STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365748	A. Building B. Wing	12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Manor	1926 Ridge Avenue Warren, OH 44484

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38094 Based on interview and record review. the facility failed to ensure Resident #239's trust account was closed within 30 days after her death. This affected one resident (Resident #239) of one resident reviewed for resident account closure. Findings include: Review of the medical record revealed Resident #238 was admitted on [DATE] and expired at the facility on [DATE]. Review of the [DATE] and [DATE] trust statement quarterly statements for Resident #239 revealed she received a private pension and social security. Her account was closed with the balance sent to the state Attorney General on [DATE]. A copy of the check dated [DATE] to close the account was provided. Interviews on [DATE] at 12:01 P.M. and 1:44 P.M. with Business Office Manager (BOM) #607 revealed the facility was without a BOM until she started working at the facility in November and closed the account as soon as it was aware of it. She verified Resident #239's trust account should have been closed within 30 days of her death.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 39969 Based on observation, interview, and record review, the facility failed to maintain a clean and homelike environment. This affected 12 residents (#1, #6, #12, #16, #20, #22, #25, #26, #27, #29, #34, and #188) of 12 residents reviewed for environment. Findings include: Tour of the facility on 12/02/21 at 10:23 A.M. with Maintenance Director (MDR) #602 revealed in Resident #25's room the cover of the air conditioner unit was removed exposing the internal parts of the unit, the bathroom door had a large area of paint peeled away, and a doorknob sized hole in the wall. Observations in Resident's #22's room revealed feces along the inside of toilet bowl and the lower right corner of the wall and door jamb was scuffed up and in disrepair. Observations of Residents #6 and #12's room revealed in the bathroom the bathtub was dirty, the toilet seat had a small amount of feces smeared on it and on the wall behind the toilet near an open toilet paper roll that was sitting on the back of the toilet. Observation in Residents #34 and #188's room revealed the floors were very dirty. There were multiple areas of scraped paint on the outside of the doors for Residents #29, #26, and #27's rooms. In Resident #26's room observed blue tape on inside wall of closet area molding, that was in disrepair and tape appeared to be holding it in place. Observation in Residents #16 and #20's room revealed the floor was very dirty. Interview on 12/02/21 between 10:23 A.M. and 10:49 A.M., MDR #602 verified the above findings. MDR #602 stated he had only been in this position for two weeks and was initially hired in housekeeping three weeks ago. MDR #603 stated the cover for the air conditioner unit in Resident #25's had been removed since he took the maintenance director position but was not aware of the hole in the bathroom door. MDR #602 stated the door jamb in Resident #22's room was on his list to be repair and that housekeeping had cleaned the resident toilet on 12/01/21 and the feces in inside of the toilet had to be new today. MDR #602 verified the observations in Residents #6 and #12's room and stated the tub was not used by the residents and so housekeeping did not clean it. MDR #602 stated the doors for Residents #26, #27, and #29's rooms needed to be repainted and the floors in Residents #34, #188, and #16, and #20's rooms needed to be stripped and waxed. MDR #602 stated he wasn't aware of blue tape on the molding of the closet area in Resident #26's but verified it was in disrepair. Tour was continued on 12/02/21 at 10:49 A.M., with MDR #603 with the addition of the Administrator and Maintenance Assistant (MA) #601. Observation of Resident #27's room revealed the walls had various nicks, crumbling and missing plaster at the bottom, left side corner of closet area, the wall along the side of the bed had a large area of a brownish smear, and wall behind headboard was in disrepair with chipped paint and missing plaster. Observation of the railing outside of Resident #29's was missing the end piece. Observation of Resident #1's room revealed the floor was very dirty, there was a large white plastic cubical that was broken down and in disrepair with a moderate amount of a brown dried substance, and in the corner behind door there was crumbs and debris. Also observed a basketball sized paint chip missing in the far-left corner of the ceiling across from the resident bed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/02/21 at 10:54 A.M., MA #601 verified the above observations and stated the brown substance could have been a spilled milkshake. Reviewed facility policy titled, Cleaning and Disinfection of Environmental Surfaces, revised June 2009, revealed housekeeping surfaces will be cleaned on a regular basis, when spills occur, and when surfaces are visibly soiled. Environmental surfaces will be disinfected (or cleaned) on a regular basis and when surfaces are visibly soiled.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38094 Based on interview and record review, the facility failed to report an incident of neglect when Resident #6 eloped and alleged misappropriation of a Resident #29's new cell phone. This affected two residents (Resident #6 and Resident #29) of three residents reviewed for reporting allegations of abuse, neglect, exploitation, or mistreatment. Findings include: 1. Resident #6 was admitted on [DATE] with diagnoses including schizoaffective disorder, bipolar type, adjustment disorder, chronic kidney disease major depressive disorder, anxiety, anemia and age related bilateral cataracts. Review of Resident #6's Minimum Data Set (MDS) 3.0 assessment of 09/03/21, revealed the resident was moderately cognitively impaired with fluctuating periods of disorganized thinking, delusions, independent for activities of daily living (ADLs) with setup help only and steady ambulation. Review of Resident #6's care plan, dated 08/04/21, revealed the resident had potential for behavior problems related to a diagnosis of schizophrenia and interventions included staff were to perform checks on Resident #6 every 15 minutes. Review of Resident #6's Elopement Risk Assessment, dated 09/02/21, revealed the resident was physically capable of leaving the facility. The assessment did not identify the resident paced around the facility. Review of Resident #10's psychiatric physician progress notes on 10/11/21 revealed Resident #10 had poor judgement regarding day-to-day activities, hallucinations and paranoia, and lacked insight regarding matters of self. Interview on 12/01/21 at 3:10 P.M. with Administrator revealed STNA #209 supervised the 6:30 P.M. smoke break, the management team left at 6:40 P.M., and at approximately 7:45 P.M. she received a phone call from LPN #305 stating Resident #6 was missing and unable to be found. Administrator stated the management team immediately drove back to the facility, started looking for Resident #6, and continued to drive around the area looking for her until 12/01/21 at 2:30 A.M. The Administrator stated the police were notified Resident #6 was missing around 9:00 P.M. and were looking for her also. The Administrator revealed Resident #10 was seen walking outside of a local business on 12/01/21 around 11:00 A.M. by Dietary Aide (DA) #507, brought back to the facility, and transported immediately to the local emergency department. Administrator stated Resident #6 told her she was walking around outside all night. Review of Self-Reported Incident (SRI) # 214952 reporting Resident #6's elopement form the facility on 11/30/21 which was discovered at approximately 7:15 P.M. revealed the SRI was created 12/01/21 at 3:34 P. M. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/02/21 at 5:21 P.M. with the Administrator verified the SRI regarding Resident #6's elopement was not completed until the next day in afternoon after the incident occurred. Review of the 2106 Abuse, Neglect, Exploitation & Misappropriation of Resident Property Policy revealed any allegations of abuse or serious bodily harm should be reported to the state agency immediately but no later then two hours after the allegation/incident. 2. Review of the medical record for Resident #29 revealed the resident was admitted on [DATE] with diagnoses including metabolic encephalopathy, type II diabetes, cirrhosis of liver without ascites, and liver failure. Resident #29's MDS 3.0 of 11/04/21 revealed the resident was moderately cognitively impaired, with fluctuating periods of inattention, verbal behaviors towards others. Interview on 11/29/21 at 10:59 A.M. with Resident #29 revealed the resident was missing a brand new phone that his mother brought him and he thought someone took it. He reported he told staff about it and they did not do anything. Interview on 11/30/21 at 8:37 A.M. with Licensed Practical Nurse (LPN) #308 verified Resident #29 received a brand new phone from his mother after his last phone caught fire on 10/07/21. She reported staff had searched for the new phone and could not find it. Interview on 11/30/21 at 8:42 A.M. with the Administrator revealed she was unaware of Resident #29 reporting his missing phone. She reported she would verify with LPN #308 and start an investigation. Review of SRI's for the facility revealed no reporting of alleged misappropriation for Resident #29's missing cell phone. Interview on 12/02/21 at 5:21 P.M. with the Administrator revealed she did not think she needed to report Resident #29's cell phone since it was not clear if the phone was lost or misappropriated. Review of the 2106 Abuse, Neglect, Exploitation & Misappropriation of Resident Property Policy revealed any allegations of misappropriation should be reported to the state agency within 24 hours of being reported to the staff person.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on interview and record review, the facility failed to ensure Resident #25's nutrition care plan was revised. This affected one resident (#25) of three residents reviewed for nutrition. Findings include: Review of the medical record for Resident #25 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, schizoaffective disorder, and severe protein calorie malnutrition. Review of care plan revised on 02/06/21, revealed Resident #25 was at increased potential for alteration in nutrition and hydration related to protein calorie malnutrition, alcohol abuse/withdrawal, anemia, dysphagia, aspiration pneumonia. On 11/28/20 magic cup supplement was discontinued related to hoarding in room. Resident #25 would usually consume 100% of diet and appropriate snacks. On 02/06/21 the resident's current body weight (CBW) was 162 pounds, BMI was 23.3 within normal weight (WNW), stable; diet was a mechanical soft with honey thick liquids, meal intakes was fair to strong; skin intact; and lab results on 01/08/21 reviewed; with no recommendations made. Review of Resident #25's quarterly Minimum Data Set (MDS) assessment, dated 10/20/21, revealed the resident had severely impaired cognition, weighed 143 pounds at the time of the assessment, and had an unplanned significant weight loss. Review of the nutrition assessment, dated 10/22/21, revealed Resident #25's diet was a puree with honey consistency liquids, had significant weight loss at 30 days that was unexplained, however, resident was out of the facility and may had weight loss. Resident's body mass index (BMI) was 19.7 below parameters for age. Weight loss at 30 days was nine pounds which was at 6.2% loss and unexplained contrary to meal intake. Estimated needs included 1,900-2,280 calories for elderly, weight maintenance, 76-91 grams of protein, and 1900-2280 milliliters (ml) of fluids. Diet should provide adequate calorie, protein, and fluid if consumed. Interview on 12/06/21 at 2:27 P.M. with the Administrator revealed the above nutrition care plan was the most recent care plan did not include Resident #25's recent significant weight loss. The Administrator stated she would check for a revised one. Interview on 12/06/21 at 3:16 P.M. with Assistant Director of Nursing (ADON) #303 verified the care plan provided wasn't updated to include the resident's significant weight loss and the last updated included an entry dated 02/06/21 of CBW 162 pounds, BMI 23.3 within normal weight, stable. ADON #303 stated Dietetic Technician (DT) #900 wrote a note addressing the weight loss and stated DT #900 was responsible for updating the nutrition care plans.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review, facility policy review, the facility failed to ensure care and services were provided, and care planned interventions were implemented for Resident #189 to identify, evaluate, and treat a right lower extremity wound. This affected one resident (Resident #189) out of three residents reviewed for wound care. Findings include: Review of Resident #189's medical record revealed an admitted [DATE] and diagnoses included cerebral infarction, dysphagia following subarachnoid hemorrhage, schizoaffective disorder, bipolar type and type two diabetes mellitus. Review of Resident #189's Minimum Data Set (MDS) 3.0 assessment, dated 10/01/21, revealed the resident had moderate cognitive impairment, was independent but required set-up help for bed mobility, and required extensive assistance of one staff member for personal hygiene. Review of Resident #189's care plan, dated 10/29/21, revealed the resident was at risk for decline in activity of daily living (ADL) function related to alteration in ADL performance and participation related to generalized muscle weakness, and interventions included preventative skin care as needed and monitor for skin breakdown. Further review revealed Resident #189 was on anticoagulant therapy and interventions included skin assessment per routine and as needed. Review of Resident #189's medical record from 11/19/21 through 11/29/21 revealed no evidence of an open area or orders for an open area on resident's right lower leg. Review of Resident #189's shower sheets on 11/22/21 and 11/26/21 did not reveal documentation of right lower leg open area or dressing. Review of Resident #189's medical record did not reveal documentation of skin assessments from 11/17/21 through 11/29/21. Observation on 11/29/21 at 1:00 P.M. of Resident #189 revealed a dressing on her right lower leg dated 11/19/21. Interview on 11/29/21 at 1:00 P.M. with Registered Nurse (RN) #400 confirmed Resident #189 had a dressing on her right lower leg dated 11/19/21. RN #400 stated she did not know anything about the dressing and would check with Assistant Director of Nursing/Minimum Data Set Nurse/Wound Nurse (ADON/MDS/WN) #303. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/29/21 at 1:09 P.M. with RN #400 stated Resident #189's treatment was discontinued and RN #400 removed the dressing from Resident #189's right lower leg. RN #400 verified the dressing was on Resident #189's right lower leg for ten days before being removed. Observation of the right lower leg revealed it was red, swollen, and a dark red scabbed area about the size of a dime could be seen. Observation of the left lower leg revealed it was slightly red and swollen. RN #400 confirmed Resident #189's lower legs were red and swollen and the right lower leg had a dark red scabbed area on it. Interview on 11/29/21 at 3:41 P.M. with ADON/MDS/WN #303 revealed Resident #189 had a seeping blister resolved 11/10/21, and the resident asked RN #401 to put a dressing on it 11/19/21 so she would not scrape it open. ADON/MDS/WN #303 stated she needed to ask RN #401 if the wound was open when she placed the dressing over it, and confirmed RN #401 did not write a progress note or call the physician for an order. ADON/MDS/WN #303 stated Resident #189's lower legs were always a little swollen, and looked like they did now. Interview on 11/29/21 at 4:15 P.M. with ADON/MDS/WN #303 revealed Resident #189 scratched her leg while she was sleeping, woke up and her right lower leg was bleeding, and she asked RN #401 to put a dressing on it. Observation on 12/01/21 12:40 PM of Resident #189's right lower leg with ADON/MDS/WN #303 revealed it was swollen, had a dark red scabbed area approximately three quarters of an inch in diameter, and the skin was reddened area around scab. ADON/MDS/WN #303 stated Medical Director #800 evaluated the wound 11/29/21 and new orders included bumex (diuretic) and wound care orders. Interview on 12/08/21 at 7:20 A.M. with RN #401 revealed Resident #189 itched her right lower leg, caused it to bleed, and she cleaned the area and placed a dressing over it. RN #401 stated she told Resident #189 to take the dressing off the next day, and confirmed she did not document the open area or notify Medical Director #800. RN #401 stated Resident #189 had congestive heart failure, her lower legs were always red and swollen, and she spent most of her time sitting in a chair in the common area and did not elevate her legs. Interview on 12/08/21 at 8:52 AM with the DON revealed skin assessments should be done twice weekly with resident showers, and bath sheets sheets were filled out on shower days and skin assessments were documented in the computer. DON stated Resident #189 liked to be independent and refused showers frequently. Review of the facility policy titled, Wound Care, revised 11/2018, included it was the policy of the facility to provide therapeutic treatment to heal wounds. Treatments implemented by a nurse required a physician's order. Wounds would be evaluated when they were noted and weekly until resolved. Wounds would be monitored for location, size, (measure length, width, and depth), tunneling, exudates, necrotic tissue, and the presence or absence of granulation tissue and epithelialization. Only pressure ulcers would be staged. Notify physician upon discovery of new skin area and when delay in healing was noted. Obtain physician orders for treatment to begin at time of discovery. Notify Resident and Representative of skin area and treatment.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review, and facility policy review, the facility failed to ensure care and services were provided, physician orders were followed, and care planned interventions were implemented to ensure one resident (Resident #6) did not elope from the facility. This affected one resident (Resident #6) out of three residents reviewed for elopement. On 12/02/21 at 2:51 P.M. the Administrator, [NAME] President of Operations #805, and the Director of Nursing (DON) were notified Immediate Jeopardy began on 11/30/21 at 7:15 P.M. when Resident #6 was unable to be located in the facility or on the facility grounds. Licensed Practical Nurse (LPN) #305 entered Resident #6's room at 7:15 P.M. to administer her night-time medications and discovered Resident #6 was not in her room. At 7:20 P.M. LPN #305 initiated a resident head count, Resident #6 was not located. The DON and Assistant Director of Nursing/Minimum Data Set Nurse (ADON/MDS) #303 were in the facility and notified Resident #6 could not be found. A thorough search of the facility and premises was conducted, Resident #6 was not found, and at 7:45 P.M. The Administrator was notified Resident #6 was missing. All available staff began to search the facility, the facility grounds, and areas and roads around the facility. The local police were notified at 9:33 P.M. that Resident #6 was missing and joined the search to locate her. The facility administration personnel searched until 12/01/21 at 2:30 A.M. and the police continued to search for Resident #6 all night without success. The temperatures from 11/30/21 at 6:30 P.M. through 12/01/21 at 10:10 A.M. ranged from 28 degrees to 40 degrees Fahrenheit (F). On 12/01/21 at 10:10 A.M. Dietary Aide (DA) #507 saw Resident #6 outside a local business while she was driving to visit her grandmother. DA #507 convinced Resident #6 to enter her car and drove her immediately to the facility. Resident #6's vital signs were taken by LP) #308. Her temperature was 96.2 F, blood pressure 107/72, pulse was 110, respirations 20, and oxygen saturation was 98 percent. On 12/01/21 at 10:30 A.M. Resident #6 was transported to the local hospital Emergency Department by [NAME] President of Operations #805 and accompanied by Transport Driver/Medical Records Associate (TD/MRA) #608 to be evaluated and treated. The police, MD #800, and Resident #6's guardian were notified Resident #6 was found and transported to the Emergency Department. The Immediate Jeopardy was removed on 12/01/21 when the facility implemented the following corrective action: On 11/30/2021 at 7:15 P.M., facility staff and LPN #305 observed Resident #6 was potentially absent from the facility during medication pass. On 11/30/2021 at 7:20 P.M., a complete head count was completed by LPN #305, 39 of 40 residents were present, staff were notified of a missing resident, and search of the facility and facility grounds was conducted of missing resident. On 11/30/2021 at 7:45 P.M. the Administrator and DON were notified by LPN #305 of Resident #6 missing. On 11/30/2021 at 7:45 P.M. through 12/01/2021 at 10:10 A.M., various management and direct care staff continued driving the local area in search of the resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/30/2021 at 8:00 P.M. all nine of nine facility doors were checked by Social Services Designee (SSD) #606 and State tested Nursing Assistant (STNA) #608 and noted to be functioning properly. On 11/30/2021 at 9:00 P.M., Medical Director (MD) #800 was notified by Assistant Director of Nursing (ADON) #303 of Resident #6 missing. On 11/30/2021 at 9:01 P.M., SSD #606 notified the local police Resident #6 missing. On 11/30/2021 at 9:15 P.M., the Administrator notified Guardian #807 of Resident #6 missing. On 11/30/2021 from 9:15 P.M. through 12/01/2021 at 4:10 P.M., facility staff conducted facility rounds to visualize facility doors every 15 minutes. On 11/30/2021 at 9:45 P.M., [NAME] President of Operations #805 educated the Administrator, DON, and SSD #606 on the Elopement Prevention Policy, Missing Resident Policy and observing for residents when exiting the facility to ensure door code was protected. On 11/30/2021 from 10:00 P.M. through 12/01/2021 at 11:59 P.M., the DON and SSD #606 educated 11 of 11 STNA staff, 5 of 5 Hospitality staff, 12 of 12 licensed nursing staff, 8 of 8 dietary staff, 1 of 1 maintenance staff, 4 of 4 housekeeping/laundry staff, 2 of 2 activities staff and 7 of 7 therapy staff members on the Elopement Prevention Policy, Missing Resident Policy, and observing for residents when exiting the facility to ensure code is protected. Staff were not permitted to work until education has been provided. On 12/01/2021 at 8:30 A.M., the Regional Director of Clinical Operations #808 educated Business Office Manager #607 on the Elopement Prevention Policy, the Missing Resident Policy, and observing for residents when exiting the facility to ensure the door code is protected. On 12/01/2021 at 10:10 A.M., Dietary Aide (DA) #507 located Resident #6 outside a local business office and she was transported to the facility. On 12/01/2021 at 10:20 A.M., Resident #6 was assessed by LPN #308, and her blood pressure was 107/72, pulse 110, respirations 20, temperature 96.2 F, oxygen saturation 98% on room air. Resident #6's mood and behavior was pleasant with no signs and symptoms of physical or emotional distress. Resident #6 denied pain or discomfort. On 12/01/2021 at 10:30 A.M., Guardian #807, MD #800, and local police were notified Resident #6 was located and appeared at her baseline but would be transported to the local hospital for evaluation. On 12/01/21 at 10:30 A.M., Resident #6 was transported to the local hospital Emergency Department by [NAME] President of Operations #805 and accompanied by Transport Driver/Medical Records Associate (TD/MRA) #608 to be evaluated and treated. On 12/01/2021 at 8:30 P.M., Resident #6 was assessed by LPN #307 upon return from hospital with no concerns. Neurological checks were initiated, and a wander guard was applied to resident. (continued on next page)

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	365748	A. Building B. Wing	12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Manor	1926 Ridge Avenue Warren, OH 44484

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/01/2021 at 8:30 P.M., Resident #6 was placed on 1 on 1 supervision until admitted into another facility (psych facility) for evaluation. On 12/01/2021 form 7:30 A.M through 4:30 P.M., ADON/MDS #303 and the DON reviewed and revised 40 of 40 resident elopement assessments. On 12/01/2021 at 4:00 P.M. ADON/MDS #303 reviewed and updated two of three facility elopement binders. On 12/01/2021 at 4:10 P.M., all 9 of 9 facility door codes were changed by the Administrator. On 12/01/2021 at 4:20 P.M., ADON/MDS #303 created an updated list for 10 of 10 residents at risk for elopement. On 12/01/2021 at 6:30 P.M., the remaining elopement book was updated to complete updates of 3 of 3 binders. On 12/02/2021 at 3:00 P.M., Resident #6 was accepted into a local behavior health facility for inpatient psychiatric stay for admission at 7:00 P.M. By 12/01/21 the Administrator/Designee conducted an Elopement Drill on 7:00 A.M. through 7:00 P.M. and 7:00 P.M. through 7:00 A.M. to ensure staff knowledge and comprehension of Elopement and Missing Resident Policy & Procedure. DON/Designee will complete a headcount on every resident on the secured unit every shift for one week, then daily for one month, then as determined by the Quality Assurance and Assessment (QAA) Committee. The Administrator/Designee will conduct random elopement drills on each shift weekly for 4 weeks to ensure staff knowledge and comprehension of Elopement and Missing Resident Policy & Procedure, then as determined by the QAA Committee. The Administrator/designee will audit by direct observation, staff entering and exiting the facility to ensure codes are entered with no resident observation on random shifts 5 times a week for 4 weeks. If a resident appears to be near or observing, the code will be changed immediately then as determined by QAA committee Although the Immediate Jeopardy was removed on 12/01/21, the deficiency remained at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is in the process of implementing their corrective action plan and monitoring to ensure continued compliance. Findings include: Review of Resident 10's medical record revealed an admitted [DATE] with diagnoses including schizoaffective disorder, bipolar type, anemia, dementia, and major depressive disorder. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #6's care plan, dated 08/04/21, revealed the resident had potential for behavior problems related to a diagnosis of schizophrenia and interventions included staff were to perform checks on Resident #6 every 15 minutes. Further review did not reveal a care plan for wandering or elopement was initiated until 12/01/21, after Resident #6 eloped from the facility on 11/30/21. Review of Resident #6's Elopement Risk Assessment, dated 09/02/21, revealed the resident was physically capable of leaving the facility. The assessment revealed it included a box to check if resident wandered, roamed, or paced, and it did not identify the resident paced around the facility. The assessment indicated Resident #6 did not display exit seeking behaviors. Review of Resident #6's Minimum Data Set (MDS) 3.0 assessment, dated 09/03/21, revealed the resident had moderate cognitive impairment and fluctuating periods of inattention, disorganized thinking and delusions. Resident #6 did not exhibit wandering behavior. Review of Resident #6's physician orders on 09/14/21 identified orders for frequent checks every day and night shift for behavior monitoring. Review of Resident #6's psychiatric physician progress notes on 10/11/21 revealed Resident #6 had poor judgement regarding day-to-day activities, hallucinations and paranoia, and lacked insight regarding matters of self. Review of Resident #6's progress notes on 11/23/21 at 12:26 P.M. revealed Resident #6 was exhibiting bizarre behavior, walking up to staff and looking into space, acting very vague and tired, acting as if she was going to collapse. Vital signs were assessed and indicated blood pressure 142/98, pulse 100, respirations 20, temperature 96.9 F, oxygen saturation 97% on room air. Resident #6 was able to ambulate back to her room with assistance, and her psychiatrist and the DON were notified of the resident's behavior. Review of Resident #6's progress note on 11/28/21 written by Nurse Practitioner (NP) #806 revealed Resident #6 was having increased bizarre behaviors and acting out. Labs were reviewed, and there were no new orders at this time. Review of the facility Elopement Risk Binder from 06/25/21 through 11/30/21 did not reveal Resident #6 was listed as an elopement risk. Review of Resident #6's facility elopement timeline revealed on 11/30/21 at 7:15 P.M. Resident #6 was potentially absent from the facility during the medication administration. On 11/30/21 at 7:20 P.M. a complete resident head count was completed, staff were notified Resident #6 was missing, and a thorough search of the facility and the facility grounds was conducted. The facility administration, resident guardian, and physician were notified Resident #6 was missing. Facility personnel and police searched for the resident through the night until she was located on 12/01/21 at 10:10 A.M. by DA #507 outside a local business, and transported first to the facility, then the local hospital emergency department for evaluation and treatment as needed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of LPN #305's Witness Statement dated 11/30/21 revealed LPN #305 saw Resident #6 at 6:20 P.M. in the common area and entered the resident's room at 7:00 P.M. to administer her medications, but Resident #6 was not in her room. It was customary for Resident #6 to pace the facility halls and LPN #305 returned to the resident's room at 7:15 P.M. and Resident #6 was still not in her room. A resident head count was completed, and Resident #6 was unable to be located. The Administrator was immediately notified Resident #6 was missing. Review of the local police department report titled, Ohio Uniform Incident Report,, dated 11/30/21 at 9:33 P. M. included the complainant (Social Services Designee (SSD) #606) was contacted and revealed Resident #6 was missing from the facility some time between 6:30 P.M. and 7:30 P.M. and suffered from chronic mental disease including depression and schizophrenia. Resident #6 was last seen wearing yellow socks, green sweatshirt, a red jacket, and a flower dress. Review of Resident #6's progress notes from 11/30/21 at 6:30 P.M. through 12/01/21 at 10:20 A.M. did not reveal documentation the resident had eloped from the facility and could not be located or that the police were notified of the elopement. Review of the Emergency Department (ED) documentation on 12/01/21 at 10:39 A.M. revealed when Resident #6 arrived at the hospital vital signs were not taken. Further review of the documentation revealed on 12/01/21 at 12:16 P.M. Resident #6 was five feet tall, weighed 113 pounds, vital signs were temperature 97.2 Fahrenheit, pulse 105, blood pressure 117/62, respirations 18, and oxygen saturation was 96 percent. The report revealed Resident #6 was brought to the ED after she escaped from her nursing home, was out all night, and returned to the nursing home this morning. Resident #6 was sent to the ED by nursing facility staff who felt her psychosis was worsening and could possibly be the reason she left the facility. Resident #6 demonstrated knowledge of leaving the facility in the winter with temperatures so cold it could be life-threatening. Resident #6 stated she wanted to go for a walk to get some fresh air, wanted to be alone with God, and came back on her own. Resident #6 did not meet criteria for in-patient treatment and was discharged back to the facility. Observation on 11/29/21 at 8:00 A.M. of the facility entrance revealed locked glass doors leading to the outside area at each end of a hallway and a code or buzzer was needed to enter and leave the facility. Observations on 11/29/21 at 10:30 A.M., 1:00 P.M., 2:00 P.M., and 4:00 P.M., and on 11/30/21 at 8:30 A.M., 10:00 A.M., and 1:00 P.M. revealed Resident #6's clothing was disheveled, her hair was pulled back and contained with a rubber-band, loose strands of hair not captured in the rubber-band were noted, and she was walking at a fast pace in the common areas of the facility. Observation on 11/30/21 at 4:15 P.M. revealed Resident #6 sitting in the common area by the entrance to the facility. Interview on 12/01/21 at 2:14 P.M. with Resident #801 revealed on 11/30/21 after the 6:30 P.M. smoke break Resident #6 was unable to be found. Resident #801 stated the doors were locked by an electronic device or a key, but somehow Resident #6 got out of the facility and was wearing only socks on her feet when she disappeared. The facility administration, nurses, and the police were looking for her all night, but she was not found. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 12/01/21 at 2:57 P.M. with STNA #209 revealed on 11/30/21 at 6:30 P.M. Resident #6 went outside to the patio for a supervised smoke break. STNA #209 stated she was supervising the smoke break and Resident #6 took a couple puffs of her cigarette, then went back inside the facility. STNA #209 stated Resident #6 tried to come back out to the smoking area after a few minutes, but STNA #209 told her not to come out because the smoke break was almost over. STNA #209 stated during smoke breaks Resident #6 would sometimes walk down the ramp from the patio towards the parking lot and she would have to follow her and bring her back to the smoking area. STNA #209 verified she did not see Resident #6 in the facility after the smoke break was over, and the staff did not realize she was missing until LPN #305 tried to find her to administer her medications around 7:00 P.M. STNA #209 stated everybody was looking for Resident #6 and the staff were worried for her safety. They did not know how Resident #6 got out of the facility. Resident #6 was not found during the remainder of STNA #209's shift and she left the facility at 10:30 P.M. STNA #209 stated the facility staff were looking for Resident #6 through the night until she was found outside a local business the morning of 12/01/21 and transported to the hospital. Interview on 12/01/21 at 3:10 P.M. with the Administrator revealed STNA #209 supervised the 6:30 P.M. smoke break, the management team left at 6:40 P.M., and at approximately 7:45 P.M. she received a phone call from LPN #305 stating Resident #6 was missing and unable to be found. The Administrator stated the management team immediately drove back to the facility, started looking for Resident #6, and continued to drive around the area looking for her until 12/01/21 at 2:30 A.M. The Administrator stated the police were notified Resident #6 was missing around 9:00 P.M. and were looking for her also. The Administrator revealed Resident #6 was seen walking outside of a local business on 12/01/21 around 11:00 A.M. by Dietary Aide (DA) #507, brought back to the facility, and transported immediately to the local emergency department. The Administrator stated Resident #6 told her she was walking around outside all night. The Administrator stated Resident #6 scored low on an exit seeking assessment. Interview on 12/01/21 at 3:19 P.M. with the Director of Nursing (DON) revealed Resident #6's legal guardian was notified she was missing on 11/30/21. Interview on 12/01/21 at 3:36 P.M. with LPN #305 revealed on 11/30/21 she worked from 3:00 P.M. until 11:30 P.M. LPN #305 stated Resident #6 continually paced around the facility and did not wear shoes, would never stop walking, and was always moving. LPN #305 stated Resident #6 went out for a supervised smoke break at 6:30 P.M. and around 6:50 P.M. she looked for her to administer medications and did not see her in her room. LPN #305 stated she administered medications to other residents then came back to Resident #6's room, she was not in her room again, and at 7:15 P.M. Resident #6 was still not in her room, and no staff members had seen her. LPN #305 stated she initiated a resident head count, searched the facility thoroughly, notified the Administrator, and told the DON, and Assistant Director of Nursing (ADON) #305 Resident #6 was missing. LPN #305 stated the outside area of the facility was thoroughly searched but Resident #6 was not found. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 12/01/21 at 4:37 P.M. with DA #507 revealed she was driving to her grandmother's house on 12/01/21 around 10:30 A.M., saw Resident #6 walking outside by a local business, knew she was missing from the facility, and stopped her car to talk to her. Resident #6 told her she was hungry and going to get something to eat. DA #507 told her she would drive her, and Resident #6 agreed to get into her car. DA #507 called to notify the facility Resident #6 was found and was told to drive her to the facility. DA #507 stated she did not remember if Resident #6 looked cold, and Resident #6 did not say what she was doing all night, she just wanted a cigarette. DA #507 stated she drove Resident #6 to the facility and she was taken from her car by facility staff. Interview on 12/02/21 at 7:52 A.M. with the Administrator and DON revealed Resident #6 returned from the hospital emergency department on 12/01/21 at 8:30 P.M. The Administrator stated Resident #6 was being continually monitored by the staff on a one-to-one basis following her return. The Administrator stated Resident #6 told her she memorized the code by watching as people went in and out of the door, and that was how she was able to leave the facility. The Administrator stated the facility had security cameras facing both entrances but, they did not record. The Administrator stated Resident #6 frequently sat in the chairs located by the door. During the day the cameras were monitored by Business Office Manager #607, and during off hours when the doorbell would ring a staff member responded and stood at the door until it was closed. The Administrator stated Resident #6 was immediately assessed by LPN #308 when she returned to the facility. Interview on 12/02/21 at 8:07 A.M. with the DON confirmed Resident #6 paced around the facility at a fast speed and it was not marked on the Elopement Risk Assessment because they did not think she was a wanderer. The DON stated she did not have a history of elopement. Interview on 12/02/21 at 8:55 A.M. with MD #800 revealed he couldn't figure out how Resident #6 was able to leave the facility, and he was not told the door alarms went off. MD #800 stated there had not been any problems with her up until now. MD #800 stated it would not be safe for anyone to be walking around all night in the cold weather, much less a 100-pound girl. MD #800 stated he called the emergency department and spoke to the nursing supervisor. The nursing supervisor told him Resident #6 had to be brought in from the parking lot a couple times while she was waiting because she walked out and wanted a cigarette. In addition, she was running through the emergency department and staff needed to bring her back to her room. MD #800 stated he had not been notified Resident #6 returned to the facility on [DATE], he thought she was still in the emergency department. Interview on 12/02/21 at 9:00 A.M. with Resident #6 revealed she was tired, wanted to sleep. She was unable to be interviewed. Interview on 12/02/21 at 11:38 A.M. with ADON #303 revealed she called MD #800 on 12/01/21 around 9:00 P.M. to notify him Resident #6 returned to the facility, he did not answer, and she did not leave a voice mail. ADON #303 stated she did not document the attempted phone call in Resident #6's progress notes. Interview on 12/02/21 at 1:17 P.M. with LPN #308 revealed Resident #6 was brought to her when she arrived at the facility after being outside walking around all night. LPN #308 stated Resident #6 was alert and oriented, had a jacket on, was bundled up with blankets and her skin was not cold. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #6's late entry progress notes on 12/01/21 at 6:38 P.M. documented by LPN #308 included on 12/01/21 at 10:20 A.M. Resident #6's skin was warm, dry, and intact, temperature of 96.2 F, blood pressure 107/72, pulse 110, respirations 20 and oxygen saturation of 98 percent on room air. The progress notes indicated Resident #6 did not have signs and symptoms of emotional distress. Interview on 12/02/21 at 9:26 A.M. with Transport Driver/Medical Records Associate (TD/MRA) #608 revealed she supervised Resident #6 while she was in the hospital until 7:00 P.M. when STNA #209 relieved her. TD/MAR #608 stated Resident #6 was not left alone while she was in the emergency department, but she was quick and impulsive and a couple times wanted a cigarette and went outside. TR/MAR #608 stated she was not aware of any emergency department staff chasing Resident #6. TR/MAR #608 stated the hospital staff did not take her temperature or any vital signs until close to 1:00 P.M., about an hour and a half after she arrived at the emergency department. Interview on 12/02/21 at 10:05 A.M. with STNA #250 revealed Resident #6 was not on 15-minute checks before she eloped from the facility, but some days she was disoriented and needed to be watched closely. STNA #250 stated for the past couple days she was keeping a close eye on her because Resident #6 told her she didn't know what was wrong with her head. Interview on 12/02/21 at 10:14 A.M. with STNA #202 and LPN #302 revealed Resident #6 was not on 15-minute checks before she eloped from the facility on 11/30/21, but she was now. STNA #202 stated there were clip boards at each of the nurse's stations for documentation of residents requiring every 15-minute checks and Resident #6 did not have a documentation record on the clipboard. LPN #302 stated Resident #6 did not have a record on the clipboard for documenting every 15-minute checks and had never been exit seeking. Observation on 12/02/21 at 10:30 A.M. of clipboards at the nurses' station for documenting residents requiring every 15-minute checks did not reveal evidence 15-minute checks were completed for Resident #6. Interview on 12/02/21 at 10:49 A.M. with STNA #212 revealed she was working on 11/30/21 and was assigned to care for Resident #6 during the time she eloped from the facility. STNA #212 stated Resident #6 was her usual self on 11/30/21 and paced around the facility continually, Resident #6 always paced around the facility at a fast speed and had done so since her admission. STNA #212 stated Resident #6 was roaming the hallways during the dance party activity on 11/30/21 at 6:00 P.M., and the dance party was winding down around 6:30 P.M. when the residents had a supervised smoke break. STNA #212 stated she never knew she was supposed to do 15-minute checks on Resident #6, but she usually knew where she was. STNA #212 stated she was with another resident during the 6:30 P.M. smoke break and did not see Resident #6 after the dance party. STNA #212 stated she talked to Resident #6 after she returned to the facility on [DATE] at 8:30 P.M. and was told by Resident #6 she needed air, wanted to feel close to God, and followed Medical Doctor #804 out of the front entrance. STNA #212 stated during supervised smoke breaks before she eloped, Resident #6 would often walk down the ramp towards the parking lot and need to be brought back to the smoking patio. Interview on 12/06/21 at 1:58 P.M. with the DON revealed there were clipboards at the nurses' stations for resident's requiring every 15-minute checks and the nurses initiated the documentation when the checks were required for a resident. The DON stated either the nurse's or the STNAs could fill the sheets out depending on who did the checks for each 15-minute period. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 12/06/21 at 3:12 P.M. with the DON and ADON/MDS #303 confirmed Resident #6 had a care plan for every 15-minute checks since 08/04/21 and physician orders for every 15-minute checks since 09/14/21 and the checks were not documented. Observation on 12/02/21 at 1:52 P.M. of the facility entrance and exit doors revealed the secured alarm system was in place and functioning, and it took 13 seconds for the doors to close after being opened. Review of facility policy titled, Elopement Prevention, undated, revealed it was the policy of the facility to ensure that the resident's environment was safe, and used the least restrictive measures possible. Residents would be assessed for elopement risk upon admission, routinely, and upon a significant change in condition. If a resident was identified to be at risk for elopement, and individualized care plan would be implemented to prevent elopement. Nursing staff would document when circumstances related to exit seeking or wandering was observed and notify the Director of Nursing.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on observation, interview, and record review, the facility failed to maintain a clean filter for Resident #37's oxygen concentrator and date the tubing. This affected one resident (#37) of one reviewed for oxygen. Findings included: Review of the medical record for Resident #37 revealed an admitted [DATE]. Diagnoses included bipolar II disorder, and chronic obstructive pulmonary disease. Review of Resident #37's quarterly Minimum Data Set (MDS) assessment, dated 11/16/21, revealed the resident had intact cognition, was independent, and required no set up help for bed mobility, transfers, and toilet use, and received oxygen. Review of Resident #37's November 2021 physician orders revealed orders for rinse oxygen concentrator filter with warm water every week and as needed at bedtime every Sunday, check oxygen concentrator filter daily and as needed at bedtime, and change oxygen tubing and set up every week and as needed at bedtime every Sunday. Observation on 11/29/21 at 4:51 P.M. of Resident #37's oxygen concentrator revealed a new container of sterile water that was undated, the tubing was undated, and the back of the machine where the filter was located was very dirty and dusty. Interview on 11/29/21 at 5:08 P.M. with Licensed Practical Nurse (LPN) #809 stated the nurses managed the oxygen tubing by changing it out and it then dating it where it is visible. LPN #809 verified Resident #37's oxygen tubing did not have a date on it and the filter was very dirty.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 39969 Based on observation and interview, the facility failed to ensure the nurse staffing information was posted daily. This had the potential to affect all 40 of 40 residents residing in the facility. Findings include: Observation on 11/29/21 at 8:42 A.M. revealed the daily posted nurse staffing information by the front entrance near the receptionist window was dated 11/24/21. At this time the Administrator verified the observation and obtained the daily nursing staffing form for 11/29/21. Observation on 11/30/21 at 9:25 A.M. of the daily posted nurse staffing information posted by the entrance near the receptionist window was dated 11/29/21. Interview on 11/30/21 at 9:30 A.M. with Medical Records (MR) #608 verified the observation. MR #608 stated the Director of Nursing (DON) completed the daily posted nurse staffing information and was responsible to ensure it was posted during the week. MR #608 stated the nurses were responsible for posting it on the weekends.

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	365748	A. Building B. Wing	12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Manor	1926 Ridge Avenue Warren, OH 44484

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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. 39969 Based on observation, interview, and record review, the facility failed to ensure a clean and sanitary kitchen. This had the potential to affect all 40 of 40 residents that consumed food from the kitchen. Findings include: During the initial tour of the kitchen on 11/29/21 from 8:43 A.M. to 9:06 A.M. with Certified Dietary Manager (CDM) #504 revealed various burnt food debris on stove, two containers that housed the foil and the saran wrap located on the stove was dirty with various food stains and grime. Located on top of the stove was various debris and dust. The wall next to stove where the waste basket was had various dried food stains. The shelves located across the from stove had various food debris. Observation of the reach-in refrigerator located to right of stove revealed the bottom grill hanging off and was covered with various food spills and the glass of the had various food splatter. The silver reach-in cooler across and against wall revealed on the inside floor of the cooler had various spills and food debris. The rack next to this cooler that housed a tray of various spices with spills of spices on the tray and also on the shelf below the had a tray of clean sippy cups with spilled spices on it. Observed on the shelf across from the rack with the spices was dried spills, an opened but emptied sugar packet, and dried paper stuck in the rim of the steam table pans stored on the shelf. Observation of the bread rack revealed four loaves of unopened bread with the used by date of 11/13/21, and two loaves of opened and one unopened bag of buns dated with use by date of 11/27/21. The reach-in freezer located in the dry storage room had debris on the floor of the freezer and reach-in cooler had a tan colored spill on floor of the cooler. Dietary Aide (DA) #506 was also observed near the dish machine with a long, full beard that was uncovered. Interview on 11/29/21 between 8:43 A.M. to 9:06 A.M. with CDM #504 verified the above observations. Review of the facility policies titled, Storage of Frozen Foods, Storage of Refrigerated Foods, and Storing Dry Food, dated April 2011, revealed food would be stored in a manner that optimizes food safety and quality. Review of the facility policy titled, Dietary: Personnel Hygiene for Sanitation, revised 12/20/20, revealed beards must be restrained using a net or face covering in the meal prep and service areas.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38094 Based on interview and record review, the facility failed to ensure medical records were complete and accurate. This affected three residents (#11,# 25, #29) of four residents reviewed for documentation. Findings include: 1. Review of the medical record for Resident #11 revealed the resident was admitted on [DATE] with diagnoses including cerebrovascular disease, unspecified psychosis, emphysema, pneumonia due to COVID-19, bradycardia, acute respiratory failure with hypoxia, cognitive communication deficit, dysphasia, and vascular dementia with behavioral disturbance. Resident #11's Minimum Data Summary (3.0) of of 10/01/21 revealed the resident was severely cognitively impaired, required extensive assist of two for Activities of Daily Living (ADL), use of a wheelchair for mobility, and significant weight loss. Review of Resident #11's care plan of 11/02/21 revealed care area for full code status with an initiation date of 08/02/12 and target date of 01/31/22, and a care area for hospice with initiation date of 06/22/21 and a target date of 01/31/22. Review of Resident #11's Hospice admission notice of 06/22/21 revealed a qualifying diagnosis of other vascular syndrome in cerebrovascular disease, with life expectancy of less than 6 months. Interview on 12/01/21 at 1:08 P.M. with Assistant Director of Nursing (ADON) #303 verified Resident #11 was on Hospice, no longer a full code and that care area should have been removed from the care plan. 2. Review of the medical record for Resident #29 revealed the resident was admitted on [DATE] with diagnoses including metabolic encephalopathy, type II diabetes, cirrhosis of liver without ascites, and liver failure, moderate protein calorie malnutrition, electrolyte and fluid balance disorder. The resident received a regular diet, regular texture and thin liquid diet. Review Resident #29's care plan of 09/19/21 revealed care areas for liver disease secondary to cirrhosis, diabetes, and non-compliance with meals, with interventions to monitor nutrition status/weights. Review of Resident #29's physician order dated 10/29/21 revealed the resident was to be weighed weekly. Resident #29's MDS assessment 3.0 of 11/04/21 revealed the resident was moderately cognitively impaired, with fluctuating periods of inattention, verbal behaviors towards others and rejection of care, supervision of setup only for activities of daily living (ADL), use of a wheelchair for mobility, no weight loss with weight of 135 pounds and height of six feet. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #29's Nutrition Assessment of 11/22/21 revealed a significant weight loss in 30 days, non-beneficial and unexplained. Weekly weights were started for four weeks for observation. Plan of Care (POC) updated, with plans to continue to monitor and make recommendations as needed. Review of Resident #29's weights in the electronic medical record revealed a weight on 10/19/21 of 118.0 pounds (lbs), 11/12/21 of 123 lbs, a crossed out inaccurate weight on 11/19/21 of 137.0 lbs and a weight on 11/26/21 of 128.0 lbs. Interview on 11/29/21 on 3:12 P.M. with Dietary Technician (DT) # 900 revealed the facility recorded weekly weights on paper. He provided a copy of Weekly Weights initiated 10/22/21 for Resident #29. The weights were listed as Week 1: 119.4, Week 2: 120.6, Week 3: 121.2, and Week 4: 121.7. He reported the weights would not trigger in the electronic record for a significant weight loss since they were on paper, and would not be accessible to anyone working remotely. He was unable to identify the exact dates of the weights and whether the resident was weighed standing or in his wheelchair. Interview on 11/30/21 on 3:09 P.M. with Director of Nursing (DON) verified the paper weights were not accessible outside of the facility for anyone working remotely. Since the weights were not in the computer they would not trigger for significant weight loss. She reported Resident #29 was weighed in his wheelchair and verified someone unfamiliar with the resident would not know that. Interview on 11/30/21 at 5:20 P.M. with State tested Nursing Assistant (STNA) #209 revealed she weighed the residents and Resident #29 was weighed standing up. She provided a stack of handwritten weights for various residents, mostly undated. She reported she weight various residents when instructed to do so by the DON. 39969 3. Review of the medical record for Resident #25 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, schizoaffective disorder, and severe protein calorie malnutrition. Review of Resident #25's quarterly Minimum Data Set (MDS) assessment, dated 10/20/21, revealed the resident had severely impaired cognition, weighed 143 pounds at the time of the assessment, and had an unplanned significant weight loss. Review of Resident #25's November 2021 physician orders revealed an order for weekly weights with a start date of 10/29/21. Review of Resident #25's weights in the electronic medical record revealed the resident was weighed on 10/29/21 at 133 pounds and the next weight documented was on 11/12/21 at 135 pounds. There were no other weights noted in the electronic medical record after 11/12/21. Interview on 11/30/21 at 11:46 A.M. with Dietetic Technician (DT) #900 confirmed the weekly weights were not in the resident's electronic medical record but was kept in a log. DT #900 revealed if the weights were entered into the computer, they would trigger weight loss.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when entering and exiting Resident #288's room, who was on transmission-based precautions. This affected one resident (#288) of one resident reviewed for transmission-based precautions, with the potential to affect all 40 residents in the facility. Findings include: Record review of Resident #288 revealed a re-admitted [DATE]. Diagnoses included schizophrenia, major depressive disorder, and chronic obstructive pulmonary disease (COPD). Review of Resident #288's November 2021 physician orders revealed the resident was on droplet/contact isolation precautions every shift for 14 days on readmission to rule out COVID-19. Review of Resident #288's progress note, dated 11/23/21 at 3:25 P.M., revealed droplet/contact isolation precautions every shift for 14 days on readmission for precautionary measures were implemented. Monitor mood and behavior every shift related to isolation. Notify physician of any changes and alterations as indicated. Resident educated on isolation precautions with verbal understanding. Resident, guardian, and primary care physician aware. Review of Resident #288's care plan, dated 11/24/21, revealed the resident required contact/droplet isolation precautions for 14 days upon admission related to COVID 19 precautionary measures. Guardian and primary care physician aware. Observation on 11/29/21 at 10:24 A.M. revealed outside of Resident #288's room were signs for contact and droplet precautions and a container of disinfectant wipes located in a white wire rack outside of the resident's room door. There was a bin with PPE outside of the room next door to Resident #288. Activities Aide (AA) #604 was observed outside of Resident #288 room with the beverage cart and asked Resident #288 if she wanted something to drink. Resident #288 stated she wanted hot chocolate. AA #604 put on gloves and made Resident #288 a cup of hot chocolate and entered Resident #288's room only wearing gloves, a surgical mask, and goggles. AA #604 was then observed exiting Resident #288 room and then removed her gloves. Interview on 11/29/21 at 10:27 A.M. with AA #604 verified the above observations and stated she was to put on a gown. AA #604 then went to the PPE bin next to Resident #288's room and stated there were no gowns. No gowns were observed in the PPE bin. AA #604 stated the surgical mask was okay to wear into the quarantine rooms. Interview on 11/29/21 at 10:37 A.M. with Registered Nurse (RN) #400, stated she was the infection control preventionist and that when staff enter the quarantine rooms there were to put on a gown, goggles, gloves, N95 or a surgical mask over the N95 mask. RN #400 stated when staff exit the room, they were to wipe the goggles using the disinfecting wipes outside of the resident's room door. RN #400 stated AA #604 had been educated repeatedly. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled, Coronavirus (COVID-19) Prevention and Management (An Addendum to the Infection Control Bundle Revised 04/20/21, revised 11/12/21 revealed newly admitted to readmitted residents will be quarantined and placed on Contact Isolation and Droplet Isolation with a private room/bathroom as available and quarantined in their room for medically necessary purposes for 14 days , unless they have been fully vaccinated and gave no known direct exposure to a person diagnosed with COVID-19 in the past 14 days. Residents on isolation or quarantine will have Droplet Precautions, Contact precautions, and how to don/doff PPE signage posted on their doorways. Residents on isolation or quarantine will have isolation carts outside of the resident room filled with the required PPE to enter the room. Required PPE (eye protection, N95 or surgical mask worn over N95 mask, gown, and gloves) will be donned prior to entry of a quarantine or isolation room. When exiting an isolation or quarantine rooms on a non-COVID-19-unit, gown, gloves, N95 or surgical mask worn over an N95 will be doffed outside of the room. Protective eyewear will be disinfected by cleaning the inner surface first then the outer surface last (clean to dirty).