealed it was the responsibility of nursing staff to provide assistance to residents who were not able to feed themselves. Residents should be fed in a manner that promoted independence, self-esteem and a sense of well being. 4. Review of the medical record for Resident #89 revealed an admitted [DATE] and diagnoses including Alzheimer's disease, anxiety disorder, depression, repeated falls, cognitive communication disorder and dementia with behavioral disturbance Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 09/07/21 revealed the resident was rarely or never understood and required extensive assistance from one staff for eating. Review of the care plan, dated 09/10/21 revealed Resident #89 was at risk for malnutrition and dehydration related to diagnoses, need for mechanically altered diet, being overweight, using psychoactive medication and being totally dependent (on staff) for meals. Interventions included providing assistance with meals as needed, honoring food preferences, providing diet as ordered, monitoring for any decrease in appetite and weighing according to facility policy. On 09/20/21 at 4:00 P.M. observation of the dinner meal revealed the trays arrived on the unit. At that time, Resident #89 was observed sitting at the same table as another resident. At 4:22 P.M. an STNA began feeding the second resident at the table. Resident #89 sat at the table until 4:43 P.M. when Housekeeping Supervisor #360 asked the STNA if Resident #89 had eaten. Upon receiving a negative response Housekeeping Supervisor #360 warmed up the resident's food and began feeding her at 4:46 P.M. On 09/20/21 at 4:33 P.M. interview with Housekeeping Supervisor #360 revealed she was an STNA and was helping to feed the residents on the memory care unit. The supervisor revealed there was only one nurse and one STNA on the unit and she knew they had a lot of residents to feed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/20/21 at 4:50 P.M. interview with Licensed Practical Nurse (LPN) #379 confirmed Resident #89 had been waiting 45 minutes after the meal had been brought to the unit to eat. She additionally confirmed she had been sitting at the table while another resident was fed. Review of the policy titled Feeding a Resident, dated October 2018 revealed it was the responsibility of nursing staff to provide assistance to residents who were not able to feed themselves. Residents should be fed in a manner that promoted independence, self-esteem and a sense of well being.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on record review, facility policy and procedure review and interview the facility failed to provide timely and adequate treatment for Resident #75 following a fall with injury. Actual harm occurred on 07/02/21 when Resident #75, who was severely cognitively impaired and required staff assistance for bed mobility and transfers, sustained a fall which resulted in bruising and swelling to her hip but was not immediately sent to the hospital for evaluation/treatment. From 07/02/21 to 07/09/21 the resident exhibited increased pain and agitation, yelling out for help and rated her pain up to a nine on a scale of one to 10 (with 10 being the worst pain). The resident was transferred to the hospital on 07/09/21 (seven days after the fall) and diagnosed with an acute closed communicated displaced right femoral interochanteric fracture requiring surgical repair and a severe displaced subacute fracture of left hemipelvis. The resident was hospitalized from 07/09/21 to 07/12/21. This affected one resident (#75) of four residents reviewed for falls. Findings include: Review of the medical record for Resident #75 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, chronic obstructive pulmonary disease, fracture of unspecified part of neck of right femur, anxiety disorder, gastro-esophageal reflux disease, depression and hypertension. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment, dated 07/19/21 revealed Resident #75 had severely impaired cognition. The assessment revealed the resident required extensive assistance from two staff members for bed mobility and was totally dependent on staff for transfers. Review of a progress note, revealed on 07/02/21 at 1:30 P.M. Resident #75 was found lying on the floor beside her bed. Range of motion was completed for all four extremities and found to be at baseline. The resident reported discomfort in her legs and feet, which the nurse noted was the resident's baseline for transfers and turning. Notifications occurred appropriately. On 07/02/21 at 1:44 P.M. the resident was given Morphine for generalized discomfort, at 3:00 P.M. Following the administration of pain medication, the resident's pain decreased to a two on a scale of one to 10. On 07/02/21 at 4:41 P.M. the resident was administered Buspirone for increased anxiety and at 4:44 P.M. she was given Ultram for pain to bilateral legs and feet, the note indicated staff were unable to rate her pain at that time due to her cognitive impairment. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 07/02/21 at 5:53 P.M. the resident was administered Morphine as the Tramadol (Ultram) was ineffective and the resident was noted to have more pain than baseline. The resident was assessed to have pink and purple bruising to the top anterior right thigh with slight swelling, however, the note indicated range of motion remained at baseline. The physician was notified of the new findings. The physician indicated to continue with as needed pain meds and stated the resident would be seen on Monday 07/05/21. The physician advised staff to call for increased pain or pain medication being ineffective. Review of Certified Nurse Practitioner #422's notes, with a date of service on 07/02/21 and signed 07/05/21 revealed nothing related to the resident's fall, pain or injury. Further review of the progress notes revealed on 07/05/21 the resident received Ultram at 8:05 A.M. for generalized pain and pain in buttocks, she received Morphine at 10:20 A.M. after yelling out about pain all over, and at 3:33 P.M. she received Morphine for generalized discomfort. Review of the hospice nurse's note, dated 07/07/21 revealed the hospice aide reported the resident had a new bruise on her right thing. When discussed with the nurse it was indicated this was the result a recent fall in the previous week and the nurse reported the resident's pain and anxiety mediations were adequate at the time. In an addendum dated 07/13/21 the hospice nurse documented the hospice aide reported the fall was on 07/05/21 and not the previous week. Review of the hospice nurse's notes dated 07/08/21 revealed the resident was experiencing severe pain intermittently in her right leg, she stated the duration was unable to be determined and the pain was assessed using the Face, Legs, Activity, Cry, Consolability (FLACC) tool. On 07/08/21 at 12:23 P.M. the resident was assessed to have continued purple and yellow bruising to the right hip, thigh, and lower leg into the ankle which was noted from her previous fall. On 07/08/21 at 1:32 P.M. the resident was administered Ultram for generalized and bilateral leg pain, she was also given Morphine at that time. In addition, the note revealed the facility called Buckeye Hospice to update them on the resident's bruising. Hospice staff indicated a nurse would be sent to see the resident. On 07/08/21 at 3:40 P.M. the Hospice nurse arrived to see the resident regarding her right lower extremity and increased pain. New orders from hospice were received to increase Morphine dose and the POA was updated. The resident received Morphine at 4:33 P.M. for generalized discomfort. On 07/09/21 at 11:44 A.M. the CNP assessed the resident and recommended an x-ray of the right leg. X-ray staff arrived at 4:58 P.M. The progress note on 07/09/21 at 6:00 P.M. indicated the resident was ordered an x-ray to the right hip due to increased bruising to her right lower extremity on that day, and it was discovered she had a right hip fracture. Hospice and Physician #424 were notified and the physician gave an order to send the resident to the emergency room . A note on 07/09/21 at 6:03 P.M. revealed Hospice Registered Nurse #427 notified the facility and the resident's power of attorney (POA) agreed to the resident being sent to the hospital. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of CNP #423's note, dated 07/09/21 revealed Resident #75 was seen for swelling an ecchymosis to the right leg. The nurse documented the resident fell on [DATE], ecchymosis and worsening edema to right hip and leg. CNP #423 documented the resident denied pain upon examination. An x-ray of the right leg was ordered. However, review of the Medication Administration Record (MAR) revealed the resident was administered Morphine Sulfate for pain on 07/09/21 at 1:00 P.M. for pain rated a nine out of 10, at 3:10 P.M. for a pain rated a seven out of 10 and at 6:30 P.M. for a pain rated an eight out of 10. Review of the hospice nurse's note, dated 07/09/21 revealed the floor nurse notified hospice the bruise and knot on the resident's right leg from a fall on Monday had progressed to bruising and swelling of the whole right leg. A visit was made to the facility to evaluate and the floor nurse stated the resident was just put into bed and was difficult to get settled due to pain. The hospice physician was consulted and Morphine was increased. An addendum dated 07/13/21 revealed the hospice nurse had asked the facility nurse if an x-ray had been performed following the fall. The facility nurse revealed one had not been done as the resident was a hospice patient and had originally admitted with a fractured pelvis and comfort care. The hospice nurse's note, dated 07/10/21 revealed the facility called to notify them an x-ray was performed and the resident had a fractured hip. The physician had recommended the resident be sent to the hospital. The resident's power of attorney was notified of the results of the x-ray and asked if he wanted to send her to the hospital, he agreed Review of the hospice aide note, dated 07/09/21 revealed the resident had been complaining of leg and bottom pain, her right leg was very swollen and bruised. The hospice aide said the facility aides reported they had kept the resident in the recliner because they were afraid to put her in bed. Review of the Medication Administration Record for June 2021 revealed the resident received Tramadol HCl 50 milligrams (mg) three times a day for pain. Further review revealed she received Morphine Sulfate Solution 20 mg per milliliter (ml) for pain as needed eight times throughout the month (once on 06/08/21, twice on 06/16/21, twice on 06/19/21, once on 06/24/21, once on 06/29/21, and once on 06/30/21). Additionally, Resident #75 received Ultram 50 mg as needed for pain rated six to ten on seven occasions in June (once on 06/01/21, twice on 06/06/21, once on 06/09/21, once on 06/10/21, once on 06/16/21, and once on 06/22/21). Review of the Medication Administration Record (MAR) for July 2021 revealed the resident received Tramadol Hcl 50 mg three times a day for pain, she did not receive Tylenol Tablet 325 mg as needed for general discomfort rated one to five. She received Morphine sulfate 20 mg/ml on 07/02/21 at 1:44 P.M. and 5:53 P.M. for a pain level of four, 07/03/21 at 10:30 A.M. for a pain of eight, 07/04/21 at 2:04 P.M. for a pain of nine and at 6:41 P.M. for a pain of nine, 07/05/21 at 10:20 A.M. for a pain of five and at 3:33 P.M. for a pain of three, 07/06/21 at 10:00 P.M. for a pain of five, 07/07/21 at 10:20 A.M. for a pain of nine and at 2:45 P.M. for a pain of seven, 07/08/21 at 9:32 A.M. for a pain of four, 1:32 P.M., for a pain of five and 4:33 P.M. for a pain of three, and on 07/09/21 at 1:00 P.M. for a pain of nine, 3:10 P.M. for a pain of seven, and 6:30 P. M. for a pain of eight. The resident received Ultram 50 mg on: 07/02/21 at 4:44 P.M. for a pain of five, on 07/05/21 at 8:05 A.M. for a pain of three, on 07/06/21 at 1:58 P.M. for a pain of six, and on 07/08/21 at 1:32 P.M. for a pain of five. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the care of plan, updated 07/22/21 revealed the resident was at risk for alteration in comfort related to fracture of the superior rim pubis and right femur fracture. Interventions included providing medications as ordered to manage pain, monitoring for adverse effects of pain medications, monitoring the effectiveness of interventions, monitoring for increased pain and notifying the physician as needed and repositioning the resident for comfort. Review of the physician progress note, dated 07/29/21 revealed Resident #75 was admitted to the hospital from 07/09/21 to 07/12/21 after her fall. She was found to have an acute closed communicated displaced right femoral interochanteric fracture, she had an open reduction and internal fixation (ORIF) surgical repair. Additionally, the resident was assessed to have a severe displaced subacute fracture of left hemipelvis with no surgical intervention provided. The physician note documented the resident was found to have a right hip fracture shortly after her fall. The physician documented the resident had little pain initially that increased after several days and she developed ecchymosis. On 09/22/21 at 3:07 P.M. interview with Buckeye Hospice Registered Nurse (RN) #388 revealed she had been unaware of Resident #75's fall until a hospice aide notified her of a bruise. Buckeye Hospice RN #388 said hospice was not made aware of the fall when it occurred, and stated the facility was not great at notifying them of changes. She was under the impression the fall occurred on 07/05/21. Buckeye Hospice RN #388 said she saw the resident once a week but went in to evaluate the resident after learning of the bruise. Upon visiting the facility, she was informed of the fall, she stated on her original visit the facility had not reported a concern with pain. Buckeye Hospice RN #388 said she had asked the facility about an x-ray, but they said they did not get one because she was hospice. Buckeye Hospice RN #388 reported she told them that was not an appropriate reason not to get an x-ray and the facility then stated there were not enough signs to order one. On 09/21/21 at 3:41 P.M. an attempted interview with Resident #75 revealed the resident said she hurt. However, the resident was unable to identify where or how much she hurt and was quickly distracted. Before the end of the conversation the resident again began saying she hurt. On 09/21/21 at 3:43 P.M. interview with Licensed Practical Nurse (LPN) #382 revealed Resident #75 was unable to tell staff where her pain was at or how severe it was. LPN #382 revealed staff use observations to assess when the resident was in pain such as yelling out, and then used a pain scale (FLACC) from the electronic medical record to number her pain based on the signs. LPN #382 reported she had recently given Resident #75 some pain medications because she had been yelling out. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 09/22/21 at 4:10 P.M. interview with the Director of Nursing (DON) verified Resident #75 had sustained a fall on 07/02/21. The DON agreed the resident's as needed pain medications were used more from 07/02/21 to 07/09/21 when comparing her use in June 2021. She stated she knew Resident #75 must have been in pain and that was why she had been advocating for the CNP to see her. In further interviews with the DON on 09/23/21 at 10:43 A.M. and 2:10 P.M. she reported the resident reported pain of eight and nine multiple times in June, so she did not think there was really an increase following her fall. However, she agreed the resident received Tramadol three times a day in June and July and seemingly needed less Morphine and Ultram in June to cover this pain. The DON then stated the increase in as needed: pain medications were because they were being used as a preventative measure, as staff figured the resident would be in pain from her fall. The DON confirmed the progress note on 07/02/21 revealed Physician #424 wanted to be notified if the resident experienced increased pain. She additionally confirmed the hospice nurse saw Resident #75 on 07/08/21 for increased pain and there was nothing to indicate the physician was notified. The DON indicated that due to the new Morphine order, the hospice nurse would have notified the hospice physician. She confirmed there was nothing to indicate the resident's physician, Physician #424, was notified. On 09/22/21 at 4:47 P.M. interview with Physician #424 revealed he had been on vacation when he was initially notified of Resident #75's fall. He stated he originally planned on seeing her the Monday after the fall (07/05/21) but did not realize he would still be on vacation. He would have expected the facility to ask one of the CNP's to see the resident when she started bruising. Physician #424 denied knowing the resident experienced bruising and swelling beginning hours after the fall. He stated if he had been aware of that he would have ordered an x-ray immediately. The physician thought that this case had been an example of poor communication with the involved parties. Physician #424 stated on 07/09/21 the nurses told him the resident began complaining of pain in the middle of the week. He stated Resident #75 had been receiving Morphine, so she probably had not been in too much pain until the fracture displaced. The physician denied ever speaking to the resident's family. On 09/21/21 at 5:21 P.M. interview with Resident #75's POA revealed he was notified of the fall originally and was called a few days later about getting an x-ray. The POA reported when the results came back, he agreed to send the resident to the hospital. Review of the FLACC scoring table revealed resident's behaviors are scored based on the severity to determine a pain score. Behaviors included breathing, negative vocalization, facial expression, body language, and consolability. Review of the policy undated Status Change in Resident Condition- Notification policy revealed the facility nurse was to notify the resident's attending physician when there was a significant change in resident's physical, mental, or psychosocial status, when there was a need to alter the resident's treatment significantly, or when deemed necessary or appropriate in the best interest of the resident.

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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** 43064 Based on observation, record review and interview the facility failed to ensure pressure relieving devices were in place as planned and failed to include documentation of interventions for Resident #75 who developed a pressure ulcer to the right knee. This affected one resident (#75) of two residents reviewed for pressure ulcers. Findings include: Review of the medical record for Resident #75 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, chronic obstructive pulmonary disease, fracture of unspecified part of neck of right femur, anxiety disorder, gastro-esophageal reflux disease, depression and hypertension. Record review revealed the resident received Hospice services. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment, dated 07/19/21 revealed the resident had severely impaired cognition and required the extensive assistance of two staff for bed mobility. Record review revealed the resident was at risk for skin breakdown with a care plan and interventions in place for skin assessments, a pressure relieving mattress, turing and repositioning and to be up in the chair often. The plan of care was updated on 08/06/21 when Resident #75 was assessed to have a pressure injury to her right inner knee. A new intervention at that time included encouraging the resident to allow staff to place a pillow between her knees while in bed, routine wound rounds with the nurse practitioner and monitoring for changes. Review of the progress note, dated 08/06/21 revealed the resident had a new area to her left knee, it was reported as being circular. A skin assessment was done, the area was cleansed and a border foam dressing was applied. A pillow was put between the resident's knees to keep pressure off the area at that time. An additional note on 08/06/21 revealed the area was actually to the resident's right knee measuring 1.5 centimeters (cm) by 1.5 cm with no depth documented. The intervention to use a pillow between the legs was deemed appropriate to continue and treatment ordered (skin prep to right inner knee every shift). A further note indicated the power of attorney was notified of the new order for skin prep to the right inner knee every shift and to encourage a pillow between the resident's knees. Review of an unavoidable pressure injury assessment document, dated 08/06/21 revealed an intervention to place a pillow between the resident's legs in relation to Resident #75's pressure area was noted. Review of wound assessments revealed from 08/06/21 through 09/21/21 the area to the right knee continued to show signs of improvement/healing. Review of the physician's orders and treatment administration record (TAR) for August and September 2021 revealed no evidence of staff applying or monitoring the use of a pillow between the resident's knees. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 09/21/21 at 3:41 P.M., 4:08 P.M. and 4:17 P.M. revealed Resident #75 was in bed lying on her left side with her legs curled up with the right leg on top of the left. It was apparent based on the location of her knees under the blanket there was nothing keeping them apart (no pillow in place). At 4:17 P.M. State tested Nursing Assistant (STNA) #334 lifted the resident's blanket and confirmed her right knee was resting on top of her left knee with no pillow or wedge observed. At the time of the observation, interview with STNA #334 revealed she was unsure if there was supposed to be something in place. On 09/21/21 at 4:48 P.M. interview with Licensed Practical Nurse (LPN) #383 revealed Resident #75 repositioned herself onto her lift side often. LPN #383 reported Resident #75 had a cushion to go between her knees and indicated it must have moved when the resident repositioned. During the interview, LPN #383 reported there was not a location to document this intervention being implemented and stated it was just something nurses usually did when a resident had a similar area. On 09/22/21 at 3:07 P.M. interview with Buckeye Hospice Registered Nurse (RN) #388 revealed there should have been an order in place for offloading pressure to the resident's knees. On 09/23/21 at 2:10 P.M. interview with the Director of Nursing (DON) and Regional Quality Assurance Nurse #426 revealed there was not a location in the medical record where nurses or STNA staff would document a pillow/wedge being in place between Resident #75's legs. Regional Quality Assurance Nurse #426 revealed the intervention was included in the Kardex for the nurses to see. The DON reported the resident did not move around a lot and indicated the STNA staff should be checking and changing the resident every two hours at which time they should ensure a pillow/wedge was in place and felt this was sufficient for the resident. Review of the policy titled Pressure Ulcer Prevention and Risk Identification revealed interventions for pressure areas were to be implemented as indicated by the physician and as determined by the interdisciplinary team.

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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** 32801 Based on record review, facility policy and procedure review and interview the facility failed to ensure Resident #57 received restorative therapy and splinting/brace use per plan of care and therapy recommendations. This affected one resident (#57) of two residents reviewed for range of motion. Findings include: Record review revealed Resident #57 was admitted to the facility on [DATE] with diagnoses including quadriplegia, multiple sclerosis, muscle weakness, diplopia and muscle spasms. Review of Resident #57's restorative order from therapy dated 07/22/21 revealed the State tested Nursing Assistants (STNA) were trained and instructed on passive range of motion (PROM). A recommendation for PROM to bilateral lower extremities times 30 reps in all directions and planes was provided at that time. Review of Resident #57's electronic TASK documentation revealed the resident was to receive PROM daily for 15 minutes including 15 reps' times two to all four extremities and for staff to assist with applying a splint to right elbow for up to eight hours during the night as tolerated. The documentation also included provisions for removal and monitoring the resident's skin related to the splint. Review of the TASK documentation revealed no evidence restorative PROM had been performed in the last 30 days and the splint had only been applied for five minutes once in the last 30 days. Resident #57 had a plan of care that identified the resident was at risk for further contractures related to multiple sclerosis (MS), impaired mobility, no voluntary movement in the bilateral lower extremity and quadriplegia. The goal developed was for the resident to maintain or have no decline in functional range of motion and tolerate program. Interventions included restorative aides would provide passive range of motion (PROM) daily for 15 minutes to 15 reps times two to all four extremities. Further review of Resident #57's plan of care revealed no evidence of a plan of care for splint/brace devices. Review of Resident #57's Minimum Data Set (MDS) 3.0 assessment, dated 09/10/21 revealed the resident was dependent on staff for all activities daily of living (ADL). Further review of the assessment revealed the resident was not receiving any type of restorative nursing program or splint or brace assistance. On 09/20/21 at 10:43 A.M. and on 09/23/21 at 10:50 A.M. interview with Resident #57 revealed staff had not offered or been performing restorative services or applying his splint/brace. The resident reported he believed he had experienced a decline in range of motion in his hands. On 09/23/21 at 10:37 A.M. interview with Registered Nurse (RN) #403 confirmed there was no documented evidence the resident received PROM per plan of care and therapy recommendation in the past 30 days. The RN also confirmed staff had only applied the splint once in the last 30 days. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility undated policy titled Restorative Nursing Program revealed the facility strived toward achieving the resident's highest functional level and maintained communication between nursing, restorative nursing and therapy. Referrals were received after discontinuation of rehabilitation services. Documentation of care was performed daily and as needed. A progress note would be documented at minimum quarterly by a registered nurse. A licensed registered nurse would evaluate the process and continued need of services quarterly.

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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** 43064 Based on record review and interview the facility failed to ensure fall interventions were implemented for Resident #49 and failed to monitor the delivery/effectiveness of interventions to prevent additional falls. This affected one resident (#49) of four residents reviewed for falls. Findings include: Review of the medical record for Resident #49 revealed an admitted [DATE] with diagnoses including dementia, type two diabetes mellitus with neuropathy, bipolar disorder, major depression, metabolic encephalopathy, delusional disorders and epilepsy. Review of the plan of care (initiated 02/08/19) and updated 08/08/21 revealed Resident #49 was at risk for falls and potential injury related to dementia, psychoactive medications, seizures, unsteady gait, recent decline in activities of daily living and recent falls. Interventions included keeping the call light in reach, using bright colored sign on walker to visually remind resident to take walker with her, encouraging the resident to use non-skid shoes or socks when up, a low bed, motion sensor when in bed, non-skid strips on floor to side of bed, toileting and assisting to bed after dinner. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment, dated 08/10/21 revealed the resident had significantly impaired cognition. The resident required extensive assistance of two staff for bed mobility and transfers and was dependent on two staff for locomotion on and off the unit. The resident had two falls since admission or prior assessment, with one fall resulting in injury. Review of the resident fall history revealed the following: Review of the progress note, dated 07/25/21 at 1:38 P.M. revealed the nurse was brought to Resident #49's hallway where the resident was found lying on her back in the hallway. Assessments for range of motion, skin, and pain were all done appropriately. However, there was nothing to indicate what fall interventions were in place at the time of the fall. A fall investigation, dated 07/25/21 revealed Resident #49 fell while carrying her purse and using rotary rollator. No additional fall interventions were documented as having been in place at the time of the fall. Review of the progress note, dated 09/09/21 at 2:45 P.M. revealed the resident was found lying beside a bed in a room that was not hers. She stated she was trying to get into bed. Assessments for range of motion and pain were done appropriately. However, there was nothing to indicate what fall interventions were in place at the time of the fall. A fall investigation, dated 09/09/21 revealed the resident fell while trying to get into bed. No additional fall interventions were documented as having been in place at the time of the 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 the progress note, dated 09/10/21 at 6:30 P.M. revealed the resident was found lying on her back in her room with her head towards the toilet and her feet towards her bed. Assessments for range of motion, skin, and pain were all done appropriately. The note indicated the resident did not have non-skid socks on at the time of the fall, a new intervention to toilet the resident between 6:00 P.M. and 7:00 P.M. was implemented following this fall. A fall investigation, dated 09/10/21 revealed the resident fell while trying to go to the bathroom. Review of the bladder continence task, the bowel continence task, and the restorative toileting program documentation, dated 09/10/21, revealed the resident was taken to the toilet at 10:15 P.M. There was no documentation to indicate she had been taken to the bathroom after her dinner. Review of the progress note, dated 09/13/21 revealed a falls team meeting was held and the immediate intervention of toileting the resident between 6:00 P.M. and 7:00 P.M. was deemed appropriate. The note indicated the resident was to be toileted often throughout the shift and staff education for proper footwear was to occur. Review of the progress note, dated 09/19/21 at 2:32 A.M. revealed the aide called the nurse to the room due to a fall. The resident was found laying on the floor with her legs extended. Assessments for range of motion, pain, and skin, were done appropriately. However, there was nothing to indicate what fall interventions were in place at the time of the fall. A fall investigation, dated 09/19/21 revealed the resident fell while going to the restroom. No additional fall interventions were documented as having been in place at the time of the fall. Review of the medical record revealed no evidence that staff monitored or documented the use of non-skid shoes or socks for the resident. On 09/22/21 at 4:10 P.M. interview with the Director of Nursing (DON) confirmed fall interventions were not documented as having been in place for the above falls. The DON revealed this was a consistent problem with the nurses that did not seem to change with education. The DON revealed it was likely related to the nurses not really getting into the care plans, out of fear of messing them up and not knowing what interventions to document. She confirmed fall interventions were something the nurses should be aware of. The DON additionally confirmed there was no documentation to indicate Resident #49 was taken to the toilet on 09/10/21 after the dinner meal, despite this being a care planned fall intervention. She stated non-skid socks were difficult to keep on the residents in the memory care unit in general as they frequently took them off. She stated the interventions were to encourage them to be in place.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on observation, record review, facility policy and procedure review and interview the facility failed to implement individualized and comprehensive nutritional interventions to ensure residents maintained acceptable parameters of nutrition, failed to ensure re-weights were obtained to identify actual weight changes and/or failed to ensure nutritional supplements were provided as ordered. Actual harm occurred when Resident #73, who had diagnoses of Parkinson's disease and dementia sustained an unplanned weight loss of 18.8 pounds/10% over three months and 29.8 pound/15.88% severe weight loss from admission (04/15/21) through 09/07/21 (less than a six month time period) related to inadequate intakes without evidence of individualized and comprehensive interventions to prevent the weight loss and/or promote weight gain for the resident. This affected three residents (#73, #63 and #29) of five residents reviewed for weight loss and nutrition. Findings include: 1. Review of the medical record for Resident #73 revealed an admitted [DATE] with diagnosis including Parkinson's disease, unspecified dementia, severe protein calorie malnutrition and type two diabetes mellitus. Record review revealed the resident was on a regular diet with regular texture and thin liquids. Review of the weight record for Resident #73 revealed on 04/15/21 (admission) the resident weighed 187.6 pounds. On 07/07/21 the resident weighed 173.8 pounds, on 08/10/21 the resident weighed 170.6 pounds, on 08/17/21 the resident weighed 163.8 pounds which demonstrated a continued weight loss following admission. On 08/30/21 the resident weighed 167.8 pounds. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 08/30/21 revealed Resident #73 was cognitively impaired and required supervision and set up assistance from staff for meals. The assessment revealed the resident had weight loss and no problems with teeth, chewing or swallowing. Review of the progress note, dated 09/01/21 at 2:17 P.M. by Registered Dietitian Nutritionist (RDN) #389 revealed Resident #73's current body weight was 161.8 pounds indicating a continued undesired weight loss of six pounds or three percent in one week related to inadequate oral intake. Resident #73's intake was 0-100% with refused meals noted. The note indicated the resident was accepting current supplement. The dietitian recommended the physician consider adding the medication Mirtazapine (anti-depressant medication also used for appetite stimulant) for augmentation of appetite. There was no evidence the physician was aware or addressed the recommendation for appetite stimulant at this time. On 09/02/21 the resident weighed 162.4 pounds and on 09/07/21 the resident weighed 157.8 pounds. Resident #73 sustained a 29.8 pound/15.88% severe weight loss from admission through 09/07/21. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the progress note, dated 09/06/21 at 2:20 P.M. by RDN #389 revealed Resident #73 had a significant weight change. The current body weight was 162.4 pounds on 09/02/21, 165.6 pounds on 08/04/21 and 181.2 pounds on 06/02/21 indicating a significant unplanned weight loss of 18.8 pounds or 10 percent over three months related to inadequate intakes. At this time the resident was on a house supplement of 237 milliliter (ml) two times daily. Current meal intake was 0-100% but noted the resident was taking 100% of the supplement and adequate fluids. The dietitian recommended an appetite stimulant and noted the physician was aware of the weight loss and recommendations. However, there was no evidence the physician addressed the recommendation for the appetite stimulant. Record review revealed on 09/16/21 supplements for weight loss and nutrition included eight ounces of super coffee every evening with dinner and 237 milliliters (ml) of house supplement three times daily were ordered. Review of the progress note, dated 09/16/21 at 8:00 A.M. revealed the physician was notified of a significant weekly weight change of eight pounds. A note by Registered Dietitian Nutritionist (RDN) #389, dated 09/15/21 at 3:28 P.M. revealed the resident's current body weight on 09/15/21 was 149.8 pounds indicating a continued, significant and unplanned weight loss of eight pounds or five percent in one week related to poor oral intake. The note indicated the resident continued to have agitation at meals and refusals but was taking house supplement decently well. The dietitian recommended an appetite stimulant, super coffee at breakfast, and to increase the house supplement plus 237 ml to three times daily to augment intake. The note revealed to continue to monitor weight weekly. There was no evidence the physician addressed the recommendation for the appetite stimulant. Review of the progress notes from 08/01/21 through 09/22/21 revealed no IDT note addressing Resident #73 significant weight loss, continued weight loss or evidence of the implementation of individualized and comprehensive interventions to prevent additional weight loss and/or to promote weight gain for the resident. Review of the physician progress notes, dated 06/21/21, 08/06/21 and 08/12/21 revealed no documentation addressing weight loss or dietitian recommendations for adding an appetite stimulant. Review of the resident's meal intakes from 08/24/21 through 09/22/21 revealed intakes were recorded by State tested Nursing Assistant (STNA) staff. The intake records revealed the resident's intakes varied from 0-100% with multiple refusals for an average of less than 50% of meals eaten. Observations made from 09/20/21 through 09/24/21 of meal times revealed Resident #73 was not up in the dining room for breakfast on any date and was observed only up for lunch on 09/23/21 and 09/24/21. During the meal observations, the resident was observed to only pick at his food and not eat. There was no evidence of staff supervision being provided for the duration of each meal observed. On 09/22/21 at 8:17 A.M. interview with STNA #331 revealed the resident was not a morning person and rarely ate breakfast. The STNA revealed the resident was usually up out of bed between 10:30 A.M. and 11:00 A.M. but was not offered a breakfast meal at that time as lunch was at 11:00 A.M. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 09/22/21 at 11:22 A.M. interview with RDN #389 revealed nutritional recommendations were written and given to the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) and then the ADON contacted the physician to get orders for the recommendation(s) and documents any changes. RDN #289 confirmed there was no documentation the physician addressed the appetite stimulant recommendation and no evidence of comprehensive and individualized nutritional interventions to prevent additional weight loss for Resident #73 and/or to promote weight gain. In addition, RDN #389 revealed she had not spoken with Resident #73's family in regards to nutritional interventions or alternative methods of feeding to address the resident's continued unplanned severe weight loss. On 09/22/21 at 3:43 P.M. interview with STNA #340 revealed Resident #73 ate depending on his mood. The STNA indicated in her opinion the resident had not been eating well since his wife had not been in the facility to visit. On 09/23/21 at 2:33 P.M. interview with the ADON confirmed the physician did not address the recommendation for an appetite stimulant as recommended by RDN #389 in September 2021. In addition, there was no evidence the physician provided any other individualized interventions to prevent additional weight loss for the resident and/or to promote weight gain. 03137 2. Review of Resident #63's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including type two diabetes mellitus, morbid obesity, history of COVID-19, essential hypertension, anxiety disorder, depressive episodes, schizophrenia, dysphagia, psychosis, hyperlipidemia, osteoarthritis and mild intellectual disabilities. Review of Resident #63's monthly physician orders revealed an order for consistent carbohydrate no added salt diet, with two oranges daily and a house pudding supplement in the evening. Review of Resident #63's annual MDS 3.0 assessment, dated 01/05/2021 revealed the resident's speech was clear, she made herself understood, understands others, her vision was adequate with corrective lens and her cognition was intact. Resident #63 had minimal depression, no indicators of psychosis or behaviors and did not reject care. Resident #63 was assessed to require supervision with set up assistance from staff for meals. The assessment revealed the resident was 63 inches tall, weighed 220 pounds, had no weight changes and was not on a planned diet for weight change. Review of Resident #63's weight record revealed on 01/05/2021 she weighed 219.6 pounds. On 02/03/2021 she weighed 211.9 pounds. On 03/02/2021 she weighed 208 pounds. On 04/06/2021 the resident's weight was 198 and there was no re-weight obtained, following a 10 pound weight loss in one month. Review of Resident #63's current plan of care for nutrition revealed Resident #63 was at risk for malnutrition and/or dehydration. Resident #63 was obese, received superfoods, was on a therapeutic diet and received insulin. The care plan revealed on 04/08/21 Resident #63 has a significant weight loss in the past three to six months and superfoods were added. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Continued review of the resident's weights revealed on 05/03/2021 she weighed 201 pounds. On 06/01/2021 she weighed 203.2 pounds and on 07/02/2021 her weight was 197.3 with no evidence a re-weight was obtained. On 08/02/2021 the resident weighed 187.4 and no re-weight was obtained. On 08/02/21 the resident's plan of care was updated to reflect the resident had again experienced a significant weight loss in the past one and six months. Review of Resident #63's nutritional assessment, dated 08/02/2021 revealed Resident #63 had an unplanned weight loss. The note indicated with the resident's intake and nutritional supplement her weight should stabilize and no recommendations were made at that time. Review of Resident #63's quarterly MDS 3.0 assessment, dated 08/20/2021 revealed the resident had an unplanned weight loss and weighed 187 pounds. On 09/08/2021 Resident #63 weighed 195.4 pounds, which was an eight pound weight gain since August 2021. No re-weight was obtained to verify the accuracy of the weight or identify actual weight changes for the resident. On 09/22/21 at 10:49 A.M. interview with the Director of Nursing (DON) revealed Resident #63 wanted to lose weight and had lost about 30 pounds. However, this was not reflected in the resident's plan of care or dietary notes. The DON revealed Resident #63 would only eat one chicken strip as the resident was very concerned about her blood sugars. On 09/22/21 at 11:39 A.M. interview with RDN #389 revealed she was not notified (dates not provided) that Resident #63 wanted to lose weight and was trying to lose weight. RDN #389 confirmed there was no evidence Resident #63 had re-weights obtained when she gained or lost five pounds or more. In addition, RDN #389 was unable to provide evidence Resident #63 had received education about safe weight loss and balanced diets. Review of the facility undated Weight Policy revealed re-weights would be completed on any weight change of five pounds or more. Re-weights would be done immediately (within 72 hours). 42015 3. Review of Resident #29's medical record revealed an admitted [DATE] with diagnoses including end stage renal disease, severe protein calorie malnutrition and dementia. Review of Resident #29's September 2021 physician's orders revealed an order for a house supplement to be given four times a day as a renal supplement. On 09/21/21 at 4:00 P.M. Resident #29 was observed to return from dialysis. The resident did not received the house supplement as ordered at that time. Review of Resident #29's September 2021 medication administration record revealed every Tuesday, Thursday and Saturday Resident #29's noon house supplement was not given as ordered. The supplement was not given as ordered on 09/02/21, 09/04/21, 09/07/21, 09/09/21, 09/11/21, 09/14/21, 09/16/21, 09/18/21 or 09/21/21. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 09/22/21 at 9:31 A.M. interview with Licensed Practical Nurse (LPN) #383 revealed Resident #29 does not receive her noon nutritional supplement on Tuesdays, Thursdays or Saturdays when she goes to dialysis. On 09/22/21 at 11:32 A.M. interview with RDN #389 revealed she was not aware Resident #29 was not receiving her noon nutritional supplement on Tuesdays, Thursdays or Saturdays. RDN #389 confirmed the resident should still be receiving the nutritional supplement four times a day even on the days she received dialysis. On 09/22/21 at 11:41 A.M. interview with the Director of Nursing confirmed the facility was not giving Resident #29 the nutritional supplement as it was ordered.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on observation, record review and interview the facility failed to implement an individualized and comprehensive treatment plan, including the delivery of anti-depressant medication as ordered for Resident #17 to assist the resident to maintain her highest practicable mental and psychosocial well-being. This affected one resident (#17) of three residents observed during medication administration. Findings include: Record review revealed Resident #17 was admitted to the facility on [DATE] with a diagnoses including major depressive disorder. Review of Resident #17's Minimum Data Set (MDS) 3.0 assessment, dated 07/08/21 revealed the resident had little pleasure, had trouble falling or staying asleep, poor appetite and felt bad about herself 7-11 times a day in the previous 14 days. The assessment revealed the resident felt down, depressed of hopeless 12-14 times in the previous 14 days. A plan of care revealed the resident had an alteration in mood due to diagnoses of stroke, major depression and sleep disorder. The resident was referred for weekly counseling. Record review revealed on 09/15/21 the resident's order for the anti-depressant medication, Celexa was decreased from 40 milligrams (mg) to 30 mg. The medication was ordered to be administered by mouth once a day in the morning. Review of Resident #17's Medication Administration Records (MAR) for 09/2021 revealed the resident was ordered Celexa 40 mg one tablet in the morning for depression. Target behaviors for the medication were lack of pleasure, lack of interest, hopelessness, tearfulness and sadness. Review of the MAR revealed the medication was discontinued 09/15/21. However, the MAR did not include in the new order for Celexa 30 mg that was obtained on 09/15/21. The new order was not entered in the electronic medical record or recorded on the MAR for continued administration as ordered. On 09/22/21 at 8:27 A.M. observation of medication administration for Resident #17 revealed the nurse did not administer Celexa to the resident. On 09/22/21 on 8:44 A.M. interview with Licensed Practical Nurse (LPN) #381 and LPN #400 revealed staff had canceled the order for Celexa 40 mg on 09/15/21 but did not enter the new order for Celexa 30 mg at that time. The LPN staff verified the resident had not received the Celexa medication since it 09/15/21 as ordered. On 09/22/21 at 9:43 A.M. interview with Resident #17 with LPN #400 present revealed the resident reported she was currently having symptoms and depression including sadness and anxiety. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/22/21 at 10:01 A.M. interview with Registered Nurse (RN) #358 revealed she had contacted the physician and received a new order to restart the Celexa at 30 mg on this date.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 32801 Based on observation, facility policy and procedure review and interview the facility failed to ensure contingency narcotics were reconciled every shift and failed to ensure an accurate accounting of narcotics were maintained. This affected two residents (#69 and #298) and had the potential to affect all 95 residents residing in the facility. Findings include: On 09/23/21 at 3:15 P.M. observation of 100 unit medication cart with Registered Nurse (RN) #387 revealed the facility contingency narcotic box was locked in bottom of the 100 medication cart. The narcotic box was a plastic box that had four green zip ties with a different number on each corner of the box. The RN reported during shift change the nurses usually verify the numbers on the box with a reconciliation sheet that was in the binder. However, the nurse was not able to find a current reconciliation sheet in the binder. The last sheet available for review was dated 07/02/2021. The RN reported she knew there was a more recent sheet because she worked Sunday and verified the number, however a new box had been delivered since she worked on Sunday. RN #387 verified she did not reconcile the narcotic box with the previous shift nurse on this date to ensure the numbers were accurate. Further observation of the medication cart revealed Resident #69's Lyrica 75 milligrams (mg) count did not match the reconciliation sheet. The blister card had 25 capsules in the package, however the reconciliation sheet indicated there was 26. Resident #298's as needed Hydrocodone/APAP 5/325 mg blister card was empty, however the reconciliation sheet indicated there should have been one remaining pill. During the observation RN #387 confirmed Resident #69's and #298's narcotic counts did not match the reconciliation sheets. The RN reported she had given both medications this morning around 8:00 A.M. and she must have forgotten to sign them out when she had administered them. On 09/23/21 at an unknown time the facility had pharmacy fax over of the emergency box delivery slip dated 09/02/21 to confirm the numbers on the narcotic contingency box. The RN reported the facility had run out of the reconciliation sheets and no one started a new sheet when the box was delivered on 09/20/21. The facility was not able to locate the reconciliation sheets from July 2021 to present. Review of the undated contingency narcotic box medication list revealed the box contained 120 controlled narcotics. On 09/23/21 at 3:38 P.M. interview with Licensed Practical Nurse (LPN) #337 revealed narcotics were to be signed out upon administration of the medication. Review of the facility policy titled Control Substance, dated 07/2016 revealed nursing staff must count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled Medication Administration, dated 2007 revealed the individual who administers the mediation dose, records the administration immediately following the medication being given.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on observation, record review, facility policy and procedure review and interview the facility failed to ensure medications were stored in original packaging, insulin was stored at appropriate temperatures and dated upon opening and controlled drugs were stored in a fixed compartment in the refrigerator. This affected three residents (#1, #49, and #60) identified as receiving insulin on 300, 400 and 600 units, one resident (#34) of one resident who had a narcotic stored in the refrigerator on the 500/600 unit, one resident (#13) who had narcotics stored in the top of the 600 medication cart and had the potential to affect all 95 residents residing in the facility. Findings include: 1. Record review revealed Resident #13 was admitted to the facility on [DATE] with a diagnosis including diarrhea. Review of Resident #13's orders and medication administration records dated 08/2021 to 09/22/21 revealed the resident was ordered Lomotil 2.5-0.025 milligrams (mg) give two tablets by mouth every six hours as needed for diarrhea from 08/04/21 until it was discontinued on 08/19/21. Observation of narcotic reconciliation count of the top of 600 cart on 09/22/21 at 7:26 A.M., with Licensed Practical Nurses (LPN's) #369 and #372 revealed Resident #13 had 20 Lomotil tablets in a blister packaging still in the narcotic box in the medication cart. Further observation revealed the foil backing on pill 20 had been broken and a piece of clear tape had been placed over the back of the foil to keep the pill in the blister packaging. LPN #369 and #372 confirmed findings during observation. LPN #372 reported once the foil backing had been broken and the pill was not administered the pill should have been destroyed and not placed back into the package and taped. 2. Record review revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including respiratory failure, fracture of right femur, severe protein-calorie malnutrition, malignant neoplasm of the upper lobe of lung, anemia, cerebral infarction, hemiplegia, pain in leg and uterus disorder. Review of Resident #34's orders revealed an order for Marinol (a control narcotic) 2.5 milligrams (mg) twice daily. Observation of the 500 and 600 medication storage room on 09/23/21 at 3:47 P.M. with the Director of Nursing (DON) revealed Resident #34's Marinol blister packet containing one Marinol was stored in a non-fixed plastic box that was able to be easily removable from the dorm size refrigerator. The DON confirmed findings and reported the plastic boxes used to be glued inside the refrigerators the plastic box could not be removed. 3. Observation of 700 medication cart on 09/23/21 at 3:50 P.M. with Registered Nurse (RN) #385 revealed there were 14 loose, unpackaged and unidentifiable pills noted throughout the cart. RN #385 confirmed findings during the observation. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled Medication Storage, dated 2007 revealed medications were to be stored properly, following manufacturer or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. Schedule II mediation and preparation must be stored in a separately locked permanently fixed compartment. Outdated, contaminated, discontinued, or deteriorated medication and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order exists. Review of the facility policy titled Medication Administration, dated 2007 revealed drugs were dispensed in the manufacturer's original container with the labeled manufacturer's expiration date. Once a medication was removed from the package/container, unused medication doses shall be disposed of according to the nursing care centers policy. 43064 4. Review of the medical record revealed Resident #1 admitted on [DATE] with a diagnosis including diabetes mellitus. Review of the physician's orders for September 2021 revealed Resident #1 was ordered Novolog Solution 100 units per milliliter (ml) to be administered five units before meals and according to a sliding scale before meals and at bedtime. Additional review revealed an order for Tresiba Solution 100 units per ml, 36 units to be injected in the morning. Observation on 09/23/21 at 3:43 P.M. with RN #425 revealed one opened vial of Novolog Solution and one open vial of Tresiba Solution for Resident #1. Neither bottle was labeled with an open date. Interview with RN #405 at the time of the observation revealed insulin was usually good for 28 days after opening. The RN confirmed the two vials of insulin had been used and there was nothing to indicate what day they had been opened. Review of the instructions for Novolog, provided by the facility revealed Novolog vials were good for 28 days after first use. Review of the instructions for Tresiba revealed it could be stored for 56 days after being opened. 5. Review of the medical record revealed Resident #49 was admitted on [DATE] with a diagnosis including type two diabetes mellitus. Review of Resident #49's physician's orders for September 2021 revealed orders for Basaglar KwikPen Solution Pen-Injector 100 units per ml with 30 ml to be injected in the morning, Novolog Solution 100 units per ml to be injected according to a sliding scale four times a day, and Trulicity 1. 5 mg per 0.5 ml to be injected every Saturday morning. Review of the medical record revealed Resident #60 was admitted on [DATE] with a diagnosis including type two diabetes. Review of Resident #60's physician's orders for September 2021 revealed an order for Insulin Novolog FlexPen to be injected according to a sliding scale four times a day. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 09/23/21 at 4:00 P.M. of the refrigerator in the medication room of the memory care unit (hall 300 and 400) with Licensed Practical Nurse (LPN) #372 revealed two thermometers indicating a temperature of 20 degrees Fahrenheit. The refrigerator contained:one vial of tuberculosis solution with packaging information that recommended temperature for storage was between 36 and 46 degrees Fahrenheit, three Novolog pens for Resident #60, two Basaglar KwikPens, two vials of Novolog and three Trulicity pens with packaging information indicating the medications should be stored between 36 to 46 degrees for Resident #49. Additional review of the temperature log for September 2021 revealed there were 26 occasions from 09/01/21 to the morning of 09/23/21 the refrigerators temperature had been below 36 degrees Fahrenheit. These observations were confirmed by LPN #372, who agreed the refrigerator was below the temperature requirements listed on the two boxes, and confirmed it was likely the rest of the medication required a similar temperature range. Review of the instructions for the Basaglar KwikPen, provided by the facility revealed unused pens were to be kept between 36 and 46 degrees Fahrenheit. Review of the instructions for Novolog pens and vials, provided by the facility revealed unopened refrigerated vials should be kept between 36 and 46 degrees Fahrenheit. Review of the facility policy titled Medication Storage, dated 2007 revealed medications were to be stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. Medication requiring refrigeration or temperatures between 36 degrees Fahrenheit(F) (2 degrees Celsius (C)) and 46 F (8 C) were kept in a refrigerator with a thermometer to allow temperatures monitoring. Insulin products should be stored in the refrigerator until opened. The date should be noted on the label for insulin vials and pens when first used. The opened insulin vial may be stored in refrigerator or at room temperature. Opened insulin pens must be stored at room temperatures. Insulin should not be frozen and if frozen do not use. Outdated, contaminated, discontinued, or deteriorated medication and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order exists. Review of the facility policy titled Medication Administration, dated 2007 revealed drugs were dispensed in the manufacturer's original container with the labeled manufacturer's expiration date. The nurse shall place a date opened sticker on the mediation if one was not provided by the dispensing pharmacy and enter the date opened. Once a medication was removed form the package/container, unused medications doses shall be disposed of accruing to the nursing care centers policy.

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	365394	A. Building B. Wing	09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare at Adams Lane	1856 Adams Lane Zanesville, OH 43701

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 03137 Based on record review and interview the facility failed to ensure the dietary manager was qualified to perform the job duties of the manager. This had the potential to affect all 95 residents residing in the facility. Findings include: Review of Dietary Manager #315's personnel file revealed on 02/23/2020 she was promoted to the position of Dietary Manager. Review of the employee's personnel file revealed no evidence Dietary Manager #315 was a certified dietary manager, certified food service manager, had similar national certification for food service management and safety from a national certifying body or had an associate's or higher degree in food service management or in hospitality, if the course study included food service or restaurant management, from an accredited institution of higher learning. On 09/23/21 at 2:49 P.M. interview with Dietary Manager #315 revealed she had not completed a Certified Dietary Manager certification training course as of this date. On 09/23/21 at 3:24 P.M. interview with the Administrator verified Dietary Manager #315 did not met the education/training requirements of a Dietary Manager.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 03137 Based on observation, staff interview and facility policy and procedure review the facility failed to store and distribute food under sanitary conditions to prevent contamination, spoilage and/or food borne illness. The affected 92 of 92 residents residing in the facility who received meal trays from the kitchen. The facility identified three residents (#39, #294 and #65) who received nothing by mouth. The facility census was 95. Findings include: On 09/22/21 at 3:10 P.M. observation of the kitchen during tray line revealed the following: a. The tray line service area had dried food debris on the food serving line and dried pieces of food on the line. Observation of three food carts, with food to be served, tray cards and beverages for the evening meal on them had dried food on them and were soiled with dried food debris. The sprinkler heads over the fryer and the grill were covered with grease encrusted dust. Two additional meal carts had dried food debris on them. The reach in refrigerator had dried food debris on the outside of it. The reach in freezer had dried strawberry ice cream on it. The pellet and plate warmer had dried food on them. On 09/22/21 at 3:45 P.M. interview with Dietary Manager #315 confirmed the above observations. b. On 09/23/21 at 10:29 A.M. observation of the kitchen revealed the steam table controls and surrounding area had dried food on it. Observation of the floor under the fryer revealed there was grease buildup and under the griddle there was dried food debris under it. In excess of 10 pans were observed stored wet and/or dirty at the time of the observation. Interview with Dietary Manager #315 at the time of the observations confirmed the above findings. c. On 09/23/21 at 11:11 A.M. observation of the 500 unit resident refrigerator revealed an open avocado dip with no date as to when it was opened and a container of opened undated cottage cheese with no resident name on it. Tartar Sauce was observed in a takeout container with no date on it. An open potato salad container was observed with no resident name and no date when opened. Interview with Licensed Practical Nurse (LPN) #337 at the time of the observations confirmed the above findings. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility Storage of Food Brought in by Outside Sources for Residents, dated 11/2016 revealed any perishable food brought in by an outside source which was not to be eaten right away shall be stored a clean, sealed container. The container shall be labeled, dated and placed in an appropriate non-dietary refrigerator. all items lacking proper labeling would be discarded. All resident foods stored in non-dietary refrigerators shall be discarded after three days.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 34299 Based on record review and interview the facility failed to establish an infection prevention and control program (IPCP) that included a comprehensive tracking system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents. This had the potential to affect all 95 residents residing in the facility. Findings include: Review of the facility infection control logs from July 2021 to September 2021 revealed the log was not comprehensive and was incomplete. Review of the infection control log, dated 07/2021 revealed a total of 18 documented infections. There were six urinary tract infections (UTI), two of which had no identified organism and one that did not meet antibiotic criteria. There was one pneumonia and one upper respiratory infection (URI) that did not meet criteria. Of the three identified wound infections, one did not have an identified organism and did not meet criteria. The blood/sepsis infection had no identified organism. The infection identified as other did not meet criteria. There were two prophylactic antibiotics prescribed with no reason why. The facility mapping was not completed for tracking trends or patterns and did not include all organisms causing the infections. Review of the infection control log, dated 08/2021 revealed a total of 16 documented infections. There were two URIs, one with no identified organism and did not meet criteria. There were three UTIs, all three had no identified organism and one did not meet criteria. The two blood/sepsis infections did not have identified organisms. Of the three wound infections two did not meet criteria. The one prophylactic antibiotic prescribed had no reason why. The facility mapping was not completed for tracking trends or patterns and did not include the organisms causing the infections. Review of the infection control log, dated 09/2021 revealed three documented infections, however the facility identified six total infections in September 2021. The infection control log had one skin infection with no identified organism and criteria not met, one UTI with no identified organism, and one pneumonia. The undocumented infections included two UTIs and one blood infection with no identified organisms. The facility mapping was not completed for tracking trends or patterns and did not include the organism causing the infections. An interview on 09/23/21 at 3:05 P.M. with the Assistant Director of Nursing (ADON) who was also the Infection Control Preventionist confirmed the infection control logs for 07/2021, 08/2021 and 09/2021 were not comprehensive and complete. The ADON revealed she was training another nurse how to complete the logs and that nurse was not present in the facility or available during the survey. Review of the facility policy titled Infection Control, dated 11/23/16 and Antibiotic Stewardship Program, dated 11/2016 revealed infection control logs should be completed to track, record and analyze infections.

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F 0921 Level of Harm - Potential for minimal harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 34299 Based on observation, interview and facility policy and procedure review the facility failed to provide a clean resident environment. The carpet throughout the facility was observed soiled with large brown and black stains. This had the potential to affect all 95 residents residing in the facility. Findings include: On 09/20/21, 09/21/21 and 09/22/21 observations conducted during the annual survey revealed the carpeting throughout the facility had large brown and black stains in multiple areas of the building. On 09/21/21 at 2:57 P.M. interview with Maintenance Director #310 confirmed the carpet was soiled throughout the facility with large brown and black stains and needed cleaned. Review of the facility policy titled Infection Control-housekeeping, dated 12/28/13 revealed the workplace would be maintained in a clean and sanitary condition.