STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365754	A. Building B. Wing	01/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Columbus LLC	44 S Souder Ave Columbus, OH 43222

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 44070 Based on observation, interview and record review, the facility failed to act promptly on the concerns brought forward during the resident council meetings for resolution including concerns of being short staffed, staff rounding timeliness, cleanliness, call lights response times, and one of the two resident and visitor elevators being broken down. This affected 19 residents (#13, #16, #18, #24, #39, #42, #48, #52, #53, #60, #63, #68, #69, #72, #73, #74, #83, #95, and #97) who attended resident council meetings, but had the potential to affect all facility residents. The facility census was 102. Findings include: Review of Resident Council meeting minutes for 10/26/22, 11/23/22, and 12/28/22 revealed the following resident concerns: -In 10/2022 residents brought up concerns related to the facility being short-handed, staff not rounding for routine care, and requesting an increase in cleaning of rooms. -In 11/2022 residents brought up concerns related to call light delays, more frequent checks and changes for incontinence, facility being short staffed and residents waiting for care for so long that they contact 911, an increase in cleaning rooms, and one of the resident and visitor elevators being broken down. -In 12/2022 residents brought up concerns related to call lights not being answered timely and concerns related to one of the two resident elevators being broken down. Review of the concern form dated 10/27/22 revealed staff were educated on the importance of timely check and changes, housekeeping staff were educated on proper cleaning and laundry, and human resources was focusing on hiring and retention. Review of the concern form dated 11/30/22 revealed call lights audits would be done randomly to ensure timely response, staff were verbally educated to not sleep on shift, human resource will focus on hiring and retention. (continued on next page)

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/09/23 at 4:15 P.M. with Resident #52 and #53 revealed concerns related to staff response to concerns or complaints. The residents revealed they went to resident council meetings and revealed their concerns, but management did not listen to the concerns and address them timely. They revealed that staffing, call lights, incontinence care, facility cleanliness, and the broken elevator have been brought up at numerous meetings with no improvements. They revealed the elevator had been broken for several months with no plan for it to be fixed. Interview on 01/10/23 at 2:15 P.M. with Director of Maintenance (DM) #77 and Assistant for Maintenance (AM) #76 revealed the resident elevator had been down since summer 2022. They were unable to provide a date of when the elevator would be getting fixed. Interview on 01/10/23 at 4:00 P.M. with the Administrator, Regional Nurse Consultant #100 and VP of Operations #101 revealed the facility had one working resident and visitor elevator. They revealed no call light audits were completed. The Administrator acknowledged long wait times to use the one working resident and visitor elevator. Interview on 01/17/22 at 4:05 P.M. with Director of Activities (DA) #72 revealed they held the resident council meeting each month and a concern form was made up for each concern and then it was provided to the manager in charge, Director of Nursing (DON), or Administrator. The manager in change was responsible for addressing the concern in order for improvements to be made and the concern did not need to be brought up again. DA #72 revealed she was supposed to receive the resident council concern forms back but did not always get them back. The facility was unable to provide any evidence that the facility had worked to get the elevator fixed timely including getting a timely quote and schedule for work to be completed. The facility also failed to provide evidence of the concerns being addressed including staffing concerns, check and changes, call light audits and housekeeping cleanliness monitoring. The facility had also not yet addressed any of the 12/2022 resident council concerns. Review of the facility policy titled, Resident Concerns and Grievances dated 09/2020, revealed the facility would provide care in a manner that promotes and respects the rights of the residents including the right to have a concern or complaint. The concern should be documented on a concern form, a designated member of the care team would notify the resident of the actions taken to resolve the concern. Follow up on a concern for resolution would be completed as soon as practicable not to exceed 30 days. This deficiency represents non-compliance investigated under Complaint Number OH00139596.

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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 - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on observation, resident interview, staff interview, and record review, facility failed to ensure a safe, clean and homelike environment. This affected three residents (#52, #53, and #71) and could potentially affect all residents residing in the facility. The facility census was 102. Findings include: 1. Review of the medical record for Resident #71 revealed an admitted [DATE]. Diagnoses included encephalopathy unspecified psychosis, anxiety, osteoarthritis, Marfans's syndrome, delusional disorder, and lymphedema. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #71 was cognitively impaired with a Brief Interview of Mental Status (BIMS) of 7 and required extensive supervision assist for transfers and mobility. The MDS revealed the resident was occasionally incontinent of urine. Review of the care plan dated 04/22 revealed Resident #71 was at risk for urinary incontinence with interventions to assist with toileting, check for incontinence and provide care daily, and observe for a pattern of incontinence. The care plan did not include any behaviors of urinating on the floor. Observation on 01/09/23 at 10:50 A.M. revealed Resident #71, who resided on the third floor, had a large puddle of urine in the middle of his room floor. There were several dried stains on the floor that also appeared to be from urine. The resident was walking around his room with blue medical shoes with velcro straps on his feet and was walking through the puddle of urine in his room and then walking down the hall. Observation and interview on 01/09/23 from 11:00 A.M. to 11:25 A.M. revealed facility staff working on Resident #71's hallway on 01/09/22 day shift included two nurses and five aides. Observation on 01/09/23 at 11:38 A.M. revealed a staff person took food into Resident #71's room and walked around the puddle of urine on the floor. The staff member did not inform other staff of the urine puddle and did not return to clean it up. Interview on 01/09/23 at 12:22 P.M. with Licensed Practical Nurse (LPN) #75 verified there was a large urine puddle on the floor of Resident #71's room. LPN #75 revealed housekeeping staff typically cleaned the rooms on one floor and then went to the next floor to clean the rooms. Interview on 01/09/22 at 6:00 P.M. with the Administrator revealed the state tested nursing assistants should be cleaning bodily fluid and urine from the floors and after it is cleaned, housekeeping would come by and sanitize the area. The Administrator revealed her expectation would be for staff to notice the urine on the floor and clean it up when found and not walk around it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for the Resident #52 revealed an admitted [DATE]. Diagnoses included hemiplegia following cerebral infarction, hypertension, anxiety, depression, dissociative and conversion disorder, undifferentiated somatoform disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 was cognitively intact with a BIMS of 14 and the resident had no coded behaviors during the review period. Resident #52 required extensive assistance of two staff members for bed mobility, limited assist of two for bed mobility, limited assist of one for dressing, supervision for eating, toileting, and personal hygiene. Resident was at risk for pressure ulcers but did not have any pressure ulcer had no wounds or skin conditions Review of the medical record for the Resident #53 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disorder, diabetes type two, schizophrenia, mild intellectual disabilities, impaired cognition, generalized anxiety disorder, bipolar disorder, shortness of breath. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #53 was cognitively intact with a BIMS of 15 and required supervision assist for mobility. Interview on 01/09/23 at 4:15 P.M. with Resident #52 and #53 revealed several environmental and safety concerns. Both residents resided in the same room on the second floor. Both residents revealed they have seen cockroaches in the hallways and in their room from time to time. They revealed the wall behind the sink in their room was crumbling and moved if any weight was applied to the sink itself. Both residents stated the sink drips on the floor and had been leaking for weeks and maintenance just put tape over the leak. Both residents revealed after a few minutes of running water it would begin to drip but it accumulated into a large puddle under the sink. Observation of the residents' room at the time of the interview revealed the sink was attached to the wall and did not have a base. The drywall where the sink was connected to the wall was crumbling with pieces of drywall on the sink and on the florr. The floor beneath the sink showed evidence of the flooring starting to [NAME] due to the leak. The pipe was not observed to be dripping during this or any subsequent observations. Interview on 01/10/23 at 2:15 P.M. with Director of Maintenance (DM) #77 and Assistant for Maintenance (AM) #76 revealed concerns of getting the resources and approval for some of the necessary fixes and repairs. DM #77 revealed he had been taping the sink for several weeks but acknowledged it was not a long-term fix. Both staff acknowledged the wall behind the sink was cracked and crumbling with crumbs of drywall falling out onto the sink ledge and floor. Review of the facility policy titled, Homelike Environment, dated 05/2017, revealed the facility would provide a safe, clean, comfortable and homelike environment. The facility staff shall maximize characteristics including clean and sanitary environments, pleasant and neutral scents. This deficiency represents non-compliance investigated under Complaint Number OH00139013, Complaint Number OH00138817, and Complaint Number OH00138760 and is an example of continued non-compliance from the survey dated 12/20/22.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on review of medical records, review of facility Self-Reported Incidents (SRI), observation of cellular phone pictures, interviews with facility staff, and review of the facility policy titled Abuse and Neglect Clinical Protocol, the facility failed to ensure residents were free from physical, verbal, and mental/emotional abuse by two facility staff members while in two resident rooms not for any apparent care or needed services. This resulted in Immediate Jeopardy and the potential for serious physical and/or psychosocial harm for two cognitively impaired residents (#95 and #98) when State tested Nursing Aide (STNA) #112 and STNA #113 engaged in acts meant to humiliate and dehumanize the residents by recording inappropriate videos and pictures on a cellular phone of explicit actions/movements towards Resident #95 and #98 which was not in accordance with facility policy. This affected two (#95 and #98) of three residents reviewed for abuse. The facility census was 102. On 01/11/23 at 5:28 P.M., the Administrator, Regional Nurse Consultant (RNC) #100 and Regional [NAME] President of Operations (RVPO) #101 were notified Immediate Jeopardy began on 12/27/22 when management staff were texted edited picture screenshots of STNA #112 engaged in inappropriate acts with Resident #95 and Resident #98 in compromising positions when both Residents #95 and #98 were cognitively impaired, while no personal care services were being provided. Review of the screenshot pictures revealed three pictures. The first edited picture was of STNA #112 lying face up on top of Resident #95 who was also lying faceup in bed with her gown open, and breasts and incontinence brief exposed with no linens/bedding on the bed. Resident #95 appeared to be in pain and appeared to be yelling out in the picture. The second edited picture was of STNA #112 sitting on Resident #95's legs facing away from the resident who was lying in bed faceup with her gown open, and breasts and incontinence brief exposed with no linens/bedding on the bed. Resident #95 appeared to be in pain and appeared to be yelling out in the picture. The third picture featured no staff and included a picture of Resident #98 lying on her left side, curled up in the fetal position, and completely naked with no linens/bedding on the resident's bed. Resident #98's face appeared to show distress. The first two pictures were edited using an application (app) editing tool which blurred or whited out sections of the picture over the staff member's face and identifiable features. A video was taken of STNA #112 abusing Residents #95 and #98 by STNA #113 and was shared in a group chat message among STNA #110, STNA #111, STNA #112 and STNA #113. On the evening of 01/03/23, STNA #110 told Housekeeping Supervisor #85 of the videos and showed the full- length unedited videos. The next morning, (01/04/23) Housekeeping Supervisor #85 informed facility management of the full context of the video and photographs and provided them the perpetrators' names. The Immediate Jeopardy was removed on 01/12/23, after the facility implemented the following corrective actions: On 12/27/22 early afternoon, Human Resources Director #56 received a picture texted to her phone of an edited-out staff member laying on Resident #95. The Administrator was immediately notified, and an investigation was initiated. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/27/22 late afternoon, the Administrator received a picture texted to her phone of an edited-out staff member sitting on Resident #95. This picture was sent from the same anonymous phone number and included accusations of abuse and threats of sending the photos to the resident's family and a local news channel. Resident #95's family was also contacted by the anonymous sender and was sent the photos. On 12/27/22, the text message stated the Assistant Director of Nursing (ADON) was involved in the abuse and therefore the ADON was suspended 12/27/22 to 01/03/22 pending investigation which found the ADON had no involvement in the incident. On 12/27/22, an abuse investigation was initiated, and an SRI was submitted to the Ohio Department of Health. On 12/27/22, the Director of Nursing (DON) and/or designee completed a head-to-toe skin check and pain assessment of Resident #95 with no new concerns identified, the physician and family were notified of the incident, and Physician #150 completed an assessment of the resident. On 12/27/22, the local police were notified of the first two pictures that were sent to facility management. On 12/27/22, RNC #100 notified the sister facility [NAME] Care of [NAME] they are not to hire or rehire any [NAME] Care of Columbus staff without prior approval of the RVPO #101 or RNC #100. On 12/27/22, residents with a Brief Interview of Mental Status (BIMS) of eight or above were interviewed or assessed to ensure they feel safe and if they had experienced abuse while living at the facility. No concerns were identified. On 12/27/22, the facility's abuse policy was reviewed, and no revisions were made. On 12/27/22, staff were educated regarding the identification of abuse, the abuse policy, prevention, reporting and investigation of abuse. The training started on 12/27/22 and all staff were required to complete the training before their next shift. On 12/28/22, a third picture was texted to the Administrator by a different anonymous phone number of Resident #98 lying naked and in a compromising position. On 12/28/22, Resident #98 was added to the SRI and facility investigation related to abuse. On 12/28/22 the local police department was notified of the incident involving the three text messages of resident photographs. The police came to the facility to begin an investigation. On 12/28/22, the DON and/or designee completed a head-to-toe skin check assessment of Resident #98 with no new concerns identified, the resident's family/guardian was notified of the incident, and Social Worker #58 completed a psychosocial assessment check in with the resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/28/22, nursing supervisors completed physical assessments/skin audits on residents with a BIMS of seven or below to identify any injuries of unknown origin or evidence of abuse or neglect. Residents with a BIMS of eight or above were interviewed by nursing supervisors to identify any issues or concerns. No concerns were identified through skin checks or interviews. On 12/28/22 at 2:00 P.M., Activity Director #72 held a resident council meeting in which residents were provided education on the facility's abuse policy and procedures. Resident #95 had psychosocial check ins by Social Worker #58 on 12/28/22, 12/29/22, 12/30/22, 01/03/23, and 01/11/23 and psychiatric services follow up on 01/04/23 and 01/09/23. Resident #98 had psychosocial check ins by Social Worker #58 on 12/29/22, 12/30/22, 01/03/23, and 01/11/23. On 01/03/22, the final SRI report was submitted to the Ohio Department of Health. On 01/11/23, the Administrator, Social Worker #58 and Clinical Manager team of unit managers were educated by RNC #100 on timely and thorough abuse investigations. On 01/11/23, Resident #98 had a pain assessment completed by Social Worker #58 with no new findings and Physician #155 was notified. The resident had a follow up with psychiatric services on 01/11/23. On 01/12/23 from 9:00 A.M. to 12:05 P.M., interviews were conducted with Human Resources Director #56, Admission Director #52, Social Service Director #58, Social Services Assistant #59, Maintenance Director #77, STNAs #55, #71, #61 and Licensed Practical Nurse (LPN) #80. All staff reported they had not observed any staff video recording residents on the units with their cellular phones. Additionally, they stated they had not observed any video recordings of residents on other staff members' cellular phones nor on any form of social media. They all stated they received training by reviewing the Abuse policy and procedures. Although the Immediate Jeopardy was removed on 01/12/23, the facility remained out of compliance at Severity Level 2 (no actual harm with the 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 on-going compliance. Findings include: 1) Review of the medical record for Resident #95 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, psychotic disorder with hallucinations, depression and anxiety, and dementia. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #95 was cognitively intact with a BIMS of 15 and required supervision of one person assist for bed mobility and extensive assist of one staff for transfers. Review of the plan of care dated 04/07/21 revealed Resident #95 required assistance with activities of daily living due to weakness, psychosis and dementia. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the SRI dated 12/27/22 revealed on 12/27/22, Human Resources Director #56 was anonymously texted an edited picture of a video screenshot of STNA #112 laying on Resident #95. Resident #95 was lying face up in bed with her gown open with both breasts exposed and wearing an incontinence brief with no bed sheets on the bed. The resident appeared to be in pain during the interaction. The staff member was laying on the resident with the staff member's back against resident's exposed chest and legs. The picture had been altered and the staff member had been blurred out. On 12/27/22, a second photograph was texted from the same anonymous number to the Administrator showing Resident #95 lying in bed with her gown open and her breasts exposed and wearing a depends, with no linens on the bed. STNA #112 was observed to be sitting on the resident's legs facing away from the resident. Resident #95's mouth was open in a yelling motion and appeared to be in pain. The staff member was again blurred out in the picture. This text message also included threats to send pictures to the resident's family and to a local news station. The investigation included an interview with Resident #95, who had no recollection of the event. The facility's investigation was completed on 01/03/23 and substantiated the allegation of abuse for Resident #95. Interview on 01/10/23 at 5:00 P.M. with RNC #100 revealed Resident #95's daughter was texted a copy of the picture along with a text claiming abuse occurred at the facility. Review of the screenshot pictures on 01/11/23 revealed the first edited picture was of STNA #112 lying face up on top of Resident #95 who was also lying faceup in bed with her gown open, and breasts and incontinence brief exposed with no linens/bedding on the bed. Resident #95 appeared to be in pain and appeared to be yelling out in the picture. The second edited picture was of STNA #112 sitting on Resident #95's legs facing away from the resident who was lying in bed faceup with her gown open, and breasts and incontinence brief exposed with no linens/bedding on the bed. Resident #95 appeared to be in pain and appeared to be yelling out in the picture. The first two pictures were edited using an app editing tool which blurred or whited out sections of the picture over the staff member's face and identifiable features. 2) Review of the medical record for the Resident #98 revealed an admitted [DATE]. Diagnoses included schizoaffective disorder bipolar type, diabetes type two, cognitive impairment, glaucoma, anxiety, and intellectual disability. Review of the MDS assessment dated [DATE] revealed Resident #98 was cognitively impaired with a BIMS of five and required extensive assistance of two staff members for bed mobility and transfers. Review of the plan of care dated 05/13/22 revealed Resident #98 had difficulty with communication due to slurring words and cognitive deficit with interventions to ask yes or no questions, make eye contact when speaking with resident and use simple or brief words. Review of the SRI dated 12/27/22 revealed on 12/28/22, a third picture was sent to the Administrator's cell phone from a different anonymous phone number featuring Resident #98. This picture was of Resident #98 lying completely naked in bed on her left side in the fetal position with no linens/bedding on the bed. The resident appeared to look sad or distressed. The investigation included an interview with Resident #98, who had no recollection of the event. The facility's investigation was completed on 01/03/23 and substantiated the allegation of abuse for Resident #98. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the third screenshot picture revealed no staff in the picture, but instead was just Resident #98 lying on her left side, curled up in the fetal position, completely naked with no linens/bedding on the resident's bed. Resident #98's face appeared to show distress. Interview on 01/09/23 at 1:51 P.M. with Police Officer #200 revealed they had not closed the investigation but revealed all further information would be found by the Ohio Department of Health investigation and reviewed by the Ohio Attorney General. Police Officer #200 revealed no arrests had been made since the identities of the perpetrators were made known by the facility investigation. Interviews on 01/09/23 from 11:00 A.M. to 2:30 P.M. with Residents #95 and #98 revealed neither resident had any recollection of the videos being taken. From brief interview, neither resident was interviewable. Interview on 01/11/23 at 9:24 A.M. with Housekeeping Supervisor (HS) #85 revealed she observed the unedited images and videos on the phone of STNA #110 on 01/03/23 who was employed at the facility. HS #85 revealed she reported the identity of the staff involved in the pictures and videos to the Administrator the next day on 01/04/22. HS #85 revealed the videos were brought to her in a bragging manner and were part of a group chat involving four STNA's (#110, #111, #112 and #113). HS #85 revealed she saw the unedited videos and pictures and could tell who was laying and sitting on the residents and who was recording the video. She stated both residents could be heard screaming in the videos as staff were messing with them while taking the videos including laughing and dancing on the residents in a sexual manner. Interview on 01/11/23 with RNC #100 and the Administrator revealed all four staff members involved were no longer working at the facility. The two staff involved in the making of the videos (STNA #112 who was perpetrating the abuse by sitting and laying on Resident #95 and STNA #113 who was recording the abuse) both stopped working at the facility on 08/16/22 and transferred to a sister facility. STNA #111 was involved in the group text message and was terminated around 12/27/22 for falsifying timeclock hours and STNA #110 who was also involved in the group text of the abuse videos and pictures was terminated 01/04/23 for falsifying a COVID-19 test to get time off after being placed on probation for numerous other infractions. Due to the timeframes of when the residents were admitted to the facility and when the staff left the facility, it was estimated by RNC #100 and the Administrator that the videos were taken, and abuse occurred between 05/20/22 and 08/20/22 and were released to facility management in retaliation. Review of a written statement from HS #85 revealed she was shown the videos and photos of abuse of Residents #95 and #98 by STNA #110 in a bragging or gloating manner from his cell phone. HS #85 revealed she saw the unedited videos from a group message that contained STNAs #110, #111, #112 and #113. HS #85 was able to go into detail of the photographs and clearly describe the staff in front of and behind the camera based on viewing the picture and the audio of STNA #112 and #113 speaking in the video. HS #85 revealed STNA #112 was trying to be funny by dancing on Resident #95 in a sexual way while STNA #113 was laughing. HS #85 revealed during this interaction, Resident #95 was screaming and yelling out. HS #85 revealed Resident #95 was exposed with both breasts showing and her incontinence brief showing. HS #85 estimated the video was a few minutes long. HS #85's statement revealed Resident #98 was naked in the video and she was able to hear STNA #113 telling Resident #98 she's a pretty mermaid. HS #85 revealed in the video Resident #98 was moving in a flowing or rocking manner and was seen without any clothes on and no bedding on the bed. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the police report dated 12/27/22 revealed facility management received through an anonymous text message, pictures of Residents #95 and #98. The police report was able to provide a partial physical description of the perpetrator based on what was still visible. The description included an African American female about five-foot nine-inch height with a [NAME] waist and a large butt and black hair. Neither resident had a recollection of the incident. Review of the personnel file for STNA's #110, #111, #112, #113 revealed no mention in their employee file of a history of abuse and no mention of the incident. All staff had been terminated for reasons not related to the abuse of Residents #95 and #98. Review of the policy titled, Abuse and Neglect Clinical Protocol, effective 03/2018, revealed the policy stated abuse was defined as a willful infliction of pain or intimidation causing mental anguish and also includes deprivations causing mental anguish. It also includes verbal abuse, sexual abuse, physical and mental abuse including abuse facilitated or enabled through the use of technology. This deficiency represents non-compliance investigated under Complaint Number OH00139008, Complaint Number OH00139010, and Complaint Number OH00139012.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365754	A. Building B. Wing	01/30/2023

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on resident interview, staff interview, ombudsman interview, and record review, the facility failed to ensure resident was given a discharge notice for an appropriate reason. This affected one (#52) of three residents reviewed for discharge. The facility census was 102. Findings include: Review of the medical record for Resident #52 revealed an admitted [DATE]. Diagnoses included hemiplegia following cerebral infarction, hypertension, anxiety, depression, dissociative and conversion disorder, and undifferentiated somatoform disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 was cognitively intact with a Brief Interview for Mental Status (BIMS) of 14. Resident #52 had no coded behaviors during the review period. Resident #52 required extensive assistance of two staff members for bed mobility. Review of the care plan dated 12/03/22 revealed Resident #52 had behaviors of making false allegations, would regularly voice complaints and could be verbally aggressive. A progress note dated 01/05/23 revealed a discharge hearing was scheduled for 01/13/23 at 10:00 A.M. However, there was no documentation in the progress notes prior to 01/05/23 that the resident was issued a 30-day discharge notification. A progress note dated 01/12/23 revealed the resident was informed her discharge hearing was cancelled and the 30-day discharge notice was rescinded, and she could remain in the facility. Review of the 30-day discharge notification dated 12/16/22 revealed Resident #52 would be discharged on [DATE]. The reasoning provided stated the welfare and needs of the resident cannot be met in the facility because a government agency had made the determination the resident does not require the level of care provided in a nursing facility or was otherwise not appropriate for nursing facility placement. Review of the 30-day discharge notification dated 12/21/22 revealed Resident #52 would be discharged on [DATE]. The reasoning provided stated the welfare and needs of the resident cannot be met in the facility because a government agency had made the determination the resident does not require the level of care provided in a nursing facility or was otherwise not appropriate for nursing facility placement. Further review of the resident's record revealed no evidence the Ombudsman was notified of either notification that the resident was being discharged . (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/09/23 at 12:00 P.M. with the Ombudsman revealed concerns related to Resident #52's discharge. The Ombudsman revealed she and Resident #52 were provided with a 30-day discharge letter dated 12/16/22, but when the Ombudsman arrived at the facility to discuss the notice, the Director of Nursing took the letter back. The Ombudsman stated she never received the letter dated 12/21/22. The resident had some confusion about the reasoning for getting the discharge letter. The Ombudsman reported being unsure why she was being discharged due to government agency decision or determination. Interview on 01/12/23 at 1:35 P.M. with the Administrator and the Assistant Director of Nursing (ADON) revealed Resident #52 was found to need an updated Level of Care due to a Quality Assurance Performance Improvement (QAPI) program review. The resident had a Level of Care submitted and it was marked as not applicable. Resident #52 was then given a discharge notice. The Administrator revealed Resident #52 had a hearing scheduled for 01/13/23 with the State Hearing Officer regarding the resident's appeal. Interview on 01/12/23 at 3:00 P.M. with Resident #52 revealed a hearing was scheduled to determine a final decision regarding the 30-day notice and discharge based on her discharge appeal. Interview on 01/12/23 at 3:25 P.M. with Corporate Social Worker (CSW) #140 revealed as part of the facility's QAPI plan the facility was performing a routine review of Levels of Care and Preadmission Screening and Resident Review (PASRR) and found Resident #52 was due for an updated Level of Care. Upon receiving the documents from the Area Agency on Aging reviewer, it was noted the Level of Care was marked as not applicable meaning the resident did not need psychiatric services. CSW #140 revealed the facility's social services designee had a lack of understanding of the document and thought not applicable meant the resident was not appropriate for skilled services and therefore not eligible for admission to the facility. CSW #140 revealed the discharge notice was being cancelled or rescinded and the resident would be allowed to remain in the facility. CSW #140 revealed she was planning to cancel the hearing as the resident would no longer be discharged and confirmed an error on the facility's part for providing a 30 day discharge notice. Review of the facility policy titled, Discharge Plan and Notice of Transfer, dated 07/2018, revealed a discharge plan shall be developed to help the resident adjust to his or her new living environment. The facility must notify the resident, resident representative and ombudsman in writing prior to a facility-initiated discharge to provide added protection for residents being inappropriately discharged . The medical record must contain evidence of the notice being provided to the ombudsman and must be provided at the same time of the notice being provided to the resident. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on resident interview, staff interview, ombudsman interview and record review, facility failed to ensure the resident's discharge notice was provided to the Ombudsman timely. This affected one (#52) of three residents reviewed for discharge. The facility census was 102. Findings include: Review of the medical record for the Resident #52 revealed an admitted [DATE]. Diagnoses included hemiplegia following cerebral infarction, hypertension, anxiety, depression, dissociative and conversion disorder, and undifferentiated somatoform disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 was cognitively intact with a Brief Interview for Mental Status (BIMS) of 14. Resident #52 had no coded behaviors during the review period. Resident #52 required extensive assistance of two staff members for bed mobility. Review of the care plan dated 12/03/22 revealed Resident #52 had behaviors of making false allegations, would regularly voice complaints and could be verbally aggressive. A progress note dated 01/05/23 revealed a discharge hearing was scheduled for 01/13/23 at 10:00 A.M. A progress note dated 01/12/23 revealed the resident was informed her discharge hearing was cancelled and the 30-day discharge notice was rescinded, and she could remain in the facility. No documentation related to the resident receiving either 30-day notice (on 12/16/22 and again on 12/21/22) and no evidence of the Ombudsman notification of the discharge letters was found in the resident's record. Review of the 30-day discharge notification dated 12/16/22 stated resident would be discharged on [DATE]. The reasoning provided stated the welfare and needs of the resident cannot be met in the facility because a government agency had made the determination the resident does not require the level of care provided in a nursing facility or was otherwise not appropriate for nursing facility placement. Review of the 30-day discharge notification dated 12/21/22 stated resident would be discharged on [DATE]. The reasoning provided stated the welfare and needs of the resident cannot be met in the facility because a government agency had made the determination the resident does not require the level of care provided in a nursing facility or was otherwise not appropriate for nursing facility placement. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/09/23 at 12:00 P.M. with the Ombudsman revealed concerns related to Resident #52's discharge. The Ombudsman revealed she and Resident #52 were provided with a 30-day discharge letter dated 12/16/22, but when the Ombudsman arrived at the facility to discuss the notice, the Director of Nursing took the letter back. The Ombudsman stated she never received the letter dated 12/21/22. The resident had some confusion about the reasoning for getting the discharge letter. The Ombudsman reported being unsure why she was being discharged due to government agency decision or determination. Interview on 01/12/23 at 1:35 P.M. with the Administrator and the Assistant Director of Nursing (ADON) revealed Resident #52 was found to need an updated Level of Care after a Quality Assurance Performance Improvement (QAPI) program review. The resident had a Level of Care submitted and it was marked as not applicable. The resident was then given a discharge notice. The Administrator revealed Resident #52 had a hearing scheduled for 01/13/23 with the State Hearing Officer regarding the resident's appeal. The Administrator revealed the letter had been sent through certified mail as well as email to the Ombudsman for notification of the 30 discharge on 12/21/22. Interview on 01/17/22 at 3:00 P.M. with Resident #52 revealed a hearing was scheduled to determine a final decision regarding the 30-day notice and discharge based on her discharge appeal. The Resident was worried she would not remember all of the details to provide to the Ombudsman herself as the Ombudsman had not received official notification of the second notice dated 12/21/22. Interview on 01/12/23 at 3:25 P.M. with Corporate Social Worker (CSW) #140 revealed the facility had no evidence of the second 30-day discharge notification being sent to the Ombudsman. She revealed staff informed her it was sent by regular mail but there were no time stamps or mail receipts as evidence this was done. CSW #140 revealed the facility should be sending the Ombudsman a copy of the 30-day discharge notice each time one was provided to the resident and evidence should be kept by email and certified mail receipts. Review of facility policy titled, Discharge Plan and Notice of Transfer, dated 07/2018, revealed the facility must notify the resident, resident representative and ombudsman in writing prior to a facility initiated discharge to provide added protection for residents being inappropriately discharged . The medical record must contain evidence of the notice being provided to the ombudsman and must be provided at the same time of the notice being provided to the resident. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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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 - Few	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** 44070 Based on observation, resident interview, staff interview and record review, the facility failed to provide assistance to a resident that required assistance with feeding. This affected one (#59) of three reviewed for nutrition. The facility had identified 25 residents (#5, #6, #12, #13, #20, #25, #27, #35, #40, #42, #50, #51, #55, #59, #61, #62, #63, #67, #68, #72, #76, #87, #88, #98, and #101) that required assistance will meals. The facility census was 102. Findings include: Review of the medical record for the Resident #59 revealed an admitted [DATE]. Diagnoses included sepsis, heart failure, respiratory failure, diverticulitis, depression, encephalopathy, and transient ischemic attack. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 was cognitively intact with a Brief Interview for Mental Status (BIMS) of 15 and required extensive assistance of two staff members for transfers. Further review of the MDS assessment dated [DATE] revealed Resident #59 required extensive assist of one staff member for eating. The MDS revealed the resident had a significant weight loss of over 5% that was unplanned. Review of the plan of care dated 07/29/22 revealed Resident #59 exhibits behaviors of making false claims and calling 911 and the state about not getting food and not getting food trays with interventions to anticipate needs, assess resident's hunger or thirst. The resident was non-compliant with dietary recommendations and will have family bring in food in forms not recommended from speech with interventions to administer medications as ordered, listen to resident needs and adjust as appropriate. The resident had the potential for nutritional risk related to weight loss with interventions to document food and fluid intakes, honor food preferences, serve diet as ordered provide supplements and dietician to evaluate for diet changes. Review of the dietary progress notes dated 12/09/22 revealed Resident #59 weighed 144 pounds on 12/08/22 which represented a significant weight loss where the resident dropped 13 pounds for a significant weight loss percentage of 8.3% in one month (from 11/03/22 to 12/08/22). The dietician reviewed the resident for the significant weight loss of 13 pounds and recommended the supplement Ensure twice daily. The resident had another small weight loss of 3 pounds on 12/14/22 and the dietician had continued to monitor the resident's weights. Review of the Kardex revealed the resident should be getting assistance with eating and nutrition including supervision and set up assist and assist from staff as needed. The facility was unable to provide evidence that food intakes were being monitored according to the care plan. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/09/23 at 11:30 A.M. revealed Resident #59 received his food tray to his room. Food was left on the tray with the warming lid covering the plate. Set up assistance was not provided or offered. Observation and interview on 01/09/23 at 12:10 P.M. of Resident #59's tray being removed from the resident's room by State tested Nursing Assistant (STNA) #55. STNA #55 revealed Resident #59 had not taken a single bite of food and confirmed she did not offer to assist the resident with eating. Resident #59's lunch tray was removed. STNA #55 revealed the resident did not require any assist from staff to eat. Interview on 01/09/23 at 12:13 P.M. with Resident #59 revealed he did not like the food at the facility and revealed he had recently lost weight. Interview on 01/09/23 at 5:35 P.M. with the Director of Nursing (DON) revealed Resident #59's assistance needs varied, but he should receive set up assist with staff offering hands on assistance as needed. The DON revealed the resident's family would bring in fast food and he had no trouble eating that food unassisted. The DON revealed her expectation would be for staff to bring his food and provide set up assistance and offer hands on assistance. If the resident declined hands on assist, allow him to try to eat on his own and then when picking up his tray if he did not eat a substantial amount of food, offer again to assist him, and then offer alternatives. Interview on 01/09/23 at 5:47 P.M. with Dietician #70 revealed she would expect staff to offer to assist or offer alternatives if they noticed a resident was not eating. Interview on 01/10/23 at 10:00 A.M. with the DON and Minimum Data Set (MDS) Coordinator #81 revealed the MDS was completed on 12/27/22 and listed Resident #59 as an extensive assist for feeds. The resident was marked as requiring hands on assist (guiding assistance, extensive assistance or total dependance) 11 of 13 times in the previous week. The updated MDS assessment dated [DATE] revealed the resident was marked as requiring hands on assist (guiding assistance, extensive assistance or total dependance) 10 of 14 times in the previous week. Review of facility policy titled Assistance with meals, dated 07/2017, revealed the facility staff will offer to assist residents who require assistance with meals. This deficiency represents non-compliance investigated under Complaint Number OH00139013 and OH00138817.

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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** 36297 Based on record review, observation, staff and resident interview, the facility failed to provide timely incontinence care to one (#59) of three residents reviewed for incontinence care and the facility failed to provide timely showers/bathing for two (#80, and #81) of four residents reviewed for showers/bathing. The facility census was 102. Findings include: 1. Review of the medical record for Resident #59 revealed an admitted [DATE]. Diagnoses included sepsis, heart failure, respiratory failure, diverticulitis, depression, encephalopathy, and transient ischemic attack. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 was cognitively intact, required extensive assistance for toileting, bed mobility and transfers. The resident was coded as always incontinent of bowel and bladder. The resident also had one stage III pressure ulcer (full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed) and two unstageable pressure ulcers (the base of the ulcer is covered by a thick layer of other tissue and pus that may be yellow, grey, green, brown, or black and therefore the stage of the ulcer cannot be determined). Review of Resident #59's medical record revealed he had pressure ulcers located on his sacrum, his right thigh and his left heel. Interview on 01/09/23 at 12:13 P.M. with Resident #59 revealed he wore incontinence briefs and revealed he would be left to sit in his urine and feces for hours at times. He revealed he was last changed at 6:00 A.M. and staff had not come in to check on him since. He reported being dry and not needing to be changed during the interview. Interview with Unit Manager #75 on 01/10/23 at 8:09 A.M. confirmed incontinence care should be provided every two hours by the State tested Nursing Assistants (STNA). Observation on 01/12/23 at 11:00 A.M. of Resident #59 with Unit Manager #75 revealed the resident was agreeable to have his incontinence brief checked. Upon observation of the resident's incontinence brief, it was noted to be saturated with urine and this was verified by Unit Manager #75. Resident #59 stated during the observation, he last received incontinence care on 01/12/23 at 5:00 A.M. (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 01/12/23 at 11:10 A.M. with STNA #55 revealed she was the staff assigned to care for Resident #59 on this day. The STNA was observed in another resident's room sitting in a resident's wheelchair and stated she was waiting to assist another staff member to get this resident ready for an appointment and then she would go to provide care to Resident #59. STNA #55 verified she had not provided any personal care to Resident #59 on this day and verified her shift started at 7:00 A.M. STNA #55 was asked how often incontinence care was to be provided and she stated twice. STNA #55 was asked to clarify what she meant by twice and she stated twice a shift. She then stated incontinence care should be provided every two hours or as needed. STNA #55 stated she checked on Resident #59 at the beginning of her shift at 7:00 A.M and he was dry and that the night shift had changed the resident prior to going off shift. STNA #55 then confirmed the present time was after 11:00 A.M. Interview on 01/12/23 at 11:11 A.M. with Unit Manager #75 confirmed STNA #55 was currently assisting get another resident ready. Unit Manager #75 was questioned if there was enough staff to complete the workload if STNA #55 had not yet provided care to a resident on her assignment and it was 11:00 A.M. and her shift had started at 7:00 A.M. Unit Manager #75 stated there should be four STNA's on the hall and revealed STNA #55 was new to the facility. Observation and interview with Resident #59 on 01/17/22 at 9:15 A.M. revealed the resident's call light was activated and the resident stated he needed to be changed. The resident stated he had last been provided incontinence care on 01/17/22 at approximately 3:00 A.M. The facility's Assistant Director of Nursing (ADON) #67 entered Resident #59's room on 01/17/22 at 9:35 A.M. The resident's incontinence care product was checked and ADON #67 verified the incontinence care product was saturated with urine. Interview with STNA #102 on 01/17/23 at 9:37 A.M. confirmed Resident #59 was on her assignment and she had not provided any care to the resident on this day. Resident #59 was provided incontinence and wound care on 01/17/23 at 9:40 A.M. by Assistant Director of Nursing (ADON) #67. When the incontinence brief was removed the resident's border foam dressing to the sacrum was only attached to the resident's skin at the top of the dressing; the other three sides of the dressing were no longer attached to the resident's skin and the border foam dressing was saturated. During the incontinence care the border foam dressing to the sacrum fell off the resident. Interview with Regional Nurse Consultant (RNC) #100 on 01/17/23 at 9:42 A.M. who was present during the incontinence and wound care verified Resident #59's incontinence brief was saturated with urine and the sacrum dressing to the sacral pressure ulcer was so saturated with urine the dressing fell off the resident during incontinence care. Review of the last three months of resident council meeting minutes revealed during the 10/27/22 meeting resident's had requested to have more frequent checks and changes. 2. Review of Resident #80's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included absence epileptic syndrome not intractable without status epilepticus, mild cognitive impairment, psychotic disorders with delusions and anxiety. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of most recent quarterly MDS assessment dated [DATE] revealed the resident has a Brief Interview of Mental Status (BIMS) score of 14 indicating the resident is cognitively intact, the resident had no behaviors, delusions or hallucinations during the review period. The resident required extensive assist with personal activities of daily living with the exception of eating which was supervision. The resident is frequently incontinent of bowel and bladder. Review of shower documentation for Resident #80 for 12/2022 through 01/2023 revealed documentation that the resident received a bed bath on 12/03/22, refused a bath/shower on 12/07/22, received a bed bath on 12/10/22, received a shower on 12/14/22, and one that was undated, but did not indicate if the resident received a bath/shower or refused. The resident had a total of four documented shower opportunities for the months of 12/2022 and 01/2023. There was no other documentation that Resident #80 received any baths/showers in December or January. Interview on 01/12/22 at 11:30 A.M. with Regional Clinical Nurse (RNC) #100 revealed Resident #80's showers were not provided twice weekly as per facility standard. 3. Review of Resident #81's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included to schizoaffective disorder, Alper's disease, bipolar disorder, and anxiety, Review of the quarterly MDS assessment dated [DATE] revealed Resident #81 was cognitively intact and had delusions, behaviors directed toward others, and wandering one to three days of the review period. Resident #81 requires supervision for all activities of daily living including bathing which is coded as set help only. The resident is always continent of bowel and bladder. The resident received seven days of antipsychotic medication during the review period. Review of Resident #81's shower sheets/documentation from 12/2022 to 01/2023 reviewed two shower sheets for the resident, one on 12/04/22 indicating the resident refused, and the other on 12/08/22 indicating the resident refused. There was no other documentation the resident received any baths/showers in December or January. Interview with the Administrator on 01/23/23 at 3:55 P.M. confirmed there were only two showers documented for the resident from 12/2022 through 01/2023. The Administrator verified the shower sheets showed Resident #81 refused both shower opportunities. This deficiency represents non-compliance investigated under Complaint Number OH00139596, OH00139013, and OH00138817.

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F 0686 Level of Harm - 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** 36297 Based on observation, record review, resident interview, staff interview and policy review, the facility failed to timely implement procedures to minimize the risk for pressure ulcers for one (#59) of three residents reviewed for pressure ulcers. This resulted in actual harm when Resident #59 developed a new stage II pressure ulcer. The facility also failed to follow the wound treatment recommendations for three (#59, #55, and #58) of three residents reviewed for pressure ulcers. The facility census was 102. Findings include: 1. Review of the medical record for the Resident #59 revealed an admitted [DATE]. Diagnoses included sepsis, heart failure, respiratory failure, diverticulitis, depression, encephalopathy, and transient ischemic attack. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 was cognitively intact with a Brief Interview of Mental Status (BIMS) of 15 and required extensive assistance of two staff members for transfers and required extensive assist of one staff member for eating. The MDS revealed the resident had a greater than 5% weight loss that was unplanned and the resident had a therapeutic diet. Review of the progress notes dated 12/09/22 revealed the dietician reviewed the resident for a significant weight loss of 13 pounds and recommended the supplement Ensure twice daily. The resident had another small weight loss of 3 pounds on 12/14/22 and the dietician had continued to monitor the resident's weights. Review of the Medication Administration report (MAR) dated 12/2022 and 01/2023 revealed the resident had been getting the supplements once daily and twice daily as ordered and the percentage of intake had been documented in the MAR. Review of the plan of care dated 07/29/22 revealed Resident #59 was at risk for potential for nutritional risk related to weight loss with interventions to document food and fluid intakes, honor food preferences, serve diet as ordered provide supplements and dietician to evaluate for diet changes. Resident #59's care plans included a care plan which stated the resident had moisture associated dermatitis to the sacrum dated 10/07/22 and the care plan was updated stating the resident had an unstageable pressure ulcer (the base of the ulcer is covered by a thick layer of other tissue and pus that may be yellow, grey, green, brown, or black and therefore the stage could not be determined) to the sacrum on 12/18/22. Interventions listed on the care plan included to provide incontinence care as needed, wound treatment as ordered, pressure reducing bed, and turning the resident. All interventions were dated 10/07/22. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #59's physician orders at the time of the survey revealed the resident had the following wound orders in place: float heels as tolerated dated 07/29/22; air mattress ordered 11/29/22; apply heel protector boots every shift for pressure reduction ordered 11/29/22; apply triad cream (barrier cream) to sacrum two times a day for wound care dated 10/07/22; cleanse buttock ischium with soap and water and apply triad cream twice daily and as needed dated 12/23/22; cleanse left heel with mild soap and water apply triad cream and cover with border foam dressing dated 12/23/22. Review of Certified Nurse Practitioner (CNP) #300's wound documentation revealed the resident was seen weekly and had his wounds measured. The documentation included the wound's size, surface area and condition of the wounds. The documentation also included the current treatment and interventions for each wound. The resident's sacral wound was acquired on 10/06/22 and documented etiology as moisture related to urine and stool incontinence. The wound was classified as moisture associated dermatitis (MASD). Sacral wound documentation was as follows: -MASD measurement on 10/06/22: 5.42 centimeters (cm) x 3.56 cm x 0.1 cm. -MASD measurement on 10/11/22: 1.29 cm x 1.05 cm x 0.10 cm. -MASD measurements on 10/18/22: 0.91 cm x 0.30 cm x 0.1 cm. -MASD measurement on 10/28/22: 1.93 cm x 2.09 cm x 0.1 cm. -MASD measurement on 11/01/22: 3.11 cm x 3.37 cm x 0.1 cm. -MASD measurement on 11/08/22: 5.75 cm x 5.02 cm x 0.1 cm. -MASD measurement on 11/15/22: 3.26 cm x 1.50 cm x 0.1 cm. Resident #59 was in the hospital from 11/15/22 through 11/29/22 and returned to the facility on [DATE]. Review of the nursing admission/readmission evaluation from 11/29/22 revealed the resident had redness to the coccyx, and a right thigh and a left heel pressure ulcer. No wound measurements or description of the areas were included in the nursing admission/readmission evaluation or in the medical record. A MASD measurement of the sacrum revealed on 12/06/22 the area was 3.84 cm x 4.60 cm x 0.1 cm. The recommended treatment for the 12/06/22 MASD documented in CNP #300's wound documentation was to cleanse the area with normal saline and apply triad paste twice daily and as needed. CNP #300's documentation on 12/13/22 revealed the sacral area was worsening and was now classified as an unstageable pressure ulcer measuring 6.79 cm x 3.83 cm. The treatment was documented as cleanse wound with normal saline, apply hydrogel (keeps the wound moist and helps to remove slough or necrotic tissue), and cover with a border foam dressing daily. Wound care interventions were updated to include a specialty bed. Review of Resident #59's physician orders revealed the facility failed to follow CNP #300's recommended treatment starting on 12/13/22 when the facility continued to use the triad paste twice daily to the wound and apply border foam. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #59 was hospitalized from 12/18/22 through 12/21/22. The medical record was silent to the disposition of the resident's skin condition on readmission to the facility from this hospitalization . There was no admission/readmission evaluation in the medical record and no documentation in the progress notes regarding the resident's skin condition. The resident's wounds were re-assessed on 12/27/22 by CNP #300, six days later. CNP #300's documentation of the unstageable area to the resident's sacrum was as follows: -12/27/22 improving wound measuring 3.51 cm x 2.65 cm, continue with normal saline, apply hydrogel and cover with a border foam dressing daily and ensure compliance with turning and specialty bed. -01/03/23 wound is stable measuring 3.67 cm x 2.60 cm, continue normal saline, apply hydrogel and cover with a border foam dressing daily and ensure compliance with turning and specialty bed. -01/10/23 wound is stable measuring 3.13 cm x 2.37 cm, continue normal saline, apply hydrogel and cover with a border foam dressing daily and ensure compliance with turning and specialty bed. Review of Resident #59's physician orders revealed the facility failed to follow CNP #300's wound treatment recommendations when the facility continued to treat the sacrum ulcer with triad paste twice daily. Resident #59's right posterior thigh skin alteration was documented in the medical record by CNP #300 as follows: -10/28/22 skin tear: 1.16 cm x 1.42 cm x 0.10 cm -11/01/22 skin tear: 1.99 cm x 2.68 cm x 0.1 cm -11/08/22 skin tear: 2.08 cm x 1.32 cm x 0.1 cm -11/15/22 skin tear: 1.35 cm 0.98 cm x 0.10 cm Wound care treatment recommendations for the above dates were documented in CNP #300's notes as cleanse with normal saline and apply triad paste twice daily and as needed. Resident #59 was in the hospital from 11/15/22 through 11/29/22 and returned to the facility on [DATE]. Review of the nursing admission/readmission evaluation documented the resident wounds as redness to the coccyx, a right thigh, and a left heel pressure ulcer. No wound measurements or description of the areas were included in nursing admission/readmission evaluation or in the medical record. The medical record had the ordered treatment for the right posterior thigh from 11/29/22 through 12/06/22 as cleanse the area with normal saline and apply triad paste twice daily and as needed. On 12/06/22 the right posterior thigh wound was assessed by CNP #300 and documented the wound to the right posterior thigh as 1.42 cm x 1.94 cm x 0.20 cm. The wound was classified as a stage III pressure ulcer (full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed) with the treatment documented as cleanse with normal saline, apply hydrogel and cover with a border foam dressing change daily. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/13/22 CNP #300 documented the right posterior thigh stage III pressure ulcer was 1.31 cm x 1.87 cm x 0.1 cm and the treatment recommendation by CNP #300 was cleanse with normal saline, apply hydrogel, and cover with a border foam dressing change daily. Resident #59 was hospitalized from 12/18/22 through 12/21/22. The medical record was silent to the disposition of the resident's skin condition on readmission to the facility from this hospitalization . There was no admission/readmission evaluation in the medical record and no documentation in the progress notes regarding the resident's skin condition. The wounds were re-assessed on 12/27/22 by CNP #300, six says later. CNP #300's documentation of the resident's right posterior thigh was as follows: -12/27/22 stage III pressure ulcer to right posterior thigh: 1.59 cm x 1.94 cm x 0.1 cm documented as stable, treatment continued as cleanse with normal saline, apply hydrogel, and cover with a border foam dressing. -01/03/23 right posterior wound classification changed to an unstageable area: 1.16 cm x 2.01 cm x 0.2 cm continue to cleanse with normal saline, apply hydrogel, and cover with a border foam dressing. -01/10/22 right posterior thigh unstageable pressure ulcer: 1.15 cm x 2.12 cm x 0.2 cm documented as stable and to continue to cleanse with normal saline, apply hydrogel, and cover with a border foam dressing. Review of Resident #59 's physician orders revealed the facility failed to follow the CNP #300's wound treatment recommendations when the facility continued to treat the right posterior thigh (buttock/ischium) ulcer with triad paste twice daily and cover with a border foam dressing. Resident #59's medical record revealed the resident acquired an unstageable pressure ulcer to the left heel on 11/14/22. CNP #300's wound documentation for the left heel was as follows: -11/15/22 unstageable: 3.14 cm x 3.99 cm cleanse with normal saline, apply hydrogel, cover with Army Battle Dressing (ABD) pad, and wrap with Kerlix/Kling. -12/06/22 unstageable: 2.79 cm x 2.64 cm, wound stable continue treatment of cleanse with normal saline, apply hydrogel, cover with ABD pad, and wrap with Kerlix/Kling. -12/13/22 unstageable: 3.50 cm x 3.81 cm, wound stable continue treatment of cleanse with normal saline, apply hydrogel, cover with ABD pad, and wrap with Kerlix/Kling. Resident #59 was hospitalized from 12/18/22 through 12/21/22. The medical record was silent to the disposition of the resident's skin condition on readmission to the facility from this hospitalization . There was no admission/readmission evaluation in the medical record and no documentation in the progress notes regarding the resident's skin condition. The wounds were re-assessed on 12/27/22 by CNP #300, six days later. CNP #300's documentation of the resident's left heel was as follows: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-12/27/22 unstageable: 2.16 cm x 2.14 cm, wound stable, continue treatment of cleanse with normal saline, apply hydrogel, cover with ABD pad, and wrap with Kerlix/Kling. -01/03/23 unstageable: 2.13 cm x 2.39 cm, wound stable continue treatment of cleanse with normal saline, apply hydrogel, cover with ABD pad, and wrap with Kerlix/Kling. -01/10/23 left heel classification was changed to a stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling) :1.24 cm x 1.64 cm x 2.03 cm, documented as an improving wound and to continue treatment of cleanse with normal saline, apply hydrogel, cover with ABD pad, and wrap with Kerlix/Kling. Review of Resident #59's physician orders revealed the facility failed to follow CNP #300's wound treatment recommendations from 12/27/22 to 01/10/23 when the facility continued wound care to the left heel ulcer as cleanse left heel with mild soap and water apply triad paste and cover with border foam dressing. Interview on 01/09/23 at 12:13 P.M. with Resident #59 revealed he used the call light to get assistance and it typically took 30 to 60 minutes for staff to come to the room. He revealed he wears incontinence briefs and revealed he will be left to sit in his urine and feces for hours at times. Observation on 01/12/23 at 11:00 A.M. of Resident #59 with Unit Manager #75 revealed the resident was agreeable to have his incontinence brief checked. Upon observation of the resident's incontinence brief, it was noted to be saturated with urine and this was verified by Unit Manager #75. Resident #59 stated during the observation, he last received incontinence care on 01/12/23 at 5:00 A.M. Interview on 01/12/23 at 11:10 A.M. with STNA #55 revealed she was the staff assigned to care for Resident #59 on this day. The STNA was observed in another resident's room sitting in a resident's wheelchair and stated she was waiting to assist another staff member to get this resident ready for an appointment and then she would go to provide care to Resident #59. STNA #55 verified she had not provided any personal care to Resident #59 on this day and verified her shift started at 7:00 A.M. STNA #55 was asked how often incontinence care was to be provided and she stated twice. STNA #55 was asked to clarify what she meant by twice and she stated twice a shift. She then stated incontinence care should be provided every two hours or as needed. STNA #55 stated she checked on Resident #59 at the beginning of her shift at 7:00 A.M and he was dry and that the night shift had changed the resident prior to going off shift. STNA #55 then confirmed the present time was after 11:00 A.M. Interview on 01/12/23 at 11:11 A.M. with Unit Manager #75 confirmed STNA #55 was currently assisting get another resident ready. Unit Manager #75 was questioned if there was enough staff to complete the workload if STNA #55 had not yet provided care to a resident on her assignment and it was 11:00 A.M. and her shift had started at 7:00 A.M. Unit Manager #75 stated there should be four STNA's on the hall and revealed STNA #55 was new to the facility. Observation and interview with Resident #59 on 01/17/22 at 9:15 A.M. revealed the resident's call light was activated and the resident stated he needed to be changed. The resident stated he had last been provided incontinence care on 01/17/22 at approximately 3:00 A.M. The facility's Assistant Director of Nursing (ADON) #67 entered Resident #59's room on 01/17/22 at 9:35 A.M. The resident's incontinence care product was checked and ADON #67 verified the incontinence care product was saturated with urine. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview with STNA #102 on 01/17/23 at 9:37 A.M. confirmed Resident #59 was on her assignment and she had not provided any care to the resident on this day. Resident #59 was provided incontinence and wound care on 01/17/23 at 9:40 A.M. When the incontinence brief was removed the resident's border foam dressing to the sacrum was only attached to the resident's skin at the top of the dressing; the other three sides of the dressing were no longer attached to the resident's skin and the border foam dressing was saturated. During the incontinence care the border foam dressing to the sacrum fell off the resident. Additionally, Resident #59's left buttock was observed to have an open area to the skin that was not documented in Resident #59's medical record. The area was red in appearance with the top layer of skin missing. Interview with Regional Nurse Consultant (RNC) #100 on 01/17/23 at 9:42 A.M. who was present during the incontinence and wound care verified Resident #59's incontinence brief was saturated with urine and the sacrum dressing to the sacral pressure ulcer was so saturated with urine the dressing fell off the resident during incontinence care. RNC #100 confirmed there was a new open area to the resident's left buttock which was observed during the incontinence and would care and the area was a stage II pressure ulcer. The new stage II pressure ulcer to the resident's left buttock was cleansed with normal saline and measured as 5. 0 cm x 2.0 cm. The staff stated CNP #300 would be notified and the facility would obtain a dressing order for the area from CNP #300. The resident's right posterior thigh border foam dressing was removed, and an unidentified white cream was noted on the skin around the wound. It could not be determined if the cream was in the wound bed. The wound was observed to have an area on the top left side of the wound that was covered in slough. RNC #100 and Assistant Director of Nursing (ADON) #67, who was performing the dressing change, both verified the current dressing orders did not include the use of any cream to the resident's skin/wound as part of the ordered treatment. RNC #100 and ADON #67 verified the wound dressing which was removed from the right posterior thigh was not the correct dressing. RNC #100 verified neither the sacrum wound, nor the right thigh wound border foam dressing was dated indicating when the dressing was last changed. Observation of the left heel pressure area revealed when ADON #67 removed the Kerlix wrap from the wound the wound was covered with a border foam dressing and not the ordered ABD pad. ADON #67 and RNC #100 both verified this at that time. The border foam dressing was not the current ordered treatment and should not be in place over the resident's left heel pressure ulcer. The border foam dressing was dated of 01/16/23 on the 7:00 A.M. to 7:00 P.M. shift. ADON #67 stated she thought the dressing was to be completed once per day with hydrogel being placed in the wound bed and covered with an ABD pad and then wrapped in Kerlix. Interview with RNC #100 on 01/17/22 at 11:30 A.M. verified Resident #59 was not provided incontinence care timely and his incontinence brief was saturated with urine at the time of the incontinence and wound care on 01/17/23 at 9:40 A.M. RNC #100 verified the etiology of the sacrum wound was documented by CNP #300 as moisture related to urine and stool incontinence. RNC #100 also verified that during the observation of incontinence and wound care Resident #59 had a new stage II pressure ulcer identified to his left buttock. RNC #100 also verified the resident did not have his skin and wound assessments completed when the resident was readmitted on [DATE] and the wounds had no documented assessment in the medical record until six days later when wound CNP #300 assessed the resident's wounds on 12/27/22. During multiple observations of Resident #59 during the days of the survey there were no observed heel boots on the resident or in the resident's room for the resident as ordered on 11/29/22. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an observation of Resident #59 with RNC #100 on 01/17/23 at 1:20 P.M. it was confirmed the resident did not have heel boots in use. RNC #100 verified the treatment orders for Resident #59 were not updated to the recommended wound treatments CNP #300 had in the wound notes for Resident #59. RNC #100 verified the treatments in place during the dressing change observation on 01/17/23 at 9:40 A.M. were not the ordered treatment for the right posterior thigh and the left heel pressure ulcer, and RNC #100 verified the resident did not have the ordered heel boots in place as ordered. Interview with ADON #67 on 01/17/22 at 1:25 P.M. confirmed the resident's orders did not match the treatments CNP #300 recommended. ADON #67 also verified she had not seen the resident use heel boots in the facility. 2. Review of Resident #58's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, bipolar disorder, suicidal ideations and history of traumatic brain injury. Review of the most recent quarterly MDS assessment dated [DATE] revealed the resident had mild cognitive impairment, required limited assist for bed mobility, transfers, and locomotion on and off the unit. Resident #58 was occasionally incontinent with bowel and bladder, had a current pressure ulcer coded as a stage III ulcer that was present on admission or re-entry to the facility. The resident was noted to have an area to his lower spine on admission/readmission evaluation dated 10/28/22. Resident #58's medical record revealed the resident's wound was followed by CNP #300 and was regularly assessed with the area being described as a stage III pressure that was stable or improving on the weekly documentation. CNP #300's recommended treatment for the stage III pressure ulcer was cleanse wound with normal saline, apply hydrogel and border foam dressing from 11/01/22 to 01/03/23. Resident #58's physician orders for the stage III pressure ulcer were documented as open area to right upper back cleanse with saline, pat dry and apply dry dressing from 10/30/22 to 01/04/23. Open area to right upper back cleanse with saline, pat dry, apply calcium alginate (dressing used for wounds with moderate to heavy drainage) and foam dressing daily dated 01/05/23 to 01/18/23. There were no other orders present for any wound or skin alteration on the resident's back during the listed time frames. Interview on 01/17/23 at 4:55 P.M. with RNC #100 verified the facility was not following CNP #300's recommended treatment of hydrogel and border foam dressing 11/01/22 to 01/03/23. 3. Review of Resident # 55's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included cerebral atherosclerosis, contracture, dementia, pseudobulbar affect, and schizoaffective disorder. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #55's physician orders at the time of the survey included may use barrier cream as needed, may keep at bedside dated 04/11/17; Calmoseptine (barrier cream) to buttock after each incontinence episode dated 05/20/21; Remedy Calazime (barrier cream) skin protectant, apply to wound to left inner thigh three times daily and as needed dated 01/19/22; Cleanse inner left thigh with normal saline, apply silver alginate (moist dressing used for infected chronic wounds) and cover with ABD dated 10/07/22; Pillow between legs to help with contraction dated 10/06/22; Cleanse right posterior thigh with normal saline, pat dry, apply hydrogel and cover with border foam dressing dated 10/12/22. Review of 12/2022 treatment administration record (TAR) for Resident #55 revealed the treatment for the right posterior thigh was cleanse right posterior thigh with normal saline, pat dry, apply hydrogel and cover with a border foam dressing, and apply skin prep to right posterior thigh. Both treatments were on the same order and were to be completed daily with a start date of 10/12/22. Review of Resident #55's 01/2023 TAR revealed the treatment for the right posterior thigh was cleanse right posterior thigh with normal saline, pat dry, apply hydrogel cover with border foam dressing and apply skin prep to right posterior thigh. Both treatments were on the same order and were to be completed daily with a start date of 10/12/22. The treatments were signed off daily as completed except 01/01/23 and 01/17/23 when the resident refused the treatment. Review of CNP #300's wound documentation revealed Resident #55's right posterior thigh wound was assessed weekly and the wound was noted as either stable or improving on all notes. CNP #300's listed the treatment for the right posterior thigh wound on 10/06/22 was cleanse with normal saline and apply skin prep. CNP #300's note from 10/13/22 revealed the treatment recommendation changed to cleanse the area with normal saline, apply hydrogel and cover with border foam dressing and to place pillows between knees for offloading for stage III pressure ulcer. This dressing remained the recommended dressing for the right posterior thigh pressure ulcer until 12/13/22 when the recommended treatment was changed to triad cream to stage III pressure ulcer, complete twice daily, place pillows between knees for offloading for stage III pressure ulcer. CNP #300 documented the right posterior thigh pressure ulcer as healed on 12/20/22 and no treatment recommendation was included in the wound documentation. The facility failed to follow CNP #300's recommendations when the facility treated the right posterior thigh with normal saline, patted dry, applied hydrogel and covered with border foam dressing from 10/12/22 and continued through 01/03/23. Review of the 12/2022 treatment administration record (TAR) for Resident #55 revealed the treatment for the left inner thigh, dated 10/07/22, was cleanse left inner thigh with normal saline, apply silver alginate and cover with ABD, change daily. Review of Resident #55's 01/2023 TAR revealed the treatment for the left inner thigh was cleanse the left inner thigh, apply silver alginate cover with an ABD pad perform daily. The treatment was initialed as completed daily except on 01/01/23 and 01/17/23 where it was documented the resident refused the treatment. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of CNP #300's wound documentation of the left inner thigh wound revealed on 10/06/22 the wound was a new pressure ulcer, called a suspected deep tissue injury with the recommended treatment of cleanse the wound with normal saline, apply silver alginate and cover with an ABD pad. CNP #300 documented the left inner thigh wound as a pressure ulcer, called a suspected deep tissue injury that was either improving or stable, with the recommended treatment of cleanse the wound with normal saline, apply silver alginate and cover with an ABD pad through 12/06/22. The wound note from 12/13/22 changed the recommended treatment to triad cream, place pillows between knees for offloading of contractions. This remained the recommended treatment through 01/03/23. Review of progress note dated 01/10/23 at 11:06 A.M. revealed the resident refused wound care from the nurse and CNP #300. No wound measurements were in the medical record for the wound from 01/03/22 through 01/10/23. Review of weekly nursing evaluation completed on 01/11/23 revealed the resident had no new skin conditions. There was no assessment of the resident's left posterior thigh in the evaluation. Review of the weekly nursing evaluation dated 01/17/23 revealed the form had the resident's vital signs but the rest of the evaluation was blank including the resident's skin evaluation and the additional comment field was also blank. Interview with RNC #100 on 01/18/22 at 9:00 A.M confirmed the facility did not follow the wound treatment recommendations from CNP #300 for Resident #55. Review of policy titled, Skin Management, dated 10/2019, revealed it is the policy of [NAME] Care to assess each resident to determine the risk of potential skin integrity impairment. Residents will have a skin assessment completed upon admission and no less than weekly by the licensed nurse in an effort to assess overall skin condition, skin integrity, and skin impairment. A head to toe assessment will be completed by a licensed nurse upon admission/re-admission and no less weekly. Residents identified at risk for skin breakdown will have appropriate preventative interventions put in place. All alterations in skin integrity will be documented in the medical record. Residents admitted or readmitted with alterations in skin integrity will be documented on admission evaluation. All newly identified areas after admission will be documented on the weekly pressure/non-pressure evaluation. The facility assigned wound nurse will complete further evaluation of the wounds identified and complete the appropriate skin evaluation on the next business day. A plan of care will be initiated to include resident specific risk factors with appropriate interventions. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of policy titled, Wound Care, dated 2001 and revised on 10/2010, revealed staff were to verify that there is a physician's order for this procedure. Review the resident's care plan to assess for any special needs of the resident. The following information should be recorded in the resident's medical record: The type of wound care given; the date and time the wound care was given; the position in which the resident was placed; the name and title of the individual performing the wound care; any change in the resident's condition; all assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound; how the resident tolerated the procedure; any problems or complaints made by the resident related to the procedure; if the resident refused the treatment and the reason(s) why; the signature and title of the person recording the data. This deficiency represents non-compliance investigated under Complaint Number OH00139013 and OH00138817.

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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** 36297 Based on observation, record review, staff interview, and policy review, the facility failed to ensure two (#52 and #58) of three residents reviewed for falls had ordered fall prevention devices in place. The facility census was 102. Findings include: 1. Review of the medical record for Resident #52 revealed an admitted [DATE]. Diagnoses included hemiplegia following cerebral infarction, hypertension, anxiety, depression, dissociate and conversion disorder, undifferentiated somatoform disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 was cognitively intact and had no coded behaviors during the review period. Resident #52 required assistance for bed mobility, dressing, supervision for eating, toileting, and personal hygiene. The resident's care plan had a risk for fall related to hemiplegia, seizure and neuropathy. Interventions included skid strips to floor next to closet dated 12/27/22 and bed dated 07/05/22, and to provide walker to assist with transfers. Review of the resident's record revealed on 12/14/22 at 5:38 P.M. the nurse was called to the resident's room by another resident. On arrival, Resident #52 was sitting on the floor and her head was leaning on her wheelchair seat next to the closet. Resident #52 stated she was putting her clothes in the closet and went to sit down, lost her balance, and fell . The nurse assessed the resident and vitals were taken, neurological checks initiated, and skin assessment completed with no skin issues identified. The resident complains of migraine but denies remembering hitting her head. Review of Situation Background Assessment Recommendation (SBAR) evaluation dated 12/15/22 revealed the resident had a neurological change and was different than herself. The resident was assessed and found that the left side of her face would not move which was a change. The resident was recommended to go to the hospital and resident refused three times. The resident had a focused evaluation on 12/16/22 which described her as having a fall without injury. Interview and observation on 01/12/23 at 11:45 A.M. with Regional Clinical Nurse (RNC) #100 verified Resident #52 had a fall care plan in place with an intervention that the resident would have nonskid strips in front of her closet and bed as fall interventions. Observation of Resident #52's room with RNC #100 revealed there were no nonskid strips in place to assist in preventing Resident #52 from falling. 2. Review of Resident #58's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, bipolar disorder, suicidal ideations and history of traumatic brain injury. (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 most recent quarterly MDS assessment dated [DATE] revealed the resident had mild cognitive impairment, no hallucinations and no behaviors. The resident required limited assist for bed mobility, transfers, locomotion on and off the unit, dressing, toileting, and supervision with eating. A progress note dated 11/26/22 at 6:24 P.M. revealed the resident had fallen and the nurse was called to the hallway as the resident was sitting on the floor next to his room with his wheelchair beside him. The resident had bleeding from his left elbow. The resident stated he was trying to sit on his wheelchair and the footrest tripped him and he fell backwards and hit the wall. Resident #58 was assessed and the Certified Nurse Practitioner (CNP) #300 was notified. The staff documented they provided the resident a smaller wheelchair that he could maneuver, and the resident had an intervention to place colored tape on the foot pedals. Review of Resident #58's care plan revealed the resident was at risk for falls with the intervention of colored tape to the foot pedals as a visual cue to lift the pedals during transfers dated 11/28/22. Observation of Resident #58 on 01/17/22 at 5:15 P.M. revealed the wheelchair had no foot pedals attached to the wheelchair and there were no foot pedals found in the resident's room. Observation of Resident #58 on 01/18/23 at 9:05 A.M. with RNC #100 revealed there were no foot pedals in the resident's room or on the resident's wheelchair. RNC #100 verified the resident's care plan had colored tape to the resident's foot pedals as an intervention to assist the resident in not having falls, but that there were no foot pedals on the wheelchair or in the resident's room. Review of the policy titled, Fall Management, dated 10/2019, revealed a care plan will be developed at time of admission with specific care plan interventions to address each resident's fall risk factors. Post fall, all falls will be discussed by the interdisciplinary team (IDT) at the first IDT meeting after the fall to determine root cause and other possible interventions to prevent future falls. The fall will be reviewed by the team, an IDT note will be written, and the care plan will be reviewed and updated, as necessary. This deficiency represents non-compliance investigated under Complaint Number OH00138817.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on observation, staff interviews, resident interviews, and record review, the facility failed to ensure adequate staffing and timeliness of call light responses. This affected three (#59, 80, and #101) of three residents reviewed for staffing. This had the potential to affect all facility residents. The facility census was 102. Findings include: 1. Review of the medical record for Resident #59 revealed an admitted [DATE]. Diagnoses included sepsis, heart failure, respiratory failure, diverticulitis, depression, encephalopathy, and transient ischemic attack. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 was cognitively intact with a Brief Interview for Mental Status (BIMS) of 15. He required extensive assistance of two staff members for transfers and he was incontinent of bowel and bladder. Review of the plan of care dated 07/29/22 revealed the resident was incontinent with bowel and bladder with interventions including check routinely for incontinence care. Interview on 01/09/23 at 12:13 P.M. with Resident #59 revealed he used the call light to get assistance and it typically took 30 to 60 minutes for staff to come to the room. He revealed he wore incontinence briefs and that he would be left to sit in his urine and feces for hours at times. He revealed he was last changed at 6:00 A.M. and staff had not come in to check on him since. He reported being dry and not needing to be changed during the interview. Observation on 01/12/23 at 11:00 A.M. of Resident #59 with Unit Manager #75 revealed the resident was agreeable to have his incontinence product checked. Upon observation of the resident's incontinence product, it was noted to be saturated with urine. Unit Manager #75 verified the incontinence product the resident was wearing was saturated with urine. Resident #59 stated he last received incontinence care on 01/12/23 at 5:00 A.M. Interview on 01/12/23 at 11:10 A.M. with State Testing Nursing Assistant (STNA) #55 revealed she was the staff assigned to care for Resident #59 on this shift. STNA #55 was observed in another resident's room sitting in a resident's wheelchair and stated she was waiting to assist anther staff member to get the resident ready for an appointment and then she would go to provide care to Resident #59. STNA #55 verified she had not provided any personal care to Resident #59 on this day and verified her shift started at 7:00 A.M. STNA #55 was asked how often incontinence care was provided and she stated twice. She was asked to clarify what she meant and was she saying twice a shift and then STNA #55 stated incontinence care should be provided every two hours or as needed. STNA #55 stated she checked on Resident #59 at the beginning of her shift at 7:00 A.M and he was dry stating the night shift had changed the resident prior to going off shift. STNA #55 then confirmed the present time was after 11:00 A.M. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 01/12/23 at 11:11 A.M. with Unit Manager #75 confirmed STNA #55 was currently assisting to get another resident ready. Unit Manager #75 was questioned if there was enough staff to complete the workload if STNA #55 had not yet provided care to a resident on her assignment and it was 11:00 A.M. and her shift had started at 7:00 A.M. Unit Manager #75 stated there should be four STNA's on the hall and revealed STNA #55 was new to the facility. Observation and interview on 01/17/22 at 9:15 A.M. of Resident #59 revealed the resident's call light was activated and the resident stated he needed to be changed. The resident stated he had last been provided incontinence care on 01/17/22 at approximately 3:00 A.M. The facility Assistant director of Nursing (ADON) #67 entered Resident #59's room on 01/17/22 at 9:35 A.M. The resident's incontinence care product was checked and it was verified by ADON #67 that the incontinence brief was saturated with urine. Interview on 01/17/23 at 9:37 A.M. with STNA #102 confirmed Resident # 59 was on her assignment and she had not provided any care to him yet on this shift. 2. Review of the medical record for the Resident #80 revealed an admitted [DATE]. Diagnoses included epileptic syndrome, mild cognitive impairment, heart failure, lymphedema, anxiety, and suicidal ideations. Review of the MDS assessment dated [DATE] revealed Resident #80 was cognitively intact with a BIMS of 15 and required extensive assistance of two staff members for transfers and mobility and personal hygiene. Review of the care plan dated 11/10/22 revealed the resident needed assistance with activities of daily living due to impaired mobility and generalized weakness with interventions including total assist with showering. Interview on 01/12/23 around 9:00 A.M. with Resident #80 revealed she missed getting her showers and wanted to receive a shower prior to an appointment. Interview on 01/12/23 at 9:38 A.M. with Regional Nurse Consultant (RNC) #100 and [NAME] President (VP) of Operations #101 confirmed Resident #80 did not receive her shower before her appointment due to a staff member leaving and the shower aide was pulled to work the floor. Review of shower sheets for Resident #80 revealed documentation the resident had only received or been offered one shower in 10/2022, 11/2022 and 12/2022. 3. Review of the medical record for the Resident #101 revealed an admitted [DATE]. Diagnoses included multiple sclerosis, COVID-19, psychotic disorder with hallucinations, anxiety, dementia without behaviors, lack of coordination, polyneuropathy, major depression, muscle spasm, and muscle weakness. Review of the quarterly MDS assessment dated [DATE] revealed Resident #101 was cognitively intact with a BIMS of 13 and required total dependence of two staff members for mobility and transfers. The resident was incontinent of bowel and bladder. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the plan of care dated 01/13/23 revealed Resident #101 had a self-care deficit with interventions including use of one to two staff for bed mobility, dressing, bathing and eating, and staff were to encourage use of the call lights for assistance. Resident #101 had bowel and bladder incontinence with interventions to clean the resident after each incontinence episode and complete two-hour checks and as required for incontinence. Observation and interview on 01/09/23 at 11:24 A.M. with Resident #101 revealed the resident's call light had been activated. The resident revealed she was requesting staff to get her up and ready for the day and change her incontinence brief, which she preferred to occur around 11:00 A.M. The resident revealed it typically took a long time for call lights to be answered. Observation on 01/09/23 at 11:38 A.M. revealed the call light button for Resident #101 had an audible alert to the nurses' station that was actively alarming. Observation on 01/09/22 at 11:52 A.M. revealed STNA #51 brought in a food tray to Resident #101. The call light was not addressed or deactivated at that time. Observation on 01/09/23 at 12:16 P.M. revealed Resident #101's call light was addressed after over 50 minutes of being activated. Interview on 01/09/23 at 12:20 P.M. with STNA #51 revealed the call light was addressed, but STNA #51 was unable to explain reasoning for the delay. Observation on 01/10/23 at 1:12 P.M. revealed Resident #101's call light was activated. The call light remained active until 1:31 P.M. when Corporate staff tracked down and informed the assigned aide to respond and provide care. Interview on 01/12/23 at 11:15 A.M. with the Administrator revealed the previous scheduler had been removed from the position and she had been trying to complete the schedule in the meantime. The Administrator revealed recent issues with scheduling due to changing the software and some errors and management staff had to fill in due to errors with scheduling. The Administrator revealed the facility had adequate staffing for each shift and revealed they scheduled two nurses and four aides on each floor for day shift and night shift and revealed staff worked 12-hour shifts. Review of facility policy titled, Staffing, dated 10/2017, revealed staffing numbers and skills required for staff should be determined by the needs of the residents based on plan of care. Review of the undated facility policy titled, [NAME] Call Light Policy, revealed the facility should be adequately equipped to ensure call light response. Residents will be educated on using the call light to call for help. All staff members who see or hear an activated call light are responsible for responding to the call light. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident Council meeting minutes for 10/26/22, 11/23/22, and 12/28/22 were reviewed. In 10/2022 residents brought up concerns related to the facility being short handed and staff not rounding for routine care. In 11/2022 residents brought up concerns related to call light delays, more frequent checks and changes for incontinence, facility being short staffed and residents waiting so long for care that they contact 911. In 12/2022 residents brought up concerns related to call lights not being answered timely. The concern forms only stated that staff were educated but the facility had no evidence of monitoring, audits or additional actions being taken to address resident concerns. This deficiency represents non-compliance investigated under Complaint Number OH00139596 and OH00138760.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 44070 Based on staff interview and record review, facility failed ensure an individual working as a nurse aide did not work over four months without completing a competency evaluation program approved by the State. This affected one (#71) four nurse aides reviewed for nurse aide training. This had potential to affect all residents. The facility census was 102. Findings include: Review of the Nurse Aide Training Competency Certificate for Non-Certified Aide #71 revealed the training was completed on 03/08/21. Interview on 01/17/22 at 1:39 P.M. with Non-Certified Aide #71 revealed she took the nurse aide training course almost two years ago and took the State tested Nursing Assistant (STNA) test in the Spring of 2021 and did not pass the test. She revealed she started working at a sister facility in town and also was giving COVID-19 tests and working for a home health agency over the previous two years. She revealed she did not have the STNA test scheduled but needed to look into it as she is due soon. Interview on 01/17/22 at 5:30 P.M with Administrator and Regional Nurse Consultant (RNC) #100 revealed the facility's corporate human resources staff informed them the requirement allowed staff to work as nurse aides up to four months at each facility, so if she moved from one job to another she would qualify and be eligible for employment. The facility was unable to provide a policy related to the hiring of non-certified aides. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36297 Based on observation, record review, facility staff interview, and policy review, the facility failed to have a medication error rate below five percent. This affected two (#81 and #91) of three residents observed for medication pass. The facility census was 102. Findings include: Medication pass on 01/10/22 from 8:57 A.M. to 9:44 A.M. by Licensed Practical Nurse #75 and #82, who provided medications to Resident #81, #80 and #91, was observed. 1. Review of Resident #81's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, Alper's disease, bipolar disorder, and anxiety, Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #81 was cognitively intact, had delusions, behaviors directed toward others, and wandering one to three days of the review period. Resident #81 requires supervision for all activities of daily living including bathing which is coded as set up help only. The resident is always continent of bowel and bladder. The resident received seven days of antipsychotic medication during the review period. Observation of LPN #75 providing medications to Resident #81 revealed the LPN provided the resident Iron 325 milligrams (mg). Review of Resident #81's medical record revealed the resident had an order for Iron 324 mg to be administered. Interview with LPN #75 on 01/10/22 at approximately 11:00 A.M.verified she provided Resident #81 Iron 325 mg and not the ordered Iron 324 mg. 2. Review of Resident #91's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included paraplegia, chronic respiratory failure, type two diabetes, vascular dementia, and hypertension. Review of the annual MDS assessment dated [DATE] revealed the resident Resident #91 was mildly cognitively impaired. Resident #91 had no delusions, hallucinations or behaviors. The resident requires extensive assist for hygiene, transfers, bed mobility, toileting, dressing and supervision with eating. Observation of LPN #82 providing medications to Resident #91 on 01/10/23 at 9:44 A.M. revealed the nurse did not have access to the Aspirin (non steroidal anti inflammatory) 81 mg the resident was ordered. LPN #82 looked for the medication in the medication room, but there was no Aspirin 81 mg available. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #82 requested for Assistant Director of Nursing (ADON) #67 to get her Aspirin 89 mg for Resident #91, ADON #67 said you mean Aspirin 81 mg and LPN #82 stated yes. At approximately 10:11 A.M. ADON #67 was observed to hand LPN #82 a medication cup containing orange, powdery-looking pills and stated the pills were Aspirin 81 mg. The medication cup was not labled and LPN #82 did not verify what medication was in the medication cup provided to her by ADON #67 other than to take ADON #67's word that the medication was Aspirin 81 mg. LPN #82 was observed to remove one of the orange, powdery-looking pills from the medication cup and place it in the medication cup with the other medications for Resident #91. LPN #82 provided the medications to Resident #91. Review of Resident # 91's medical record revealed the resident was ordered Aspirin 81 mg enteric coated daily on 05/11/17. In an interview with LPN #82 on 01/10/23 at approximately 10:15 A.M. she was asked how she knew what medication was in the medication cup provided to her by ADON #67. LPN #82 stated I know what Aspirin looks like and I trust ADON #67. LPN #82 verified the medication was not identified and the medication cup was placed in the top of the medication cart. LPN #82 stated ADON #67 must have gotten the medication off another cart instead of getting an entire bottle from central supply. Interview with ADON #67 on 01/10/23 at 1:39 P.M. verified she provided LPN #82 with Aspirin 81 mg chewable tablets for the nurse to provide to Resident #91, and not an enteric coated Aspirin 81 mg that was ordered for the resident. During medication pass observation resident medications were available for use for the residents. There were 32 opportunities observed with two errors for a medication error rate of 6.25% Review of policy titled, Administering Medications, dated 2021 with a revision on 04/19, revealed medications are administered in accordance with prescriber orders, including any required time frame. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 36297 Based on observation, and facility staff interview, the facility failed to store medication correctly. This had the potential to affect 22 residents (#82, #83, #84, #85, #86, #87, #88, #89, #90, #91, #92, #93, #94, #95, #96, #97 #98, #99, #100, #101, and #102) who reside on the left side of the 300 hall. The facility census was 102. Findings include: Observation of medication pass on 01/10/22 revealed LPN #82 did not correctly store medication on her medication cart. The LPN was providing medications for the residents who lived on the left side of the 300 hall. Observation of LPN # 82 providing medications to Resident #91 on 01/10/23 at 9:44 A.M. revealed the nurse did not have access to the Aspirin (non steroidal anti inflammatory) 81 mg the resident was ordered. LPN #82 requested for Assistant Director of Nursing (ADON) #67 to get her Aspirin 89 mg for Resident #91 on 01/10/23 at approximately 9:55 A.M. ADON #67 said you mean Aspirin 81 mg and LPN #82 stated yes. At approximately 10:11 A.M on 01/10/23 ADON #67 was observed to hand LPN #82 a clear plastic 30 cubic centimeters (cc) medication cup with several orange, powdery-looking pills in the cup and stated the pills were Aspirin 81 mg. The cup was unlabeled and LPN #82 did not verify what medication was in the medication cup provided to her by ADON #67 other than to take ADON #67 word that the medication was Aspirin 81 mg. LPN #82 was observed to remove one of the orange, powdery-looking pills from the medication cup and place it in the medication cup with the other medications for Resident #91. LPN #82 provided the medications to Resident #91. On 01/10/23 at approximately 10:15 A.M. LPN #82 was interviewed and asked how she knew what medication was in the medication cup provided to her by ADON #67. LPN #82 stated I know what Aspirin looks like and I trust ADON #67. LPN #82 verified the medication was not identified and the medication cup was placed in the top of the medication cart. LPN #82 stated ADON #67 must have gotten the medication off another cart instead of getting an entire bottle from central supply. Interview with ADON #67 on 01/10/23 at 1:39 P.M. verified she provided LPN #82 multiple pills in a clear plastic cup and that ADON #67 stated they were Aspirin 81 mg chewable pills. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident with transportation to and from laboratory services outside of the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36297 Based on record review, observation, and facility staff interview, the faciity failed to provide transport for one (#59) of four residents reviewed for transportation. The facility census was 102. Findings include: Review of the medical record for the Resident #59 revealed an admitted [DATE]. Diagnoses included sepsis, heart failure, respiratory failure, diverticulitis, depression, encephalopathy, and transient ischemic attack. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 was cognitively intact and required extensive assistance for toileting, bed mobility and transfers. The resident was coded as always incontinent of bowel and bladder. The resident had one stage III pressure ulcer ((full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed) and two unstageable pressure ulcers (the base of the ulcer is covered by a thick layer of other tissue and pus that may be yellow, grey, green, brown, or black and therefore the stage could not be determined). Review of Resident #59's medical record revealed Resident #59 had appointment on 01/17/23 with an outside eye doctor and needed to arrive at 2:30 P.M. for a 2:45 P.M. appointment . A progress note dated 01/17/23 at 3:45 P.M. revealed Resident #59's eye appointment was rescheduled for 03/20/23. The note was silent as to why the appointment had to be rescheduled. During an interview with Resident #59 on 01/17/23 at 9:05 A.M. the resident revealed he did not go to the eye appointment on the prior day due to a facility transportation issue. During an interview with Transportation Aide (TA) #64 on 01/18/23 at approximately 9:30 A.M. he was asked if he knew why Resident #59 did not go to his appointment on 01/17/23. TA #64 responded that he did not know. Interview with Regional Nurse Consultant (RNC) #100 and Assistant Director of Nursing (ADON) #67 on 01/18/23 at 11:45 A.M. confirmed Resident #59 did not go to the appointment. ADON #67 thought it had to do with a transportation issue with the facility. Interview with the Administrator on 01/18/23 at 12:06 P.M. revealed there was confusion with TA #64. The Administrator stated he was new to his role and thought Resident #59 was a resident who drove himself to appointments. The Administrator verified the nursing staff had communicated to TA #64 that Resident #59 had an appointment, but the transport driver thought the resident drove himself to appointments so he did not plan to take the resident to the appointment. When TA #64 realized the resident did need transport he was not able to arrange the transport in the time frame needed. The Administrator stated the appointment was rescheduled, but it was pointed out that the appointment was now scheduled for 03/20/23, two months from now. The Administrator stated the facility was trying to find a sooner date for the resident to go to the appointment. (continued on next page)

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled, Special Needs, dated 10/2022, revealed the facility would assist residents in making appointments and arranging transportation and would communicate relevant information with outside providers to ensure safe continuous care with the residents. This deficiency represents non-compliance investigated under Complaint Number OH00138760.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on observation, resident interview, staff interview and record review, the facility failed to provide an accurate therapeutic diet as ordered by the physician. This affected one (#59) of three residents reviewed for nutrition. The facility identified 15 residents (#5, #6, #11, #15, #25, #35, #41, #45, #50, #51, #55, #59, #76, #83, #87) on mechanically altered diets. The facility census was 102. Finding include: Review of the medical record for the Resident #59 revealed an admitted [DATE]. Diagnoses included sepsis, heart failure, respiratory failure, diverticulitis, depression, encephalopathy, and transient ischemic attack. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 was cognitively intact with a Brief Interview for Mental Status (BIMS) of 15 and required extensive assistance of two staff members for transfers. The MDS revealed the resident had greater than a 5% weight loss that was unplanned and the resident had a therapeutic diet ordered. Review of the plan of care dated 07/29/22 revealed Resident #59 was non-compliant with dietary recommendations and will have family bring in food in forms not recommended by speech with interventions to administer medications as ordered, listen to resident needs and adjust as appropriate. The resident was at risk of oral or dental problems with interventions to provide diet as ordered and provide therapy for adaptive equipment. The resident had the potential for nutritional risk related to weight loss with interventions to document food and fluid intakes, honor food preferences, serve diet as ordered provide supplements and dietician to evaluate for diet changes. Review of physician orders dated 12/19/22 revealed a diet order of regular diet with dysphasia advanced texture with mechanical ground and minced diet with no added salt. Review of dietary notes dated 12/09/22 revealed the resident weighed 144 pounds on 12/08/22 which was a loss of 13 pounds for a significant weight loss percentage of 8.3% from 11/03/22 to 12/08/22. The facility was unable to provide evidence that food intakes were being monitored according to the care plan. Observation on 01/09/23 at 11:30 A.M. revealed Resident #59 received his food tray to his room. Observation and interview on 01/09/22 at 12:10 P.M. with State tested Nursing Assistant (STNA) #55 who was removing Resident #59's tray from his room, revealed Resident #59 had not taken a single bite of food. Observation revealed Resident #59 received a pureed diet and did not appear to take a single bite of food. Interview on 01/09/23 at 12:13 P.M. with Resident #59 revealed he did not like the food at the facility and did not want to eat a pureed diet and did not understand why his food got all mashed up. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/09/23 at 5:35 P.M. with the Director of Nursing confirmed Resident #59 had a diet order for dysphasia advanced with mechanical ground and minced texture and was unsure why the resident was receiving his food in pureed form. Interview on 01/09/23 at 5:47 P.M. with the Dietician #70 revealed Resident #59 should be on dysphasia soft or mechanical soft not pureed texture. Dietician #70 revealed the facility had diets types of regular, dysphasia mechanical and dysphasia pureed. Dietician #70 revealed no knowledge of the resident needing pureed food and revealed the nurses had spoken with her about getting a speech evaluation to give him a more liberalized diet back to regular texture. Review of the undated facility policy titled, Therapeutic Diet, revealed the facility should have a physician order for a resident's diet in accordance with the resident's preferences. Diets will be determined based on resident choice, preferences, treatment goals and wishes. The diet order should match the terminology from the kitchen. The dietician should document information related to a resident's response to their therapeutic diet. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 44070 Based on record review and staff interview, facility failed to identify deficiencies through the Quality Assurance Performance Improvement (QAPI) program and monitor for improvement. This had the potential to affect all facility residents. The facility census was 102. Findings include: Review of the QAPI daily huddle book revealed it listed daily medical changes, hospitalization s, falls, resident concerns and complaints similar to resident council meeting minutes. This included notes taken during the daily huddle and interventions such as fall interventions, missed wound treatments or lab draw issues. Interview on 01/17/22 at 5:30 P.M. with the Administrator revealed the facility had no records of QAPI meetings being held since the 2nd quarter of 2022. The Administrator revealed the weekly meeting included issues with care and interventions or fixes for specific issues but did not go over systemic concerns or findings and did not monitor the effectiveness of the interventions. The facility was unable to provide any QAPI documentation related to current projects or quarterly meeting minutes. The facility was unable to provide a policy or procedure guide related to their QAPI/Quality Assessment and Assurance (QAA) program. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 44070 Based on record review and staff interview, the facility failed to ensure Quality Assessment Performance Improvement (QAPI) meetings were scheduled quarterly and attended by at least the minimum staff. This had the potential to affect all facility residents. The facility census was 102. Findings include: Review of the QAPI daily huddle book revealed it listed daily medical changes, hospitalization s, falls, resident concerns and complaints similar to resident council meeting minutes. This included notes taken during the daily huddle. Interview on 01/17/22 at 5:30 P.M. with the Administrator revealed the facility had no records of QAPI meeting minutes for the previous two quarters (third and fourth quarter of 2022). The Administrator revealed she had started since the last QAPI meeting and was unsure why no QAPI meetings had been held in the last six months. The Administrator revealed facility was doing daily QAPI huddles, but revealed the Medical Director was not present for these daily and weekly meetings. The facility was unable to provide any QAPI documentation related to quarterly meeting minutes, attendance logs or list of participants. The facility was unable to provide a policy or procedure guide related to their QAPI/Quality Assessment and Assurance (QAA) program. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36297 Based on the unprecedented global pandemic that resulted in the Presidential declaration of a State of National Emergency dated 03/13/20, Nursing Home Guidance from the Centers for Disease Control (CDC), medical record review, observations, interview with facility staff, and review of facility policy, the facility failed to appropriately implement the use of Personal Protective Equipment (PPE) and isolation procedures to prevent the spread of the SARS-CoV-2 virus (COVID-19) among facility residents. This resulted in Immediate Jeopardy when the facility staff failed to utilize PPE properly when coming into contact with COVID-19 positive residents. Staff members were observed to provide care and services to one COVID-19 positive resident (#101) without donning the appropriate PPE and then proceeded to provide care and services to 17 COVID-19 negative residents (#82, #83, #84, #85, #87, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, and #103) on the 300 hall without changing their N-95 masks or cleansing their eye protection. No isolation bins were placed outside resident rooms and isolation signage from resident room doors had been removed on the 300 hall. The facility also allowed five residents (#45, #70, #80, #87, and #98) who were COVID-19 negative to remain in a room with a COVID-19 positive roommate. Additionally, the facility failed to follow proper isolation precautions for seven residents (#46, #77, #86, #88, #89, #101, and #102) who tested positive for COVID-19 from 12/30/22 to 01/02/23 but were removed from isolation precautions prior to the recommended 10 days of isolation on 01/09/23. This placed 20 residents (#45, #70, #80, #82, #83, #84, #85, #87, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, and #103) at risk for the likelihood of serious harm, negative health outcomes/complications and/or death. The facility census was 102. On 01/11/23 at 5:28 P.M., the Administrator and Regional Nurse Consultant (RNC) #100 were notified Immediate Jeopardy began on 12/28/22 when Resident #98 who was COVID-19 negative was allowed to cohort in the same room as Resident #97 who tested positive for COVID-19 on 12/28/22. The facility allowed an additional four residents (#80, #70, #87, and #45) who tested negative for COVID-19 to cohort in the same rooms as four residents (#81, #69, #86, and #46) who tested positive for COVID-19 between 12/29/22 to 01/04/23. On 01/09/23 staff members were observed to provide care and services to one COVID-19 positive resident (#101) without donning the appropriate PPE and then proceeded to provide care and services to 17 COVID-19 negative residents (#82, #83, #84, #85, #87, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, and #103) on the 300 hall without changing their N-95 masks or cleansing their eye protection. No isolation bins were placed outside resident rooms and isolation signage from resident room doors had been removed on the 300 hall. The Immediate Jeopardy was removed on 01/12/22, when the facility implemented the following corrective actions: On 01/09/23, Resident #87 was moved from room [ROOM NUMBER]B to room [ROOM NUMBER]B. On 01/10/23, Resident #45 was moved from room [ROOM NUMBER]A to room [ROOM NUMBER]B. On 01/10/23, Residents #45, #70, #80, #87, #98 tested negative for COVID-19. On 01/11/23, The Director of Nursing (DON)/designee assessed Residents #45, #70, #80, #87, #98 for signs and symptoms of COVID-19. No concerns/issues were noted. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 01/11/23, the DON/designee tested all residents that have not been COVID-19 positive in the last 30 days for COVID-19. All residents were negative. On 01/11/23, the DON/designee, audited all COVID-19 positive residents to ensure isolation bins were placed outside of each COVID-19 positive room and stocked with appropriate personal protective equipment and ensured COVID-19 signage was on the door of each COVID-19 positive room. On 01/11/23, the facility's policies and procedures for Infection Control related to COVID-19 were reviewed. No revisions were made. On 01/11/23, The DON/designee started Infection Control Education related to COVID-19 including: Cohorting COVID-19 Residents, wearing appropriate PPE in COVID-19 positive rooms, what residents are COVID-19 positive, and how to identify what residents are in isolation for being COVID-19 positive. Staff members are not permitted to work a shift until education had been completed (Leave of Absence LOA's, vacations, illness, etc.). The education will be completed by 01/13/23. Starting 01/12/23, the DON/designee will audit daily for one week, two times/week for three weeks and then weekly for four weeks to ensure that staff are wearing appropriate PPE in COVID-19 positive rooms, isolation bins are outside of each COVID-19 positive room, correct COVID-19 signage is posted on the door or beside the door (as visual aid for staff), and to ensure that no COVID -19 negative resident is cohorting in a room with a COVID-19 positive resident. Results of the Audits will be forwarded to the Quality Assurance and Performance Improvement (QAPI) committee for review. Although the Immediate Jeopardy was removed on 01/12/23, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective actions and monitoring to ensure on-going compliance. Findings include: During interviews on 01/09/23 with State tested Nursing Assistants (STNA's) #51 and #53 between 11:00 A. M. and 11:55 A.M. revealed the facility had no current residents in COVID-19 isolation. On 01/09/23 from 11:00 A.M. to 11:55 A.M., Licensed Practical Nurse (LPN) #75 was observed to remove isolation signage from resident room doors on the third floor. On 01/09/23 at 11:52 A.M., STNA #51 was observed to bring a food tray into Resident #101's room. STNA #51 was wearing an N-95 mask upon entering but did not put on eye protection, gown or gloves before entering the resident's room and did not change her mask after exiting the room. Interview with the Administrator on 01/09/23 at 6:00 P.M. revealed the facility was still in COVID-19 outbreak status as there were seven residents (#46, #77, #86, #88, #89, #101, and #102) who had not completed their COVID-19 isolation and should remain in isolation. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation on 01/10/23 at approximately 9:30 A.M. revealed LPN #82 and STNA #104 responded to Resident #101's call light. The staff stopped at the isolation bin outside the door and put on gowns and gloves in addition to the N-95 mask and eye protection the staff were already wearing. The staff was observed to read the signage on the door that stated the resident was in droplet precautions. Staff entered the resident room and were observed to provide the resident with her morning medications. When staff left the room, they discarded their gowns and gloves in the trash can at the head of the resident's bed, walked across the room to the sink and washed their hands. The two staff exited the resident's room and shut the resident's door. The staff did not remove or change their N-95 mask and did not disinfect or replace their eye protection. In an interview on 01/10/23 at 9:35 A.M., LPN #82 verified the staff discarded their gowns and gloves in the trash can which was located at the head of Resident #101's bed and walked across the room to complete hand hygiene. LPN #82 also verified eye protection was not removed or disinfected when she exited Resident #101's room. LPN #82 stated she wore the same N-95 for her entire shift unless it was too soiled to continue to wear. LPN #82 verified she had COVID-19 positive residents on her assignment and COVID-19 negative residents on her assignment. LPN #82 was caring for five residents (#86, #88, #89, #101 and #102) who were COVID-19 positive and in isolation, in addition to 17 residents (#82, #83, #84, #85, #87, #90, #91, #92, #93, #94, #95, #96, #97, #98, #99, #100, and #103) who were COVID-19 negative. Review of the facility list of active COVID-19 positive residents as of 01/10/23 revealed seven residents (#46, #77, #86, #88, #89, #101, and #102) tested positive for COVID-19 from 12/30/22 to 01/02/23 and were removed from COVID-19 isolation on morning of 01/09/23. Review of the facility policy titled, COVID-19 Resident Policy, dated 03/20 and updated 10/22, revealed all current residents will have daily temperature monitoring. Residents will be monitored for potential symptoms of COVID-19. When residents are suspected or confirmed with COVID-19, the Charge Nurse will immediately move the resident to a private room, or a private location while waiting for a private room. Ideally the room should be as far away from other resident rooms and common areas (i.e., room at end of hall near emergency exit) and resident should have dedicated bathroom or bedside commode. If no private rooms are available, move resident as far away from others as possible, at a minimum of 6 feet, with privacy curtains pulled. Only residents with the same respiratory pathogen may be cohorted in the same room, a resident with COVID-19 should not be cohorted in the same room as a resident with an undiagnosed respiratory infection. Every shift monitoring of temperature and respiratory symptoms. The resident will be placed on Droplet Precautions. The door should remain closed at all times unless contraindicated for safety reasons. An isolation cart must remain outside of the room or in a donning and doffing area. Follow the proper procedure when removing personal protective equipment: Remove gloves, face shield/goggles, and gown, prior to leaving the patient's room ensuring not to touch any part of equipment that may have been contaminated. After leaving the room, and closing the door, remove mask carefully by using the straps and avoid touching the outside of the respirator or mask. Wash hands with soap and water after removing personal protective equipment; if hands are not visibly soiled an alcohol-based hand sanitizer may be used. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Long term care facility residents with COVID-19 should remain on standard contact and droplet precaution for 10 days after symptoms first appeared or positive test results (unless severe illness and then 20 days must have passed). Must be 24 hours after resolution of fever, without use of fever reducing medication, and improvement in symptoms. Review of the online Centers for Disease Control (CDC) COVID-19 guidance titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 09/23/22 revealed the recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection described below (e.g., patient placement, recommended PPE) also apply to patients with symptoms of COVID-19 (even before results of diagnostic testing) and asymptomatic patients who have met the criteria for empiric Transmission-Based Precautions based on close contact with someone with SARS-CoV-2 infection. However, these patients should NOT be cohorted with patients with confirmed SARS-CoV-2 infection unless they are confirmed to have SARS-CoV-2 infection through testing. Place a patient with suspected or confirmed SARS-CoV-2 infection in a single-person room. The door should be kept closed (if safe to do so). Ideally, the patient should have a dedicated bathroom. If cohorting, only patients with the same respiratory pathogen should be housed in the same room. Healthcare personnel (HCP) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a National Institute for Occupational Safety & Health (NIOSH) approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). Five COVID-19 positive residents (#46, #69, #81, #86 and #97) were in dual occupancy rooms with roommates (#45, #70, #80, #87, and #98) who were tested and COVID-19 negative but continued to cohort with their COVID-19 positive roommate. Review of Resident #45's medical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included but were not limited to chronic obstructive pulmonary disease, diabetes type two, and vascular dementia. Resident #45's medical record lacked evidence that the resident was having his temperature taken daily and to him being observed daily for signs and symptoms of COVID-19. The medical record also did not have documented evidence of the resident or responsible party being notified of the facility COVID-19 outbreak and that the resident was cohorting with a COVID-19 positive roommate. Review of Resident #70's medical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included but were not limited to malignant prostate cancer with metastases to the bone. Resident #70 was admitted to hospice services on 08/26/22 for his terminal cancer diagnosis. Resident #70's medical record lacked evidence that the resident was having his temperature taken daily and to him being observed daily for signs and symptoms of COVID-19. The medical record also did not have documented evidence of the family being notified of the facility having a COVID-19 outbreak and that the resident was cohorting with a COVID-19 positive roommate. Review of Resident #80's medical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included but were not limited to heart failure, obstructive sleep apnea, and history of pulmonary embolism. Resident #80's medical record lacked evidence that the resident was having her temperature taken daily and to her being observed daily for signs and symptoms of COVID-19. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365754	A. Building B. Wing	01/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Columbus LLC	44 S Souder Ave Columbus, OH 43222

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #87's medical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included but were not limited to multiple sclerosis, generalized weakness, epilepsy, hypertension, and type two diabetes. Resident #87's medical record lacked evidence the resident was having her temperature taken daily and to her being observed daily for signs and symptoms of COVID-19. Resident #87 had a guardian over her care. The medical record also did not have documented evidence of the guardian being notified of the facility having a COVID-19 outbreak and that the resident was cohorting with a COVID-19 positive roommate. Review of Resident #98's medical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included but were not limited to Vitamin D deficiency, type two diabetes and intellectual disabilities. Resident #98's medical record lacked evidence that the resident was having her temperature taken daily and to her being observed daily for signs and symptoms of COVID-19. Resident #98 had a guardian over her care. The medical record also lacked documented evidence of the guardian being notified of the facility having a COVID-19 outbreak and that the resident was cohorting with a COVID-19 positive roommate. Interview with the Director of Nursing (DON) on 01/10/23 at 12:30 P.M. revealed Resident #80 remained in her room when the roommate, Resident #81 tested positive for COVID-19 on 12/29/22. The DON stated Resident #80 was educated but refused to move rooms. Review of Resident #80's care plan revealed on 01/05/23 the resident was at risk for COVID-19 and educated to move rooms and the resident declined, stating she did not care. The education was documented as being provided six days after the roommate tested positive for COVID-19. Interview with RNC #100 on 01/10/23 at 4:04 P.M. confirmed COVID-19 isolation was not implemented correctly at the facility and the family and guardians were not notified of the COVID-19 outbreak. RNC #100 verified residents in isolation should have isolation signage on their door, the resident room should have isolation trash bins near the resident room door, staff should be changing their N-95 mask when they exit a COVID-19 positive room, and staff should either replace their eye protection or disinfect the eye protection they wore into the COVID-19 positive room. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365754	A. Building B. Wing	01/30/2023

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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 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Report COVID19 data to residents and families. 36297 Based on observation, record review, and faciliy staff interview, the facility failed to ensure residents, their responsible parties, physicians and the health department were notified of COVID-19 positive cases in the facility. The facility census was 102. Findings include: Review of facility COVID-19 positive resident documentation revealed the facility had 21 residents (#28, #46, #58, #59, #69, #72, #73, #74, #75, #76, #77, #81, #86, #88, #89, #99, #100, and #101) who tested positive for COVID-19 on the following dates 12/28/22, 12/29/22, 12/30/22, 12/31/22, 01/02/23 and 01/04/23. The facility did not have documentation of responsible party notification of the COVID-19 positive cases in the facility and that the facility was in outbreak status. Interview with Regional Nurse Consultant (RNC) #100 on 01/11/23 at 11:30 A.M. verified the facility did not notify the health department, residents, their responsible parties, or physicians of the COVID-19 positive cases in the facility. Review of the facility policy titled, COVID-19 Resident Policy, dated 03/20 revised on 10/22, revealed the Department of Health should be notified (if required) of residents symptomatic with fever and respiratory illness and otherwise no known COVID-19 contact, a cluster (e.g., 3 residents or HCP with new-onset respiratory symptoms over 72 hours) of residents or HCP with symptoms of respiratory infections. This deficiency is based on incidental findings discovered during the course of this complaint investigation.